ILWU WAREHOUSE WELFARE FUND

Summary Plan Description

January 1, 2015

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PLAN ADMINISTRATIVE OFFICE

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FOREWORD

This Summary Plan Description has been prepared to give you basic information concerning the benefits available to you through the ILWU Warehouse Welfare Fund or "Trust". Summarized in this booklet are eligibility requirements which you must satisfy in order to qualify for benefits, the benefit plans available to you, and the procedures for review or appeal of claims. The booklet also provides information about the administration of the Trust and your rights under the law.

The benefits outlined in this booklet are available to you and your eligible Dependents (as outlined in the Eligibility section), provided you are working or have worked under the jurisdiction of a Collective Bargaining Agreement between your Employer and Warehouse Union Local 6, ILWU that provides for participation in this Trust, or your coverage is provided pursuant to a Subscription Agreement between your Employer and the Trust. EVERY COLLECTIVE BARGAINING AGREEMENT DOES NOT PROVIDE FOR ALL BENEFITS OFFERED BY THE TRUST. IF YOU HAVE ANY SPECIFIC QUESTIONS CONCERNING EITHER YOUR BENEFITS OR YOUR ELIGIBILITY, PLEASE CONTACT THE PLAN ADMINISTRATIVE OFFICE.

The insert in the back of this booklet contains a general summary of benefits available through the Health Maintenance Organizations (HMOs) and other healthcare providers. A general summary of benefits for vision, prepaid dental, life and accidental death and dismemberment, and chiropractic and acupuncture coverage are also included in the insert in the back of this booklet. A detailed description of the provisions of these plans are described in separate booklets (Evidence of Coverage) and are available, free of charge, from the Plan Administrative Office. A description of the dental PPO benefits and the Teamsters' Assistance Program (TAP) is contained in this booklet.

This booklet is being given general distribution to be certain everyone who is entitled to receive a copy does so. Because of this, you may receive a Summary Plan Description booklet whether or not you are currently eligible for benefits.

Various coverages summarized in this booklet are provided by the Trust in accordance with the terms of the policies and agreements issued by the various healthcare providers. You are cautioned that no Employer or Union, nor any representative of any Employer or Union, is authorized to interpret the various insurance policies, agreements, or the coverages provided by these documents, nor can any such person act as an agent of the Trustees in any matter relating to these contracts, agreements, or coverages. Only the full Board of Trustees is authorized to interpret the Trust.

Accordingly, any questions you may have pertaining to your participation in the ILWU Warehouse Welfare Fund summarized in this booklet should be directed to the Plan Administrative Office, and are subject to final interpretations by the Trustees. Any questions regarding the specific benefits summarized in this booklet should be directed to the Plan Administrative Office.

REMEMBER, this booklet is only a summary of the plans available. If there is a conflict between this summary and any specific policy of insurance or Evidences of Coverage, the provisions of those documents govern. The specific polices of insurance or Evidences of Coverage may be obtained free of charge from the Plan Administrative Office.

The Board of Trustees intends to continue your health plan as long as sufficient Trust assets are available. However, the Board of Trustees reserves the sole right to change all or any of the plans from time to time, to discontinue all or any of the plans from time to time in the sole and absolute discretion of the Board of Trustees.

The Board of Trustees is given the right and authority to construe or interpret any of the terms or provisions of the Plan or Trust Agreement and any such construction or interpretation shall be binding on all persons to the fullest extent of the law.

RELATIONSHIP BETWEEN THE TRUST AND HEALTH CARE PROVIDERS

No health care Provider is an agent or representative of the Trust. The Trust does not control or direct the provision of healthcare services and/or supplies to Employees and beneficiaries by anyone. The Trust makes no representation or guarantee of any kind concerning the skills or competency of any healthcare Provider. The Trust makes no representation or guarantee of any kind that any Provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all healthcare Providers and all entities (and their agents, Employees, and representatives) which contract with the Trust to offer other health-related services or supplies to participants and beneficiaries.

ELIGIBILITY

Employees

Initial Eligibility

If you are an employee of a participating employer on the date your employer begins participation in the ILWU Warehouse Welfare Fund, you will become eligible for benefits on the first day of the month immediately following a month in which you work eighty (80) hours of paid employment for an Employer who is required by the **"Collective Bargaining Agreement"** to contribute to the Trust and your Employer timely makes the required contribution to the Trust on your behalf.

If you are hired after your Employer has begun participation in the Trust, you will become eligible for benefits subject to the terms of your Collective Bargaining Agreement and rules of the Trust, provided that your Employer makes the required contributions to the Trust in a timely manner on your behalf. In general, an employee will become eligible for benefits on the first day of the month following the third month in any six consecutive months during which he or she works eighty (80) hours of paid employment for an Employer who is required by the Collective Bargaining Agreement to contribute to the Trust. Your Collective Bargaining Agreement may however include a different requirement for gaining initial eligibility for benefits in the Trust.

Exceptions

If you have been eligible for benefits under another "collective bargaining agreement" between the Union and your Employer within the last twelve (12) months or prior to the expiration of your seniority period, you will become eligible for benefits on the first day of the month immediately following a month in which you work the hours required under the Collective Bargaining Agreement and your employer makes the required contribution to the Trust on your behalf.

Enrollment for Benefits

When you are hired, you will be furnished with an enrollment package so you can indicate your choice of medical and dental plans (see pages 19 and 20 of this booklet concerning "Choice of Medical Plans" and "Choice of Dental Plans"). When you select the medical plan you want for yourself and your family, you must also complete the appropriate HMO enrollment form, which is supplied by your Employer or the Plan Administrative Office.

You cannot be properly enrolled for benefits until the Plan Administrative Office receives the necessary applications and forms. Therefore, if your Employer fails to provide you with the enrollment package, you should ask for it. If your Employer cannot provide the enrollment package, contact the Plan Administrative Office immediately. Coverage may be denied if the Trust enrollment application and appropriate HMO enrollment form are not received by the Plan Administrative Office within thirty (30) days from the date you become eligible.

Continuing Eligibility

After you establish Initial Eligibility, you remain eligible as long as you continue working the hours required under the Collective Bargaining Agreement each calendar month, or complete the required combined hours in a calendar month under the Trust and the IEDA Welfare Trust Fund.

Eligibility is terminated on the first day of the month following the month in which:

1) You fail to complete the required hours of paid employment in a calendar month for Employer(s) who contribute to the Trust or combined hours under the Trust and the IEDA Welfare Trust Fund;

2) Your entitlement, if any, to extended eligibility due to disability, layoff or lockout has expired; or

3) Your employer fails to make the required contributions on your behalf.

Military Leave of Absence

If you are on a military leave of absence from your employment, and the period of military leave is less than thirty-one (31) days, you will continue to be eligible for coverage under the Trust during the thirty-one (31) day leave with no self-payment required, provided you are in an eligible status under this Trust at the time your military leave begins. Your last employer will be responsible for the contributions required for this coverage.

If you are on a military leave of absence from your employment, and the period of military leave is longer than thirty-one (31) days, your rights to continue health coverage are set forth below in the Section entitled "Continuation of Coverage Under Federal Law (COBRA)."

Upon release from active service, your eligibility may be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") described on pages 17 and 18 of this Summary Plan Description.

Extension of Eligibility Due to Disability, Layoff or Lockout

Due to Disability

If you are an eligible Employee who has established seniority with your Employer in accordance with the Collective Bargaining Agreement, and you are unable to work because of disability, your eligibility may be continued during your disability at the expense of your Employer (if provided by your collective bargaining agreement), but not for more than twelve (12) months from the occurrence of the disability.

Your Employer has the right to require a doctor's certificate or other reasonable proof of your disability.

NOTE: Employees whose eligibility is continued under a period of disability may lose their eligibility for such continued coverage if a layoff occurs, which would have affected them had they been Actively at Work. If, at the time of recall from such layoff, an Employee is still disabled as the result of the same occurrence, he or she becomes eligible for the remainder of any unused continued eligibility.

Due to Layoff

If you are an eligible Employee and have established two (2) or more years of seniority with your Employer and you are laid off, your eligibility (excluding life and accidental death and dismemberment benefits) may be continued by the Plan during your layoff, up to a maximum of four (4) months. *You can defer the extended coverage but only up to twelve (12) months, provided you were receiving alternate coverage (i.e. spouse's plan) during your layoff and such alternate coverage terminates. You must provide proof to the Plan Administrative Office that the alternate coverage was terminated.* Only four (4) months of extended coverage will be granted in any twelve (12) month period. Extended coverage due to layoff will be provided only to Employees whose Collective Bargaining Agreements provide for this coverage. **Y*ou must contact the Plan Administrative Office in order to apply for this extension.***

Due to Lockout

If you are an eligible Employee and have established two (2) or more years of seniority with your Employer and your Employer has established a lockout of some or all of its unionized Employees, you will be eligible for extended coverage. For purposes of this paragraph, a lockout is established if either a) the bargaining unit to which you belong is locked out, or b) another bargaining unit is locked out and you refuse to work due to such lockout. If this lockout provision applies to you, your eligibility (excluding life and accidental death and dismemberment benefits) will be continued up to a maximum of one (1) month. Only one (1) month of extended coverage will be granted in any twelve (12) month period. ***You must contact the Plan Administrative Office in order to apply for this extension.***

If you have any questions concerning an extension of eligibility due to disability, layoff or lockout, you should call or write to the Plan Administrative Office.

Dependents

Initial Eligibility

Once an Employee qualifies for eligibility (Initial and Continuing Eligibility), eligible Dependents are also entitled to the benefits provided by the Trust, as long as the Employee remains eligible. Eligible Dependents will be covered under the same medical, prescription drug, vision, and dental programs selected by the eligible Employee. There are no life or accidental death and dismemberment benefits for Dependents.

