

# **TEAMSTER MULTI-BENEFIT TRUST**

## **HEALTH PLAN**

### **SUMMARY PLAN DESCRIPTION**

**Effective January 1, 2011**



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## **An Important Message to Participants**

We are pleased to welcome you as a participant in the Teamsters Multi-Benefit Trust Health Plan (“Plan”). This booklet, together with the evidence of coverage booklets prepared by each of the providers listed in this booklet describes the benefits available to you as a participant in the Plan and is intended to serve as your Summary Plan Description (“SPD”), required by the Employee Retirement Income Security Act of 1974 (“ERISA”). This SPD includes important information to help you understand and appropriately access your benefits. The information in this booklet is effective January 1, 2010 and supersedes and replaces all information previously provided to you.

There are a number of benefit options referenced in this booklet. You must consult the terms of your Collective Bargaining Agreement to determine which of these benefits is available to you and to your dependents. Your eligibility is determined by the terms of your Collective Bargaining Agreement and the rules of the Teamsters Multi-Benefit Trust (“Trust” or “Trust Fund”).

Depending upon the terms of the Collective Bargaining Agreement between your Employer and your Union, the following benefit programs are provided for you and your eligible Dependents under group insurance contracts entered into by the Trust:

- Medical, Hospital Plan (Attachment # 1)
- Dental Plan (Attachment #2)
- Vision Plan (Attachment #3)
- Member Assistance Program (MAP)/Legal Benefit (Attachment #4)

This booklet should be read in conjunction with the Evidence of Coverage documents which contain full details for each of these coverages provided to you and your Dependents. The terms of these legal documents will control all questions concerning any subject matter covered in this booklet. Please see page 25 for the contact information for each of the organizations providing benefits described in Attachments 1 through 4.

The Trust also provides Death and Accidental Death and Dismemberment Benefits to you and your eligible Dependents. These benefits are self-funded. This means that benefit are paid directly from the assets of the Trust. A description of these benefits is contained in a separate document entitled Teamsters Multi-Benefit Trust Death and Accidental Death Benefit Plan which is included with your enrollment packet. A copy may also be obtained by contacting Benefit Programs Administration at the number listed below.

The Joint Board of Trustees listed at page 3 of this booklet is the Plan Administrator. The Board has contracted with Benefit Programs Administration to perform routine administration for the Plan as a third-party administrator. Benefit Programs Administration is responsible for the operation of the Trust Administrative Office which is sometimes referred to as the Fund or Trust Office. If you have any questions regarding any benefit program or the administration of Plan which are not fully answered by this booklet, and the Evidence of Coverage booklets for each

provider, please contact either Benefit Programs Administration at the address and numbers listed below or the specific provider at the numbers listed on page 25 of this booklet:

Benefit Programs Administration  
1200 Wilshire Blvd., Fifth Floor  
Los Angeles, California 90017-1906  
Telephone: (888) 410-1756 or (562) 463-5040  
Fax. No. (562) 463-5894

Please be aware that the information and answers given over the phone or orally in person are not binding upon the Board of Trustees or, any health or dental insurer and cannot be relied upon in any dispute concerning your benefits.

IT IS IMPORTANT that you inform the Trust Administrative Office promptly of any change in your name or your address, so you can receive timely notice of any Plan changes and other information required by law. If you marry, divorce, legally separate, acquire a new dependent, change a beneficiary, enter military service, terminate employment, or become disabled, or if a Dependent no longer qualifies as a Dependent under the Plan, be sure to contact the Trust Administrative Office to find out how these events may affect your rights or your Dependent's rights to benefits.

The Board of Trustees reserves the right to amend the type of benefits and eligibility rules. From time to time the Board of Trustees may find it necessary to change the provisions of the Plan or Plan providers. If this occurs, you will be advised of any changes. If there are major amendments to the Plan you will receive updated information which should be kept as part of this booklet.

Benefits are not vested. The Trustees have full authority to modify, limit or terminate health coverage at any time as they deem appropriate. Plan benefits shall be provided only so long as sufficient assets are available.

*Board of Trustees*

**Summary Plan Description**  
**General Information About the Plan**

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ADMINISTRATIVE OFFICE  
TEAMSTERS MULTI-BENEFIT PLAN  
Benefit Programs Administration  
1200 Wilshire Blvd., Fifth Floor  
Los Angeles, California 90017-1906  
Telephone: (888) 410-1756 or (562) 463-5040  
Fax. No. (562) 463-5894

Office Hours: Monday through Friday, excluding holidays  
8:00 a.m. to 5:00 p.m.

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BOARD OF TRUSTEES

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Rick Middleton, Chairman  
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Elizabeth Sanchez  
Tom Secret

### **Notice Regarding the Plan's Grandfathered Status**

The Multi-Benefit Trust believes that this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your Plan or any policy providing coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator c/o Benefit Programs Administration whose contact information appears on page 3 of this booklet. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

### **Eligibility Rules for Active Employees and Their Eligible Dependents**

#### **Am I Required to Enroll in the Plan to Receive Benefits?**

Neither you nor your Dependents will have coverage until you have submitted a completed enrollment application to the Trust Administrative Office, and have been notified that your enrollment is complete and your participation has been approved. New Employees must enroll within a specific period of time after being hired as described in the Evidence of Coverage booklets issued by the insurance providers listed on page 25. Otherwise, enrollment is limited to the annual open enrollment period that occurs in February of each year. If you have questions regarding enrollment you can contact each of these providers directly at the numbers listed on Page 25 or contact Benefit Programs Administration at (888) 410-1756 or (562) 463-5040.

#### **Employee Eligibility**

##### **Who Is Eligible for Benefits?**

If you are an Employee of an Employer who is required to contribute to the Trust Fund on your behalf and who makes the required contributions you will be eligible for those benefits specified in the Collective Bargaining Agreement between your Employer and your Union.

##### **What if I am an Employee of a Newly Participating Employer in the Trust?**

If you are an Employee of an Employer on the first date the Employer becomes obligated to contribute to the Trust Fund, you will become eligible on the effective date of coverage of your Employer. For Example: You are working for the Employer on May 31, and your Employer enters into a collective bargaining agreement with the Union effective June 1. Your coverage will begin on June 1, so long as the required contributions are made to the Trust on your behalf.

