BAY AREA DELIVERY DRIVERS SECURITY FUND

INITIAL NOTICE TO EMPLOYEES AND DEPENDENTS
about the
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

AVISO EN ESPAÑOL

Este noticia contiene un resumen en ingles de sus derechos y beneficios bajo el Bay Area Delivery Drivers Security Fund. Si tiene alguna dificultad en comprender cualquier parte de este noticia puede communicarse con Bay Area Delivery Drivers Security Fund 4160 Dublin Blvd., Suite 400, Dublin, California 94568, o llamar a los teléfonos 1-800-654-1824. Las horas de la oficina son de 8:30 a.m. a 5:00 p.m. Una traducción en español esta a su disposición en la oficina de su union o planta.

THIS IS A VERY IMPORTANT NOTICE REGARDING YOUR RIGHT TO CONTINUATION OF ACTIVE EMPLOYEE HEALTH COVERAGE

You and your dependents should read this notice carefully and keep it with your records. COBRA is a federal law that requires most employers to allow employees and their covered dependents to continue group health coverage at their expense for a period of time after employer-paid coverage would otherwise end. This notice summarizes your rights and obligations under COBRA as Bay Area Delivery Drivers Security Fund (hereinafter referred to as the "Fund") participants. This summary is subject to change without notice as interpretations or changes of the law occur. For additional information about your rights and obligations under the Fund and under federal law, you should review the Summary Plan Description or contact the Plan Administrator.

COBRA EVENTS

If you are an ***employee*** participating in the Fund, you have a right to pay for and continue health coverage under COBRA ("COBRA Coverage") if you lose your employer-paid coverage because of one of the following "qualifying events":

- Termination of your employment for reasons other than your gross misconduct; or
- Retirement, or
- Reduction in the hours of your employment (through layoff, disability leave, medical leave, plant closure and loss of coverage due to labor dispute.). If you are on an approved leave of absence subject to the Family and Medical Leave Act, your failure to return to work at the end of your approved leave or your communication to your employer of your intent not to return at the end of your approved leave will constitute a "qualifying event." If you are on an approved military leave of absence subject to the Uniformed Services Employment and Reemployment Rights Act for less than 31 days and you fail to return to work at the end of the leave, your "qualifying event" occurs on the first day after you fail to return to work at the end of your leave.

If you are the ***spouse**** or ***dependent child*** of an employee participating in the Fund, you have the right to elect and pay for COBRA Coverage if you lose your employer-paid coverage because of any of the following "qualifying events":

- The death of the employee;
- A termination of the employee's employment for reasons other than his or her gross misconduct;
- A reduction in the employee's hours of employment (through layoff, illness or approved leave and including retirement);
- Divorce of the employee; or
- In the case of a ***dependent child***, the dependent ceases to be a "dependent child" under the Fund.

Spouse and dependent children who do not have dependent medical coverage under the Fund on the day before a qualifying event are not eligible for COBRA Coverage.

However, a child born to or placed for adoption with an employee during a period of COBRA Coverage is a qualified beneficiary. The covered employee or family member must notify the Fund's Administrative Office within 30 days of the birth or placement for adoption to enroll the child for COBRA Coverage.

***Spouse in this document also refers to domestic partner as defined by the Fund.**

COBRA BENEFITS

You may elect and pay for one of two levels of COBRA Coverage:

- Medical coverage (including enrollment in Kaiser, if available under your Plan), and prescription drug, or
- The coverage described above plus vision and dental coverage (if available under your Plan).

The COBRA payment will be higher if you elect the option including vision and dental coverage. Life and accidental death and dismemberment benefits are not available under COBRA. If Plan coverage is changed for active employees or dependents, COBRA Coverage will be modified the same way.