All eligible Dependents must be enrolled, including newly-acquired Dependents (and newborn children). Services and reimbursement can be delayed, or denied to Dependents who are not properly enrolled. You may obtain the necessary forms to enroll newly-acquired Dependents from your Employer or the Plan Administrative Office. Coverage may be denied if the necessary forms are not received by the Plan Administrative Office within thirty (30) days from the date your dependent becomes eligible.

In addition, if you declined to enroll your dependent(s) when you become eligible to enroll in the plan because of other health insurance of group health plan coverage, you may be able to enroll your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your dependent's other coverage). However, you must request enrollment within thirty (30) days after your dependents other coverage ends (or after the employer stops contributing toward the other coverage.) ***To request special enrollment or obtain more information, please contact the Plan Administrative Office***.

Eligible Dependents are your: (1) legal spouse; (2) domestic partner meeting the requirements listed below; and (3) dependent children under age 26, including adopted children, and stepchildren. If you enroll a new Dependent within thirty (30) days of marriage, registration of domestic partnership, birth, and placement of adoption, coverage for your new Dependent will be effective retroactively, back to the date of marriage, registration of domestic partnership, birth or placement.

You and your domestic partner must provide the Plan Administrative Office a signed, notarized Declaration of Domestic Partnership certifying that (a) neither partner has had a different domestic partner or spouse less than six months before they signed the Declaration of Domestic Partnership (unless you had a partner who died); (b) neither partner is related to the other; (c) you and your domestic partner have assumed mutual obligations for the welfare and support of each other; and (d) you and your domestic partner live together. If you and your domestic partner are living in a California city or county providing for such registration, and have registered as domestic partners with a California city or county or the State of California, you can provide the Plan Administrative Office with a copy of the Certificate of Domestic Partnership instead of the Declaration of Domestic Partnership.

If your domestic partner does not qualify as a dependent under Internal Revenue Code Section 152, the benefits provided to your domestic partner are taxed. The value of the imputed income resulting from the domestic partner benefits will be reported to your Employer for inclusion on your W-2 Form unless your domestic partner qualifies as a dependent under the Internal Revenue Code. To prove the dependent status of your domestic partner for tax purposes, submit a copy of your personal income tax return annually to the Plan Administrative Office. Notwithstanding the foregoing, effective January 1, 2002, for California State tax purposes only, the value of medical coverage provided to your domestic partner will NOT be imputed to you as gross income if certain requirements are met. In order to take advantage of this law, the domestic partnership must be established in accordance with the provisions of California Family Code Section 297. If you think this may apply to you, please contact the Plan Administrative Office for a copy of California Family Code Section 297.

An unmarried dependent child over age 26, who is incapable of supporting him/herself because of mental or physical handicap which began prior to age 26, will continue to qualify as an eligible Dependent as long as the child remains disabled, unmarried, and is dependent on the Employee or Employee's spouse or domestic partner for support and maintenance. Proof of such incapacity and dependency must be furnished to the Plan and/or Provider(s) upon request. Disabilities that occur after your child is no longer eligible are not covered.

Termination of Dependent Eligibility

Dependent Eligibility will terminate on the last day of the month in which:

1) The Employee ceases to be eligible.

2) The Dependent, as defined by the Trust, no longer qualifies as an eligible Dependent.

3) Your spouse or registered domestic partner enters into full-time military, naval, or air service.

4) In the event of a divorce, your spouse's eligibility will terminate when the final decree is issued.

5) Your Domestic Partner eligibility will terminate when you provide a Statement of Termination of Domestic Partnership, which can be obtained by contacting the Plan Administrative Office.

However, when the Dependent's eligibility terminates, the Dependent (other than a domestic partner and any children of a domestic partner) may have the right to elect COBRA coverage under the Trust. Although domestic partners and children of domestic partners are not entitled to COBRA coverage under federal law, they will be eligible for continued coverage through the Trust provided they meet the COBRA requirements. See page 14 for more information about COBRA requirements and rights.

Retirees

Initial Eligibility

You will be eligible to participate on a voluntary basis in a Retiree Plan for medical, prescription drug, dental, chiropractic and vision coverage only (no TAP benefits and life and AD&D benefits) under this Trust if:

1) You earn at least five (5) years of active service with a Contributing Employer, or have been actively employed for at least five (5) years pursuant to a Collective Bargaining Agreement between your employer and the Warehouse Union Local 6, ILWU; and

2) You are retired from the industry as an officer or collectively bargained Employee of the Warehouse Union Local 6, ILWU and are at least 60 years of age, or are currently receiving a disability pension benefit from Social Security, or receiving a pension benefit from the industry. A pension benefit from the industry is defined as:

    a) A pension pursuant to a Collective Bargaining Agreement between your employer and Warehouse Union Local 6, ILWU ; or

    b) A pension from the Distributors Association Warehousemen's Pension Trust; and

3) You have earned at least twelve (12) consecutive months of service with a Contributing Employer, or have been employed for at least (12) consecutive months pursuant to a Collective Bargaining Agreement between your Employer and the Warehouse Union Local 6, ILWU, immediately prior to your benefit effective date; and

4) You are not eligible under any group health care plan, except if you are eligible under the Distributors Association Pensioners Hospital and Medical Trust; and

5) You do not return to work in the industry in a position covered by a Collective Bargaining Agreement between an Employer and Warehouse Union Local 6, ILWU; and

6) You do not return to work for an employer in the industry who is not signatory to a Collective Bargaining Agreement with Warehouse Union Local 6, ILWU; and

7) You have at least twelve (12) consecutive months of healthcare coverage immediately prior to your benefit effective date, unless you are on a non-permanent disability leave and no longer have healthcare coverage through your employer and enroll within three months after losing healthcare coverage through your employer.

Termination of Retiree Coverage

Retiree coverage will terminate upon the earliest of the following dates:

1) The date the Trust terminates; or

2) The date of expiration of the period for which you fail to make the required self payment to the Trust; or

3) The first day of the month following the date you elect to dis-enroll from the Trust; or

4) The date of your death; or

5) The date the Trust no longer offers Retiree coverage; or

6) The date you return to work in a position covered by a Collective Bargaining Agreement between an Employer and Warehouse Union Local 6, ILWU, or for an employer in the industry who is not signatory to a Collective Bargaining Agreement with Warehouse Union Local 6, ILWU; or

7) The date you enroll in a Medicare Part D prescription drug plan.

You are required to self pay 100% of the full cost of coverage. The self payment rates are subject to change in the sole and absolute discretion of the Board of Trustees. If you decide to dis-enroll from the Retiree Plan, or fail to make the required self payment to the Trust, or enroll in a Medicare Part D prescription drug plan, you cannot reinstate your eligibility for coverage under this Retiree Plan. You can reinstate Retiree eligibility if you dis-enroll from the Retiree Plan to return to work, provided during this time you are receiving employer sponsored health coverage through your or spouse's employer and can re-qualify for coverage upon retirement by satisfying the initial eligibility rules noted above. You can also dis-enroll from optional dental coverage and still maintain medical plan coverage under this Retiree Plan provided you continue to make the required self-payment, however you will not be able to reinstate your eligibility for dental coverage.

Enrollment

You must have a current enrollment form on file. You must also report any changes in your address or Dependents to the Plan Administrative Office. If you are an eligible Retiree from a non-Contributing Employer, or a Retiree from the Distributors Association Pensioners Hospital and Medical Trust who chooses to enroll in this Trust, you will be required to complete an enrollment form and follow the Trust's enrollment procedures (see section entitled "Choice of Medical Plans"). Your primary coverage will consist of medical, prescription drug, vision and chiropractic coverage. These benefits cannot be selected individually. Dental coverage is optional and requires an additional contribution in the form of a higher self-payment rate (see section entitled "Choice of Dental Plans").

If you choose to decline Retiree coverage when you initially become eligible, you may delay enrollment for yourself and your eligible Dependents under the following circumstances:

1. If you are not yet eligible for Medicare when you first retire, you may delay enrollment in the Retiree Plan when you become eligible for Medicare; or

2. If you acquire a new spouse or a new Dependent, as defined by the Trust, you may enroll yourself and your Dependent(s) in the Retiree Plan no later than sixty (60) days after the date you acquire the new Dependent(s); or

3. If on the date you initially became eligible for coverage under the Retiree Plan you were covered under other health insurance coverage (including, for example, coverage provided through your spouse, such as COBRA continuation coverage, individual insurance or Medicare) and that coverage terminates, you may enroll yourself and your Dependent(s) in the Retiree Plan no later than sixty (60) days after the termination date of other health insurance coverage.

4. If you acquire a new spouse or new Dependent and you request enrollment as described above, coverage will be effective retroactively, back to the date you acquired the new dependent. Otherwise, coverage will begin on the first day of the calendar month beginning after the date the Plan receives the request for special enrollment.

No gap in coverage is allowed between your coverage under active employment, or as a Retiree under the Distributors Association Pensioners Hospital and Medical Trust, and your eligibility for coverage as a Retiree under this Trust, except for the circumstances noted above. Your Dependents must be enrolled under the same HMO plan in which you are currently covered. If you are age 65 or otherwise eligible for Medicare (receiving a disability pension benefit from Social Security), you will be required to assign Medicare Parts A and B to the HMO plan in order to receive coverage. The prescription drug benefits offered by the HMOs are better than the standard Medicare Part D prescription drug plans. If, however, you elect to enroll in a Medicare Part D plan, you will lose all of your coverage under this Retiree Plan. Once enrolled, you will be allowed the option to change your HMO plan one time within a twelve (12) month period.