### **What if I Go to Work for an Employer Who Is Already Participating in the Trust?**

Newly hired Employees who go to work for an Employer who is already participating in the Trust will be eligible for benefits on the first day of the second month a contribution is received by the Trust on the Employee's behalf, provided that the two contributions have been made within a period of six consecutive months.

If your Employer's Collective Bargaining Agreement provides for Death Benefits and Pre-Paid Legal Service benefits you will be eligible for these benefits on the first day of the month in which the first Employer contribution is received by the Trust on your behalf.

However, when an Employer first enters into a Collective Bargaining Agreement requiring contributions to the Trust, or when you are first hired by an Employer who is already contributing to the Trust, there may be a waiting period which is described in your Collective Bargaining Agreement before contributions are required to be made on your behalf. This may cause a delay in eligibility for benefits since any hour you work during a waiting period will not count toward establishing your Eligibility for benefits.

***FOR EXAMPLE***, if your Collective Bargaining Agreement states that contributions are due on the first day of the month following the completion of sixty days of continuous employment, the hours you work during the first sixty-day period will not be counted in determining whether you are eligible under the Plan.

### **What If I Go to Work for a Participating Employer and I Was Covered Under Another Teamster Plan?**

If you are employed by an Employer who participates in the Trust after you terminate covered employment under any other trust fund plan covering members of the International Brotherhood of Teamsters, you will become eligible on the first day of the month following the termination of your coverage under the other Teamster plan, so long as your covered employment begins within thirty days from the date of termination of your previous employment and your new Employer is obligated to make the first contributions no later than the first day of the month following thirty days of your employment.

Please refer to the Evidence of Coverage booklet for each insurance provider for additional information regarding eligibility for benefits and circumstances that may affect your benefits.

### **Continuing Eligibility**

Once you initially become eligible for benefits, you will remain eligible so long as you remain employed with the participating Employer, your Employer pays the required contribution each month on your behalf to the Trust Fund.

### **Can My Coverage Be Extended if I Am Disabled?**

If you suffer an accident or illness causing Total Disability while you are eligible for coverage, the Trust will continue coverage for you for one (1) calendar month beyond the month in which your Employer ceases to be contractually obligated to remit contributions on your behalf.

### **When Do I Become Eligible for Benefits if My Coverage Previously Terminated Because of A Disability?**

If you return to Covered Employment after your coverage previously terminated due to Disability and you return to work after one calendar month but within one year, you will become eligible for benefits on the first day of the month next following your return.

If you return to Covered Employment after one calendar year from the date on which the Disability commenced, you must reestablish eligibility under the Plan as new Employee.

### **When Does My Eligibility for Benefits End?**

Your eligibility as the Employee ends on the earliest of the following dates:

1. The first day of the month for which a required contribution is not made on your behalf by your Employer;
2. The date your Employer is no longer obligated under the terms of a Collective Bargaining Agreement under which you are employed to contribute to the Trust;
3. The date the Plan terminates;
4. The date on which you enter full-time military service in the Uniformed Services of the United States which exceeds 31 days.

Please refer to the Evidence of Coverage booklets for the particular coverage for a complete description of other circumstances which may cause your eligibility for benefits or a particular benefit to terminate.

## **Dependent Eligibility**

### **How Do My Dependents Become Eligible for Benefits?**

Your dependents who meet the definition of "Dependent" (see below) under the Plan become eligible for benefits on the date you become eligible.

### **Who Are My Eligible Dependents Under the Plan?**

1. Your legal Spouse or your Domestic Partner.
2. Your natural children (born to you), adopted children, step-children, foster children or children placed for adoption who are less than 26 years of age and who are not eligible to enroll in another employer's group health plan.
3. Your unmarried children, regardless of age, who are financially dependent upon you for support and who are incapable of self-support because of mental or physical incapacities that existed prior to reaching age 19. Proof of such incapacity must be presented to the Trust Administrative Office within 30 days of the date coverage would otherwise end due to age and thereafter periodically at the request of the Board of Trustees.

### **Who Is Not an Eligible “Dependent” Under the Plan?**

1. A dependent who is serving in the Uniformed Services of the United States is not eligible as a Dependent under this Plan.
2. An Employee’s Spouse shall cease to be a Dependent under this Plan on the date set forth for termination of marriage in the Judgment of Dissolution or Nullity.
3. An Employee’s Domestic Partner shall cease to be a Dependent under this Plan on the date of termination of the Domestic Partnership.

### **When Can I Enroll a Newly Acquired Dependent?**

Dependents are eligible to enroll for coverage on the Employee's eligibility date if the Employee has eligible Dependents as of that date; or upon one of the following HIPAA Special Enrollment opportunities:

- a. Marriage:
  - i. The individual must request special enrollment by completing an Enrollment or Change Form and submitting it to the Trust Administration Office within thirty (30) days of the marriage. The new spouse and any newly eligible Dependents resulting from the marriage will be effective no later than the first day of the first calendar month beginning after the date the Trust Administration Office receives the request for special enrollment and completed Enrollment Form. A certified copy of marriage certificate must be furnished to the Trust Administration Office.
- b. Birth, Adoption or Placement for Adoption:
  - i. The Employee must request special enrollment by completing an Enrollment or Change Form within thirty (30) days of the birth, adoption or placement for adoption:
    - The newborn child’s effective date will be the date of birth;
    - The adopted child’s effective date will be the date of adoption;
    - In the case of placement for adoption, the child’s effective date will be the date of placement for adoption.
- c. Dependent Loss of Other Group Coverage:
  - i. If the Dependent’s loses other group coverage, the Dependent may be eligible to enroll.
  - ii. The Enrollment Form and HIPAA Certificate of Creditable Coverage must be submitted to the Trust Administration Office not later than thirty (30) days after the loss of other group coverage.

If the addition of a Dependent results in an increase in the monthly contribution, the contribution increase will take effect the first of the month that the new dependent is eligible for coverage.

