Bay Area Delivery Drivers Security Fund

Summary Plan Description

January 1, 2007

IMPORTANT NOTICE TO EMPLOYEES, SPOUSES AND DEPENDENTS

The Board of Trustees of the Bay Area Delivery Drivers Security Fund is pleased to provide the welfare program outlined in this booklet. This Benefits Booklet and the Summary and Supplemental Information Insert (called "Insert" in the rest of this Booklet) that accompany it provide a summary of your health and welfare benefits plan (referred to in this booklet as "the Plan").

This booklet applies to Bay Area Delivery Drivers Plans 5, 6 and 6A and Retiree Plans 11A and 11B. Which of these Plans is your Plan is stated in your collective bargaining agreement. There are separate Inserts for each of these Plans and your copy of this booklet should have an Insert inside the front cover pocket. For example, if you work for UPS you are in Plan 6. Because all plans offered by the Fund are not the same, the Inserts are not identical and you should contact the Administrative Office at 800-654-1824 or 925-449-7070 if you have any questions about whether you have the right Insert. Note that your Insert also contains important contact information for both the Administrative Office and the companies that provide Plan benefits.

This booklet and Insert together are your Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA). Note that if you have chosen Kaiser HMO coverage instead of the medical benefits described in this booklet, you will receive another booklet Kaiser's "Explanation of Coverage", a booklet called "*Your Health Plan Coverage"* and materials describing your coverage under the Kaiser HMO which is part of, and should be kept with, this SPD.

Please read this information carefully and share it with your family. It is intended to be your primary resource for information about your health and welfare benefits. From time to time the Board of Trustees may find it necessary to change Plan rules or benefits and, if this happens, you will be notified. Any additional information you receive should be considered part of and kept with this SPD.

We have done our best to present this information in a comprehensive, straightforward manner that is easy to understand. If you need additional information, you may contact the Fund Administrator by telephone at 800-654-1824 or 925-449-7070. As a convenience to you, the Fund Administrator will provide answers on the telephone on an informal basis. However, the answers supplied by the Fund Administrator are not binding on the Board of Trustees, who have sole discretion to interpret and apply the Plan. Only the Board of Trustees is authorized to interpret the Plan described in this booklet. No individual Trustee, employer or union representative is authorized to interpret the Plan on behalf of the Board or to act as an agent of the Board.

This document does not serve as a guarantee of continued employment or benefits. The Board of Trustees reserves the right to change, reduce or terminate these benefits at any time. **The benefit program summarized in this booklet is the program in place as of January 1, 2007 (unless specifically stated otherwise).** It supersedes and replaces any prior Summary Plan Descriptions issued by the Bay Area Delivery Drivers Security Fund.

FOREIGN LANGUAGE NOTICE

This booklet contains a summary in English of your rights and benefits under the Bay Area Delivery Drivers Security Fund. If you have any difficulty in understanding any part of this booklet, you may contact the Fund Administrator at Bay Area Delivery Drivers Security Fund, P.O. Box 2358, Livermore, California 94551-2358 or call 800-654-1824 or 925-449-7070.

AVISO EN ESPANOL

Este folleto 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 folleto, puede comunicarse con Bay Area Delivery Drivers Security Fund, P.O. Box 2358, Livermore, California 94551-2358 o llamar a los telefonos 800-654-1824 or 925-449-7070.

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ELIGIBILITY RULES – ACTIVE EMPLOYEE PLANS 5, 6 & 6A

The Bay Area Delivery Drivers Security Fund sponsors three different health plans for active (*i.e.,* not retired) employees. Which plan is *your* plan is determined by the collective bargaining agreement (or subscriber agreement) between your union and employer. If you are unsure of which Plan is yours, call your local union, your employer or the Fund Administrator.

You are eligible to participate in the Bay Area Delivery Drivers Security Fund if:

- You are employed by an employer who has a collective bargaining agreement or an approved subscription agreement with a participating local union which provides for participation in a plan sponsored by the Fund,
- You work (or are compensated for) at least as many hours as required under the collective bargaining agreement for your employer to be obligated to contribute on your behalf,
- Your employer contributes to the Fund on your behalf on time and in the full amount required by the Fund, and
- You have completed and submitted an enrollment form to the Fund.

MINIMUM HOURS OF SERVICE REQUIREMENT

You are eligible to begin coverage under the Plan once you have met the Minimum Hours of Service Requirement as provided in the collective bargaining agreement (and/or approved subscription agreement) between your union and your employer.

You can begin coverage on the first day of the calendar month that follows the month in which you completed the service requirement. For most Plan participants, this will be the first day of the month that follows the month in which you complete your 80th hour of service. For example, if your first day of work is in May and your collective bargaining agreement requires you to work 80 hours before you begin participating in the Plan *and* you complete 80 hours of work by May 15, your coverage would begin on June 1st (provided that your employer makes the required contribution and your contract does not exempt probationary employees from the contribution obligation).

ENROLL IN THE PLAN

Although you may be eligible to participate in the Plan, you must also *enroll* to receive plan benefits. Benefits will not begin until the Administrator's Office has received your enrollment form. Enrollment forms can be obtained from the Fund Administrator and

from the Union. To ensure that you are eligible for benefits as soon as you meet the eligibility requirements, you should submit your enrollment form before completing the minimum eligibility requirements.

DESIGNATING YOUR BENEFICIARY

Several Plan benefits, including the Life Insurance, Accidental Death and Dismemberment and Survivor Income Life Insurance benefits, require you to designate a beneficiary. When you enroll in the Plan you should fill out and submit the beneficiary designation form. Your designation will determine who receives these benefits if you die. If you have not designated a beneficiary, the Plan will follow the rules on page 60 of this booklet.

KEEPING YOUR ELIGIBILITY

After you have met the initial eligibility requirements, you will maintain your eligibility from one month to the next if:

- You have worked the number of hours required under the collective bargaining agreement between your union and employer (typically 80 or more hours in a month), and
- Your employer makes the required contribution to the Fund on time and in full on your behalf, as required in its collective bargaining agreement, or
- You are not working, but the collective bargaining agreement still requires your employer to make payments on your behalf (because you are on leave, disability, etc.), or
- You have continued coverage by self payment (see "Continuation Coverage" beginning on page 11, or
- You qualify for continuation of health plan coverage if totally disabled (see page 11).

Contributions paid for hours worked in one month pay for coverage for the following month. For example, when your employer makes contributions on your behalf for the hours you worked in March, this contribution pays for your coverage for April.

Paid time off, such as vacations, sick leave and holidays, are counted as 'work hours' for eligibility purposes, and your employer is still obliged to contribute to the Fund on your behalf during such periods (unless the collective bargaining agreement specifically states otherwise).

ELIGIBILITY RULES–RETIREE PLANS 11A & 11B

To be eligible for the Retiree plan(s), you must *satisfy all* of the following rules:

First, you are eligible to participate in the Retiree plan if you are receiving:

- A pension from the Western Conference of Teamsters Pension Fund (or another Plan recognized for this purpose by the Board of Trustees), or
- Social Security old age benefits, or

- A pension from a plan sponsored by an employer that has participated in the Fund for at least ten consecutive years and has a current collective bargaining agreement and approved subscription agreement with a participating local union, or
- Federal Social Security disability benefits for which you qualified while working in employment covered by the Fund as an active employee; **and**

Second, while an active employee you must have been eligible for benefits under a Bay Area Delivery Drivers Security Fund Plan for active employees **for at least 60 months, including at least 48 out of the last 60 months immediately preceding the effective date of your pension or disability**; **and**

Third, you make the required monthly copayment, which is due on the first day of each calendar month. If you fail to make the payment within thirty days of the date it is due, your coverage will be terminated and cannot be reinstated; **and**

Fourth, the Employer from which you retired remains a contributing employer in one or more of the Fund's Plans for active employees: **IF YOUR FORMER EMPLOYER LEAVES THE FUND, ITS RETIREES LOSE ELIGIBILITY IN THE RETIREE PLAN EFFECTIVE AT THE END OF THE MONTH IN WHICH THE EMPLOYER STOPS CONTRIBUTING TO THE FUND.**

Why does a retiree lose eligibility in the Retiree Plan if his former Employer leaves the Trust Fund? Because the Retiree Plan is primarily funded through the contributions for active employees. Note, however, that if your former Employer files for bankruptcy and/or goes out of business, your retiree coverage will still continue.

DEPENDENT ELIGIBILITY RULES FOR ALL PLANS

Your dependents will be covered by the Plan when you establish eligibility or, if you are already enrolled in the Plan, when the dependent becomes an eligible dependent through birth, marriage, or adoption. You must make sure to *enroll* your eligible dependents in the Plan by contacting the Fund Office: they will not be entitled to benefits until they are enrolled. Different eligibility requirements apply for domestic partners, and are outlined under *"Domestic Partners"* on page 5.

DEFINITION OF A DEPENDENT

An eligible dependent is:

- Your legal spouse
- Effective January 1, 2005, your domestic partner (as defined by California's Family Code)
- Unmarried children who are younger than age 19, and who primarily depend on you for financial support, including:
    - your natural child
    - your stepchildren (including children of your Domestic Partner) who live in your household

- legally adopted children on the date they are placed with you in your home in anticipation of final adoption and who are entirely supported by you and live in your household
- children over whom you have been appointed Legal Guardianship
- children designated as your dependents in a valid and approved Qualified Medical Child Support Order, or for whom you have been designated as the child's legal guardian

- Unmarried dependent children who are over age 19, but under age 24 (age 21 for life insurance benefits) and are full-time students
- Unmarried mentally or physically disabled children of any age who are unable to support themselves and are primarily dependent on you for their support provided, (1) they were eligible and totally and permanently disabled before age 19; and (2) you furnished proof of the ongoing total and permanent disability within 31 days of your child reaching age 19 (and as may also be periodically required by the Fund after age 19)

A "full time student" is a student who is enrolled in an accredited school or college, is considered by that school or university as a full-time student, and is dependent upon you for financial support.

WHEN YOUR DEPENDENTS' ELIGIBILITY BEGINS

If you have dependents on the date you first become eligible to participate in the Plan, your dependents also become eligible on that date (but you must still enroll them to receive benefits). If you are already enrolled when you acquire a new dependent, the dependent becomes eligible on the following dates:

- For Your **Spouse**: The date on which a licensed officiant or other qualified and licensed public official solemnizes your marriage (*i.e.*, your marriage ceremony), ***provided*** that you enroll your spouse in the Plan ***and*** you submit your marriage certificate (in which case Plan coverage will be retroactively instituted back to the date of the ceremony)
- For Your Dependent **Child**: upon the child's birth or the date when you assume legal responsibility for the child (subject to the applicable age limits described above).
- For Your **Domestic Partner**: the first day of the month that follows the month in which you completed an application of enrollment of your domestic partner **and** provided the necessary documents to the Fund Administrator (see page 6)

If you are an active employee—***not a retire***e—and you die leaving only your spouse or domestic partner, he/she will remain eligible for the twenty-four (24) months after your death (starting with the first day of the month immediately following the date of your death) or until he or she remarries or enters into another domestic partnership. If you die leaving only dependent children, they will remain eligible for two years or until s/he no longer qualifies as a dependent, whichever occurs first.

If you die leaving both a spouse (or domestic partner) ***and*** dependent child(ren), your children's eligibility will be based on your surviving spouse's or domestic partner's participation. For example, if you die and your spouse/domestic partner remarries one year later, your child(ren) dependent on your spouse will also lose their coverage.

Note that these extensions of coverage for a spouse and dependent child(ren) run concurrently with any COBRA rights that may exist, not in addition to such rights. At the end of the two year extension described here, your spouse or dependent child(ren) may remain eligible to continue coverage through COBRA (see page 11). Note, however, Domestic Partners and the dependent child(ren) of a Domestic Partner are ineligible for COBRA (see page 12).

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order ("QMCSO") is a child support order which the Fund has determined to be qualified that creates, recognizes or assigns a child's right to receive benefits as your covered dependent. When a QMCSO providing for coverage of a child as your dependent is submitted to the Fund, the Fund will review the Order to determine whether it satisfies the legal requirements for a QMCSO (in other words, whether it is *"qualified"*). A medical child support order is not qualified unless it includes at a minimum all of the following:

- Name and last known address of the parent who is covered under this Plan,
- Name and last known address of each child to be covered under this Plan,
- A description of the type of coverage to be provided to each child named in the order, and
- The period of time the coverage is to be provided to each child.

QMCSOs should be sent to the Fund Administrator. If you do not enroll your child as required by the QMCSO, the Fund Administrator will do so when a valid QMCSO is received. The child named in the QMCSO will be enrolled in the Plan option you are enrolled in, unless the QMCSO specifies a particular option.

If you are not enrolled in the Plan, but a Qualified Medical Child Support Order is entered which requires you to provide support to your child, if you are otherwise eligible, the Fund will enroll you and the child named in the QMCSO. If you do not choose a Plan option, you will be automatically enrolled in the Indemnity Medical Plan and will be responsible for any employee contributions required by your collective bargaining agreement.

You may not drop health care coverage for children covered by a QMCSO unless you submit written evidence that the QMCSO is no longer in effect.

DOMESTIC PARTNERS

To be eligible for coverage as your dependent, you and your domestic partner must be of the same gender unless you or your domestic partner is over age 62: opposite sex domestic partners are covered if either of you are over age 62. You and your domestic partner must be each other's sole domestic partner and have filed a Declaration of Domestic Partnership with California's Secretary of State. To register as domestic partners with the State of California you and your partner must meet the following requirements:

- Neither of you is currently married or legally separated

- You and your domestic partner are at least 18 years old
- You and your domestic partner are of sound mind (*i.e.*, are legally competent to enter into a contract)
- You and your domestic partner are not related to such a degree that would prohibit you from marrying in the State of California
- Neither you nor your domestic partner is anyone else's domestic partner
- You both are jointly responsible for each other's basic living expenses
- You and your domestic partner share a common residence

For your domestic partner to receive benefits, you must enroll in the Plan by submitting to the Fund Administrator:

- An application of enrollment,
- A copy of your notarized Declaration of Domestic Partnership that you have filed with the Domestic Partner Registry of California's Secretary of State, and
- A copy of the Certificate of Domestic Partnership issued to you and your domestic partner by the Secretary of State.