Dependents of Retirees

Dependents, as defined by the Trust, are also eligible for benefits, as long as you, the Retiree, are eligible.

Dependent coverage will terminate upon the earliest of the following dates:

1) The date the Trust terminates; or

2) The date of expiration of the period for which the Retiree fails to make the required self payment to the Trust; or

3) The first day of the month following the date the Retiree is no longer covered under the plan; or

4) The date of the Dependent's death; or

5) The date the Dependent, as defined by the Trust, no longer qualifies as an eligible Dependent; or

6) The date the Trust no longer offers Retiree coverage.

In addition, the surviving spouse and children of a deceased Retiree, who are eligible Dependents at the time of death, will remain eligible for coverage until the earliest of the following dates:

1) Death of the surviving spouse, or remarriage; or

2) The date the child(ren) of the deceased Retiree no longer qualifies as a Dependent(s) as defined by the Trust.

Qualifying Events

The Retiree's non-Medicare spouse or children, as eligible Dependents, may elect continuation coverage for up to a maximum of thirty-six (36) months under COBRA if there is loss of coverage due to:

1) Death of Retiree (Retiree coverage continues for the surviving non-Medicare spouse provided he or she does not remarry); or

2) Divorce or legal separation; or

3) Child(ren) no longer qualifies as a Dependent(s) as defined by the Trust.

Please refer to the section entitled "Continuation of Coverage under Federal Law (COBRA)" for a complete description of the requirements and procedures under COBRA.

Retiree coverage is not guaranteed. The Board of Trustees reserves the right to modify the benefits, change the contribution rates or terminate coverage at any time.

Qualified Medical Child Support Order (QMCSO)

Under the Omnibus Budget Reconciliation Act of 1993, the Trust must recognize any Qualified Medical Child Support Order (QMCSO), and enroll as directed by the Order any child of a Trust participant specified by the Order. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court which:

- Provides the child of a Trust participant with child support or health benefits under the Trust; or

- Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Employee parent does not enroll the child, the non-Employee parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

- The name and last known mailing address of the participant and the name and mailing address of each child covered by the order;

- A reasonable description of the type of coverage to be provided by the Plan to each such child, or the manner in which such type of coverage is to be determined; and

- The period to which such Order applies.

In addition, a properly completed National Medical Support Notice will be deemed to be a Qualified Medical Child Support Order.

Further, a Medical Child Support Order will not qualify if it would require the Trust to provide any type or form of benefit or any option not otherwise provided under the Trust, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Upon receipt of a Medical Child Support Order, the Plan Administrative Office will notify the participant and each child of the receipt of the Order and the Trust's procedures for determining whether the Medical Child Support Order is qualified. Each child will also be notified of his or her right to designate a representative to receive copies of all notices sent to the child with respect to a Medical Child Support Order.

Upon receipt of a Medical Child Support Order, the Plan Administrative Office will review the Order to verify that it meets the standards set forth above. The Plan Administrative Office will make such a determination within a reasonable period, and notify the participant and each child of the determination. If the Order is a qualified Order, the child will be enrolled in the Plan.

Any payment for benefits by the Trust under the Medical Child Support Order to reimburse expenses advanced by the custodial parent or legal guardian shall be made to the custodial parent or legal guardian if so required by the Medical Child Support Order.

NOTE: A Dependent will be eligible for coverage only if his or her full name, date of birth, and relationship to the Employee has been registered with the Plan Administrative Office by filing a Trust change form.

Family and Medical Leave Act (FMLA)

Under the **FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)**, you may be entitled to family or medical leave. If you are eligible and elect to take **FMLA** leave, your coverage under the Trust will continue with no interruption of active employment until the earlier of the end of such leave, or the date you notify your Employer you do not intend to return to work at the end of the **FMLA** leave. Under the law, Employers must grant unpaid leave to an eligible Employee for one or more of the following reasons:

1) To care for the Employee's child after birth, or placement for adoption or foster care;

2) To care for the Employee's spouse, son or daughter, or parent, who has a serious health condition; or

3) For a serious health condition that makes the Employee unable to perform the Employee's job.

Continued active participation in the Trust while on **FMLA** leave will be at your option. Premiums will continue to be paid on your behalf while you are on **FMLA** leave so long as your Employer pays the required contributions to the Trust on your behalf. If you elect not to continue your benefits during the **FMLA** leave, your coverage will be reinstated on your return to active working status on or before the end of the **FMLA** leave.

You must contact your Employer to determine your eligibility for FMLA leave. It is not the role of the Trustees or the Plan Administrative Office to make this determination.

CONTINUATION OF COVERAGE UNDER FEDERAL LAW (COBRA)

If eligibility under the Trust terminates due to one of the following Qualifying Events, Employees and Dependents who were covered by the health care plans on the day before the Qualifying Event have the right to continue health coverage (medical, prescription drug, vision care and dental benefits), under a federal law known as Consolidated Omnibus Budget Reconciliation Act (COBRA):

1) Lay-off or reduced hours of covered employment;

2) Termination of employment due to quit or discharge, for reasons other than gross misconduct;

3) Disability (which results in termination of employment or loss of coverage due to your reduced hours);

4) Leave of absence;

5) Retirement;

6) Death of spouse or parent (in the case of a Dependent);

7) Your divorce or legal separation;

8) Loss of Dependent status of a child; or

9) The Employee's entitlement to Medicare (in the case of a Dependent) if it results in a loss of the Dependent's group health coverage.

Employees and Dependents will be required to pay for the continued health coverage at group rates, which may be higher than the group rates for Employees who are employed under the Collective Bargaining Agreement.

If employment has been reduced or terminated (items 1 through 5 above), you and your Dependents are entitled to eighteen (18) months of continued coverage under the Trust from the date of the Qualifying Event. Each of the other listed events (items 6 through 9) entitles eligible Dependents to thirty-six (36) months of continued coverage (maximum continuation period allowed) from the date of the Qualifying Event. If the Dependent has continued coverage because of the Employee's termination or reduction in hours (items 1 through 5 above), the Dependent may extend coverage from eighteen(18) months (29 if disabled as described below) up to a maximum of thirty-six (36) months if a second Qualifying Event (items 6 through 9) occurs during the first 18 (or 29) month coverage period.

If you, the Employee, become entitled to Medicare (even if that event is not a Qualifying Event), the maximum period of coverage for your Dependents for such event, or for any subsequent Qualifying Event is the 36-month period beginning on the date the Employee becomes entitled to Medicare.

Although domestic partners are not entitled to COBRA coverage under federal law, they will be eligible for continued coverage through the Trust provided they meet the COBRA requirements. Please contact the Plan Administrative Office for more information regarding continued coverage for a domestic partner.

Extended Continuation Coverage for Disabled Individuals

If you are entitled to eighteen (18) months of continuation coverage, and if you are determined to be disabled under the terms of the Social Security Act at any time during the first sixty (60) days of COBRA continuation coverage, you are eligible for up to an additional eleven (11) months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, you must notify the Plan Administrative Office within sixty (60) days after you receive a determination of disability from the Social Security Administration, provided that notice is given before the end of the initial eighteen (18) months of continuation coverage. You must also notify the Trust within thirty (30) days of the final Social Security determination indicating you are no longer disabled. During the additional eleven (11) months of continuation coverage, your premium will be approximately 50% higher than it was during the first eighteen (18) months. However, if you, the disabled individual, do not elect COBRA coverage, the cost for electing Dependents will not be more than was permitted to be charged in the first eighteen (18) months of continuation coverage

Cost of COBRA Continuation Coverage

As previously mentioned, the coverage required by law is available **only at your own expense**. If you or your Dependent(s) elect to continue coverage, the full cost, plus an administrative charge, if applicable, will be charged.

Life and Accidental Death and Dismemberment Benefits are not included under the COBRA Continuation of Coverage law. Dental coverage need not be continued; however, dental coverage must be either continued at an additional cost along with the Trust's other health care coverage (medical, prescription drug and vision benefits), or rejected.

Election of COBRA Continuation Coverage

You or your Dependents must elect to continue coverage within sixty (60) days following receipt of a COBRA notice and election form from the Plan Administrative Office advising of COBRA continuation of coverage, or within sixty (60) days following the date Employee or Dependent coverage would terminate, whichever is later.

If the Qualifying Event is divorce or legal separation from the Employee or a child's loss of Dependent status, the Employee or Dependent must notify the Plan Administrative Office within sixty (60) days after the later of the date of the applicable Qualifying Event or the date coverage under the group health plan would otherwise end. Group health coverage would otherwise end as of the date of the Qualifying Event unless COBRA continuation coverage is elected.

The initial premium, which must include premiums due from the date your eligibility would have terminated, must be paid to the Plan Administrative Office within forty-five (45) days following submission of the COBRA election form.

You or your Dependents are also responsible for sending in payments for required monthly premiums in full and on the premium due date, as established by the Plan Administrative Office. If any premiums are not received within thirty (30) days of the due date, eligibility for the COBRA continuation of coverage will terminate.

COBRA continuation coverage is only available to Employees and/or Dependents who were covered under the health plans on the day before the Qualifying Event, except that a child who is born to or placed for adoption with the covered Employee during the period of COBRA continuation coverage will also be eligible, provided that the covered Employee elects COBRA continuation coverage for himself during the election period and elects coverage for the child within thirty (30) days of the child's birth or placement for adoption.

Coverage Options under the Affordable Care Act

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through Covered California, the State's Health Benefit Exchange ("Exchange"). By enrolling in coverage though the Exchange, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Being eligible for COBRA does not limit your eligibility for a tax credit through the Exchange.