## **SAME SEX DOMESTIC PARTNER AND OPPOSITE SEX DOMESTIC PARTNER AGE 62 OR OLDER**

In compliance with California Law AB2208, a Declaration of Domestic Partnership must be filed with the Secretary of State of California and Notarized by a Notary Public. The Trust Administration Office will accept the fully completed documentation up to thirty (30) days after the acceptance by the Secretary of State. Coverage will be effective the first of the month following receipt of the documentation and a completed Change Form by the Trust Administration Office. If the employee fails to submit the Declaration of Domestic Partnership and a completed Change Form within thirty (30) of registering with the Secretary of State, the Domestic Partner will not be eligible for enrollment until the proper documentation and Change Form is provided to the Trust Administration Office during the Employer's next Open Enrollment period.

"Notice of Termination of Domestic Partnership" must be filed with the Secretary of State and notarized by a Notary Public. Coverage will terminate at the end of the month following receipt of the notice and a completed Change Form. A Domestic Partner whose coverage has been terminated is not eligible for COBRA.

Employees may not enroll another Domestic Partner within six (6) months of providing notice of the termination of Domestic Partnership.

## **OPPOSITE SEX DOMESTIC PARTNERS, UNDER AGE 62**

Opposite sex Domestic Partners, under the age of 62, must complete and notarize the Teamsters Multi-Benefit Trust Affidavit of Domestic Partnership and furnish at least three of the five required documents listed in the Affidavit.

Upon approval by the Administrator, coverage will be effective on the first of the month following receipt by the Trust Administration Office of the three required documents as well as a completed Change Form. If the Employee fails to submit a completed Change Form and the required supporting documents referenced above within thirty (30) days of the notarization of the Teamsters Multi-Benefit Trust Affidavit of Domestic Partnership, the Domestic Partner will not be eligible for enrollment until the proper documentation and Change Form is provided to the Trust Administration Office during the Employer's next Open Enrollment period. A Domestic Partner whose coverage has been terminated is not eligible for COBRA.

Employees may not enroll another Domestic Partner within six (6) months of providing notice

of the termination of Domestic Partnership.

To request special enrollment or obtain more information, contact the Trust Administration Office at:

Benefit Programs Administration  
1200 Wilshire Blvd., Fifth Floor  
Los Angeles, California 90017-1906  
Telephone: (888) 410-1756 or (562) 463-5040  
Fax. No. (562) 463-5894

**Qualified Medical Child Support Order**

Special Rules apply to Dependents added to the Plan under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order requiring the Plan to provide health coverage for a child of a Participant. Copies of the Fund's QMCSO procedures are available from the Trust Office, without charge. Please contact the Trust Administrative Office if you need further information regarding QMCSOs.

**Termination of Eligibility for Dependents**

Your Dependent's Eligibility for coverage will terminate on the earliest of the following dates:

1. The date the Employee's eligibility terminates for any reason;
2. The date he or she no longer meets the definition of Dependent under the Plan;
3. The date the Plan terminates or no longer provides coverage for Dependents of active Employees.

Please review Termination of Coverage provisions contained in Evidence of Coverage booklets for each coverage for a full description of events which may lead to termination of coverage.

## **Special Enrollment - Health Information Portability and Accountability Act of 1996**

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

## **Special Enrollment Rights Under "SCHIP"**

If you decline enrollment for yourself or your Dependents (including your Spouse) because of coverage under a state Medicaid Plan or a State Children Health Insurance Plan "SCHIP," you may be able to enroll yourself and your Dependents in this Plan if you or your Dependent loses eligibility for that other coverage or if you become eligible for state premium assistance after April 1, 2009. However, you must request this special enrollment within 60 days after your or your Dependent's coverage terminates under the Medicaid Plan or State Plan, or within 60 days after you or your Dependent are determined to be eligible for state premium assistance.

## **Extensions of Coverage During Leaves of Absence**

### **Military Leave**

Continuation of coverage may be available to you under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA was enacted by Congress to provide protections to individuals who are members of the "Uniformed Services." "Uniformed Services" 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.

If you take a military leave for 30 Days or less, you will continue to receive benefits for up to 30 days. If you take a military leave for more than 30 days, USERRA permits you to continue coverage for you and your Dependents at your own expense, at a cost of 102% of the cost of coverage for up to 24 months. The maximum period of continuation coverage for health care under USERRA is the lesser of: (1) 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 Plan.

If you make this election, you will be required to submit any required self-payment, which may include administrative costs, to your Employer. If you do not elect to continue your coverage during a period of service in the Uniformed Services of the United States, upon your return to work, your coverage will be reinstated at the same benefit level immediately preceding your service, if you are eligible for reemployment under the criteria established under USERRA.

Your rights to self pay under USERRA are governed by the same conditions described in the COBRA section of this booklet. If you elect continuation coverage under USERRA, the COBRA and USERRA coverage periods will run concurrently.

For more information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA), contact the Trust Administrative Office.

### **Family and Medical Leave Act**

Your Employer may be required to comply with the Family and Medical Leave Act of 1993 (“FMLA”). FMLA eligible Employees will receive up to 12 weeks of unpaid leave within any rolling 12-month period for the birth or placement of a child for adoption or foster care, to care for your child, Spouse or your parent with a serious health condition, your own serious health condition. Qualifying Exigency Leave, which is leave to handle exigencies related to a family member’s active duty military service or call to active duty.

In addition, qualified employees are entitled to 26 weeks of Covered Service Member Family Leave during a 12-month period to care for a spouse, son, daughter, parent or next of kin who has a serious injury or illness incurred in the line of active duty.

Requests for FMLA leave must be directed to your Employer. The Trust Administrative Office cannot determine whether or not you qualify for FMLA leave. If you qualify for leave under the FMLA, your Employer must continue to pay for your health coverage during any approved FMLA leave. You and your eligible Dependents will continue to be covered under this Plan provided you were eligible when the leave began. Coverage will be continued while you are absent from work on an FMLA leave as if there were no interruption of active employment. Coverage will continue until the earlier of the expiration of the FMLA leave or the date you give notice to your Employer that you do not intend to return to work at the end of the leave.