TAX CONSEQUENCES OF DOMESTIC PARTNER ELIGIBILITY

Unless otherwise indicated (*e.g.*, as pertain to federal COBRA rights), your domestic partner is eligible for coverage to the same extent coverage is available to a legal spouse. However, federal tax laws require the Fund to determine how much of the monthly employer contribution to the Fund is attributable to the coverage of your domestic partner and to **report that amount as additional taxable income paid to you** unless you can show that for purposes of your federal income tax returns you have primary responsibility for your domestic partner's living expenses. In other words, if your domestic partner has a job or supports himself or herself through his or her own employment, you will have to pay the employee payroll taxes each quarter on part of the monthly employer contribution paid on your behalf.

Your employer must agree to pay any employer payroll taxes on the value of your domestic partner coverage. The Fund Administrator will mail to you and your employer a notice indicating the "fair market value" of the domestic partner coverage as well as a form for your employer to fill out indicating either that it will pay its share of the payroll taxes for your domestic partner coverage or affirm that it does not consider your domestic partner's benefits as taxable income. You may also be asked to provide supporting documentation and/or complete an attestation form certifying that you are primarily responsible for your domestic partner's living expenses.

The fair market amount will vary from year to year but is likely to be 40% or more of the monthly employer contribution.

YOUR DOMESTIC PARTNER'S ELIGIBILITY DATE

Coverage for a domestic partner and any eligible children of your domestic partner begins on the first day of the month after you submit the enrollment form, Declaration of

Domestic Partnership and Certificate of Domestic Partnership. Your domestic partner's coverage, and the coverage of any dependent children of your domestic partner, terminates on the earliest of the following dates:

- The date you and/or your domestic partner terminate your domestic partnership,
- The date a Notice of Termination of Domestic Partnership is filed with the Secretary of State,
- The date a Petition to Terminate your Domestic Partnership is filed in Court,
- The date on which you are no longer eligible for coverage, or
- The date dependent coverage for a spouse or child would terminate under the terms of the Plan.

ENROLLING IN THE PLAN

Although you may meet the Plan's requirements for eligibility, to receive benefits you and your dependents ***must*** also enroll in the Plan. You must do so ***before*** the Plan will provide coverage. As part of enrollment, you must provide copies of the following (as applicable):

- A marriage certificate for your spouse
- A Certificate and a Declaration of Domestic Partnership for your Domestic Partner
- Birth certificates for each of your dependent children
- Certificates of adoption or the equivalent for any adopted children
- For a foster child, the initial placement order or subsequent final orders placing the child in your foster care and the Foster Family Placement Contract you enter into with the applicable government agency
- For children over whom you have legal guardianship, a copy of the court order granting you legal guardianship

ENROLLMENT FOR NEWLY ELIGIBLE ACTIVE EMPLOYEES

When you first become eligible for the Plan, you must select a medical coverage provider. You may choose between either the Medical Plan or the Kaiser HMO. **If you do not make a choice, you will be automatically enrolled in the "Indemnity Medical Plan" described here.**

If you are enrolled in the Indemnity Medical Plan you can change to the Kaiser HMO option only during the annual open enrollment period, described below.

When you enroll for medical benefits in the active plan, you will be automatically enrolled for the following benefits:

- Dental benefits
- Vision coverage (through the Vision Service Plan)
- Employee Life Insurance and Survivor Income Benefits

- Dependent Life Insurance (if applicable for your spouse and/or eligible children)
- Accidental Death & Dismemberment (AD&D) Insurance
- Prescription Drug Coverage
- Alcoholism and Chemical Dependency Benefits (unless you have elected Kaiser, in which case you will receive this type of coverage through Kaiser)

ENROLLMENT FOR RETIREES IN THE RETIREE PLAN

You will not be eligible for the Retiree Plan until you enroll in the Plan (even if you have been covered without interruption under the Active Employee Plan prior to your retirement).

To enroll in the Retiree plan (see page 2 for eligibility rules) you must provide the following:

- Retiree Application competed by you and an officer of your Local.
- Copy of Pension Award Letter from Western Conference of Teamsters (or another Plan recognized for this purpose by the Board of Trustees) or
- Documentation showing you are eligible for (old age) Social Security Benefits or
- Documentation showing you are eligible for Social Security Disability Benefits.

Dependents who were eligible under your Active coverage will continue to be covered under your Retiree plan as long as they meet the definition of a dependent (see page 3).

All benefits remain the same as Active Employees **except Retirees and their dependents are not eligible for**:

- Dental benefits
- Dependent Life Insurance (there is a reduced Life Benefit for the Retiree)
- AD & D and survivor income benefit
- Short-Term Disability Income Coverage

ADDING OR DROPPING DEPENDENTS

If you are enrolled in either the Medical Plan or the Kaiser HMO and newly marry, establish a domestic partnership, or add a dependent child to your family you must notify the Fund Administrator. You must enroll your spouse or child within thirty days of the date of marriage or birth or adoption. If you drop dependents, for example, because of divorce or placement for adoption, you must notify the Fund Administrator, and you must complete and submit a new Bay Area Delivery Drivers Security Fund Enrollment Form to the Fund Administrator.

KAISER FOUNDATION HMO HEALTH PLAN

Kaiser Foundation Health Plan coverage is provided through the Fund as an alternative to the Indemnity Medical Plan benefits described in this booklet and the Plan–specific inserts. A description of the benefits available through the Kaiser Health Plan will be provided during the Open Enrollment Period or may be obtained by contacting the Fund Administrator.

If you choose to be covered under the Kaiser HMO Plan for medical/hospital benefits, Alcohol and Chemical Dependency Treatment benefits will also be provided through Kaiser. Any other benefits for which your group is eligible will be provided through the Fund.

HMO OPEN ENROLLMENT REQUIREMENTS

You and your eligible dependents will be automatically covered by the indemnity medical plan, unless you timely elect the Kaiser HMO option**. You must make this election on a separate HMO enrollment form**. Send your completed HMO enrollment form to the Fund Administrator for processing. Do not send this enrollment form directly to the HMO. The election you make applies to your entire family. **If you do not choose HMO coverage when you first become eligible for coverage, you will have to wait until the next annual Open Enrollment Period to elect Kaiser coverage.** The Kaiser Open Enrollment Period is ordinarily during the month of July – this is the only time you can switch to the Kaiser HMO plan.

Provided that you keep the Fund aware of any changes in your home address, you will receive a notice, normally in June of each year, of your option to change to the HMO plans, and instructions regarding how to secure enrollment literature and forms for changing your provider. You may request from the Fund Administrator a packet explaining your options and containing a change request form.

WHEN COVERAGE ENDS

ACTIVE PLAN PARTICIPANTS

Your coverage generally ends on the earliest of the following:

- The date the Plan terminates
- The end of the month for which the last employer contribution is made on your behalf
- The 32nd day after you enter the U.S. armed services on a full-time basis (if you fail elect to self-pay as described on page 21)
- The date your eligibility for coverage ends as described under "Continuation Coverage" beginning on page 11
- The date your employer ceases to be a Participating Employer
- The date you retire, are pensioned, leave voluntarily, or are dismissed from employment, or the date you otherwise stop active work for your employer

RETIREE PLAN PARTICIPANTS

Coverage ends for Retirees and their dependents upon:

- The date the Plan terminates or contributions made on your behalf cease
- The first day of the month for any month in which you have failed to make the required monthly co-contribution on time and in full
- The Retiree's Death
- When the employer from which you retired continues in operation but ceases to be a Participating Employer

DEPENDENTS OF ACTIVE AND RETIREE PLAN PARTICIPANTS

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

- The date your dependent ceases to be an eligible dependent under the Plan (for example, for your spouse upon divorce or your children when they reach the Plan's maximum age allowed for dependent children)
- The date your coverage terminates
- The date your dependent enters the U.S. armed services on a full-time basis.
- The date the Plan terminates, or the date the Plan terminates coverage for dependents

CONTINUATION COVERAGE

In this chapter you'll find information on:

- Extended coverage during a period of disability, a family leave or military leave
- Your right to pay for a limited period of continuation coverage under federal or state law

This chapter describes your rights under the rules of the Plan, and under federal and state law, to purchase continued coverage when your employer-paid coverage ends.

CONTINUATION OF HEALTH PLAN COVERAGE IF TOTALLY DISABLED

In the event that you cease active work because you become Totally Disabled (see definition on page 81), the Fund will extend health coverage for you and your dependents for a period not to exceed six months, provided that you remain continuously and Totally Disabled and are not gainfully employed. If your total disability ends or you become employed prior to the end of that six month period, your extended coverage will end before expiration of the full six month period. The six month period will commence with the first day of the month following the last month in which your coverage would have terminated but for this extension

Once the six month period ends, you may extend coverage of certain Plan benefits by electing and paying for COBRA Continuation Coverage, as described below.

COBRA CONTINUATION COVERAGE

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that requires the Fund to provide you and your eligible dependents with the opportunity to continue your health coverage at your expense when your employer-paid health coverage ends as the result of a "Qualifying Event." COBRA applies to medical, dental and vision coverage but not to life insurance, AD&D insurance, and loss of time or disability coverage; however, you may convert your life insurance coverage to an individual policy as described under *"Conversion Privilege For Group Life & Survivor Income Insurance Coverage"* on page 65.

Under the circumstances, explained below, you must inform the Fund Administrator when you or your dependent experiences a COBRA "qualifying event" that entitles you to COBRA coverage (excepting a loss of employment or reduction hours, which your employer must report). If you are enrolled in the Kaiser HMO option, you may also be eligible for "Cal-COBRA," a California law allowing for continuation coverage, explained below.

YOUR COBRA "QUALIFYING EVENTS"

You become eligible for COBRA when a "qualifying event" occurs. A qualifying event occurs when:

- Your employment is terminated, or
- Your work hours are reduced such that you do not meet the service requirements under the collective bargaining agreement necessary to require your employer to make the monthly health coverage contribution on your behalf (for example, the labor agreement requires a contribution after you work 80 hours or more in a month but you only work 60 hours).

YOUR DEPENDENTS' COBRA "QUALIFYING EVENTS"

Your dependents become eligible for COBRA when they experience the following qualifying events:

- Your employment is terminated
- Your work hours are reduced, resulting in your loss of coverage
- You divorce (for spouse and step-children only, not your dependent natural or adopted children)
- Your dependent ceases to be eligible for coverage under the terms of the Plan (e.g., your child reaches the maximum age limitation, or your child is no longer a full-time student)
- You die*

* See the special eligibility rules for your spouse and dependents described under "When Your Dependents' Eligibility Begins" on page 4.

Note: To elect COBRA coverage, you must be covered under the Plan on the day before the qualifying event. Children born, adopted or placed with you for adoption during COBRA continuation coverage can be added to your COBRA coverage, as can a new spouse if you marry during your COBRA coverage period, however such new dependents do not experience a qualifying event if any of the above events occur during your COBRA coverage.

Also note that under federal law your domestic partner and his or her eligible dependents are *not* eligible for COBRA continuation coverage. Domestic partners may, however, be eligible for Cal-COBRA continuation coverage if enrolled in the Kaiser HMO. Check your HMO plan description for more information.

COBRA NOTIFICATION REQUIREMENT

You and your dependent are responsible for informing the Fund Administrator of a qualifying event such as divorce, legal separation, reaching an age limit, or loss of full-time student status. If you lose coverage because you experience a qualifying event related to your employment, your employer will inform the Fund. **If you divorce your dependent no longer meets the Plan's eligibility rules, you must inform the Fund Administrator within 60 days of the qualifying event or 60 days from the date your coverage ends, whichever is later.**

Your notification must be made in writing on a form that may be obtained, for no cost, by calling the Fund Administrator at the number below. Notice can be provided by anyone acting on your or your dependent's behalf. If you fail to provide notice within this time period, you will not be able to elect COBRA continuation coverage. You must send notice of a Qualifying Event to the Fund Administrator at *Bay Area Delivery Drivers Security Fund, P.O. Box 2358, Livermore, California 94551-2358.*

The notice must contain, at a minimum, the name of the participant and any spouse or dependents seeking COBRA coverage, a description of the Qualifying Event and the date on which the Qualifying Event occurred. If the notice is incomplete, you may be asked by the Fund Administrator to provide additional information.

Your Employer must notify the Plan of other Qualifying Events (such as your termination, a reduction in your hours or your death) within **30 days** of your loss of coverage.

If your Plan coverage ends because of your death, termination of employment or because of reduced work hours, you and your dependents will receive information from the Fund Administrator regarding your COBRA coverage rights within thirty days of any of these events. You and/or your dependents will then have **60 days** to elect COBRA coverage.

NOTICE OF UNAVAILABILITY OF COBRA

If you or your dependent provide the Fund Administrator with a notice of a Qualifying Event, second Qualifying Event or a determination of disability by the Social Security Administration, and the Plan Administrator determines that you or your dependent is not entitled to COBRA coverage or extended COBRA coverage, the Fund Administrator will send you or your dependent a notice that explains the reasons why you are not entitled to COBRA coverage. This notice will be sent to you within **14 days** of receiving the initial notice of a Qualifying Event.