When Can I enroll in Exchange coverage? You always have 60 days from the time you lose your job-based coverage to enroll in the Exchange. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Exchange coverage.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Exchange? If you sign up for COBRA continuation coverage, you can switch to Exchange coverage during the open enrollment period. You can also end your COBRA continuation coverage early and switch to an Exchange plan if you have another qualifying event such as marriage or birth or a child through something called a "special enrollment period." Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Exchange coverage through a special enrollment period, even if the Exchange open enrollment period has ended.

If I choose Exchange coverage, can I switch back to COBRA continuation coverage? If you sign up Exchange coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Other Coverage Options

If you lose group health coverage, you may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Termination of COBRA Continuation of Coverage

Eligibility for COBRA continuation of coverage will terminate on the first day of the month following the occurrence of any one of the events listed below:

1) Failure to remit the required premium payment in full and on time (not later than thirty (30) days following the due date established by the Plan Administrative Office, or no later than forty-five (45) days following submission of the initial COBRA election form).

2) You or your eligible Dependents receive coverage, as an Employee or as a Dependent, under any other group health plan, provided, however, that if the successor group health plan excludes coverage for a pre-existing condition, you may continue COBRA coverage as long as the successor plan's pre-existing condition applies to you (but not beyond the end of the maximum COBRA coverage period as described above).

3) You or your Dependents become entitled to and are receiving Medicare benefits;

4) The date the Trust ceases to provide group health coverage to any Employees.

5) You or your Dependents have continued coverage for additional months due to a disability, and there has been a final determination by social security that you or your Dependents is no longer disabled. (In this case, coverage ends on the first of the month that begins more than thirty (30) days after the Social Security Administration makes a final determination that you or your Dependent are no longer disabled or at the end of the applicable 18 or 36-month maximum coverage period described above, whichever occurs last).

6) You reach the end of your maximum COBRA continuation coverage period as described above.

7) Termination of the Plan.

If you have elected coverage under a region-specific plan (such as a region-specific HMO) and you relocate to an area not covered by that plan, alternative coverage may not be available. If the Trust offers other coverage to Employees that is available in, or can be executed to, your new location, you may elect to receive that coverage (some restrictions apply). However, COBRA continuation coverage will not be provided to you if none of the coverages offered to Employees are available in the area to which you relocate.

NOTE: Once COBRA continuation of coverage terminates, you or your Dependents (if eligible) may have the right to convert health insurance (medical only) to conversion coverage under the "Right to Convert" health insurance provisions provided by one of the health maintenance organizations. You must check the appropriate HMO Evidence of Coverage booklet for details regarding conversion to individual plan coverage.

Rights Under USERRA

This section provides information about your rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Congress enacted USERRA to provide protection to individuals who are Members of the "uniformed services," which is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency. One of the protections provided by USERRA is that Employees covered under a group health plan must be given an opportunity to elect to continue coverage for themselves and/or their dependents if they take leave to serve in the uniformed services (hereinafter "military leave").

The maximum period of continuation coverage for health care under USERRA is the lesser of:

1) A period of twenty-four (24) months (beginning from the date you leave work due to your military leave); or

2) The day after the date you fail to timely apply for or return to a position of employment with an Employer participating in the Trust after your return from military leave.

If you elect continuation coverage, the COBRA and USERRA continuation periods will run concurrently.

Generally, your right to continuation coverage is governed by COBRA, as described above. However, in the event you choose continuation of coverage, you have the some additional rights under USERRA. First, if your military leave is for fewer than thirty-one (31) days, then you will be required to pay your regular employee share, if any, for health coverage. Your last employer will be responsible for the employer share of contributions required for this coverage. Second, if you become covered by another group health plan or entitled to Medicare during the USERRA maximum coverage period described above, the continuation coverage elected by you and your Dependents will not be terminated.

CHOICE OF MEDICAL PLANS

As a new Employee, when you become eligible for coverage for the first time, you must complete a Trust enrollment application and medical provider enrollment form designating the Health Maintenance Organization (HMO) of your choice. These medical plans are described in separate booklets called Evidence of Coverage. It is important that you understand the benefits provided under the medical plans before you make your selection and complete the necessary enrollment forms. The Evidence of Coverage booklets and the HMO Summary of Benefits and Coverage (SBC) can be obtained, free of charge, by contacting the Plan Administrative Office.

It is important you send the completed Trust enrollment application and medical provider enrollment form to the Plan Administrative Office. Your eligible Dependent(s) will be covered under the same medical plan you select for yourself. Services can be delayed or denied unless you have made your selection in writing, and all the required information has been correctly submitted. The Evidence of Coverage booklet for each medical plan contains the insuring provisions, including applicable limitations and exclusions for each medical plan. In addition, the Evidence of Coverage booklet will provide information on how to file a grievance or an appeal in the event of a dispute or problem regarding a medical service. If you have any questions regarding your medical plan coverage, please contact the Plan Administrative Office before incurring any expenses.

We encourage you to contact the Plan Administrative Office to determine the medical plan that applies to you.

See the benefits insert in the back of this booklet for a summary of benefits under these different medical and prescription drug plans.

Health Maintenance Organizations

A health maintenance organization (HMO) offers comprehensive medical care from a group of Providers under contract to the HMO. In an HMO, you must select a Primary Care Physician from among those employed by or under contract to the HMO. However, covered services and supplies are provided by the HMO facilities either at no cost to you or with minimal copayments. Further, there are no claim forms to file.

Except for certain medical emergencies or authorized referrals, you must use physicians or Hospitals affiliated with the HMO. If you do not use physicians or Hospitals authorized by your HMO, neither the Trust nor the HMO will be responsible for the charges you incur.

To enroll in one of the HMO plans, you must live within the service area of the HMO. If you do not reside within any of the HMO service areas, please contact the Plan Administrative Office. You will be instructed as to which medical plan you are entitled.

CHOICE OF DENTAL PLANS

The Trust offers two dental plans for you to choose – a preferred provider network plan and a prepaid managed care plan. You must select one of the dental plans and complete the appropriate dental provider enrollment form. Enrolling in one of these dental plans is similar to enrolling in the medical plans. You must complete the appropriate enrollment form. The enrollment form can be obtained by contacting the Plan Administrative Office.

Dental Benefits

Under the preferred provider network plan or "dental PPO plan", you may visit any licensed dentist you wish. However, you receive maximum benefits available under the plan when you choose network or PPO dental offices. If you decide to use an *out-of-network* or non-PPO dentist, your out-of-pocket costs will increase for most procedures. Covered services are subject to an annual maximum.

With the prepaid managed care plan, you must go to one of the participating dentists in order to receive coverage, however many of the routine services require no copayment. Under the managed care plan, there is no annual maximum for most services.

Dental PPO Plan Benefits

Dental benefits under the dental PPO plan are payable only for the following procedures and are subject to coinsurance and maximums. Benefits are also subject to the limitations and exclusions described in this section.

We encourage you to contact the Plan Administrative Office to determine the dental plan that applies to you.

Benefits	**Master Plan**	
	PPO	**Non-PPO**
	Plan will pay	
Diagnostic & preventative benefits	100%	50%
Basic benefits	80%	50%
Crowns, jackets & cast restoration benefits	80%	50%
Prosthodontic benefits	70%	50%
Deductible		
Per patient per calendar year	$25	$25
Maximums		
Per patient per calendar year	$2,000	$2,000
Orthodontics		
Orthodontics benefits	50%	50%
Orthodontic lifetime maximum per patient	$2,000	$2,000

NOTE: You only receive the maximum benefits available under the plan when you choose a PPO dental office. A directory of PPO dentists can be obtained free of charge by contacting the Plan Administrative Office.

Benefits	**Alternate Plan**

	PPO	Non-PPO
	Plan will pay	
Diagnostic & preventative benefits	80%	50%
Basic benefits	80%	50%
Crowns, jackets & cast restoration benefits	50%	50%
Prosthodontic benefits	50%	50%
Deductible		
Per patient per calendar year	$25	$25
Maximums		
Per patient per calendar year	$1,500	$1,500
Orthodontics		
Orthodontics benefits	50%	50%
Orthodontic lifetime maximum per patient	$1,500	$1,500

NOTE: You only receive the maximum benefits available under the plan when you choose a PPO dental office. A directory of PPO dentists can be obtained free of charge by contacting the Plan Administrative Office.

Dental PPO Plan – Exclusions and Limitations

Exclusions

The following expenses for dental services and supplies are not covered:

1) Expenses for house or hospital calls and hospitalization costs (e.g. facility-use fees).

2) Expenses that are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Provider's benefits would be in excess to the third-party benefits and therefore, the Provider would have right of recovery for any benefits paid in excess.

3) Prescription and non-prescription drugs, vitamins or dietary supplements.

4) Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the schedule of benefits.

5) Procedure which are cosmetic in nature as determined by the Provider (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

6) Elective procedures (e.g. the prophylactic extraction of third molars).

7) Congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

8) Dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered.

9) Diagnostic services and treatment of jaw joint problems by any method unless specifically covered. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

10) Treatment of fractures and dislocations of the jaw.

11) Treatment of malignancies or neoplasms.

12) Services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

13) Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

14) Preventive restorations.

15) Periodontal splinting of teeth by any method.

16) Duplicate dentures, prosthetic devices or any other duplicative device.

17) Procedures for which in the absence of insurance the Member would incur no charge.

18) Procedures for plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

19) Any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

20) Treatment and appliances for bruxism (e.g. night grinding of teeth).

21) Any claims submitted to the Provider by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

22) Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).