## **Continuation Coverage Under COBRA**

COBRA continuation coverage is a temporary extension of coverage under the Plan. The right to COBRA continuation was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you qualify for COBRA continuation coverage you and your dependents have the option of continuing their health care coverage on a limited basis after coverage would otherwise terminate. You and each of your Dependents should read this entire section carefully so that you understand the options available to you.

If you or your Dependent lose coverage under the Plan as a result of a Qualifying Event described below, coverage may be continued for a limited period under COBRA Continuation Coverage by making monthly payments to the Trust Fund. *If you do not take advantage of COBRA coverage, you may have limited coverage under a new insurance plan if you have a break in coverage of more than 63 days.*

### **What Benefits Are Available Under COBRA Continuation Coverage?**

You, your Spouse or your Dependent Children have the option of electing COBRA coverage to continue the coverages provided through the Trust described in this booklet. If you choose

COBRA continuation Coverage, you will be entitled to the same coverage that you had on the day before the event that caused your coverage under end.

### **COBRA Eligibility (COBRA Qualifying Events)**

A life event that causes a loss of coverage is called a “Qualifying Event.” COBRA continuation coverage is available to you if coverage would otherwise end because of the following Qualifying Events:

#### **Qualifying Events for the Employee:**

1. Your hours are reduced so that you are no longer eligible to participate in the Plan;
2. Your employment ends for any reason other than gross misconduct.

#### **Qualifying Events for your Dependent Spouse are:**

1. the Employee’s death;
2. the Employee’s hours of employment are reduced; the Employee’s employment ends for
3. any reason other than the Employee’s gross misconduct; or
4. the Employee’s divorce or legal separation.

#### **Qualifying Events for your Dependent Child are:**

1. parent-employee dies;
2. parent-employee’s hours of employment are reduced;
3. parent-employee’s employment ends for any reason other than his or her gross misconduct;
4. parents’ divorce or legally separate; or
5. your child ceases being eligible for coverage under the Plan as a “Dependent child.”

### **Who Is Eligible for COBRA Continuation Coverage?**

COBRA continuation coverage must be offered to each person who is a “Qualified Beneficiary.” A Qualified Beneficiary is someone who will lose coverage under the Plan because of a “Qualifying Event.” Depending on the type of qualifying event, Employees and their spouses or Dependent children may be Qualified Beneficiaries. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

*In the event the Trust Office receives timely notice of a Qualifying Event, but the individual is not entitled to COBRA continuation coverage, the Administrator will advise the individual of the unavailability of COBRA coverage and the reason or reasons why coverage is unavailable within 14 days of receipt of notice. It is your responsibility to keep the Trust Administrative Office informed of your correct mailing address so as to prevent any delay in communications regarding Your COBRA continuation coverage.*

### **Who Can Elect COBRA Coverage?**

If there has been a Qualifying Event, you, your Spouse or Your Dependent Child can individually elect to continue benefits under COBRA, as provided in this section. If you elect to continue coverage under COBRA, coverage benefits will automatically be extended to all other eligible Qualified Beneficiaries in the family who lost coverage as a result of the same Qualifying Event.

### **How Do I Obtain COBRA Continuation Coverage?**

Benefit Programs Administration COBRA continuation coverage for the Plan. Your Employer has the responsibility for notifying Benefit Programs Administration within 30 days of the Qualifying

Event or loss of coverage, whichever is later, if the Qualifying Event is your death, reduction of your hours, termination of employment or your entitlement to Medicare.

You as the Employee, your Spouse, your Dependent Children or any representative acting on behalf of you or your Dependent(s), have the responsibility of informing the Trust Office of a divorce, legal separation, or of a child losing Dependent status in writing within the 60-day period following the Qualifying Event, or the date coverage terminates, whichever is later.

If you do not provide written notice to the Trust Office of the Qualifying Event within the 60-day period after the Qualifying Event, you and your Dependents will lose the right to continue your coverage through self-payments under COBRA. Notice should be sent to Teamsters Multi-Benefit Trust c/o Benefit Programs Administration at the address listed on page 3 of this booklet. Please contact Benefit Programs Administration at (888) 410-1756 or (562) 463-5040 regarding the required information for the written notice.

The Trust Administrative Office will promptly send you, your Spouse, and/or your Dependent children notice of the date on which coverage ends, together with the information and forms which must be submitted to the Trust Administrative Office to elect COBRA coverage. The information from the Trust Administrative Office will describe the Plan's procedures for electing COBRA and will indicate the cost of coverage, if elected.

COBRA continuation coverage will be offered to each eligible Qualified Beneficiary. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. For example, Your Spouse may elect coverage even if you do not, you may elect COBRA continuation coverage on behalf of your Spouse and Dependents, and parents may elect COBRA continuation coverage on behalf of any Dependent child who is a Qualified Beneficiary.

### **Is There a Time Limit for Applying for COBRA Continuation Coverage?**

You, your Spouse, and/or your Dependent(s) will have only 60 days from the date you lose coverage or the date of the election notice sent by the Trust Administrative Office, whichever is later, to apply for COBRA coverage. *If you, your spouse and/or Dependent do not elect COBRA coverage within this 60-day period, you and/or their right to continue coverage under COBRA will be lost and neither you, your Spouse and/or your Dependents will have any group coverage through Plan 105 after the date specified in the notice from the Trust Office that coverage ends.*

### **What is the Cost of COBRA Continuation Coverage?**

Your cost for COBRA Continuation Coverage is calculated in accordance with Federal law. You may be charged 102% of the cost of coverage as allowed by federal legislation. COBRA rates will be increased during the 19th month through 29th month of continuation coverage for disabled employees with a Social Security Disability determination as permitted by Federal legislation. You and your Dependents may be charged up to 150% of the cost of coverage during this additional period as allowed by federal legislation.