ELECTING COBRA COVERAGE

After being notified of a Qualifying Event, the Fund Administrator will send a letter to you and your dependents explaining your options to continue coverage. This letter will be sent to the address of record maintained by the Fund Administrator. **You and your dependents are responsible for keeping the Fund Administrator informed of your current mailing address.**

It is important that you read this letter carefully. You and your dependents have 60 days from the later of (a) the date they receive the notice letter, or (b) the date coverage terminates, to make a written election to continue coverage under COBRA. **If you do not elect COBRA coverage within the 60-day election period, you and/or your dependents will lose the right to elect COBRA coverage.**

You will be asked to choose between COBRA "Core" or COBRA "Core-Plus" coverage (see "Cobra Coverage Options," below, for an explanation of each type of coverage).

If you elect COBRA continuation coverage, you pay the full cost of coverage for you and your dependents plus a 2% administration fee (102% of the cost of the coverage to the Fund). This amount is established annually by the Board of Trustees. The premium rates will not change for twelve months following a rate change unless the Board revises the Plan.

Your first payment should be sent with your COBRA election form, but must be made within 45 days of the date on which you elect COBRA coverage. Payment will not be accepted after 45 days from that date, and you must pay for any services or costs you incurred from the time your coverage terminated. Your first payment must cover the cost of COBRA coverage retroactive to the date your employer-paid coverage ended. You are responsible for ensuring that the amount of the first payment is enough to cover this entire period. You may contact the Fund Administrator to confirm the correct amount of your first payment. **Subsequent payments will be due the first day of each month, and will not be accepted more than 30 days late.** If you make a monthly payment later than the first of the month, but before the end of the grace period for that month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. **Your COBRA coverage will terminate if you do not make your premium payment before the 30-day grace period ends.**

WHEN COBRA COVERAGE BEGINS

If you choose COBRA coverage at any time during the 60-day election period, coverage will be retroactive to the date of the Qualifying Event.

COBRA PAYMENT SHORTFALLS

If you or your dependent remits a timely monthly contribution to the Fund Administrator, but the payment is significantly less than the amount due, the COBRA coverage will be terminated immediately. The Fund considers any COBRA payment to be significantly less if it is short by $50 or 10% of the monthly COBRA payment, whichever amount is less.

For payments that are not significantly less than the amount due, but are still short of the actual monthly COBRA payment, the Fund Administrator will notify you or your dependent of the amount of the deficiency and permit you or your dependent to pay the balance within 30 days of the date of the notice of deficiency. You or your dependent is responsible for paying all deficiencies. If you do not receive such a notice from the Fund for payments not significantly less than the amount owed, your payment will be deemed to be sufficient payment for that month only and should not be understood to indicate that you can reduce your COBRA premium in future months.

DURATION OF COBRA COVERAGE

The maximum period for which you, your spouse or your dependents may continue coverage under COBRA is as follows:

Employees: 18 consecutive months from the date of the Qualifying Event.

Dependents:

- If employer-paid coverage ends as a result of the employee's reduction of hours or termination, coverage may be continued under COBRA for a maximum period of 18 consecutive months from the date of the Qualifying Event.
- If employer-paid coverage ends as a result of the employee's death or divorce, COBRA coverage may be continued for a maximum of 36 consecutive months from the date of the Qualifying Event.*
- If employer-paid coverage for a dependent child ends because the child no longer qualifies as a "dependent" under the Plan, the child may continue coverage under COBRA for a maximum of 36 consecutive months from the date of the Qualifying Event.*

* Although a spouse or dependent child may have more than one Qualifying Event, the maximum duration of COBRA Continuation Coverage is 36 consecutive months from the date of the *first* Qualifying Event.

Disabled Employee and Disabled Dependents:

If coverage ends and the employee or dependent is certified as "disabled" pursuant to Titles II or XVI of the Social Security Act) at any time during the first 60 days after the COBRA Qualifying Event, COBRA coverage may be continued for up to an additional 11 months for a total of 29 months.. To qualify for this additional COBRA period, you must notify the Trust Fund within 60 days of the Social Security Administration's disability determination (and no later than the end of your first 18 months of COBRA coverage). The extra 11 months of disability COBRA coverage will be subject to a higher monthly COBRA cost.

You or any affected dependent must also notify the Fund Administrator within 30 days of a determination that you are no longer disabled. The additional COBRA continuation coverage (i.e., coverage beyond the original 18 months) will end if you or any affected dependent is no longer disabled.

EXTENDED COVERAGE DUE TO A SECOND QUALIFYING EVENT

If your dependents have COBRA coverage due to your termination or reduction in work hours, and another Qualifying Event (such as your death, a divorce or a child's loss of dependent status) occurs during the initial 18-month COBRA period, your affected dependents are entitled to an additional 18 months of COBRA continuation coverage.

If you become entitled to Medicare either (1) *after* you have elected COBRA coverage, your dependents may continue coverage for up to 36 months from the date of the original Qualifying Event; or (2) within the 18 months *before* your termination or reduction in hours, your covered dependents may continue coverage for up to 36 months from the date you became entitled to Medicare.

You or your dependents must notify the Plan of any second Qualifying Event within 60 days after it occurs. Your failure to timely inform the Fund Administrator will result in your loss of the right to extend COBRA coverage.

EFFECT OF NOT ELECTING COBRA

In deciding whether or not to elect continuation coverage, you should remember that if your group health coverage is not continued it might affect your rights under the federal law as follows:

- If you have more than a 63-day period without any health coverage your next group health plan can impose preexisting condition exclusions.
- Your rights to purchase individual health insurance policies that do not impose preexisting condition exclusions may be limited if you forgo continuation coverage in your group plan for the maximum time available to you.

You should also remember that you have the right to request special enrollment in another group health plan which might be available to you (such as through your spouse's employer) within 30 days after termination of your group health coverage if the loss of coverage is due to the events listed above. You will also have this same special enrollment right if you elect COBRA and continue coverage to the end of the period allowed.

WAIVER OF COBRA

If you waive your right to continue coverage under COBRA and if within the 60-day election period you decide that you would like to continue coverage, you may revoke that waiver as long as you send in the election form within that 60-day period. However, your coverage will only be reinstated as of the date of your election and you will not have coverage for any claims that you may have incurred between the date of your loss of coverage due to a Qualifying Event and the date that you revoked your waiver and elected COBRA.

SPECIAL COBRA RIGHTS FOR TRADE DISPLACED EMPLOYEES

If you lost coverage under the Plan because your employer shifted production to another country or because of detrimental competition from foreign imports, you may be eligible for a tax credit for your COBRA payments, provided you qualify for trade adjustment assistance or alternative trade adjustment assistance from the federal government and your state government. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance. Under the new tax provisions, eligible individuals can take a tax credit on their tax returns of 65% of premiums paid for qualified health insurance, including COBRA coverage. Advance payments of the tax credit may also be available.

If you have already lost medical coverage under the Plan, but within six months become eligible to receive trade adjustment assistance, you may also be entitled to a second COBRA election period. To qualify, you must provide a copy of the certificate issued to you by your state workforce agency entitling you to federal trade adjustment assistance to the Fund Administrator, which will provide you with a COBRA election notice. Your

election to continue coverage must be made within 60 days from when you first become eligible for trade adjustment assistance, but no later than six months after you lost Fund medical plan coverage. If you elect COBRA during this period, COBRA will begin on the first day of the second election period. Your COBRA period, however, will be measured from the date you lost coverage under the Plan. In other words, the second election period will not extend the length of COBRA coverage.

If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

WHEN COBRA COVERAGE ENDS

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

- The end of the 18-, 29- or 36-month COBRA coverage period (whichever is applicable)
- The thirtieth (30th) day an outstanding COBRA payment is delinquent or short
- The date your employer terminates its participation in the Plan and its active employees are enrolled in another group health plan (e.g. if this Plan is replaced with another plan).
- The date you or your dependent becomes covered by another group health plan, unless that plan limits or excludes coverage of your or your dependents' preexisting condition, in which case the date the preexisting condition is covered by the other plan or the end of the 18, 29, or 36 month COBRA period, whichever occurs first
- The date a person on COBRA coverage becomes entitled to Medicare Part A, Part B or both
- The month that begins 30 days after a disabled person on extended COBRA coverage is no longer disabled
- The date the Plan terminates (however if the Plan is replaced, coverage may continue under the new plan)
- The date coverage is terminated for cause on the same basis as for a similarly situated non-COBRA beneficiary, e.g., for filing a fraudulent claim or making a misrepresentation to the Fund Administrator. (The Trustees reserve the right to rescind coverage to the effective date of coverage.)

NOTICE OF EARLY TERMINATION

If the Plan terminates COBRA coverage prior to the end of your or your dependent's 18-, 29- or 36-month coverage period, the Fund Administrator will provide you or your dependent with a notice as soon as practicable following the Fund Administrator's determination to terminate COBRA coverage. The notice will explain the reason for the early termination, the effective date of the termination, and the availability of alternative group or individual coverage, if any.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, you should keep the Fund Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

COBRA COVERAGE OPTIONS

You and your dependents must elect either:

- COBRA "Core-Only": hospital-medical and prescription coverage only, or
- COBRA "Core-Plus": hospital-medical, prescription, dental coverage and vision care.

COBRA Core-Plus will cost more than COBRA Core-Only because more benefits are provided. Benefits are the same as for eligible employees and deductibles and copayments will apply as if there has been no gap in your coverage. The COBRA rates are adjusted annually and may be obtained from the Fund Administrator. Once you have elected Core-Only coverage you may not change to Core-Plus, and vice versa.

Although Life Insurance Benefits are not continued under COBRA, when your life insurance benefits end you will have the option to convert to an individual policy, as described on page 65 of this booklet.

AUTOMATIC COVERAGE FOR DEPENDENTS

When you choose to continue coverage, the coverage for your eligible dependents will continue automatically, unless your spouse independently declines coverage. If you do not elect coverage, your dependents may elect COBRA coverage on their own.

CONTINUATION OF COVERAGE AFTER COBRA

At the end of the 18-, 29-, or 36-month COBRA period, you may be entitled to enroll in an individual conversion plan if you are a Kaiser participant. This plan may cost more and provide fewer benefits than your group health coverage and you will generally have only 30 days to apply for this coverage after you lose group coverage. Contact Kaiser if you are interested in this option.

MEDICAL EXTENSION FOR DISABILITY

If you or your dependent is totally disabled at the time your active coverage ends, or at the time of your COBRA qualifying event, and you do not elect COBRA continuation coverage, the Plan will extend coverage for up to twelve months, **but coverage will only extend to services required for the treatment of the illness or injury causing the disability.** The twelve-month period begins on the first day of the month. Coverage will continue without employer payment for up to twelve months, but will terminate the earliest of:

- When the total disability ceases, or
- When you or your disabled dependent begins to receive coverage under another health plan (and your health costs are not excluded by the preexisting condition rules of the other health plan), or
- One year after the extension starts (*i.e.*, the last day of the twelve month period following the date of extension).

CALIFORNIA CONTINUATION OF COVERAGE RIGHTS

If you live in California and are enrolled in Kaiser, under "Cal-COBRA" you can extend coverage beyond the 18 or 29 months permitted under federal COBRA. California law requires HMOs in the state to offer qualified beneficiaries who exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage, to a total of 36 months from the date federal COBRA began. **This state law requirement does not apply to the self-insured Bay Area Delivery Drivers Medical Plan and is only available to individuals who have elected Kaiser coverage**. Therefore, your decision to choose the Medical Plan or Kaiser will affect your right to continuation coverage. However, because federal COBRA beneficiaries generally have the same enrollment rights as active employees, you may be able to switch to an HMO even after you elect COBRA coverage to take advantage of these state rights. Cal-COBRA coverage may be subject to a higher monthly cost than federal COBRA coverage.

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:

- Have a Medi-Cal share-of-cost of no more than allowed under HIPP provisions, **and**
- Have a high cost medical condition for which the average monthly cost is twice the amount of the monthly COBRA premium.

In addition, persons unable to work because of disability due to HIV/AIDS may qualify if they have a total monthly income less than a percentage allowed under HIPP provisions of the poverty level established by the federal government.

To Enroll in HIPP or to find out more information and requirements, call 800-952-5294.

WITHDRAWAL OF A CONTRIBUTING EMPLOYER

Loss of eligibility because your employer or former employer leaves the Fund is not a COBRA Qualifying Event. However, if you or your dependents are already COBRA covered when your former employer stops contributing to the Fund, you may continue your coverage under COBRA to the end of your continuation period (i.e., 18 months, 36 months) until the active employees formerly covered by this Fund are enrolled in a new Plan. At that point your COBRA Continuation Coverage will be terminated under this Plan since your former employer is required to provide COBRA Continuation Coverage for you and/or your dependents under its new plan for "similarly situated" active employees.

If you are retired from a Participating Employer and thereby enrolled in the Retiree Plan, and your former employer withdraws from the Plan, your retiree coverage ends.

FAMILY LEAVE

The federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) provide that in certain situations employers of 50 employees or more are required to grant leave of **up to three months** to employees to take care of family needs such as the birth and/or care of a newborn, a newly adopted child, care of an ill child or spouse, or for the care of your own serious health condition. The employer is required to continue the employee's health coverage during FMLA/CFRA leave.

It is not the role of the Trustees or the Fund Administrator to determine whether you are entitled to leave with continuing medical care under the FMLA or CFRA. Any disputes regarding continuation of benefits during a leave must be resolved by the employer and the local union.