23) Procedures that are (a) part of a service but are reported as separate services or (b) reported in a treatment sequence that is not appropriate or (c) misreported or that represent a procedure other than the one reported.

24) Specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).

25) Fees for broken appointments.

26) Procedures which are not dentally necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Provider will apply.

Limitations

The following limitations apply to dental services and supplies:

1) Full mouth x-rays – one (1) every five (5) year(s).

2) Bitewing x-rays – one (1) set per six (6) months under age fourteen (14) and one (1) set per twelve (12) months age fourteen (14) and older.

3) Oral Evaluations: Comprehensive and periodic – two (2) of these services per twelve (12) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s). Limited problem focused and consultations – one (1) of these services per dentist per patient per twelve (12) months. Detailed problem focused – one (1) per dentist per patient per twelve (12) months per eligible diagnosis.

4) Prophylaxis – two (2) per twelve (12) months. One (1) additional for Members under the care of a medical professional during pregnancy.

5) Fluoride treatment – two (2) per twelve (12) months under age nineteen (19).

6) Space maintainers – one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

7) Sealants – one (1) per tooth per three (3) year(s) under age sixteen (16) on permanent first and second molars.

8) Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fourteen (14).

9) Periodontal Services:

   a) Full mouth debridement – one (1) per lifetime.

   b) Periodontal maintenance following active periodontal therapy – two (2) per twelve (12) months in addition to routine prophylaxis.

   c) Periodontal scaling and root planing – one (1) per twenty-four (24) months per area of the mouth.

d) Surgical periodontal procedures – one (1) per twenty-four (24) months per area of the mouth.

e) Guided tissue regeneration – one (1) per tooth per lifetime.

10) Replacement of restorative services only when they are not, and cannot be made, serviceable:

a) Basic restorations – not within twelve (12) months of previous placement.

b) Single crowns, inlays, onlays – not within five (5) year(s) of previous placement.

c) Buildups and post and cores – not within five (5) year(s) of previous placement.

d) Replacement of natural tooth/teeth in an arch – not within five (5) year(s) of a fixed partial denture, full denture or partial removable denture.

11) Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) year(s) thereafter.

12) Pulpal therapy – one (1) per eligible tooth per lifetime. Eligible teeth limited to primary anterior teeth under age six (6) and primary posterior molars under age twelve (12).

13) Root canal retreatment – one (1) per tooth per lifetime.

14) Recementation – one (1) per twelve (12) months. Recementation during the first twelve (12) months following insertion of the crown or bridge by the same dentist is included in the crown or bridge benefit.

15) An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.

16) Payment for orthodontic services shall cease at the end of the month that you or your Dependent loses eligibility for coverage.

17) Intraoral Films: Occlusal – two (2) per twenty-four (24) months.

Some exclusions and limitations may be waived depending on the Member's medical condition. Only American Dental Association procedure codes are covered.

Managed Care Dental Plan

Please see the benefits insert in the back of this booklet for a summary of benefits offered under the prepaid managed care dental plan. The Plan Administrative Office can provide you with the Evidence of Coverage booklet, which contains the insuring provisions, including applicable limitations and exclusions for the Managed Care Dental Plan. In addition, the Evidence of Coverage booklet will provide information on how to file a grievance or an appeal in the event of a dispute or problem regarding a dental service.

We encourage you to contact the Plan Administrative Office to determine the dental plan that applies to you.

CHANGING PLANS / SELF-DIRECTED ENROLLMENT

You have the option to change your medical or dental plan at any time during the year or "self-direct" your enrollment, but only once in any twelve-month period. Changes are effective the first day of the month following the date the Plan Administrative Office receives the appropriate medical provider and/or dental enrollment form. If you do not wish to change your medical or dental plan, you need do nothing.

You must complete the medical provider and/or dental enrollment form indicating the change in coverage, which is supplied by the Plan Administrative Office. Services can be delayed or denied unless you have made your selection in writing, and all the required information has been correctly filled in and submitted to the Plan Administrative Office within thirty (30) days from the date you are eligible to change your medical or dental plan. The Plan Administrative Office can provide you with information regarding the HMO or dental plan available, including brochures or Evidence of Coverage booklets which describe the medical or dental benefits in more detail.

VISION BENEFITS

Employees enrolled for vision coverage have the choice of seeing a network or out-of-network licensed optometrist or ophthalmologist. However, most services are covered in full, less the applicable copayment, when received from a network Provider. If you obtain services from an out-of-network Provider, you will be reimbursed in accordance with the reimbursement schedule less any applicable copayments once the appropriate claim form is submitted. No claim forms are required for services rendered by a network Provider. Please see the insert in the back of this booklet for a general summary of benefits offered by the Trust. The Plan Administrative Office can provide you with the Evidence of Coverage booklet free of charge, which contains the insuring provisions, including applicable limitations and exclusions for the vision plan. In addition, the Evidence of Coverage booklet will provide information on how to file a grievance or an appeal in the event of a dispute or problem regarding a vision related service.

A directory of network doctors can be obtained free of charge by contacting the Plan Administrative Office.

CHIROPRACTIC AND ACUPUNCTURE BENEFITS

The Trust provides chiropractic and acupuncture care to all eligible Employees and Dependents. Covered services must be received from a participating chiropractor and/or acupuncturist. Except in the case of an emergency, chiropractic and/or acupuncture services received from a non-participating provider will not be covered.

Covered services are those within the scope of chiropractic and acupuncture care that are supportive or necessary to help achieve the physical state enjoyed before an Injury or illness. Services are furnished for the diagnosis and/or treatment of a neuro-musculoskeletal condition associated with an Injury or illness, including the following: examinations, manipulations, conjunctive physiotherapy, x-rays, and emergency services. Covered services must be medically necessary and preauthorized by the Provider.

Please see the insert in the back of this booklet for a general summary of benefits offered by the Trust. The Plan Administrative Office can provide you with the Evidence of Coverage booklet free of charge, which contains the insuring provisions, including applicable limitations and exclusions for the chiropractic and acupuncture plan. In addition, the Evidence of Coverage booklet will provide information on how to file a grievance or an appeal in the event of a dispute or problem regarding a chiropractic or acupuncture related service.

LIFE AND ACCIDENTAL AND DISMEMBERMENT BENEFITS

To be eligible for life and accidental death and dismemberment benefits, you must meet all of the Trust's eligibility requirements set forth on page 4, AND YOU MUST be on your Employer's active payroll with unbroken seniority, in accordance with the Collective Bargaining Agreement.

NOTE: Your Employer may provide life and accidental death and dismemberment benefits equal to or greater than that provided through the Trust, in which case your coverage will be provided directly by the Employer and not through the Trust. Please refer to your Collective Bargaining Agreement to determine whether you are eligible for life and accidental death and dismemberment benefits, and if so, the level of coverage.

Please see the insert in the back of this booklet for a general summary of benefits offered by the Trust. The Plan Administrative Office can provide you with the Evidence of Coverage booklet free of charge, which contains the insuring provisions, including applicable limitations and exclusions for the life and accidental death and dismemberment benefits. In addition, the Evidence of Coverage booklet will provide information on how to file a grievance or an appeal in the event of a dispute or problem regarding a claim.

TEAMSTERS' ASSISTANCE PROGRAM (TAP)

Substance (Alcohol and/or Drug) Abuse Benefit

The Trust has retained the Teamster's Assistance Program (TAP) to manage the alcohol and substance abuse benefit to eligible Employees and their eligible Dependents.

The TAP counselor may recommend treatment consisting of Detoxification (where appropriate), Inpatient treatment, outpatient care or a combination of the above. The TAP counselor will refer treatment through your HMO. Follow-up services, aftercare meetings and fellowship activities are also available through TAP.

Eligibility

Employees and Dependents become eligible for the Teamsters' Assistance Program when BOTH of the following conditions are satisfied:

1) You are eligible under the Trust as outlined in the Employee and Dependent Eligibility sections of this booklet (beginning on page 4); and

2) You have been eligible under the Trust for at least three (3) months during the preceding 24-consecutive month period immediately prior to the date treatment commences.

Benefits

Your benefits under TAP are:

- Telephone information and referral – TAP counselors can provide substance abuse and mental health resource information upon request and are available by telephone;

- Face-to-face substance abuse assessment and referral – TAP counselors are available for a face-to-face assessment appointment to help determine whether there is a substance abuse related problem and if necessary, provide referral to the appropriate inpatient treatment facilities available through the HMOs;

- Monitored aftercare – TAP counselors will develop a continuing care plan to support ongoing abstinence and recovery;

LEGISLATION AFFECTING HEALTH CARE BENEFITS

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for you or your newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal and state law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay that is less than forty-eight (48) hours (or 96 hours).

In addition, under California law, if the attending Provider, after consulting with the mother, discharges the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours), the group health plan must cover a post-discharge visit for the mother and newborn within forty-eight (48) hours of discharge when prescribed by the treating physician. The visit shall be provided by a licensed health care Provider whose practice includes postpartum care and newborn care and shall include at a minimum, parent education, assistance and training in bottle feeding and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall determine, after consulting with the mother, whether the post-discharge visit shall occur at home, the Plan's facility or the treating physician's office after assessment of certain factors including the transportation needs of the family and environmental and social risks.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 requires that if your health plan provides medical and surgical benefits for a mastectomy, and if you were to need a mastectomy, you would also be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery/reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and/or
- Treatment of the physical complications of the mastectomy that may arise, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the attending physician and the patient. If you would like more information on mastectomy benefits, please contact the Plan Administrative Office at (800) 543-9117.