MAXIMUM COVERAGE PERIOD FOR EACH QUALIFYING EVENT

For any qualified beneficiary, the COBRA Coverage period may be up to **18 months** if the qualifying event is an employee's termination of employment or reduction in hours. For a spouse or dependent child, the COBRA Coverage period may be up to **36 months** for any qualifying event other than an employee's termination of employment or reduction in hours. These coverage periods may be extended or shortened under the following circumstances:

1. **If an employee or covered dependent is disabled** at the time of the qualifying event or within the first 60 days after a qualifying event, the maximum COBRA Coverage period for all qualified beneficiaries may be up to **29 months** from the date of the termination of employment or reduction in hours. Pursuant to Title II or Title XVI of the Social Security Act, the Social Security Administration will determine whether the disability exists and when it began.
2. **If a dependent covered under COBRA experiences a second qualifying event** (for example, the employee dies, gets divorced, or the dependent child stops being eligible under the Fund as a dependent child) within the 18-month or 29-month coverage period, the maximum COBRA Coverage period may be extended to up to **36 months**. An event is a "second qualifying event" only if the event would have caused the dependent to lose coverage under the Fund had the first qualifying event not occurred, but a termination of employment following a reduction in hours that was a qualifying event is never a second qualifying event.
3. **If an employee's termination of employment or reduction of hours occurs within 18 months after the employee becomes entitled to Medicare**, the maximum COBRA Coverage period (for the spouse and dependent child) may be extended to up to **36 months** from the date the employee became so entitled. For example, if an employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Coverage for his dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

***Note*:** If you are enrolled in Kaiser when your federal COBRA coverage ends, you may be entitled to an additional period of continuation coverage, up to a total of 36 months from the date federal COBRA began, under California law. Contact your HMO for further details.

YOUR OBLIGATIONS TO NOTIFY THE BAY AREA DELIVERY DRIVERS SECURITY FUND

You or a dependent are obligated to inform the Administrative Office about the following situations (Notice may be provided on the Bay Area Delivery Drivers Security Fund Notice of COBRA Event Form):

- **Disability of a Qualified Beneficiary**. To extend the COBRA Coverage period to up to 29 months because of a qualified beneficiary's disability, you or a dependent must be or become disabled within the first 60 days after the COBRA "qualifying event," and you must notify the Fund **before the end of the first 18 months of COBRA Coverage and within 60 days after the notice of determination of disability by the Social Security Administration ("SSA")**. The SSA notice of determination of disability must be enclosed with your notification to the Fund (the Fund address and phone number are at the end of this notice). You must also notify the Fund within 30 days after the SSA's final determination that you or your dependent is no longer disabled.
- **Qualifying Events**. You or a dependent must inform the Fund about an employee's divorce or a child's loss of dependent status under the Fund. If you (employee) die after electing COBRA Coverage, your dependent must notify the Fund of your death. If one of these events happens, send the enclosed form to the Fund within 60 days of the date of the event. **If the Fund Administrative Office is not notified by you or a family member within 60 days following the divorce or the child's loss of dependent status, your dependent's COBRA rights will be lost** (if you need additional forms, call the Fund at 1-800-654-1824).
- **Enrollment in Medicare or other health coverage of a Qualified Beneficiary.** To obtain the Medicare extension, provide notice of the enrollment in Medicare within 30 days of electing COBRA. Notice of enrollment in Medicare or other health coverage after electing COBRA must be provided immediately.

The notices described above must be provided within the timeframes discussed above and may be provided on Bay Area Delivery Drivers Security Fund Notice of COBRA Event Form (available at no cost by calling the Fund Administrative Office). Notice is considered timely if postmarked on or before the due date or hand delivered on or before the due date. Oral notice, including notice via the telephone, is not acceptable. Electronic notice, including notice via e-mail or facsimile, is not acceptable. Notice must include the following information in order to be considered proper:

- Name of the individual experiencing the COBRA event (the qualified beneficiary)
- Name of the Employee and ID# or Social Security Number
- Date of the COBRA event
- Type of COBRA event
- Address of the qualified beneficiary

If the Fund Administrative Office receives notice of a qualifying event for someone who is not a qualified beneficiary, notice of ineligibility will be provided to that person within 14 days of receipt of the notice.

When the qualifying event is the end of employment or reduction of hours of employment, or death of the employee, your employer will notify the Administrative Office of the qualifying event. The Administrative Office will, in turn, notify you and your dependents of your COBRA rights.