To the extent that you are entitled to leave with continuing medical coverage, the Plan will provide continuing medical coverage so long as required monthly contributions are received from your employer. Rights under this section are independent of your rights under COBRA, or the Plan's extension of coverage for disabilities. However, a COBRA Qualifying Event may occur if you do not return to work at the end of your FMLA/CFRA leave, or if you give your employer definite notice that you do not intend to return to work.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This federal law may affect your health coverage if you are enrolled or become eligible to enroll in a health plan that excludes coverage for preexisting medical conditions. The Fund does not exclude coverage for preexisting medical conditions. However, the information contained in this section is important if your coverage ends and you become eligible for coverage in another plan.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a preexisting condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a preexisting condition exclusion.

Please note that your prior health coverage may not be used to reduce any preexisting condition limitation if there has been a break in coverage of 63 days or more between your loss of coverage under this Plan and the beginning of coverage under your new plan.

CERTIFICATE OF COVERAGE

When you or your dependent lose medical, dental and/or vision coverage under the Plan, the Trust Fund will send to your last known address a "Certificate of Coverage" that states how long you were continuously covered under the Plan. You will receive this Certificate even if you elect to continue your coverage through COBRA (as described beginning on page 11).

You may need this Certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that existed prior to your enrollment in the new group plan (for more information on this, see "Health Insurance Portability and Accountability Act" on page 20).

If you have any questions or need a Certificate of Coverage, contact the Fund Administrator.

LEAVE FOR MILITARY SERVICE

The Uniformed Services Employment and Re-Employment Rights Act (USERRA) provides that your employer-paid coverage under the Plan continues if you leave your job for active duty or training in the U.S. Armed Forces for a period of 31 days or less. If the leave extends beyond 31 days, you are entitled to self-pay for coverage for up to 24 months from the date your leave started, or the date your leave ends if you do not reapply for employment with your employer, whichever occurs first. If you elect to continue coverage under USERRA, the amount charged will be determined by the Board of Trustees from time to time and shall not be more than one hundred two percent (102%) of the full premium under the Plan, determined in the same manner as the applicable premium under COBRA. The procedure for electing USERRA self-pay coverage is the same as the procedure for electing COBRA, described on page 11.

INDEMNITY MEDICAL PLAN BENEFITS

For Active and Retired Participants

In this chapter you'll find:

Basic vs. Major medical

- Annual deductible
- Maximum you pay each year for covered charges
- Lifetime maximum for benefit payments
- Participating providers
- Required pre-authorizations
- Special provisions regarding women's health care
- Additional Exclusions from medical coverage

The text in this Chapter is intended to be used with the medical insert that applies to your Plan. This Chapter describes Medical Plan benefits—if you elected the Kaiser HMO option instead, the Fund Administrator or Kaiser will send you Kaiser's *Your Health Plan Coverage,* a booklet describing the Kaiser medical benefit plan. That information should be considered part of and kept with this SPD.

BASIC VS. MAJOR MEDICAL

The Medical Plan pays two types of medical benefits—Basic Medical and Major Medical:

- Benefits are paid under Basic Medical first. To the extent covered charges remain after Basic Medical benefits have been paid, benefits are then paid under Major Medical.
- Both Basic Medical and Major Medical are subject to benefit-specific limits. Major Medical is also subject to a lifetime maximum on the amount the Fund will pay in benefits.
- Some benefits are payable **only** under Basic Medical or only under Major Medical. See your insert for more information.

ANNUAL DEDUCTIBLE (MAJOR MEDICAL ONLY)

The deductible is the amount you must pay in **covered charges each calendar year** before your Plan starts paying major medical benefits.

Basic Medical coverage does not have a deductible.

Major Medical coverage is payable after you have satisfied the deductible shown on your insert. Only charges to which a deductible applies can be used to satisfy the deductible. The deductible is waived for home health care and hospice care.

FAMILY DEDUCTIBLE MAXIMUM

Once a certain number of covered individuals in your family have met the deductible, you will have satisfied the maximum deductible for your entire family. Your Insert shows you how many individual deductibles you must pay in a calendar year to satisfy the Family Deductible.

END-OF-YEAR CARRYOVER

If you incur charges during the last 3 months of a calendar year that are applied toward satisfying the deductible for that year, those charges will also be applied toward your deductible for the next calendar year.

COMMON-ACCIDENT DEDUCTIBLE

If you and your covered dependents incur Major Medical covered charges as a result of injuries suffered in a common accident, just one deductible will be applied during each calendar year to those charges.

However, this common accident provision will not apply if greater medical benefits would be paid in the absence of this provision.

MAXIMUM YOU PAY EACH YEAR FOR COVERED CHARGES (MAJOR MEDICAL ONLY)

Under Major Medical, you and the Fund each pay a percentage of covered charges. After a calendar year's Major Medical covered charges for an individual reach a certain level (shown in your Insert), the Fund pays 100% of covered charges for that individual for the rest of the calendar year (up to the Plan's lifetime maximum – see Insert).

However, out-of-pocket payments for the following benefits, which are subject to their own annual maximums, are not counted toward this out-of-pocket maximum:

- Outpatient psychiatric treatment and psychological testing
- Acupuncture
- Diabetes education

Note: Benefit-specific limits and the lifetime maximum continue to apply to Major Medical benefits even after you have reached the level at which Fund coverage changes to 100%. Any charges beyond such limits or maximums remain non-covered charges.

LIFETIME MAXIMUM FOR BENEFIT PAYMENTS (MAJOR MEDICAL ONLY)

The Fund will not pay more than the lifetime maximum shown in your Insert for all Major Medical covered charges incurred by an individual during his lifetime.

PARTICIPATING PROVIDERS

Your medical care costs will be significantly lower if you use a "participating provider"—a physician, hospital, laboratory or other health care provider who has contracted with the Plan's preferred provider organization—the *Blue Cross Prudent Buyer Plan*—to provide services at a special network rate.

- Because participating providers charge less, the Fund saves money when you use their services.
- You also save when you use a participating provider because less will be charged against your Major Medical lifetime maximum. Also, the percentage you pay will be applied to the participating provider's discounted rate, rather than the full rate of a non-participating provider.
- You may use a non-participating provider if you wish, but be aware that the costs will be higher.

Finding a Participating Provider

You can find participating providers online by using the provider finder at www.bluecrossca.com. Lists of Blue Cross Prudent Buyer participating providers are also available at no charge from the Fund Administrator.

REQUIRED PRE-AUTHORIZATIONS

All Plans require that you get advance approval for certain services.

The following chart provides an overview of the Plan's pre-authorization requirements:

Requirements for Pre-Authorization	
Situation	**Requirement**
Admission to a hospital for mental health treatment	• Non-emergency admissions must be reviewed and approved in advance by Blue Cross. • If you or a dependent is admitted on an emergency basis, you must have the hospital contact Blue Cross so that it can conduct a concurrent review.
Hospice care	• Services must be pre-authorized by the Fund.
More than 15 visits for chiropractic or physical therapy	• Visits in excess of 15 per course of treatment must be pre-approved by the Fund as medically necessary.

HOSPITAL ADMISSIONS FOR MENTAL HEALTH TREATMENT

Pre-admission review and authorization is required for non-emergency inpatient mental health hospitalizations. The purpose is to determine whether inpatient care is medically necessary or whether alternative forms of care may be more appropriate. Review and authorization must take place **before** the non-emergency hospital admission.

Blue Cross performs reviews of hospital admissions. The toll-free number for Blue Cross is 800-274-7767. Pre-authorization is ordinarily provided by telephone and in many cases on the same day as your physician's call.

After you are admitted, concurrent review is designed to ensure that each day of your hospital stay is medically necessary. Concurrent review occurs at required intervals. In many cases, the review will confirm that the intended length of stay is medically appropriate. However, if the intended length of stay does not appear to Blue Cross to be medically necessary, a Blue Cross physician will consult with your physician regarding your treatment plan.

If you or your dependent is admitted for mental health treatment on an emergency basis, please ensure the hospital contacts Blue Cross so that concurrent review may begin.

HOSPICE CARE

Hospice services require pre-authorization by the Fund. You are responsible for ensuring that your physician calls the Fund Administrator (at 800-654-1824 or 925-449-7070) to obtain pre-authorization.

CHIROPRACTIC CARE AND PHYSICAL THERAPY

Also called "musculoskeletal therapy", the Plan will not cover more than 15 visits per course of treatment unless you receive pre-authorization beforehand. Benefits will be payable for more than 15 visits if the additional visits are approved in advance as medically necessary. You are responsible for seeing that your physician calls the Fund Administrator (at 800-654-1824 or 925-449-7070) to obtain this advance approval.

Appealing a Decision

Requests for required pre-authorizations are considered "pre-service claims" (*or "urgent care claims," if a decision needs to be made on an expedited basis*). If you disagree with the decision made on your request for pre-authorization, you may appeal it. See the information on the applicable type of claim in "Filing a Claim for Benefits and Claim Appeals Procedures" on page 83, later in this booklet.

SPECIAL PROVISIONS REGARDING WOMEN'S HEALTH CARE

Federal law guarantees coverage for treatment of the following conditions applicable to women:

- Under the Women's Health and Cancer Rights Act of 1998, all plans that cover mastectomies are also required to cover related reconstructive surgery. The Medical Plan complies with this requirement. Available reconstructive surgery includes both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage is also available for breast prostheses and for the physical complications of mastectomy, including lymphedemas. Charges for these services will be covered medical charges for a covered person that has had a mastectomy.

- Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans generally may not 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 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 may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay that doesn't exceed 48 hours (or 96 hours). The Medical Plan complies with these requirements.

CONDITIONS OF PAYMENT

The Fund only pays charges for services and supplies that are "medically necessary," and the charge must be a "covered medical charge" as defined below.

"MEDICALLY NECESSARY"

With respect to each service and supply, the term "medically necessary" means that the service or supply meets all of the following tests:

- It is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects, and birth defects.
- It is appropriate for the symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards.
- It is not mainly for the convenience of the covered person or the covered person's physician or other provider.
- It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in an acute care hospital or other facility, this test means that the covered person needs to be confined as an inpatient due to the nature of the services rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through outpatient treatment.

The requirement that services and supplies must be medically necessary does not apply to the preventive care that is specifically covered by the Medical Plan.

"COVERED MEDICAL CHARGE"

A "covered medical charge" is a charge that is made for a medically necessary service or supply (with the exception mentioned above under the heading "Medically Necessary") for preventive care) that is furnished to a covered person and meets all of the following tests:

- It is a covered medical charge under Basic Medical coverage or Major Medical coverage.
- It is incurred while the patient is covered by the plan. (*A charge is deemed to be incurred at the time the service or supply for which the charge is made is rendered or furnished*.)

- It is not excluded under any listing contained in the "Not Covered" or "Exclusions from Coverage" sections of this booklet or by the plan's "General Limitations and Exclusions."

The following two factors also determine whether a charge is covered:

- ***Usual, Customary and Reasonable (UCR):*** Any part of a charge that exceeds the UCR charge that applies to a service or supply will not be covered.
- ***Benefit maximums.*** Once you reach a benefit maximum, the charges to which a benefit maximum applies are no longer considered covered charges.

COVERED SERVICES AND SUPPLIES — BASIC MEDICAL

Use of the term "covered medical charges" in this section describing the Plan's Basic Medical coverage assumes that the charges meet the tests discussed under "Conditions of Payment" above. See your Insert for information concerning the amount of covered charges payable by the plan.

HOSPITAL SERVICES AND SUPPLIES — BASIC MEDICAL

Covered medical charges are the charges listed below:

- The room and board charge of an acute care hospital for each day a covered person is an inpatient, up to the maximum number of days and the covered charge limit shown in the benefits chart in your insert
- The charges of an acute care hospital, other than room and board charges, for the following:
  - Medical services and supplies furnished to a covered person who is an inpatient, including hospital charges for blood, plasma, or private duty nursing
  - Medical services and supplies (including charges for blood or plasma) furnished to a covered person for emergency outpatient treatment of injuries sustained in an accident. The treatment must start within 48 hours after the accident occurred.
- Laboratory tests and x-ray examinations (including charges for blood count or urinalysis) that are prerequisite to hospitalization and are performed on an outpatient basis within 7 days before the covered person is admitted to the hospital for surgery
- The charges for professional ambulance service to or from a local acute care hospital where treatment is given, up to the maximum shown on your Insert

Note: If a hospital admission is for mental health treatment, benefits for hospital services and supplies will not be payable unless the admission is pre-authorized. See "Required Pre-Authorizations" earlier in this chapter.

Also note: Some benefits for hospital services and supplies shown on your insert are payable per Period of Disability.

NEWBORN NURSERY CARE

(This benefit is available only to a newborn of employees or spouses: dependents' newborns are* not *covered.)

The charge for routine nursery care furnished to a newborn well baby while the mother is an inpatient is a covered medical charge. The requirement that benefits be paid only for a charge that is medically necessary does not apply to this benefit.

Benefits for newborn "well babies" are limited to those payable for covered charges incurred for routine nursery care and miscellaneous hospital services from birth until release from the hospital. Any limits shown on your insert for hospital supplies and services for dependents will apply to well-baby care benefits.

ADDITIONAL ACCIDENT COVERAGE — BASIC MEDICAL

To be payable under this additional accident coverage benefit, charges must be incurred for treatment of injuries sustained in an accident within three (3) months of that accident. Only charges that exceed the benefits paid under any other Basic Medical coverage will be paid under this benefit.

Covered medical charges are the charges listed below, up to the maximum shown on your insert:

- The charges of an acute care hospital, ambulatory surgical center, or urgent care center
- The charges of a physician or nurse
- The charges for medical and dental services and supplies
- The charge for professional ambulance service to or from any of the following local facilities where treatment is given: an acute care hospital, an ambulatory surgical center, or an urgent care center

SURGERY AND ANESTHESIA — BASIC MEDICAL

Covered medical charges are the charges made by a physician or allied health professional for the professional services listed below, up to the maximum shown on your insert for all procedures performed during a period of disability. The maximum paid for any particular procedure is determined under a "Relative Value Schedule."