Health Insurance and Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

The Trust maintains privacy practices regarding your protected health information, which explains the possible uses and disclosures of this information by the Trust.

Your Rights

You have the right to:

- Get a copy of your health and claims records;
- Correct your health and claims records;
- Request confidential communication;
- Ask us to limit the information we share;
- Get a list of those with whom we've shared your information;
- Get a copy of this privacy notice;
- Choose someone to act for you; and
- File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends; and
- Provide disaster relief.

Uses and Disclosures

The Trust may use and share your information in the following circumstances:

- Help manage the health care treatment you receive;
- Run our organization;
- Pay for your health services;
- Administer your health plan;
- Help with public health and safety issues;
- Do research;

- Comply with the law;

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director;

- Address workers' compensation, law enforcement, and other government requests; and

- Respond to lawsuits and legal actions.

Your Rights in More Detail

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- The Trust will provide a copy or a summary of your health and claims records, usually within 30 days of your request. The Trust may charge a reasonable, cost-based fee.

Ask to correct health and claims records

- You can ask the Trust to correct your health and claims records if you think they are incorrect or incomplete. Ask how to do this by contacting the Trust Administration Office.

- The Trust may say "no" to your request, but an explanation in writing within 60 days will be provided to you.

Request confidential communications

- You can ask the Trust to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- The Trust will consider all reasonable requests, and must say "yes" if you tell the Trust you would be in danger if not doing so.

Ask to limit what the Trust uses or shares

- You can ask the Trust not to use or share certain health information for treatment, payment, or our operations.

- The Trust is not required to agree to your request, and the Trust may say "no" if it would affect your care.

Get a list of those with whom information was shared

- You can ask for a list (accounting) of the times the Trust has shared your health information for six years prior to the date you ask, who it was shared with, and why.

- The Trust will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Trust to make). The Trust will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. The Trust will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- The Trust will make sure the person has this authority and can act for you before any action is taken.

File a complaint if you feel your rights are violated

- You can complain if you feel the Trust has violated your rights by contacting the Trust using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- The Trust will not retaliate against you for filing a complaint.

Your Choices in More Detail

For certain health information, you can tell the Trust your choices about what can be shared. If you have a clear preference for how the Trust shares your information in the situations described below, please contact the Plan Administrative Office and describe how you wish to share your information and the Trust will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care;

- Share information in a disaster relief situation.

If you are not able to tell the Trust your preference, for example if you are unconscious, the Trust may go ahead and share your information if it believes it is in your best interest. The Trust may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Trust *never* shares your information unless you give it written permission:

- Marketing purposes;

- Sale of your information;

- Psychotherapy notes.

Uses and Disclosures in More Detail

How does the Trust typically use or share your health information?

The Trust typically uses or shares your health information in the following ways:

- **Help manage the health care treatment you receive -** The Trust can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

- **Run the organization of the Trust–** The Trust can use and disclose your information to operate the Trust and contact you when necessary. The Trust is not allowed to use genetic information to decide whether you will be given coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*

- **Pay for your health services –** The Trust can use and disclose your health information as it pays for your health services. *Example: The Trust shares information about you with your dental plan to coordinate payment for your dental work.*

- **Administer your plan -** The Trust may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with the Trust to provide a health plan, and the Trust provides your company with certain statistics to explain the premiums the Trust charges.*

Other Uses and Disclosures

Any other use or disclosure not described in this Notice will only be made with your authorization.

Revocation of Prior Authorization

You may revoke a prior authorization granted for psychotherapy notes, marketing, sales or any other authorized use and disclosure.

How else can the Trust use or share your health information?

The Trust is allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. The Trust has to meet many conditions in the law before the Trust can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

The Trust can share health information about you for certain situations such as:

- Preventing disease;

- Helping with product recalls;

- Reporting adverse reactions to medications;

- Reporting suspected abuse, neglect, or domestic violence; and

- Preventing or reducing a serious threat to anyone's health or safety.

Do research

The Trust can use or share your information for health research.

Comply with the law

The Trust will share information about you if state or federal laws require it, including with the Department of Health and Human Services, to ensure compliance with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

The Trust can share health information about you with organ procurement organizations. The Trust can also share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

The Trust can use or share health information about you:

- For workers' compensation claims;
- For law enforcement purposes or with a law enforcement official;
- With health oversight agencies for activities authorized by law;
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

The Trust can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- The Trust is required by law to maintain the privacy and security of your protected health information.
- The Trust will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Trust must follow the duties and privacy practices described in this notice and give you a copy of it.
- The Trust will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Officer, specified below, at the Plan Administrative Office:

Daniel M. Costa
DMC Insurance Administrators, Inc.
P.O. Box 757
Pleasanton, CA 94566
Phone: (800) 924-1226

Changes to the Terms of this Notice

The Trust can change the terms of this Notice, and the changes will apply to all information the Trust maintains about you. The new Notice will be available upon request by contacting the Plan Administrative Office.

Notice of Medi-Cal Health Insurance Premium Program (HIPP)

If you are eligible for Medi-Cal, you may qualify for the Health Insurance Premium Payment Program (HIPP). Under this program, the California Department of Health Services will pay your COBRA premium for you. To be eligible for this program you must:

- Be Medi-Cal eligible;
- Have a high cost medical condition (e.g. pregnancy, HIV/AIDS, organ transplants);
- Have either a current private health coverage policy or access to health coverage through an employer (includes COBRA and Cal-COBRA, but excludes policies issued through the California Managed Risk Medical Insurance Board (MRMIB). ***Note: The policy must not exclude coverage for the beneficiary's specific high cost medical condition.**
- Not be enrolled in a Medi-Cal managed care plan; and
- Not be enrolled in a county organized health plan.

In addition, if you are unable to work because of disability due to HIV/AIDS you may qualify if you have a total monthly income less than the percentage allowed under the HIPP provisions of the poverty level established by the federal government. To enroll in HIPP or to find out more information about the requirements for enrollment, call **1-866-298-8443**.

California Mental Health Parity Law

The Trust's HMOs cover two different categories of mental health care at different levels: Crisis intervention and serious mental disorders. Crisis intervention is short-term, medically necessary acute treatment for a medical condition you are unable to recover from without assistance. To be covered, there must be a good chance you will get better. Care is provided at the lowest level of care that is consistent with safe medical practice.

California law also requires medical benefit programs to cover the diagnosis and treatments of the following serious mental illnesses and emotional disturbances at the same rates they cover other health care: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorders (autism), anorexia nervosa, bulimia nervosa. Serious mental disorders also include serious emotional disturbances of a child, as indicated by the presence of one or more mental disorders from the Diagnostic and Statistical Manual (DMS) of Mental Health (other than substance abuse or developmental disorders) as a result of the mental disorder, the child must behave inappropriately for his or her age and must also meet one of the following criteria:

- The child has a substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed, or the mental disorder has been present for more than six months and is likely to continue for more than one year without treatment.

- The child is psychotic, suicidal or potentially violent.

- The child meets the special education eligibility requirements under California law.

The medical benefit program will pay for medically necessary services. If you need more information about covered services, call your HMO.

California Citizen's Right to Review Whether a Treatment is Experimental or Investigational for HMO Plans

If coverage for a proposed treatment is denied because it is considered experimental or investigational, you may ask that the denial be reviewed by an external independent review organization that has a contract with the California Department of Managed Health Care. To request the review, contact your HMO. To qualify for this review:

You must have a life threatening or seriously debilitating condition. It must meet one or both of the following descriptions:

- Life threatening – the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.

- Seriously debilitating – causes major irreversible morbidity.

The proposed treatment must be recommended by either:

- A HMO physician; or

- A board certified or board eligible physician qualified to treat you. This physician must certify in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.

If this review is requested either by you or by a qualified Provider who is not affiliated with your HMO, you must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:

- Peer-reviewed scientific studies published in medical journals with nationally recognized standards;

- Medical literature meeting the criteria of the National Institute of Health's National Library for indexing the Index Medicos, Excerpt Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;

- The Medical Journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act;

- The American Hospital Formulary Service-Drug Information, and American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

- Findings, studies or research conducted by or under the auspices of the federal government agencies and nationally recognized federal research institutes; and

- Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within five (5) days of receiving your request for review, the HMO will send the reviewing panel all relevant medical records and documents in their possession as well as any additional information submitted by your physician. Information the HMO receives subsequently will be sent to the review panel within five business days. The external independent review organization will complete its review and render its opinion within thirty (30) days of receiving your request for review (or seven days in the case of an expedited review). This timeframe may be extended up to three (3) days for any delay in receiving the necessary records.

Notice Of Loss Of Grandfathered Status

Under the Affordable Care Act, informally known as the Healthcare Reform Law, the medical plans offered through the Trust are not considered “grandfathered plans”.

Since the medical plans are not considered grandfathered, the medical plans must comply with additional consumer protections under the Affordable Care Act, such as providing preventative care coverage without any cost sharing and providing coverage to eligible children up to age 26, even if the child has separate coverage available through his or her employer. For more information about any of these requirements, please contact your HMO provider directly or the Plan Administrative Office.

CLAIMS APPEAL AND REVIEW PROCEDURES

No Employee, Dependent or other beneficiary shall have any right or claim to benefits under the Trust, except as specified in this Summary Plan Description or Trust Agreement. Any dispute as to eligibility type, amount or duration of benefit under the Trust, or any amendment or modification thereof shall be resolved by the Board of Trustees and/or the designated carrier under and pursuant to the Trust and the Trust Agreement, and its decision of the dispute shall be final and binding upon parties to the dispute. No action for benefits may be brought unless and until the Employee, Dependent or other beneficiary in accordance with the claims appeal and review procedures (1) has submitted a written claim for benefits, (2) has been notified that the application is denied, (3) has filed a written request for a review of the application through all levels of appeals with the Plan Administrative Office as applicable, and (4) has been notified in writing that the Trust has confirmed the denial of the claim.