### **When Do COBRA Coverage and Self-Payments Begin?**

Although you have up to 60 days to make an election, COBRA coverage must begin the first day of the month in which full coverage would otherwise terminate. Payment of the first contribution must be received by the Trust Administrative Office within 45 days of the date that the

Administrative Office receives notification from a Qualified Beneficiary that the Qualified Beneficiary chooses COBRA Continuation Coverage. If a Qualified Beneficiary waits until the end of the election and the payment period, payment for each full month which has passed since the date the Plan coverage terminated must be included with the first payment. Subsequent payments will be due the first day of each month. If payment is not received within 30 days of the due date, COBRA Continuation Coverage will be terminated and all rights to continue coverage will cease.

### **For How Long Will COBRA Coverage Continue?**

COBRA Continuation Coverage can continue for up to 18, 29 or 36 months depending on the COBRA qualifying event.

#### **18 Months – (You and Your Dependents)**

If you lose coverage as a result of (1) a reduction in work hours or leave of absence (other than approved FMLA leave); (2) work stoppage; (3) termination of employment through resignation, layoff, discharge, or retirement, you can choose continuation coverage for up to 18 months; however, if your employment ends due to gross misconduct, you will not qualify for COBRA continuation coverage.

#### **29 Months – (You and Your Dependents)**

COBRA Continuation Coverage continues for an additional 11 months (up to a total of 29 months) if within the first 60 days of COBRA coverage you or an eligible Dependent is or becomes permanently disabled (as determined by the Social Security Administration). In this event, you or your Dependent must notify the Trust Office of the Social Security determination no later than 60 days after it is received and before the end of the initial 18-month COBRA continuation period to be eligible for this COBRA extension.

#### **36 Months – (Your Dependents only)**

COBRA Continuation Coverage continues for up to 36 months for your Dependents (spouse and Dependent children) from the date any of the following COBRA Qualifying Events occurs: 1) your death; 2) your divorce or legal separation; 3) your becoming entitled to Medicare; 4) your Dependent ceases to be a Dependent under the terms of the Plan.

If a Spouse or Dependent Child becomes eligible for and chooses COBRA coverage due to the Employee's reduction of hours or termination of employment, and thereafter experiences a second Qualifying Event (such as the death of the Employee, divorce, or the Employee's entitlement to Medicare), a Spouse or Dependent child may continue COBRA coverage for up to 36 months from the original eligibility date.

If you lose coverage under the Plan due to the termination of your employment or the reduction in your hours within 18 months after becoming entitled to Medicare benefits, your Spouse and Dependents may continue COBRA coverage for up to 36 months from the date of your Medicare entitlement.

*For Example*, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and Dependent children can continue up to 36 months after the date of Medicare entitlement, which in this example is 28 months after the date of the Qualifying Event (36 months less 8 months).

If you elect continuation coverage any extension of coverage under COBRA and, if available under USERRA (described below) will run concurrently.

### **Can COBRA Coverage Be Extended Because of Disability?**

If you, your Spouse or Dependent are entitled to the COBRA Continuation Coverage for the 18-month period, that period can be extended for the person who is determined to be entitled to Social Security Disability Income benefits, and/or any other covered family members for up to 11 additional months so long as all the following conditions are met:

1. You are entitled to the 18 months of COBRA Continuation Coverage;
2. You are determined to be disabled under the terms of the Social Security Act as of the date of the original Qualifying Event or become disabled anytime during the first 60 days of COBRA Continuation Coverage; and
3. You report the disability determination to the Administrative Office within 60 days of the date you received the Social Security disability determination or within 60 days of the date you received this Summary Plan Description, whichever is later, and prior to the end of the 18-month continuation period.

To qualify for this additional period of coverage, you must provide Benefit Programs Administration at the address listed at page 3 of this booklet with written notice of the disability determination within the 60-day period. The written notice must be accompanied with a photocopy of the entire Social Security Administration determination. If you do not submit written notice to the Administrator within the 60-day period you will not be eligible for this extension under COBRA.

### **When Does an Extension of COBRA Coverage Due to Disability End?**

The extension of COBRA Continuation Coverage up to 29 months will end the earlier of

1. The last day of the month during which the Social Security Administration has determined that you and /or your Dependent is no longer disabled.
2. The end of the 29-month period after the Qualifying Event.
3. The date the disabled individual first becomes entitled to Medicare after electing COBRA. If at a subsequent date, the Social Security Administration determines that you are no longer disabled, you must provide the Trust Office with written notice of the Social Security Administration's final determination that you are no longer disabled within 30 days of the final determination or within 30 days of the date you received this Summary Plan Description, whichever is later. This written notice must be addressed to Benefit Programs Administration at the address listed on page 3 of this booklet. The Notice must contain the following information: the Plan name, the Employer's name, the names and social security numbers of the Employee and Dependents and the date the Social Security Administration determined that the individual is no longer disabled. The written notice

must be accompanied with a photocopy of the entire Social Security Administration determination and submitted to the Trust Administrative Office.

### **What Happens in Cases Where There Are Multiple Qualifying Events?**

If you lose coverage because your employment terminates or your hours are reduced within 18 months after becoming entitled to Medicare, your Spouse and eligible Dependents may continue coverage for up to 36 months from the date of your Medicare entitlement.

If you die, divorce or legally separate or become entitled to Medicare, or if your Dependent child ceases to be a Dependent under this Plan during the 18-month period of COBRA coverage, your family has experienced a second Qualifying Event which may allow them to continue COBRA coverage for up to a maximum of 36 months from the date of the first Qualifying Event. To be eligible for this extension of coverage under COBRA either you, your Spouse and/or Dependent or any representative acting on their behalf must provide written notice to the Trust Administrative Office listed on page 3 of this booklet of the second Qualifying Event within 60 days after the date of the second Qualifying Event.