For surgical procedures that are performed in a physician's office, an outpatient hospital facility, or an approved ambulatory surgical center, the Fund will also pay an amount up to the maximum shown on your insert for surgical supplies used in connection with the surgery. Any charges exceeding that amount are considered charges under the Major Medical component.

SURGERY GUIDELINES

If two or more surgical procedures are performed at the same time, the covered medical charges will be limited to those incurred for the major procedure plus no more than 50%

of those incurred for each lesser procedure that adds significant time or complexity. The benefit for performing surgery includes normal follow-up care and the administration of any local, digital block, or topical anesthesia. Reduced benefits may be paid for the administration of other anesthetics if done by the operating or assisting surgeon.

DOCTOR VISITS — BASIC MEDICAL

COVERED

- The professional services charges made by a physician (up to the maximums shown on your Insert) for:
  - office visits
  - visits in an acute care hospital
  - visits at any other place

Note: In addition to the other limitations on mental health hospital admissions noted above, charges for inpatient treatment of mental, nervous, or emotional disorders or conditions will be covered charges only if they are incurred while the patient is confined in a hospital for at least 24 hours.

NOT COVERED

The following are excluded from coverage under Basic Medical:

- outpatient visits for psychological testing or psychiatric treatment (*such visits are covered only under Major Medical*).
- visits for acupuncture (*such visits are covered only under Major Medical*).
- visits for outpatient chiropractic or physiotherapy (*such visits are covered only under Major Medical*).
- visits for diabetes instruction (*such visits are covered only under Major Medical*).
- home health and hospice (*such visits are covered only under Major Medical*).
- phone consultations.

DIAGNOSTIC X-RAY AND LABORATORY SERVICES — BASIC MEDICAL

Covered medical charges are the charges made by a physician, allied health professional, or laboratory for laboratory tests or x-ray examinations, up to the maximums shown on your Insert.

"Specified disabilities" include only the following: poliomyelitis, scarlet fever, typhoid fever, diphtheria, leukemia, spinal meningitis, encephalitis, rabies, tetanus, tularemia, and smallpox.

For the disabilities specified above, covered medical charges are the charges listed below (up to the maximum shown on your insert) that are incurred for treatment of a specified disability within 2 years after that disability is contracted and that exceed the benefits paid under all other Basic Medical coverage for treatment of that disability:

- the charges of an acute care hospital, ambulatory surgical center, or urgent care center
- the charges of a physician or allied health professional
- the charges for medical services and supplies
- the charge for private duty nursing by a registered nurse who is other than a member of the patient's family and who does not normally reside with the patient, when authorized by the attending physician
- the charge for professional ambulance service, or railroad or airplane transportation, from the place where the covered person is when the specified disability is contracted to a hospital or sanitarium qualified to provide treatment for the disability

Physical Exams

Physical exam coverage is for the employee only, and benefits will be payable (up to the maximum shown on your Insert) for the charges of a physician or health screening facility for a routine physical examination, including the charges for routine diagnostic tests and x-rays in connection with the physical examination.

Cancer Screens

Preventive care benefits are also payable for routine screening for cancer, including cervical cancer. Covered screenings will be based on American Cancer Society recommendations and guidelines provided they also meet approval of the Federal Food and Drug Administration

NOT COVERED

- Any physical examination required for employment or for which an employer is required to pay
- School/sports examinations

COVERED SERVICES AND SUPPLIES – MAJOR MEDICAL

Use of the term "covered medical charges" in this section describing the Plan's Major Medical coverage assumes that the charges meet the tests discussed under "Conditions of Payment" above. The Major Medical Plan covers the charges listed below, to the extent benefits are not payable under Basic Medical. See your Insert for information on the percentage payable by the Plan for different services and supplies.

HOSPITAL SERVICES AND SUPPLIES — MAJOR MEDICAL

COVERED

- The room and board charge of an acute care hospital for each day a covered person is an inpatient
- The charges of an acute care hospital, other than room and board charges, for medical services and supplies furnished to a covered person who is an inpatient
- The charges of an acute care hospital for medical services and supplies furnished on an outpatient basis
- The charges of an outpatient hospital and ambulatory surgical center
- The charges for professional ambulance service to or from a local acute care hospital where treatment is given

Note: If a hospital admission is for mental health treatment, benefits for hospital services and supplies will not be payable unless the admission is pre-authorized. See "Required Pre-Authorizations" earlier in this chapter.

SURGERY, ANESTHESIA, AND RADIATION THERAPY — MAJOR MEDICAL

COVERED

The charges of a physician or allied health professional for the following professional services:

- Surgery, subject to the Surgery Guidelines below
- Anesthesiology, subject to the Surgery Guidelines below.
- Radiation treatment

Surgery Guidelines: If two or more surgical procedures are performed at the same time, the covered medical charges will be limited to those incurred for the major procedure plus no more than 50% of those incurred for each lesser procedure that adds significant time or complexity. The benefit for performing surgery includes normal follow-up care and the administration of any local, digital block, or topical anesthesia. Reduced benefits may be paid for the administration of other anesthetics if done by the operating or assisting surgeon.

DOCTOR VISITS AND VISITS TO OTHER PRACTITIONERS — MAJOR MEDICAL

COVERED

- The charge of a physician or allied health professional for the following professional services:
  - office visits
  - visits in an acute care hospital
  - visits at any other place
- *See "Doctor Visits Basic Medical" on page 29 regarding doctor visits for mental health treatment.*
- The charge for acupuncture treatment by a certified acupuncturist or other allied health professional, subject to the maximum benefit and limit on sessions shown on your Insert
- Covered medical charges for up to 15 outpatient visits for chiropractic or physical therapy per course of treatment (unless additional treatments are pre-approved as medically necessary)
- The following incurred for the initial office visit concerning infertility: laboratory test, and screening laparoscopy for the purpose of determining the cause of the infertility
- Allergy testing (except for the tests listed under "Not Covered" immediately below)

NOT COVERED

- Phone consultations
- Any charges made for artificial insemination, in vitro fertilization, or any other treatment for infertility
- The following allergy tests: cytotoxic, sublingual, and provocative neutralization testing

MENTAL HEALTH TREATMENT — MAJOR MEDICAL

COVERED

- Charges for inpatient treatment of mental, nervous, or emotional disorders or conditions, but only if such charges are incurred while the patient is hospital-confined for at least 24 hours. Note: All non-emergency admissions for psychiatric treatment require pre-authorization, as explained under "Required Pre-Authorizations" earlier in this chapter.
- Charges of a physician for outpatient psychological testing or outpatient treatment of mental, nervous, or emotional disorders or conditions, subject to the limit on sessions shown on your insert

PREVENTIVE CARE — MAJOR MEDICAL

COVERED

- Charges for generally accepted tests for routine cancer screening (covered screenings will be based on American Cancer Society recommendations and guidelines)

- The charges for well child care for a dependent child who is under 17 years of age are listed below. The requirement that benefits be paid only for a charge that is medically necessary does not apply to this benefit.
- Well child care charges include the following:
    - The charge of a physician for the initial pediatric examination of a newborn performed before the child is released from nursery care
    - The charges of a physician for no more than 18 outpatient visits at about these ages: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, and 16 years
- The covered services at each outpatient visit may include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests, in keeping with prevailing medical standards

NOT COVERED

- School/sports examinations

DIABETES TREATMENT AND MANAGEMENT **MAJOR MEDICAL**

Covered medical charges include charges for the following equipment and supplies if they are not covered by your Plan's prescription drug program:

- blood glucose monitors and blood glucose testing strips
- blood glucose monitors designed to assist the visually impaired
- insulin syringes
- visual aids (except eyewear) to assist the visually impaired with proper dosing of insulin
- ketone urine testing strips
- lancets and lancet puncture devices
- pen delivery systems for the administration of insulin
- podiatric devices to prevent or treat diabetes-related complications

Covered medical charges also include charges incurred for a diabetes self-management training program, up to $100 per calendar year, that:

- teaches a covered person the proper use of the equipment, supplies, and medications prescribed for the treatment of diabetes and/or
- provides additional diabetes outpatient self-management training, education, and medical nutrition therapy.

Diabetes self-management training, education, and medical nutrition therapy must be provided by a physician, nurse, dietitian, pharmacist, or other licensed health care provider who is licensed or registered to provide the diabetes training, education, or medical nutrition therapy.

For coverage of insulin pumps and all related necessary supplies for the pump see "Durable Medical Equipment, Prostheses, and Medical Supplies" on page 34 below.

HOME HEALTH CARE — MAJOR MEDICAL

The Fund pays 100% of the covered charges incurred for home health care services provided by an approved home health care agency, subject to the lifetime maximum shown on your insert for benefits payable under Major Medical. The Major Medical deductible does not apply to home health care.

For benefits to be payable:

- the services must have been prescribed by a physician, to be performed in your home,
- the services must have been prescribed as medically necessary for the care and treatment of bodily injury or disease, and
- the services must be performed by or under the supervision of a person who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a hospital.

The benefits payable for such services will not exceed the amount that would have been payable had the services been performed in a hospital.

NOT COVERED

- Housekeeping and custodial care.

HOSPICE CARE — MAJOR MEDICAL

If a covered person is terminally ill with a prognosis of 6 months or less to live, the Fund will pay benefits for services rendered by an approved hospice agency at 100% of the covered charges incurred, subject to the lifetime maximum shown on your insert for benefits payable under Major Medical. The Major Medical deductible does not apply to hospice care.

Benefits will be provided for both inpatient and home hospice care, including palliative and supportive medical and nursing services.

Benefits will be payable only if the attending physician establishes and reviews the treatment plan and submits the plan to the Fund Administrator for approval before services are provided.

DURABLE MEDICAL EQUIPMENT, PROSTHESES, AND MEDICAL SUPPLIES (IF PRESCRIBED BY A PHYSICIAN) — MAJOR MEDICAL

COVERED DURABLE MEDICAL EQUIPMENT

The charge to rent or purchase durable medical equipment. Durable medical equipment is equipment that:

- is designated for repeated use,
- is mainly and customarily used for medical purposes, and
- is not generally of use to a person in the absence of a disease or injury.

Durable medical equipment includes, but is not limited to, equipment such as hospital beds, wheelchairs, iron lungs, traction apparatus, insulin pumps, intermittent positive pressure breathing machines, braces, and crutches.

The purchase of durable medical equipment will be covered only if the purchase price of the equipment is less than the rental costs.

COVERED MEDICAL DEVICES SUCH AS INSULIN PUMPS, CPAP MACHINES AND WHEELCHAIRS

The Plan covers usual, reasonable and customary charges for the initial purchase of medical devices such as insulin pumps for diabetics, Continuous Positive Airway Pressure (CPAP) machines for the treatment of sleep apnea, and wheelchairs. The Plan will cover usual, reasonable and customary charges for one replacement device provided that at least *two* of the following conditions are met:

- old device is out of warranty
- old device is no longer supported by the manufacturer or the manufacturer has gone out of business
- old device cannot be repaired for less than the cost of a new device
- replacement parts for old device are no longer available
- (if applicable to intended purpose of the device) old device cannot utilize or deliver the drug required in the proper dose or amount as specified by the patient's physician

COVERED PROSTHETICS

The Plan covers usual, reasonable and customary charges for the initial prosthetic device and any medically necessary repairs to that device. If a prosthetic is determined to be beyond reasonable repair the Plan will cover one replacement prosthetic.

OTHER COVERED CHARGES

- The charge of a physician or allied health professional for casts, splints, surgical dressings, and other medical supplies
- The charge for oxygen, blood, blood products, anesthetics, or other medical supplies
- Orthotics (limited to once every two years)

NOT COVERED

Air conditioners, air purifiers, heat lamps, heating pads, bed boards, orthopedic shoes, gravity traction devices, exercise bicycles, weight lifting equipment, whirlpool baths, hot tubs and specially equipped vans. This is only a partial list of the types of equipment and devices the Fund does not consider durable medical equipment and is provided for illustrative purposes. If you have a question concerning whether a particular item will be covered call the Plan Administrator's Office.

ADDITIONAL SERVICES AND SUPPLIES — **MAJOR MEDICAL**

COVERED

- The charge of a physician, allied health professional, or laboratory for a laboratory test or x-ray examination
- The charge for the professional services of a nurse for private duty nursing, but only during a period for which the Fund Administrator validates a physician's certification that:
  - those nursing services are medically necessary, and
  - for outpatient nursing, the covered person would be an inpatient at an acute care hospital or other facility in the absence of those nursing services.
- The charge for professional ambulance service to or from a local acute care hospital or other facility where treatment is rendered
- The charge (on the same basis as any other disease) for obstetrical services, prenatal care, operations for ectopic pregnancy, and miscarriage; however, benefits for the pregnancy of a dependent daughter will be payable only for treatment of the complications of pregnancy

ADDITIONAL EXCLUSIONS FROM MEDICAL COVERAGE

In addition to the general exclusions to Plan coverage listed on page 68 and elsewhere in this booklet, the following exclusions apply to benefits provided under both the Basic and Major Medical coverage. No Medical Plan benefits will be paid for or in connection with the following:

1. Charges for artificial insemination, in-vitro fertilization, hormone therapy or any other treatment of infertility
2. Charges for cytotoxic, sublingual and provocative neutralization testing
3. Charges incurred for a treatment that is not generally accepted by the medical profession, or is listed as experimental, under investigation or limited to research: by the federal Food and Drug Administration (FDA), the American Medical Association (AMA), Diagnostic and Therapeutic Technology Assessment (DATTA), or the Office of Medical Application of Research of the National Institute of Health Office of Technology Association (OMT). However, if a treatment has not been addressed by one of the organizations listed above, the Plan may determine if a treatment is appropriate based on the advice of its medical review and/or the review of an independent medical reviewer or other medical experts.