If you have a claim for a benefit (other than the services under the Teamsters' Assistance Program or dental PPO plan through United Concordia) that does not involve Trust eligibility, you must follow the claims appeal and review procedure set forth in the Evidence of Coverage booklets provided by the various healthcare providers and insurers, as applicable. For details about each organization's claims appeal and review procedures, please refer to that organization's Evidence of Coverage booklet or contact the organization directly. You may obtain any applicable Evidence of Coverage booklet free of charge from the Plan Administrative Office.

If you have a general question as to your eligibility under the Trust, please call the Plan Administrative Office.

The Trustees have complete and sole discretion to interpret the Trust documents and to determine eligibility. Such determinations shall be conclusive and binding on all persons.

Claims Procedures

If you have a claim for a benefit under the Teamsters Assistance Program or TAP (described on page 26) or dental PPO plan under United Concordia (described on page 20), or if your claim involves Trust eligibility, the following claims procedures apply:

1) **Initial Claim for benefits or Trust eligibility.** An initial claim for a benefit must be made (either orally or in writing) to the TAP Executive Director at 300 Pendleton Way, Oakland, CA 94621-2101, telephone number (800) 253-8326, or to the United Concordia claims administrator at 21700 Oxnard Street, Suite 500, Woodland Hills, CA 91367. An initial claim for Trust eligibility must be made with the Plan Administrative Office whose address and phone number is on page 1.

2) **If your claim for benefits or Trust eligibility is denied** in whole or in part, the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office will notify you in writing. The notice will explain in detail the reasons for denial with specific reference to the Trust provisions upon which the denial is based, a description of any information or material necessary to perfect the claim and an explanation of the right to appeal. The notice will also include any other information required by 29 C.F.R. 2560.503-1.

The time for which a TAP or dental PPO plan benefit or Trust eligibility determination will be made is based on the type of claim. There are four types of claims, defined as follows:

1) Urgent care claim: a claim for medical care or treatment where the application of the time periods for making non-urgent care determinations; (a) could seriously jeopardize your life or health or your ability to regain maximum function, or (b) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2) Pre-service claim: a claim for health benefits that the plan will not approve unless you obtain plan authorization before obtaining the medical care that is the subject of the claim.

3) Post-service claim: a claim for health benefits that is not a pre-service claim or an urgent care claim.

4) Concurrent care claim: a claim regarding an on-going course of treatment that was previously approved for a specific period of time or number of treatments.

Urgent Care Claims

If you failed to follow the proper claims procedures when you filed your urgent care claim, you will be notified of the improper filing and how to correct it within twenty-four (24) hours after the claim was received by the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office.

If you filed a proper and complete urgent care claim, you will receive notice of the benefit determination within seventy-two (72) hours after it was received by the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office. Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent care claim that is not complete, you will be notified with twenty-four (24) hours after the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office received the claim stating the information that is necessary to complete the claim. You will have forty-eight (48) hours to provide the additional information. You will be notified of the decision within forty-eight (48) hours of receiving the additional information or within twenty-four (24) hours after your deadline to provide the additional information expires, whichever is sooner.

Pre-Service Claims

If you failed to follow the proper claims procedure when you filed your pre-service claim, you will be notified of the improper filing and how to correct it within five (5) days after the claim was received by the TAP Executive Director, United Concordia claims administrator, or the Plan Administrative Office.

If you filed a proper and complete pre-service claim, you will receive notice of the benefit determination within fifteen (15) days after it was received by the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office, unless an extension, up to fifteen (15) days, is necessary due to matters beyond the control of the plan. You will be notified within the initial fifteen (15) day period if an extension is necessary.

If you filed a pre-service claim that is not complete, you will be notified within fifteen (15) days after the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office received the claim stating the information that is necessary to complete the claim. You have forty-five (45) days to provide the additional information. You will be notified of the decision within fifteen (15) days after receiving the additional information or within fifteen (15) days after the 45-day deadline to provide the additional information expires, whichever is sooner.

Post-Service Claims

If you filed a proper and complete post-service claim, you will receive notice of the benefit determination within thirty (30) days after it was received by the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office, unless an extension, up to fifteen (15) days, is necessary due to matters beyond the control of the plan. You will be notified within the initial thirty (30) day period if an extension is necessary.

If you filed a post-service claim that is not complete, you will be notified within thirty (30) days after the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office received the claim stating the information that is necessary to complete the claim. You have forty-five (45) days to provide the additional information. You will be notified of the decision within fifteen (15) days after receiving the additional information or within fifteen (15) days after the 45-day deadline for you to provide the additional information expires, whichever is sooner.

Concurrent Care Claims

If your concurrent care claim is also an urgent care claim, your claim will be decided within 24 hours, provided your claim is made to the TAP Executive Director, United Concordia claims administrator, or Plan Administrative Office at least twenty-four (24) hours prior to the end of the approved treatment. A determination on your request for the extended treatment will be made within twenty-four (24) hours from receipt of request. If your claim for extended treatment is not made at least twenty-four (24) hours prior to the end of the approved treatment, the claim will be treated as an urgent care claim and decided according to the timeframes described above.

If your concurrent care claim is not an urgent care claim, and there is a reduction or termination of the course of treatment (other than by a plan amendment or termination) before the end of the period of time or number of treatments, you will be notified and this will be considered a denial of a claim. The notification will be made sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit. If you decide to appeal, you must follow the appeal provisions described below.

Review Procedures

If your claim for a benefit under TAP, dental PPO plan, or your claim for Trust eligibility is denied, the following review procedures apply:

1) You must file a request for review with the Plan Administrative Office within one hundred and eighty (180) days of your receipt of the denial notice. Failure to file a request within the 180-day period will constitute a waiver of your right to appeal the denial or to take any other action with respect to it, although the Board of Trustees may consider an appeal submitted up to one year from the date of the denial notice provided that good cause is shown for the delay. An appeal shall be in writing and shall state in clear and concise terms the reason or reasons for disputing the denial.

2) You shall be advised of the Trustees' decision in writing within the time periods set forth below. The decision will include a specific reason for the decision with specific references to the pertinent provisions of the Trust on which the decision is based and any other information required by 29 C.F.R. 2560.503-1.

If you file an appeal, you will be provided the opportunity to submit written comments, documents, records, and other information relating to your claim. You will be provided, upon request and free of charge, reasonable access to, and copies of , all documents, records, and other information relevant (that is not privileged or protected) to your claim. As part of the appeal process, the Plan Administrative Office will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial determination.

The review on appeal will not afford deference to the initial determination and will be conducted by an appropriate named fiduciary, which is the Board of Trustees or a sub-committee of the Board of Trustees, who is neither the individual who made the initial determination that is the subject of the appeal, nor the subordinate of that individual. In deciding an appeal of a benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that individual will not be the person who was consulted in connection with the initial determination (or his/her subordinate). Upon request, you will be provided with the identification of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse determination, without regard to whether the advice was relied upon in making the determination.

Urgent Care Claim Appeals

For an urgent care claim, you may request an expedited appeal of the adverse determination and such request may be submitted orally or in writing to the Plan Administrative Office. In addition, the expedited review process will provide that all necessary information shall be transmitted between you and the Plan Administrative Office by telephone, facsimile, or other available similarly expeditious method.

For appeals of an urgent care claim, the appeal will be conducted and you will be notified by the Plan Administrative Office of the decision within seventy-two (72) hours from receipt of a request for appeal of a denied claim.

Pre-Service Claim Appeals

For appeals of a pre-service claim, you will be notified by the Plan Administrative Office of the decision within thirty (30) days from receipt of a request for appeal of a denied claim.

Post-Service Claim Appeals

For appeals of a post-service claim, appeal will be conducted and you will be notified by the Plan Administrative Office of the decision within sixty (60) days from receipt of a request for appeal of a denied claim.

The decision of the Board of Trustees, with respect to a request for reconsideration, shall be final and binding upon all parties, including the claimant and any person claiming through the claimant.

The Trustees have complete and sole discretion to make all factual findings incident to your appeals. The Trustees' decisions are subject to judicial review only for abuse of discretion. For complete claims and appeals procedures of the Trust, please contact the Plan Administrative Office.

DEFINITIONS

Actively at Work means performing every duty of your job in the Contributing Employer's usual place of business.

Board of Trustees means the plan sponsor and fiduciary of this Trust who has exclusive authority and discretion to administer the Plan and to manage the assets of the Trust.

Certificate of Domestic Partnership means a document issued by a city, county or state that certifies the registration of your domestic partnership.

Collective Bargaining Agreement means the collective bargaining agreements between the Employers and Union which provide for contributions to the Trust (contributions to the Trust can also be required under a **Subscription Agreement** for those Employees not covered by a collective bargaining agreement).

Contributing Employer means an Employer who is required to make contributions to the ILWU Warehouse Welfare Fund.

Declaration of Domestic Partnership means the notarized form or affidavit used to declare the establishment of your domestic partnership.

Dependent means those individuals that meet the eligibility requirements specified on pages xxx of the Eligibility section of this booklet.

Detoxification means supervised physical withdrawal from alcohol or drugs.

Employee or Full-time Active Employee means any Employee who is Actively at Work for at least eighty (80) hours per calendar month for Contributing Employer(s).

Evidence of Coverage means the booklet provided by your HMO, vision, dental, chiropractic or life and AD&D Provider describing the terms and benefits of your medical, vision, dental, chiropractic or life and AD&D plan.