### **Can COBRA Coverage End Early? (Before the 18, 29, or 36 month periods)**

Even though you may have elected COBRA Continuation Coverage and have been advised that it is available for a certain period, your coverage may be terminated if there is any of the following happens:

1. The first day of the month for which a timely payment is not received by the Trust Office;
2. The day on which this Plan is terminated;
3. The first date, after the date of the COBRA election on which either you or your eligible Dependent(s) first become covered by another group health plan (including a retiree health plan), and that Plan does not contain any legally applicable exclusion or limitation with respect to pre-existing conditions that the Qualified Beneficiary may have. If such a limitation or exclusion for such pre-existing condition exists, coverage will not terminate until the date the condition is covered under the new plan, or the maximum time allowed under COBRA has been reached, whichever occurs first;
4. The first date, after the date of the COBRA election, on which you or your eligible Dependent(s) (the Qualified Beneficiary) first become entitled to Medicare benefits under Title XVIII of the Social Security Act;
5. The date the Employee's Employer stops making contributions to the Plan on behalf of its active employees, and provides alternative coverage to those employees under another plan; or
6. 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 are no longer disabled. In this case, coverage ends on the first of the month that begins more than 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-month maximum coverage period described above, whichever occurs last.

### **Will I Receive Notice of the Early Termination of COBRA Continuation Coverage?**

If in the event COBRA coverage will terminate before the end of the maximum coverage period, the Trust Office, as soon as practicable after a determination that coverage will terminate, will give notice to each Qualified Beneficiary of the reason or reasons for the early termination of coverage, the date of termination of coverage, and any rights to alternate group or individual coverage which may be available to the Qualified Beneficiary.

### **When Does COBRA Coverage End:**

COBRA continuation coverage will automatically terminate upon the earlier of the following:

1. The occurrence of any of the events described above; or
2. At the end of the last day of the maximum coverage period (18, 29, 36 months) applicable to the Qualified Beneficiary under COBRA.

### **What If I Acquire a New Dependent While I am Receiving COBRA Continuation Coverage?**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage has been extended because you are self-paying for COBRA Continuation Coverage, you may add the Dependent to your coverage for the balance of your COBRA coverage period.

For Example, if you have a baby three months prior to the end of your COBRA coverage period, you may enroll the new baby for the last three months of your COBRA coverage period.

If new Dependents are acquired through marriage, birth, or placement for adoption after COBRA Continuation of Coverage has begun, they may be added by contacting Benefit Programs Administration at the address and telephone numbers listed on page 3 of this booklet. Newborn and adopted children or children placed for adoption may have separate COBRA rights.

To enroll a new Dependent (newborn, child placed for adoption, etc.) for COBRA coverage, you must notify the Trust Administrative Office within 31 days of acquiring the new Dependent. There may be a change in the COBRA premium as a result of the addition of a new Dependent.

### **What if My Spouse or Dependent Is Covered under another Plan and Loses Coverage While I am Making Self Payments for COBRA Continuation Coverage?**

If, while you are enrolled in COBRA Continuation Coverage, your Spouse or Dependent child loses coverage under another group health plan, you may enroll the Spouse or Dependent child in this Plan for coverage for the balance of the period of your COBRA Continuation Coverage so long as the following conditions are met:

1. Your Spouse or Dependent child must have been eligible for COBRA Continuation Coverage at the time of your Qualifying Event, but not enrolled;
2. When COBRA Coverage enrollment under this Plan was offered and declined, the Spouse or Dependent child must have been covered under another group health plan or had other health insurance coverage;

3. The loss of coverage must be due to: exhaustion of COBRA continuation coverage under another plan; termination as a result of loss of eligibility for coverage; or the termination of the employer's contributions toward the other coverage;
4. Loss of eligibility cannot be due to the failure of your Spouse to pay premiums on a timely basis or termination of coverage for cause.

To add a Spouse or Dependent child after loss of other coverage, they must be enrolled no later than 30 days after the termination of the other coverage. Adding a Spouse or Dependent child may result in an increase in the amount paid for COBRA continuation coverage.

### **What If I Have Questions Regarding Coverage Under COBRA?**

If you have any questions regarding COBRA continuation coverage under this Plan or need information regarding notices required to be given, you should contact: the Trust Office at the telephone numbers and address listed at page 3 of this booklet.

You may also contact the United States Department of Labor, Employee Benefits Security Administration (EBSA) at the address listed on page 25. The addresses and phone numbers of the Regional and District Offices are also available through the EBSA's website [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **California COBRA Option**

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If you have a qualifying event that results in less than 36 months of coverage, and you have maintained that coverage for the maximum period of time, you may be eligible to continue your medical benefits for an additional period of time under California COBRA. This coverage is only available to Participants enrolled in an HMO medical plan. You can receive additional information regarding your "Cal-Cobra" rights directly from your HMO plan (See telephone numbers listed in your Evidence of Coverage booklets for the providers listed on page 25 of this booklet).

### **The Trade Act of 2002**

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Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 2002. You may be entitled to a second opportunity to elect COBRA coverage for yourself and certain family members if they did not already elect COBRA coverage, but only if you elect coverage within 60 days after you qualify for trade adjustment assistance under the Trade Act and only if elected during the six months immediately after your group health plan coverage ends. If you qualify or think you may qualify for assistance, contact the Trust Administrative Office for additional information. You must contact the Administrative Office promptly after qualifying for assistance under the Trade Act of 2002 or you will lose your special COBRA rights.

## **Medi-Cal Health Insurance Premium Program (HIPP)**

You may qualify for the Health Insurance Premium Payment Program (HIPP) offered by the state of California. Under HIPP, the California Department of Health Services will pay your COBRA premium if you meet all eligibility requirements established by the California Department of Health Services. To enroll in HIPP, or to find out more information, you should call the California Department of Health Services' HIPP toll-free number at **(866) 298-8443**.

## **Individual Conversion Privilege Option**

Once your continuation coverage under COBRA terminates, you or your Dependents may have the right to convert your medical coverage to conversion coverage as detailed in the Right to Convert Health Insurance provisions contained in the evidence of coverage booklets which can be obtained free of charge from the Trust Administrator. Generally, you must submit your conversion application and initial premium to the insurance carrier within 31 days from your loss of eligibility. The individual plan coverage may not be identical to your current coverage and the monthly cost for the individual policy is determined by the insurance carrier.

## **Information Required by the Health Insurance Portability & Accountability Act (HIPAA)**

A federal law called the Health Insurance Portability and Accountability Act, commonly referred to as HIPAA, requires that this Plan furnish you with certain information.