4. Any service or supply that is not incurred as the result of a disease or injury or is not medically necessary, except as specifically provided
5. Any service or supply that is shown as not covered in the "Covered Services and Supplies" sections of this chapter or the plan's "General Limitations and Exclusions"
6. Any service or supply that is not prescribed by a physician or by an allied health professional who is practicing within the scope of his license
7. Any drugs or medicines, other than those furnished to a covered person who is an inpatient or medically necessary drugs administered in a physician's office (Note: see "Prescription Drug Benefits" beginning on page 42 for information on prescription drug benefits.)
8. Custodial care, regardless of who prescribes or renders such care
9. Treatment of an addiction to, dependence on, or abuse of a drug or chemical (including alcohol) (Note: see "Benefits for Treatment of Alcoholism and Chemical Dependency" beginning on page 39 for information on benefits for alcoholism and chemical dependency treatment.)
10. Eye refractions, orthoptics, glasses, contact lenses, or the fitting of glasses or contact lenses, except for the first pair of glasses or first pair of lenses for use after cataract surgery (Note: see "Vision Benefits" beginning on page 53 for information on vision benefits.)
11. Hearing aids, any examination for hearing aids, or the fitting of hearing aids
12. Routine physical examinations, except as specifically provided for in the physical examination benefit for employees or the well child care benefit
13. Reversal of sterilization
14. Any procedure performed mainly to improve the appearance of the covered person, unless it is reconstructive surgery following a mastectomy or it is for cosmetic surgery for repair of damage sustained in an accident and the charges are incurred within 1 year from the date of the accident or within a reasonable time thereafter
15. Any service or supply to diagnose, treat, repair, or replace the teeth, gums, or supporting structure of the teeth, or repair of damage to sound natural teeth unless the damage is sustained in an accident and the charges are incurred within 1 year from the date of the accident. "Sound natural tooth" means a tooth that is organic and formed by the natural development of the body (not manufactured), has not been extensively restored, and has not become extensively decayed or involved in periodontal disease. (Note: see "Dental Benefits" beginning on page 47 for information on dental benefits.) **Note:** This exclusion will not exclude benefits for facility or anesthesia charges incurred for a child under age 7 or for a person of any age who is severely disabled or whose health would be at serious risk without the use of general anesthesia for purposes of dental treatment.
16. Charges for care in a rest home or convalescent facility
17. Treatment related to gender changes or complications therefrom
18. Any treatment related to sexual dysfunction not explicitly covered elsewhere
19. Smoking cessation programs
20. Preventive care except as specifically provided
21. Environmental equipment

22. Radial Keratomy, Lasik or any procedure to reduce or replace need for glasses or contact lenses
23. Replacement of Durable Medical Equipment or prosthesis except as specifically included on page 35.
24. Expenses related to diet control or counseling, weight loss or physical conditioning even if ordered by a physician (except the diabetes self-management training program described on page 33)
25. Expenses related to the treatment of obesity (except for surgery to treat Morbid Obesity)
26. Expenses associated with a dependent child's pregnancy, except for complications of pregnancy
27. A private hospital room that is not medically necessary
28. Chelation therapy except for acute arsenic, gold, mercury or lead poisoning
29. Charges for any services related to alternative medicine, including holism, homeopathic treatment, orthomolecular services, massage therapy and any other kind of similar treatment

BENEFITS FOR TREATMENT OF ALCOHOLISM AND CHEMICAL DEPENDENCY

For Active and Retired Participants

In this chapter you'll find:

- A quick-reference guide to your benefits
- How the plan works
- Required pre-authorizations and other actions
- Providers you may use
- Covered treatments
- Exclusions from coverage

The benefits described in this chapter are available to you only if you are enrolled in the Medical Plan. If you elected Kaiser HMO coverage, your benefits for treatment of alcoholism and chemical dependency are provided through Kaiser.

Treatment of alcoholism or other chemical dependencies under the Plan is provided exclusively through the Teamsters Assistance Program of Northern California (TAP).

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Summary of Alcoholism and Chemical Dependency Benefits	
Benefits for Covered Services	
Inpatient detoxification (Basic Medical)	• Plan pays 100% of usual, reasonable, and customary charges for a stay of up to 3 days in an acute care facility as part of your Basic Medical coverage. These amounts do not count toward your Rehabilitative Benefit under TAP ($7,500/$3,750). • Lifetime Maximum: Up to 2 confinements.
Inpatient rehabilitative treatment at an approved facility (TAP)	• First admission: Plan pays 100% of covered charges, up to $7,500. Second admission: Plan pays 50% of covered charges, up to $3,750. • Lifetime Maximum: Up to 2 treatments of up to 30 days each.
Outpatient rehabilitative treatment	• Plan pays 80% of usual, reasonable, and customary charges. • Limit of 50 visits and $2,000 in benefit payments per calendar year.

HOW YOUR TAP COVERAGE WORKS

The plan provides for three types of treatment: inpatient detoxification, inpatient rehabilitative, and outpatient. All three require notification of TAP or pre-authorization

by TAP, and all three are subject to benefit limits. Full coverage up to the above-referenced limits requires completion of the program and restricts the facilities and programs you may use.

Other than detoxification, these benefits are separate from your medical benefits, so they are not subject to any medical plan deductibles or lifetime maximum benefits. Covered charges for treatment of alcoholism or chemical dependency do not count toward any calendar-year limit on amounts you have to pay for your covered medical charges.

REQUIRED PRE-AUTHORIZATIONS AND OTHER CONDITIONS OF COVERAGE

The following chart provides an overview of the requirements that apply to the different types of treatment.

Requirements for Payment of Benefits	
Type of Treatment	**Conditions of Payment**
Inpatient detoxification	Benefits will not be payable unless you • notify TAP within 48 hours of your admission, and • begin a rehabilitative program immediately following detoxification treatment.
Inpatient rehabilitative	Benefits will not be payable unless you • obtain pre-authorization for your admission from TAP, and • use a TAP-approved facility.
Outpatient treatment	Benefits will not be payable unless you • obtain pre-authorization for your treatment from TAP, and • use a TAP-approved provider.
Note: If you start a rehabilitative program and do not complete it in full, no benefits will be payable for future detoxification or rehabilitative charges.	

To request pre-authorization or notify TAP of an admission for detoxification, call 510-562-3600. All communication with TAP is strictly confidential.

Note: Requests for required pre-authorizations are considered "pre-service claims" (*or "urgent care claims," if a decision needs to be made on an expedited basis*). If you disagree with the decision made on your request for pre-authorization, you may file an appeal. See the information on the applicable type of claim in *"Filing a Claim for Benefits and Claim Appeals Procedures"* beginning on page 83.

PROVIDERS YOU MAY USE

For inpatient rehabilitative treatment, the Plan covers only TAP-approved facilities. For outpatient treatment, you may use only TAP-approved providers. The TAP counselor will refer you to an approved facility or provider when you call for the required pre-authorization.

For inpatient detoxification, you may use any licensed acute-care facility (provided you notify TAP within 48 hours of admission). Remember, however, that costs will be lower if you use a Blue Cross Prudent Buyer facility. Call the Fund Administrator or go online to www.bluecrossca.com to find a Prudent Buyer facility.

COVERED TREATMENTS

INPATIENT DETOXIFICATION TREATMENT

Benefits for detoxification in a licensed acute care facility are payable under your Basic Medical coverage at 100% of usual, reasonable, and customary charges. This benefit allows a maximum of two treatments of up to three days during each covered person's lifetime.

INPATIENT REHABILITATIVE TREATMENT

The Plan allows up to two TAP-authorized treatments of up to 30 days each during a covered person's lifetime.

The Fund will pay 100% of covered charges for the first admission, to a maximum of $7,500, and 50% of covered charges for the second admission, to a maximum of $3,750.

OUTPATIENT TREATMENT

The Fund will provide coverage for TAP-authorized outpatient treatment for up to 50 visits per year, payable at 80% of usual, reasonable, and customary charges up to an annual maximum of $2,000 per individual per year.

EXCLUSIONS FROM COVERAGE

The Fund will not pay benefits for:

1. any treatment for which you fail to comply with the requirements shown under "Required Pre-Authorizations and Other Conditions of Coverage" earlier in this chapter
2. any treatment that exceeds the limits described under "Covered Treatments" above
3. any treatment excluded under the Plan's "General Limitations and Exclusions" (see page 68)

PRESCRIPTION DRUG BENEFITS

For Active and Retired Participants

In this chapter you'll find:

- A quick-reference guide to prescription drug benefits
- How the plan works
- Mandatory Maintenance Mail Service Program
- Medicare Part D Creditable Coverage
- Use of retail pharmacies
- Mail-order service
- Covered prescription drugs
- Exclusions from coverage

Whether you are enrolled in the Medical Plan or the Kaiser HMO option, your prescription drug coverage is provided under the program described here.

Your Plan provides benefits for medically necessary drugs you purchase at retail pharmacies or through the plan's mail-order service. The Fund has contracted with Prescription Solutions to administer these benefits.

The following chart is intended to provide a convenient quick-reference guide to your prescription drug benefits. More detailed information follows the chart.

Summary of Prescription Drug Benefits	
Benefits for Covered Drugs	
Prescription filled at a participating retail pharmacy	As of January 1, 2008 here are no co-pays for covered prescription drugs filled at a participating retail pharmacy.
Prescription filled at a non-participating retail pharmacy	Plan benefits will be limited to 175% of the wholesale cost for the smallest therapeutic package plus a $1.65 professional fee. You will pay any amount over this limit.
Prescriptions ordered through the plan's mail order service	You must use the mail order service for all maintenance medications.

HOW THE PLAN WORKS

If you use a participating retail pharmacy or the mail-order service, you will pay nothing for your prescription to be filled.

You may also use a non-participating pharmacy, but you will be responsible for any part of the cost that is beyond the Plan's limit.

Prescriptions will be covered for no more than a 100-day supply.

Prescription drug benefits are separate from your medical benefits, so they are not subject to any medical plan deductibles or lifetime maximum benefit limitation. The covered

charges of prescription drugs do not count toward any calendar-year limit on amounts you have to pay for your covered medical charges.

(***Note:*** *The benefits described in this chapter do not apply to prescription drugs furnished to you while you are in the hospital, which are covered, depending on where you are enrolled, under the Medical Plan or Kaiser's hospital benefits*.)

ALL PLAN PARTICIPANTS: MANDATORY MAINTENANCE MAIL SERVICE PROGRAM

Effective January 1, 2008, all plan participants taking a prescribed Maintenance Medication for a period longer than 90 days must use the Prescription Solutions mail order pharmacy. AFTER 90 DAYS YOUR PRESCRIPTION WILL NOT BE COVERED UNLESS YOU USE THE MAILORDER PROGRAM. **If you fill your maintenance medication prescription through a retail pharmacy after the first 90 days it will not be covered under your Plan.** ("Maintenance Medications" are detailed on page 77). If you are an active participant, once you have filled a prescription for six months through the mail order service, you may go back to filling the prescription through a retail pharmacy.

You can contact the Mail Order Pharmacy at 1-800-562-6223 (if you provide the name and phone number of the doctor who prescribed your maintenance medication, Prescription Solutions can obtain your prescription directly from your doctor). Or, your Doctor can call Prescription Solutions at 1-800-791-7658 to authorize a new prescription.

MEDICARE PART D CREDITIABLE COVERAGE

Whether you are enrolled in a retiree plan or active plan, the prescription drug coverage offered by the Fund is comparable to prescription drug plans offered under Medicare "Part D" (Medicare prescription drug coverage). The federal Centers for Medicare and Medicaid Services (CMS) will consider your coverage under the Fund to be "creditable," which means that, on average, the Fund will pay as much or more for your prescription drug coverage than Medicare would pay if you enrolled in Part D. How much the Fund must charge its Retirees for coverage is also dependent upon receipt of the Medicare Part D payment to the Fund for providing "creditable coverage": *Therefore, you should **not** enroll in Medicare Part D coverage if you have prescription drug coverage under the Bay Area Delivery Drivers Security Fund.*

Medicare expects you to enroll in a Part D drug plan as soon as you become eligible, and charges higher premiums to late enrollees, *unless you are already covered by creditable prescription drug coverage* like your coverage under the Bay Area Delivery Drivers Security Fund. Because your coverage under this plan is deemed "creditable," by Medicare for purposes of Part D, if you decide to enroll in Part D in the future – because, for example, your Fund coverage terminates – you will not be penalized for late enrollment in Part D. If your Fund coverage ends, you will have 62 days to enroll in another Medicare Part D drug plan without incurring a late enrollment premium.

USE OF RETAIL PHARMACIES

PARTICIPATING PHARMACIES

Prescription Solutions has a large network of participating retail pharmacies. Using a participating pharmacy works to your advantage in the following ways:

1. You do not have to worry about submitting a claim for reimbursement.
2. Your prescription is covered at 100%. You have no co-pay

To take advantage of these features, you must present your Prescription Solutions identification card to the pharmacy each time you have a prescription filled.

NON-PARTICIPATING PHARMACIES

You also have the option of filling your prescriptions at a pharmacy that is *not* part of the Prescription Solutions Pharmacy Network. If you use a non-participating pharmacy, you will have to pay the full cost of the prescription at the time of purchase and request reimbursement afterward. Benefits paid by the Fund for a drug purchased at a nonparticipating pharmacy are limited to 175% of the wholesale cost for the smallest therapeutic package plus a $1.65 professional fee. Submit to the Fund Administrator for payment the tag attached to your prescription drug which shows the following: name of patient, RX number, name of drug, strength, quantity purchased and manufacturer of drug.