Hospital means an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which: 1) provides room and board and nursing care to its patients; 2) has a staff with one or more physicians available at all times; 3) provides 24-hour nursing service; 4) maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of Sickness or Injury; and 5) has organized facilities on its premises for major surgery, or an agreement to provide surgical facilities at other locations. A licensed, state-approved hospice and a birthing home or center that has an obstetrician consultant and certified nurse-midwives on its staff will be considered a Hospital. The term Hospital does not include an Institution, or that part of an Institution, used mainly for: 1) nursing care; 2) rest care; 3) convalescent care; 4) care of the aged; 5) custodial care; or 6) educational care.

Injury means an Injury to the body that is sustained accidentally.

Inpatient means a Member who is confined in a hospital, convalescent or skilled nursing facility or residential treatment facility.

Institution means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to a Member ; such as, a Hospital, convalescent or skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric day treatment facility, alcohol or drug dependency treatment center, alternative birthing center, home health center, hospice, or any other such facility approved by the Provider.

Member means a person who is eligible for benefits under this Trust. Member is also referred to as a **Participant**.

Plan Administrative Office means the Administrative Office of ILWU Warehouse Welfare Fund, located at: P.O. Box 757, Pleasanton, California 94566.

Participating Provider Group means a group of independent physicians under contract with the HMO.

Primary Care Physician means a physician assigned to provide primary care to you and your family. A Primary Care Physician may belong to a Participating Provider Group or employed directly by the HMO.

Provider means the carriers, companies or clinical professionals that provide services to the Trust.

Qualifying Event means an event which qualifies an Employee or Dependent for continuation of benefits coverage under the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, and any amendments thereto.

Retiree means an eligible Retiree specified on page 8 of the Eligibility section of this booklet, who are eligible to participate in the **Retiree Plan**.

Sickness means illness or disease.

Statement of Termination of Domestic Partnership is the form that terminates domestic partner coverage upon receipt by the Plan Administrative Office.

Trust means ILWU Warehouse Welfare Fund (also referred to as the **Plan**).

Trust Agreement is the agreement that establishes the Trust and sets forth the methods for administering the Trust, including the methods of receipt, investment and disbursement of funds under the Trust.

Union means the Warehouse Union Local 6, I.L.W.U.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974

PLAN NAME

ILWU Warehouse Welfare Plan

TRUST SPONSOR:

Board of Trustees
ILWU Warehouse Welfare Fund

NAME AND ADDRESS OF PLAN ADMINISTRATOR:

Board of Trustees, ILWU Warehousemen's Welfare Fund
P.O. Box 757
Pleasanton, CA 94566
(800) 924-1226

TYPE OF ADMINISTRATION:

The Trust is administered by the Board of Trustees with the help of the Plan Administrative Office and staff, consultants, attorneys and accountants, etc.

Some of the benefits are provided through group insurance policies and pre-paid service plans, or organizations, which have agreements with the Trust. The benefits provided through these policies and agreements are governed by the terms of those contracts. Copies of these documents are available for inspection at the Plan Administrative Office. Payments by the Trust are subject to the terms of the Collective Bargaining Agreement and to the availability of funds to the Trust.

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS:

The following third party administrator has been designated by the Trustees as the agent for service of legal process.

Mr. Daniel M. Costa
DMC Insurance Administrators, Inc.
1181 Quarry Lane, Suite 400
Pleasanton, CA 94566

Service may also be made on any Trustee.

INTERNAL REVENUE SERVICE PLAN IDENTIFICATION NUMBER: 94-6102389

PLAN NUMBER: 501

TYPE OF PLAN:

Employee welfare benefit plan, which provides medical, vision, prescription drug, dental, chiropractic, acupuncture, life and accidental death and dismemberment, and alcohol and substance abuse assessment and referral benefits. Please note that not every collective bargaining agreement provides for all benefits offered by the Trust. If you have any questions concerning your benefits or your eligibility, please contact the Plan Administrative Office.

PLAN FISCAL YEAR ENDS: June 30

APPLICABLE COLLECTIVE BARGAINING AGREEMENTS:

The Trust is maintained in accordance with Collective Bargaining Agreements between various Employers and Warehouse Union Local 6, I.L.W.U. The Collective Bargaining Agreements require contributions from the participating Employers to provide the benefits described in this booklet. The basis for contributions by the Employer and the types of benefits to be provided are listed in the Collective Bargaining Agreements. Copies of the Collective Bargaining Agreements are available for inspection at the Plan Administrative Office during regular business hours, and upon written request, will be furnished by mail. You will be charged for the cost of being furnished such a copy. You may also request information as to whether a particular Employer or employee organization is a sponsor of the ILWU Warehouse Welfare Fund, and if an Employer or employee organization is a plan sponsor, the sponsor's address.

All contributions to the Trust are made by individual Employers in compliance with Collective Bargaining Agreements in force with its affiliated Local Union or a recognized Subscription Agreement.

The benefits provided by this Trust, while intended to remain in effect indefinitely, can be provided only as long as the parties to the Collective Bargaining Agreements continue to require contributions to the Trust sufficient to underwrite the cost of the benefits. Should contributions cease and the reserves expended, the Trustees would no longer be obligated to furnish coverage. These are not guaranteed lifetime benefits.

SOURCE OF FINANCING OF THE PLAN AND IDENTITY OF ANY ORGANIZATION THROUGH WHICH BENEFITS ARE PROVIDED:

Benefits are provided from the Trust's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and are held for the purpose of providing benefits to participants and defraying reasonable administrative expenses.

Dental PPO and TAP benefits are paid directly from the Trust and are not insured by any contract of insurance. HMO medical benefits, vision, managed care dental, chiropractic, acupuncture, life and death and dismemberment benefits are provided through carriers and are fully insured or otherwise guaranteed. For more information, see "Insurers and Providers of Service to the Trust" below.

TRUST TERMINATION:

The Board of Trustees may terminate the Trust or amend or eliminate benefits under the Plan pursuant to its authority under the Trust Agreement. In no event will the termination of the Trust result in a reversion of any assets to a participating Employer.

NAMES AND ADDRESSES OF TRUSTEES:

EMPLOYER TRUSTEES

James O. Beard – Chairman
Beard Affiliates
5 Thomas Mellon Circle, Suite 111
San Francisco, CA 94134

Tim Brekke
1181 Quarry Lane, Suite 400
Pleasanton, CA 94566

Tom Dillon
CMTA
1181 Quarry Lane, Suite 400
Pleasanton, CA 94566

UNION TRUSTEES

Larry Morrison -
Secretary
ILWU Local 6
99 Hegenberger Road
Oakland, CA 94621

Jose Nunez
ILWU Local 6
99 Hegenberger Road
Oakland, CA 94621

Corey Tacconi
ILWU Local 6
99 Hegenberger Road
Oakland, CA 94621

***INSURERS AND PROVIDERS OF SERVICE TO THE TRUST*:**

All benefits, with the exception of dental PPO and TAP benefits, are provided through policies underwritten by insurers, and any claims dispute involving the insurer must be handled directly with the insurer. Dental PPO benefits are self-funded and are provided by the Trust. United Concordia administers the payment of dental claims for the dental PPO plan. Alcohol and substance abuse assessment and referral services are provided through a service agreement with TAP. Any claims dispute involving the dental PPO plan or alcohol and substance abuse assessment and referral services must follow the claims appeal and review procedures outlined on pages 35-39. The insurers and Providers of service to the Trust are as follows:

Life and Accidental Death & Dismemberment Benefits

Dearborn National
36788 Eagle Way
Chicago, IL 60678
(800) 778-2281

Hospital, Medical, Surgical, Prescription Drug & Vision Benefits

Kaiser Permanente
Regional Administration, Northern California
1800 Harrison Street, 13th Floor
Oakland, CA 94612
(800) 464-4000
www.kp.org

United Healthcare
5995 Plaza Drive
Cypress, CA 90630
(800) 624-8822
www.uhcwest.com

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195
www.vsp.com

Dental Benefits

United Concordia Companies, Inc.
440 Deer Path Road
Harrisburg, PA 17110
(800) 332-0366
www.unitedconcordia.com

United Healthcare Dental
5995 Plaza Drive
Cypress, CA 90630
(800) 624-8822
www.uhcdental.com

Chiropractic & Acupuncture Benefits

Landmark Healthplan of California, Inc.
1610 Arden Way, Suite 280
Sacramento, CA 95815
(800) 638-4557
www.lhp-ca.com

Alcohol & Substance Abuse Assessment and Referral

Teamsters Assistance Program (TAP)
300 Pendleton Way
Oakland, CA 94621
(510) 562-3600
(800) 253-8326 (outside of SF Bay Area)

STATEMENT OF ERISA RIGHTS

As a participant covered under this Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that all Trust participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrative Office and at Union Local offices all Trust documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Trust with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain upon written request to the Plan Administrative Office, copies of documents governing the operation of the Trust, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrative Office may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

You can reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Fiduciaries

In addition to creating rights for Trust participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Trust's benefits. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in a way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Trust documents or the latest annual report from the Trust and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Trust Administration Office to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrative Office. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Trust's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Trust fiduciaries misuse the Trust's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Trust or your benefits, you should contact the Plan Administrative Office. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administration Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free number to receive complaints: (800) 400-0815. If a Member has a grievance against one of the health care Providers offered by this Trust, the Member should contact that organization and use its grievance process as outlined in its Evidence of Coverage booklet. If a Member requires help with a complaint involving an emergency or with a grievance that has not been satisfactorily resolved by the health care Provider, you may call the Department's toll-free telephone number.