One of the purposes of HIPAA is to help families minimize the impact of pre-existing condition exclusion. A pre-existing exclusion is where a medical plan may not cover certain illnesses until an individual is covered under the Plan for a designated period of time, typically 12 months.

The health plans offered through the Trust do not contain any pre-existing condition exclusions. When you become eligible for benefits under this Plan all covered benefits become effective on the date you become eligible for benefits. However, each of the medical plans do have certain plan limitations and exclusions and described in the Evidence of Coverage booklets for each provider.

### **Certificate of Group Health Coverage**

When you lose eligibility under this Plan, you will be furnished with a "Certificate of Group Health Plan Coverage". This Certificate provides you with evidence of your prior health coverage under this Plan. You may need to furnish this Certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions before you enroll. This Certificate may need to be provided to your new plan if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six months prior to your enrollment in the new plan.

It is important to check with the administrator of your new plan to see if you will need to provide this Certificate.

**Information Regarding HIPAA Privacy Statement and Notice of Privacy Practices.**

As a participant in the Plan you have certain rights under HIPAA with respect to your health information. HIPAA requires that employee welfare plans such as the Teamster Multi-Benefit Trust Health Plan protect the privacy of your personal health information (“PHI”). A complete description of your rights under HIPAA can be found in the Plan’s Notice of Privacy Practices which is included in your enrollment materials. You may also obtain a copy free of charge by contacting Benefit Programs Administration at the numbers listed on page 3 of this booklet.

For additional information and assistance with respect to your rights as provided by HIPAA you can contact the United States Department of Labor as follows: United States Department of Labor, Employee Benefits Security Administration, 1055 E. Colorado Boulevard, Suite 200, Pasadena California 91106. Telephone: (626) 229-1000.

**Summary of Plan Benefits**

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All coverages will be made available under Trust for Employees and their covered Dependents to the extent applicable in full compliance with the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA), the Women’s Health and Cancer Act of 1998 (WHCRA), and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Genetic Information Nondiscrimination Act of 2008 and the Patient Protection Affordable Care Act and Health Care and Education Reconciliation Act (“Affordable Care Act”).

**Prior Notice of Plan Changes**

In the event the Trustees make material changes in the Plan with respect to your benefits, you will receive at least 60 days’ notice prior to the effective date of the change, as required by Affordable Care Act.

**Benefits Are Fully Insured**

Plan benefits are fully insured and provided to Employees and their eligible Dependents under group health contracts entered into between the Trust Fund and the insurance providers listed on page 25 of this booklet. Summaries of the benefits for each of these insured benefits can be found in Attachments 1 through 4 of this booklet. A complete copy of the Evidence of Coverage for each of these benefits may be obtained free of charge directly from the insurance company or by calling the Trust Administrative Office at (888) 410-1756 or (562) 463-5040.

## **The Women's Health and Cancer Rights Act Special Notice Regarding Mastectomy Coverage**

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If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prosthesis;
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided by your medical health plan listed in Attachment #1 of this booklet. If you have any questions about Plan coverage of mastectomies or reconstructive surgery or if you would like more information on WHCRA benefits, please call the Trust Administration Office at: (888) 410-1756 or (562) 463-5040.

## **Newborns' and Mothers' Health Protection Act of 1996 Special Notice Regarding Maternity Coverage**

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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 the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **Death and Accidental Death and Dismemberment Benefits**

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Please see the Teamsters Multi-Benefit Trust Death and Accidental Death Benefit Plan Summary Plan Description for a description of benefits which may be available to you and your beneficiaries in the event of either you or your Dependents death or accidental death and dismemberment. A copy can be obtained free of charge from the Trust Administrative Office.

## **Claims Procedures**

### **Except Death and Accidental Death Benefit Claims**

Your health and welfare benefits are fully insured by the companies listed on page 25 of this booklet. These companies will decide your claim in accordance with a reasonable claims procedure required by ERISA

Generally, you will not be required to submit a claim. If you need to file a claim or if you have received an adverse benefit determination you will be required to follow the claims procedures detailed in the certificate of insurance coverage booklet issued by them.

Please see the Evidence of Coverage booklets issued by the insurers listed on page 26 of this booklet for information about how to file a claim and for details regarding the particular insurance company's claims procedures.

If your claim is denied in whole or in part you may appeal to the insurance company for a review of the denied claim. Your insurance company will decide your appeal in accordance with the reasonable claims procedures required by ERISA.

#### **Important Appeal Deadlines**

You should refer to the Evidence of Coverage booklets issued by your health insurance carrier to determine the time limits for filing an appeal. If you fail to file an appeal within the required period you will lose the right to challenge the denial of your claim in court because you will have failed to exhaust your internal administrative appeal rights.

Please refer to your Evidence of Coverage booklet issued by your health insurance provider for information about how to appeal a denied claim and for details regarding a particular providers' claims procedures. A copy can be obtained free of charge from the Trust Administrative Office.

## **Acts of Third Parties - Third Party Liability**

The Evidence of Coverage booklet contains information about your insurance provider's right to subrogation or reimbursement of benefits where either you or your Dependent is injured or becomes ill because of the actions of a third party. Although your insurance provider will cover your medical expenses you may be obligated to reimburse your provider from the funds you receive from the third-party up to the value of the benefits you received from your insurance provider.

## **Disclosure Information**

### **Important Information About the Plan Required by ERISA**

#### **Name of the Plan**

The Plan is officially known as the Teamsters Multi-Benefit Trust Health Plan. The Death and Accidental Death and Dismemberment benefits are provided through the Teamsters Multi-Benefit

Death and Accidental Death Plan formerly known as the South Bay Teamsters and Employers Health and Welfare and Related Benefits Trust Fund Death and Accidental Death Benefit Plan.

**Plan Sponsor's Employer Identification Number and Plan Number**

This Plan has been assigned 93-6231741 as its employer identification number (EIN) by the Internal Revenue Service and its Plan Number is 501.

**Plan Year End Date**

The Plan operates on a Plan year ending December 31.