Participating Pharmacy List

A list of participating pharmacies is available at no cost from the Fund Administrator. You can also call Prescription Solutions (800-788-7871) or go online (www.rxsolutions.com) to find a participating pharmacy.

MAIL-ORDER SERVICE

Pre-addressed envelopes for using the Prescription Solutions mail-order service are available from the Fund Administrator. This service offers a convenient way to fill prescriptions for drugs you will be taking on a longer-term basis.

The first time you have a prescription filled through the mail-order service, you will be asked to complete a health history profile for your protection.

No copayment is required for mail order prescriptions.

When your prescription is sent to you, the package will include a form and envelope for ordering refills. You may also order refills by phone (800-562-6223) or online at www.rxsolutions.com.

COVERED PRESCRIPTION DRUGS

There is no "formulary" or list of covered drugs. Generally, a drug will be covered if it has been approved by the U.S. Food and Drug Administration (FDA) and not prescribed for treatment excluded by the Plan. The drugs in the following list are examples of drugs typically covered by the Plan. If you have a question regarding whether a particular drug is covered, you may call the Prescriptions Solutions help desk at 800-788-7871.

Benefits are payable for the following:

- Pharmaceuticals requiring a written prescription and dispensed by a licensed pharmacist (or by a hospital pharmacy during a period not involving hospital confinement for the treatment of an illness or injury)
- Compounded dermatological preparations such as ointments and lotions that must be prepared by a pharmacist according to your physician's prescription
- Therapeutic vitamins, cough mixture, elixir terpin hydrate, N.F., antacids, and eye and ear medications prescribed by your physician to be used in the treatment of a specific illness
- Insulin and diabetic supplies
- Prescription contraceptives
- Epinephrine, U.S.P., ephedrine sulfate – 25 mg. (3/8 gr.), ferrous sulfate, U.S.P
- Injectable drugs only if purchased exclusively through Prescription Solutions' "Specialty Drug" mail order (see "Mail Order Service" above)

  Note: However, the following Injectable drugs are exempt from the mail order requirement: (1) Injectables routinely administered at a doctor's office or hospital (*e.g.,* chemotherapy) covered under the Medical Plan (or Kaiser); and (2) Injectables that must be taken immediately to address life-threatening circumstances. For this purpose, "life threatening circumstances" is not intended to apply to any medication required to treat a serious medical condition but only to circumstances where the symptoms presented make it necessary to administer the Injectable immediately.

For the drugs that are **not covered** by the Plan, see the "Exclusions from Coverage" section below.

EXCLUSIONS FROM COVERAGE

No prescription drug benefits will be paid for the following:

1. patent or proprietary medicines not requiring a prescription
2. contraceptive devices (other than prescription contraceptives or diaphragms)
3. immunization agents, biological sera, blood or blood plasma, or medication prescribed for parenteral use or administration (except insulin)
4. appliances and other non-drug items
5. multiple and non-therapeutic vitamins, cosmetics, dietary supplements, or health and beauty aids

6. smoking cessation medication
7. drugs for which reimbursement is provided or paid for by any other group plan or federal, state, county, or municipal government program
8. any single filling or refilling of a prescription for drugs taken in accordance with the doctor's directions in excess of a 100-day period unless a prior written agreement has been reached with the Fund
9. prescription charges due to occupational injuries or due to sickness covered by Workers' Compensation laws or similar legislation
10. drugs not approved by the FDA
11. prescription drug claims filed more than 90 days after the prescription is filled
12. any charges excluded under the Plan's "General Limitations and Exclusions" beginning on page 68.
13. cosmetic, health or beauty aids
14. fertility drugs

DENTAL BENEFITS

For Active Participants Only

In this chapter you'll find:
- A quick-reference guide to dental benefits
- How the plan works
- Recommended pre-determination
- Preauthorization of Dental Benefits
- Covered services
- Exclusions from coverage

Note: **THERE ARE NO DENTAL BENEFITS FOR RETIREES**. *If you are a retiree, the information in this chapter does* ***not*** *apply to you.*

The text in this chapter supplements the information in your Insert.

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Summary of Dental Benefits	
General Plan Features	
Calendar-year deductible	No deductible
Maximums for benefit payments	See the benefits chart in your Insert
Benefits for Covered Services All percentages payable by the plan are subject to the maximums for benefits payments shown on your insert.	
Diagnostic and Preventive Benefits	
Diagnostic: • **Oral examinations** • **X-rays** • **Diagnostic models** • **Emergency palliative treatment** • **Specialist consultation**	Plan pays 90% of covered charges
Preventive: • **Prophylaxis (cleaning) (twice in a calendar year)** • **Fluoride treatment (for children to age 18 only) (twice in a calendar year)**	Plan pays 90% of covered charges

Basic Benefits	
• **Fillings** • **Space maintainers** • **Sealants on permanent first and second molars for dependent children** • **Oral surgery** • **Root canals** • **Periodontics (treatment of gums and bones supporting teeth)**	Plan pays 90% of covered charges
Major Restorative Benefits	
• **Crowns and cast restorations**	Plan pays 90% of covered charges
Prosthodontic Benefits	
• **Bridges** • **Dentures**	Plan pays 90% of covered charges
Orthodontic Benefits	
• **Orthodontia**	Plan pays 70% of covered charges

HOW THE PLAN WORKS

You may use any licensed dentist you wish.

The Fund will pay the percentage of covered charges shown in the chart above, subject to the two maximums shown on the benefits chart in your Insert:

- a calendar-year maximum on benefits for services other than orthodontia, and
- a lifetime maximum on benefits for orthodontia.

RECOMMENDED PREDETERMINATION

After an examination, your dentist will determine the treatment to be provided. If the cost of the services will be $500 or more, it is strongly recommended that your dentist ask the Fund Administrator for a predetermination of benefits before proceeding with the proposed treatment.

Predetermination is always recommended for orthodontic work.

To obtain a predetermination of benefits, your dentist should submit an attending dentist's statement to the Fund Administrator. (*If your dentist needs a claim form for this, he or she can get one from the Fund Administrator.*) The Fund Administrator can

then advise you and your dentist ahead of time whether the proposed treatment is covered under the plan and, if so, the amount that will be payable by the Fund for such treatment.

If you request predetermination for treatment while you are an active participant and then retire, the predetermined treatment will be covered if the services are rendered within one month of your retirement date.

COVERED SERVICES

Subject to the dental benefit maximums shown on your Insert, the Fund pays the percentages shown below for the covered charges, not to exceed the Usual, Customary and Reasonable Charge of services received from a licensed dentist.

To be covered, services must be necessary and customary, as determined by the standards of generally accepted dental practice.

DIAGNOSTIC AND PREVENTIVE SERVICES

The Fund pays 90% of covered charges for the following:

- Diagnostic services
- Oral examinations
- X-rays (full-mouth X-rays limited to once every three years, bite-wing X-rays limited to twice each calendar year under age 18 and once each calendar year thereafter)
- Diagnostic models
- Emergency palliative treatment
- Specialist consultation
- Preventive care
- Prophylaxis (cleaning) (limited to two times in a calendar year)
- Fluoride treatment for children to age 18 (limited to two times per calendar year)

Diagnostic and Preventive services that **are not** covered, include

- Cleanings where gross residual calculus remains
- X-rays that are diagnostically unacceptable
- Sealants on previously restored teeth unless the restoration was to the lingual or buccal surfaces only
- Fluoride treatment for individuals age 18 or older—and fluoride treatment more than twice in a calendar year for a covered dependent under age 18
- Dietary planning for control of dental caries
- Separate instruction in oral hygiene and “plaque control”
- Space maintainers where first permanent and second deciduous molars are in occlusion

- Spacers when spaces have closed or the crowns of erupting teeth have penetrated alveolar bone

BASIC SERVICES

The Fund pays 90% of covered charges for the following:

- Fillings—amalgam, synthetic porcelain, and plastic restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) **Note:** For composite fillings on posterior teeth, the maximum the plan pays is the amount it would pay for amalgam fillings
- Space maintainers
- Sealants on permanent first and second molars for dependent children
- Oral surgery—extractions and certain other surgical procedures, including pre- and post-operative care
- Endodontics—treatment of the tooth pulp
- Periodontics—treatment of gums and bones supporting teeth

MAJOR RESTORATIVE SERVICES

The Fund pays 90% of covered charges for the following:

- Crowns and cast restorations for treatment of carious lesions that cannot be restored with amalgam, synthetic porcelain, or plastic restorations

The following restorative expenses **are not** covered:

- Replacement of crowns, fixed partial dentures, and removable prosthetic appliances (dentures, full and partial) within five years of placement
- Cast restorations when the tooth can be restored with an amalgam or with a composite resin restoration
- Composite resin restorations on posterior teeth
- Dowels, posts, and pins unless insufficient coronal structure remains to retain the crown restoration
- Any porcelain cast metal crown or porcelain fused to metal crown for patients under age 16 (allowance will be made for acrylic or stainless steel crown)
- Two restorations on a single tooth surface during one visit
- Permanent restorations performed within two months of remineralization (recalcification)
- Allowance for multiple restorations on one tooth that exceed the cost of a covered crown
- Pulp capping unless the pulp is exposed or nearly exposed
- Crowns with defective margins
- Grossly under-filled or over-filled root canal fillings
- Interim partial dentures (stayplates) except (1) to replace extracted anterior teeth for adults during healing period; (2) as an anterior space maintainer for children; or (3) as a

temporary alternative to a permanent prosthesis in the presence of progressive periodontal disease likely to lead to further tooth loss

PROSTHODONTIC SERVICES

The Fund pays 90% of covered charges for the following:

- Prosthodontics (procedures for construction or repair of fixed bridges or partial or complete dentures)

ORTHODONTIC SERVICES

The Fund pays 70% of covered charges for Orthodontia.

Benefits for orthodontia will be extended after eligibility expires for expenses incurred for a course of treatment begun before eligibility was lost. This extension will end 6 months from your loss of coverage or, if earlier, the date you are eligible for another plan of coverage or the date the plan is terminated.

EXCLUSIONS FROM COVERAGE

Dental benefits will not be paid for the following:

1. Dental x-ray examinations made because of dental injury resulting from an accident
2. Any treatment performed by someone other than a licensed Dentist, except for charges for dental prophylaxis (cleaning and scaling) performed by a licensed dental hygienist
3. Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services
4. Replacement of a lost or stolen appliance more often than once every 5 years
5. Extra-oral grafts or implants or the removal of implants, except under special circumstances when pre-authorized by the Fund Administrator
6. Replacement of an existing denture that, in the opinion of the attending dentist, is or can be made satisfactory
7. Any treatment for bruxism, including any removable dental appliances that are designed to minimize the effects of bruxism (grinding) and other occlusal factors
8. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves, and other tissues
9. Any services or procedures started before the patient became eligible for services under the plan
10. Prescribed drugs, premedication, or analgesia, unless necessity is documented
11. Experimental procedures
12. Any hospital costs or any additional fees charged by the dentist for hospital treatment
13. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including, but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw)

malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth)

14. Services for injuries or conditions that are payable under Workers' Compensation or employer liability laws
15. Services that are provided by any federal or state government agency or are provided without cost by any municipality, county, or other political subdivision (except Medi-Cal benefits)
16. Dental supplies or services for which benefits are provided under any other group plan or any other hospital, surgical, or medical benefit or service plan, union welfare plan, or employee benefit plan for which any employer, directly or indirectly, makes contributions or payroll deductions
17. Cosmetic procedures (other than covered orthodontic treatment).

VISION BENEFITS

For Active and Retired Participants

In this chapter you'll find:
- A quick-reference guide to vision benefits
- How the plan works
- Covered services and supplies
- Optional extras
- Additional discounts
- Low vision benefit
- Exclusions from coverage

Your vision benefits cover you and your enrolled dependents for regular examinations and for lenses and frames necessary to correct your vision. Vision benefits are provided through the Vision Service Plan (VSP).

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Summary of Vision Benefits		
Benefits for Covered Services and Supplies		
Item	**VSP Provider**	**Non-VSP Provider**
Exam (once every 12 months)	Covered in full	Plan reimburses up to $42
Frames (once every 24 months, if needed)	Covered up to plan allowance	Plan reimburses up to $45
Eyeglass lenses (once every 12 months, if needed):		
• **Single vision**	Covered in full	Plan reimburses up to $40 per pair
• **Bifocal**	Covered in full	Plan reimburses up to $60 per pair
• **Trifocal**	Covered in full	Plan reimburses up to $80 per pair
• **Lenticular**	Covered in full	Plan reimburses up to $125 per pair
Contact lenses (once every 12 months, in lieu of all other lens and frame benefits)		
• **Visually necessary (with prior approval from VSP)**	Covered in full	Plan reimburses up to $210 for professional fees and materials
• **Elective**	Professional fees and materials covered up to $105	Plan reimburses up to $105 for professional fees and materials
Low vision benefit	*See the separate chart in "Low Vision Benefit" later in this chapter.*	

HOW THE PLAN WORKS

VSP PROVIDERS

As noted above, vision care services are provided through an arrangement with Vision Service Plan (VSP). You can receive a higher level of benefits by obtaining services and supplies from a VSP provider.

Steps for using a VSP provider are as follows:

- Call any VSP participating doctor to make an appointment (you do not need to obtain a benefit form from VSP first). Identify yourself as a VSP member and provide your VSP member identification number and the name of the group plan ("Bay Area Delivery Drivers Security Fund").
- If you need assistance locating a VSP participating doctor, call VSP at 800-877-7195 or log on to the VSP website at www.vsp.com and use the "Find a doctor" feature.
- After you have scheduled an appointment, the VSP participating doctor will contact VSP to verify your eligibility and plan coverage.
- When you go for your visit, pay the doctor any amount due if you have incurred charges that are not covered in full. VSP will pay the doctor directly for the balance of the charges.