IMMEDIATELY INFORM YOUR EMPLOYER AND THE FUND ADMINISTRATIVE OFFICE WHENEVER YOU OR ANY OF YOUR DEPENDENTS HAVE A CHANGE OF ADDRESS SO NOTICES CAN BE SENT TO THE CORRECT ADDRESS.

COBRA ELECTION

You and/or your dependents may elect COBRA Coverage by filing a COBRA election form with the Fund within 60 days after the later of (1) the date on which your employer-paid Bay Area Delivery Drivers-coverage ended because of a qualifying event, or (2) the date you are notified about your COBRA rights (except following loss of employer-paid coverage as a result of divorce or change in dependent status about which ***you*** must notify the Fund). Election forms may be obtained by calling the Fund at 1-800-654-1824.

A covered employee or spouse of the covered employee may elect COBRA Coverage for all eligible family members. However, the covered employee, his or her spouse and dependent children, each have an independent right to elect COBRA Coverage. Thus, if the employee does not elect COBRA Coverage, his or her eligible dependents may still choose (and pay for) COBRA Coverage.

IF YOU DO NOT ELECT COBRA COVERAGE WITHIN THE ELECTION PERIOD AND YOU DO NOT HAVE ANY OTHER SELF-PAY RIGHTS, YOUR BAY AREA DELIVERY DRIVER COVERAGE WILL END.

PAYMENTS

You will not have to show that you are insurable to elect COBRA Coverage, but you will have to pay the full cost of COBRA Coverage plus a 2% administrative fee (the administrative fee is 50% for months 19-29 if coverage is extended due to the disability of a qualified beneficiary). The cost is determined annually by the Bay Area Delivery Drivers Security Fund.

Your first COBRA payment can be sent with the election form (call the Fund Office for the amount) or you will be billed. Regardless, the first payment is late if not received by the Fund within 45 days of the date you elect COBRA Coverage. The first payment covers the period back to the date your employer-paid Bay Area Deliver Driver-coverage ended. Thereafter, payments are due on the first of the month and are late if they are not received within 30 days of the due date.

You are responsible for making sure that the amount of your first payment is correct and paid timely. Call the Fund Administrative Office at 1-800-654-1824to confirm the correct amount of your first payment. Failure to pay the premium within 45 days of electing COBRA coverage for the first month or 30 days of the due date for subsequent months will result in a loss of your COBRA Coverage.

END OF COBRA COVERAGE

COBRA Coverage ends when any of the following events occurs:

- Your 18, 29 or 36-month COBRA period ends;
- You fail to make a timely payment for your COBRA Coverage;

- You become covered under another group health plan that has no pre-existing condition exclusions or limitations that apply to you after electing COBRA Coverage. If the other plan has applicable exclusions or limitations, your COBRA Coverage will terminate after the exclusion or limitation no longer applies;
- You become entitled to Medicare (Part A or Part B) coverage after electing COBRA Coverage;
- If you became entitled to a 29-month maximum coverage period due to a disability of a qualified beneficiary, and there is a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled (however, COBRA Coverage will not end until the month that begins more than 30 days after the determination);
- For any reason the coverage of a participant not on COBRA would terminate (e.g., fraud); or
- When the Bay Area Delivery Drivers Security Fund terminates.

The Employee, spouse or dependent child will be required to reimburse the Fund for any claim that is mistakenly paid by the Plan for expenses incurred after the date coverage is supposed to terminate for any of the reasons listed above, or because you did not provide timely notice of an extension.

CONSIDER COBRA COVERAGE CAREFULLY

In deciding upon whether to elect COBRA Coverage, there are a number of considerations that you should take into account, including:

- whether a guaranteed right to buy health coverage is important to you;
- whether other group health coverage -- such as coverage under another employer's plan -- is available;
- the cost, scope, and level of COBRA Coverage compared with that of any other available group coverage or individual health coverage;
- when you will have the right to enroll in the other coverage; and
- whether other available health coverage would exclude benefits for a medical condition that you or a family member has.