**Type of Plan:**

The Plan is an employee welfare benefit plan subject to ERISA which provides hospital, medical, prescription drug, dental and vision benefits chiropractic, mental health and substance abuse and employee assistance and pre-paid legal benefits through contracts of insurance, and a self-funded death and accidental death and dismemberment benefit.

**Name and Address and Telephone No. of Plan Sponsor and Administrator**

Board of Trustees of the Teamsters Multi-Benefit Trust  
c/o Benefit Programs Administration  
1200 Wilshire Blvd., Fifth Floor  
Los Angeles, California 90017-1906  
Telephone: (888) 410-1756 or (562) 463-5040  
Fax. No. (562) 463-5894

**Type of Administration:**

The Teamsters Multi-Benefit Trust formerly known as the South Bay Teamsters and Employers Health and Welfare and Related Benefits Trust Fund was established and is maintained pursuant to collective bargaining agreements between participating Local Unions of the International Brotherhood of Teamsters and various Employers signatory to these collective bargaining agreements. It is a Joint Trusteed Labor-Management Trust which was created to provide health and welfare benefits to Employees and their eligible dependents.

The Board of Trustees is the Plan Administrator. However, the Board of Trustees has contracted with a third-party administrator, Benefit Programs Administration to provide day to day administrative services for the Trust Fund. Benefit Programs Administration maintains and manages the office which is referred to as the Trust Fund Office, or Trust Administrative Office and whose mailing address is 1200 Wilshire Blvd., Fifth Floor, Los Angeles, California 90017-1906.

**Right to List of Employers and Employer Organizations Sponsoring the Plan**

As a participant in this Plan you may obtain, upon written request to the Plan Administrator: (a) a complete list of the employers and employee organizations sponsoring the Plan, or (b) information as to whether or not a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

Complete copies of the Collective Bargaining Agreements, Plan Document, Trust Agreement,

Annual Audit Statement and a list of all participating employers and employer organizations are available at the offices of Benefit Programs Administration. A participant or his representative may request copies in writing from Benefit Programs Administration at a reasonable charge for each document requested.

**Name and Address of Agent for Service of Legal Process**

The person designated as the Plan’s agent for service of process is:

Lance Phillips, Administrator  
Benefit Programs Administration  
1200 Wilshire Blvd., Fifth Floor  
Los Angeles, California 90017-1906

Service may be made upon the agent or upon a member of the Board of Trustees at the address listed below.

**Name, Title and Principal Business Address of the Trustees**

The Board of Trustees means the group of individuals who have responsibility for managing the operations of the Teamsters Multi-Benefit Trust who are appointed by participating Employer and Union sponsors.

Richard Middleton  
Business Manager  
Teamsters Local 572  
450 Carson Plaza Drive  
Carson, California 90746

Daniel Murphy Sr. Vice-President  
Labor Relations  
FirstGroup America, Inc.  
600 Vine Street, Suite 1400  
Cincinnati, Ohio 45202

Lourdes Garcia  
General Counsel  
Teamsters Local 572  
450 Carson Plaza Drive  
Carson, California 90746

Tom Secrest, Vice President  
Labor Relations  
FirstGroup America, Inc.  
600 Vine Street, Suite 1400  
Cincinnati, Ohio 45202

**Source of Funding for the Plan**

The Plan is funded by contributions made by Employers signatory to collective bargaining agreements requiring payment of contributions to the Teamsters Multi-Benefit Trust. Death and Accidental Death and Dismemberment Benefits are paid directly from the Trust assets. All other benefits are funded through group insurance contracts with organizations listed on page 25 of this booklet.

**Insurance Contracts Control**

Benefits hereunder are provided solely pursuant to contracts of insurance entered into between the Western Alliance Health and Welfare Trust Fund and the respective insurance companies and health and dental maintenance organizations. If the terms of this document conflict with the terms of such contracts, the terms of the insurance contracts, group health and dental agreements will control, unless superseded by applicable law.

**Names and Addresses of Plan Insurers and Service Providers**

Please see page 25 for a complete list of Plan insurers. A list of Plan service providers appears on page 25 of this booklet.

### **Amendment and Termination**

The benefits described in this booklet, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to Collective Bargaining Agreements continue to require contributions into the Plan sufficient to underwrite the cost of the benefits. Should contributions cease and their reserves be expended, the Trustees would no longer be obligated to furnish coverage. These are not guaranteed lifetime benefits. The Board of Trustees shall, in their sole discretion and without notice to eligible Persons or Employers or Union, but on a nondiscriminatory basis, reserve the right to:

1. Terminate or amend either the amount or conditions with respect to any benefits or provisions of the Plan even though such termination or amendment affects claims in process and/or expenses already incurred; and
2. Alter or postpone the method of payment of any benefit; and
3. Amend any provisions of these rules and regulations.

### **Your Rights Under the Employee Retirement Income Security Act of 1974, as Amended (“ERISA”)**

As a participant in Teamsters Multi-Benefit Trust you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

#### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Administrative Office, or at other specified locations such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) s filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

#### **COBRA and HIPAA Rights**

Continue health care coverage for yourself, your spouse or your 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 SPD and the documents governing the Plan for the rules governing

your COBRA continuation coverage rights.

Reduction or elimination or exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with 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 elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Action by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning a qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in 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 if, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need any assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the

Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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.

## **Benefit Plan Service Providers And Benefit Summaries**

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<i>Benefit</i>	<i>Healthcare Provider</i>	<i>Member Services Phone Number</i>
<i>Medical &amp; Prescription Drug</i>	Health Net of California	(800) 522-0088
	Kaiser Permanente	(800) 464-4000
<i>Dental</i>	Liberty Dental	(888) 703-6999
<i>Vision</i>	Vision Service Plan (VSP)	(800) 877-7195
<i>Legal Benefit</i>	Optum Health	(877) 225-2267
<i>Member Assistance Plan</i>	Optum Health	(877) 225-2267



**TEAMSTERS MULTI-BENEFIT TRUST  
HEALTH PLAN**

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**Effective Date  
January 1, 2011**