Note: Under Federal law (the Health Insurance Portability and Accountability Act or HIPAA), a pre-existing condition exclusion or limitation of your new group health plan might not apply at all to you, depending on the length of your **creditable health plan coverage** under the Bay Area Delivery Drivers Security Fund prior to enrolling in the other group health plan. However, if there has been a **break of 63 days or more after you lose Bay Area Delivery Drivers coverage** and before you are covered by any new plan, **the benefit of HIPAA creditable coverage will be lost**. Your new plan could disregard your old coverage prior to this break, and **it could enforce preexisting condition limitations against you** or your dependents. Therefore, carefully consider electing COBRA Coverage, before letting this 63-day period expire. (A notice of your creditable coverage will be sent to you when you lose coverage under the Plan or when you have the right to elect COBRA Coverage.)

CONVERSION COVERAGE

If you are enrolled in Kaiser, you may convert your coverage to an individual medical policy offered by the HMO when your COBRA Coverage ends or at any time during your COBRA Coverage. This HMO-sponsored individual medical policy usually costs more and may provide fewer benefits than the group medical plan provided by the HMO. There are no conversion rights under the self-funded indemnity medical, prescription drug, vision or dental coverages. Life insurance conversion privileges are described in the Benefits Booklet. You may not continue life insurance coverage under COBRA.

PLAN INFORMATION

If you have any questions about COBRA or need additional forms, please call the Fund toll-free at: 1-800-654-1824 or write the Fund at:

Bay Area Delivery Drivers Security Fund
4160 Dublin Blvd., Suite 400
Dublin, California 94568

BAY AREA DELIVERY DRIVERS SECURITY FUND - NOTICE OF COBRA EVENT FORM

Mailing Address: 4160 Dublin Blvd., Suite 400, Dublin, CA 94568

This form should be completed by an employee, dependent or an authorized representative to notify the Fund Administrative Office of the employee's death or divorce, a child's loss of dependent status under the Fund provisions, a determination of disability or cessation of disability, or the employee's enrollment in Medicare (Part A or Part B). This notice must be provided according to the deadlines described below. Additional information may be requested by the Fund Administrative Office. Such additional information must be provided within 15 business days of the request or your notice will be deemed incomplete and your COBRA rights will be lost. **WARNING: If your notice is late or is incomplete, COBRA Coverage may be lost.**

***Complete the following*:**

Name of Employee: _____

(the employee or former employee who was covered by the Fund):

ID# or Social Security No: _____ Telephone: (_____)_____

Address of Employee: _____

Name of qualified beneficiary(ies): _____

_____

Address of qualified beneficiary(ies) (*if different*): _____

_____

(If you need additional space to include all qualified beneficiaries or addresses, please attach another sheet of paper)

Event Description (*check one and complete*):

Unless otherwise noted, provide notice of these events within 60 days after the date of the event.

- ❑ Divorce of Employee and Spouse Date of divorce: _____
  Attach a copy of the divorce decree.
- ❑ Employee's child ceased to be an eligible dependent under the terms of the Plan because (*check one*):
  ❑ Attainment of Plan limitation age (19 or 26 for students) ❑ Loss of student status ❑ Marriage ❑ Other (*explain*): _____
  Date of event causing loss of eligibility: _____
- ❑ Death of former employee who was covered under COBRA at the time of death. Date of death: _____
  Attach a copy of the death certificate.
- ❑ Coverage under another group health plan without preexisting condition exclusions that apply to you.
  Date of coverage:_____
- ❑ Coverage of qualified beneficiary under Medicare. Date of Medicare enrollment: _____
  (*Attach a copy of the Medicare card showing the date of entitlement*).
- ❑ Disability determination by the Social Security Administration (*you must include a copy of the determination letter).*
  ❑ Determination of Disability. **Provide notice within 60 days of determination and within first 18 months of COBRA.**
  ❑ End of Disability. **Provide notice within 30 days of determination.**
  Date of SSA determination: _____

Certification, Signature, and Date:

I certify that the above information is true and correct.

I am the *(check one*): ❑ employee or former employee ❑ spouse or former spouse ❑ former dependent child ❑ other

Signature_____ Date_____

Print Name _____ Tel. No. _____

Address _____

Mail or hand-deliver completed form to address above. Oral, faxed and electronic notices are not permitted.

-For Plan Use Only-

Date Notice of COBRA Event received: _____ Date of postmark, if mailed: _____