NON-VSP PROVIDERS

You may choose to use a non-VSP provider **instead** of a VSP provider (any licensed optometrist, ophthalmologist, or dispensing optician). However, plan benefits will then be limited to the applicable reimbursement allowances.

If you use a non-VSP provider, you will need to pay the doctor in full at the time of your visit and then file a claim for reimbursement with VSP. See the section called "Filing a Claim for Benefits and Claim Appeals Procedures" beginning on page 83 for more details.

COVERED SERVICES AND SUPPLIES

The Plan provides the benefits described below. You are responsible for the cost of any upgrades or departures from plan coverage or, if you get elective contact lenses or use non-VSP providers, any costs beyond the reimbursement allowances.

Benefits for frames and lenses include such professional services as prescribing and ordering proper lenses, assisting in the selection of frames, verifying the accuracy of the finished lenses, and proper fitting and adjustment of glasses.

EXAMS

The Plan covers an examination of the visual functions once every 12 months, including the prescription of corrective eyewear where indicated.

If you use a VSP provider, the Plan pays the full cost. If you use a non-VSP provider, the Fund will reimburse you for the cost of the exam up to $42.

FRAMES

The plan will cover frames for your corrective eyewear once every 24 months if replacement is necessary.

If you use a VSP provider, the plan will pay an amount up to the Plan allowance, which is currently $115.00, but may change from time-to-tome. Check with VSP or the Fund Administrator. If you use a non-VSP provider, the Plan will reimburse you for up to $45 for the purchase of frames.

See also "Optional Extras" later in this chapter for information on frames whose cost exceeds the Plan allowance.

EYEGLASS LENSES

The Plan will cover new lenses once every 12 months if a prescription change is warranted.

If you use a VSP provider and do not request any optional extras, the Plan will cover the full cost. If you use a non-VSP provider, the Plan will reimburse you for up to the following amounts:

- Single vision: up to $40 per pair
- Bifocal: up to $60 per pair
- Trifocal: up to $80 per pair
- Lenticular: up to $125 per pair

See "Optional Extras" later in this chapter for information on options such as blended or progressive multifocal lenses or UV protection.

CONTACT LENSES

Contact lenses are available once every 12 months in lieu of all other lens and frame benefits.

Once you obtain contact lenses under the Plan, you will not be eligible for other lenses for 12 months or new frames for 24 months.

VISUALLY NECESSARY

Coverage of contact lenses at the visually necessary level requires prior authorization by VSP.

The Plan will cover the full cost of contact lenses dispensed by a VSP provider that are deemed medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

If you use a non-VSP provider to obtain visually necessary contact lenses, the Plan will reimburse you for up to $210 for professional fees and materials.

See the box following "Additional Discounts" for information regarding prior authorization.

ELECTIVE

Contact lenses that are not determined to be visually necessary will be considered elective.

The Plan will cover up to $105 of the costs for professional fees and materials for elective contact lenses, whether you use a VSP or non-VSP provider.

OPTIONAL EXTRAS

Your vision benefits are designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses and frames and you will pay the additional costs for these options:

- a frame that costs more than the VSP plan allowance
- blended lenses
- oversize lenses
- photochromic lenses or tinted lenses, except Pink #1 and Pink #2,
- progressive multifocal lenses
- coating of the lens or lenses
- laminating of the lens or lenses
- cosmetic lenses
- optional cosmetic processes
- UV (ultraviolet) protected lenses
- low vision care other than that specified under "Low Vision Benefit" later in this chapter

ADDITIONAL DISCOUNTS

If you would like an additional pair of glasses or would like to be fitted for contact lenses in addition to glasses, you can take advantage of the Plan's additional discounts program. Discounts are available only if you use VSP providers.

ADDITIONAL PAIRS OF EYEGLASSES

You will be entitled to a discount of 20% toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a VSP provider. "Additional pair" means any complete pair of prescription glasses purchased beyond the benefit frequency allowed under the Plan.

PROFESSIONAL SERVICES FOR CONTACT LENSES

You will also be entitled to a discount of 15% on professional fees for elective contact lens evaluations and fittings. To receive this discount, you must receive these services from the VSP doctor who performed your covered eye examination and you must receive them within 12 months of when you had the exam. Discounts are applied to the doctor's usual and customary fees for such services.

Contact lens **materials** will be provided at the doctor's usual and customary charges, with no discount.

This discount is subject to change.

LOW VISION BENEFIT

If you have severe visual problems that are not correctable with regular lenses, you may be eligible for supplementary testing and supplemental care aids under the Plan's low vision benefit. **Payment of the low vision benefit is subject to prior authorization by VSP** (*see box above*).

The low vision benefit is summarized in the chart below.

Low Vision Benefit		
General Benefit Features		
Maximum Benefit	$1,000 every 2 years	
Copayment	25% of VSP provider charges for supplemental care aids	
Benefits for Covered Services and Supplies		
Item	**VSP Provider**	**Non-VSP Provider**
Supplementary testing	Covered in full	Plan reimburses up to $125
Supplemental care aids	Plan covers 75% of cost	Plan reimburses up to 75% of what VSP provider would charge

Supplementary testing means complete low vision analysis and diagnosis with a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated. Supplemental care aids include subsequent low vision aids as visually necessary or appropriate.

If you use a non-VSP provider, you will be responsible for any supplementary testing charges over the $125 reimbursement allowance. Your reimbursement for supplemental care aids will be limited to 75% of what VSP would pay a VSP provider. You will be responsible for your copayment (the other 25% of what would be due a VSP provider), plus any amount beyond what a VSP provider would charge for supplemental care aids.

Obtaining Prior Authorization for Coverage of Necessary Contact Lenses or the Low Vision Benefit

Prior authorization is required for coverage of contacts as visually necessary or for coverage of the low vision benefit discussed above.

Your eye care provider will need to furnish VSP with the information it needs to decide whether prior authorization should be granted. VSP providers will have a pre-certification form they can use for this purpose. Non-VSP providers should contact VSP 800-877-7195 to find out what is needed.

Once a request for prior authorization is received (assuming it has all the required information), a decision is generally made within 3 to 5 days.

If VSP decides contact lenses are not visually necessary for you or you are not eligible for the low vision benefit, you may appeal the decision as explained in the section on claims and appeals at the end of this booklet.

In the case of contact lenses, you also have the option of having your lenses covered as elective contact lenses instead.

EXCLUSIONS FROM COVERAGE

No benefits will be paid for professional services or materials connected with the following:

1. orthoptics or vision training and any associated supplemental testing
2. plano lenses (less than a $\pm$.38 diopter power)
3. two pairs of glasses in lieu of bifocals
4. replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available
5. medical or surgical treatment of the eyes
6. corrective vision treatment of an experimental nature
7. costs for services and/or materials above Plan benefit allowances
8. the additional costs associated with the items listed under "Optional Extras"
9. services and/or materials not indicated in this chapter as covered Plan benefits
10. any service or supply excluded under the plan's "General Limitations and Exclusions" beginning on page 68.

LIFE, AD&D AND SURVIVOR INCOME INSURANCE BENEFITS

Life Insurance: Active Participants
Life Insurance: Retirees (Reduced Benefit)
AD&D Insurance: Active Employees
Survivor Income: Beneficiaries Of Active Employees

In this section you'll learn about:

- How the Plan Works
- Your Beneficiary
- Life Insurance
- Accidental Death & Dismemberment insurance
- Survivor Income benefits
- Continuation Of Coverage for Active Employees
- Conversion Privilege For Group life & Survivor Income Insurance

HOW THE PLAN WORKS

The Life, AD&D and Survivor Income insurance benefits help protect you and your family against the financial consequences of death or serious injury. These benefits are provided through an insurance policy issued by the ReliaStar Life Insurance Company. The following description is a summary of the Life, AD&D and Survivor Income insurance benefits insured by ReliaStar Life Insurance Company. You can request from the Fund Administrator a booklet produced by ReliaStar Life that explains the full terms and conditions of these benefits. If there is a discrepancy between this summary and ReliaStar Life's booklet, ReliaStar Life's booklet will control.

If you have questions about your insurance benefits, including your right to convert to an individual policy should you lose eligibility in the group policies, you can call the Fund Administrator at 800-654-1824. If you're covered as an active employee, below is a summary of these benefits:

- Your life insurance benefit pays a lump-sum benefit to your beneficiary in the event of your death.
- The accidental death & dismemberment insurance benefit (AD&D) pays a lump-sum benefit to you in the event of accidental dismemberment, or to your beneficiary in the event of accidental death.
- The survivor income benefit provides a monthly income for your survivors if you die.
- Dependent life insurance benefits cover your spouse and eligible dependent children, so that if one of them dies, a lump sum benefit is paid to you.

RETIREES ARE COVERED BY A REDUCED LIFE INSURANCE BENEFIT AND ARE NOT ENTITLED TO AD&D INSURANCE, SURVIVOR INCOME INSURANCE, SPOUSE OR DEPENDENT CHILD INSURANCE BENEFITS.

Whether active or retired, the dollar amount(s) of your coverage are shown on the Insert for your group.

YOUR BENEFICIARY

When you enroll in the Plan, you will be asked to fill out a death benefit beneficiary designation form. You may name any person or persons you wish and you may name the portion of the benefit that is to go to each such beneficiary. If you name more than one beneficiary, but don't assign the portion that is to go to each beneficiary, the benefit will be divided among them equally. Your beneficiary designation will apply to the Life, AD&D and Survivor Income Life Insurance benefits.

If you do not designate a beneficiary or if your beneficiary dies before you, this benefit will be paid (in this order) to the surviving individual(s) in the first of the following groups that has at least one surviving member:

- your spouse or domestic partner
- your children
- your parents
- your sibling
- your estate

Changing Your Beneficiary

You may change your beneficiary designation at any time by completing a new beneficiary designation form and sending it to the Fund Administrator. The change or changes will not be effective until the Fund Administrator receives the new form. You do not need anyone's consent to change your beneficiary designation. However, designation or revocation of a beneficiary by any means other than a signed beneficiary form provided by and filed with the Fund Administrator will not be effective.

LIFE INSURANCE

If you die while you are eligible for benefits, your designated beneficiary or beneficiaries will receive a lump-sum benefit. The amount of this benefit, which is stated in your Insert, depends on which bargaining unit you belong to. To receive benefits your beneficiary must be living on the tenth day after your death.

DISABILITY EXTENSION

If you become Totally Disabled while covered by this benefit before you reach age 60, life insurance protection is extended up to age 65, as long as you remain disabled, and provided you meet the conditions explained below. The amount of your life insurance benefit under the disability extension is determined by the schedule in effect at the time you became disabled. You are eligible to apply for the disability extension if:

- You became Totally Disabled before your 60th Birthday,
- You were eligible for the Life Insurance benefit on the date you suffered the illness or injury causing your Total Disability, and
- You provide written notice to ReliaStar Life of your Total Disability within 12 months of becoming Totally Disabled (or as soon as reasonably possible). Such notice must be submitted while you are still living and still Totally Disabled.

The Disability Extension lasts as long as you remain Totally Disabled up to age 65. ReliaStar Life will require you to submit proof of your Total Disability and may require you to undergo a medical examination (at no cost to you). ReliaStar Life may require you to have ongoing medical examinations, but not more often than once per year.

Disability Extension will end the earliest of:

- The date you are no longer Totally Disabled
- The date on which you fail to supply proof of your Total Disability to ReliaStar Life
- The date you turn 65 years of age

If your disability extension expires but you have returned to covered work, your Life Insurance will resume under the Fund's group policy currently in effect (if any). If your extension expires and you are no longer eligible for Fund benefits, you may be able to convert your policy into an individual policy (see below).

Application for your Disability Extension, and notice and proof of your disability can be sent to the Fund Administrator.

DEPENDENT LIFE INSURANCE

If you're covered as an active employee, the Fund also provides a limited life insurance benefit in the event of the death of:

- your spouse or domestic partner, or
- your eligible dependent child from the age of 14 days until the 19th birthday (the 21st birthday in the case of full-time students);

provided such individual is not also covered under the Plan as an active employee, is not on active military duty and lives inside the United States

The amount of this benefit, which is paid to you if your spouse or child dies, is shown on your Insert.

Coverage for your dependents generally ends on the earliest of:

- the date your coverage ends
- the date you retire
- the date the person no longer qualifies as an eligible dependent
- The date your disability extension starts

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

The AD&D insurance benefit covers active employees only and is paid if you die or are severely injured in a covered accident. This benefit is also insured by ReliaStar Life.

Your maximum benefit amount is shown on your insert. The following schedule shows what portion of the maximum benefit is paid for losses that result due to and within 180 days of a covered accident.

Schedule of AD & D Benefits	
Description of Loss	**Benefit**
• **Life** • **Both hands, both feet or sight of both eyes** • **One hand and one foot** • **Speech and hearing in both ears** • **One hand or foot and sight of one eye**	Full maximum benefit
• **One hand or one foot** • **Sight of one eye**	One-half the maximum benefit
• **Speech** • **Hearing in both ears** • **Thumb and index finger of same hand**	One-fourth of maximum benefit

Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of an eye means the entire and permanent loss of the sight of that eye. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger mean loss by being permanently, physically, entirely severed. Note that the death benefit that is paid under AD&D insurance is in addition to the life insurance benefit described in the previous section.

EXCLUSIONS

AD&D insurance benefits will not be paid for any of the following:

1. Suicide or intentionally self-inflicted injury, while sane or insane
2. Physical or mental illness
3. Bacterial infection or bacterial poisoning. Exception: Infection from an acute or wound caused by an accident.
4. Riding in or descending from an aircraft as a pilot or crew member
5. Any armed conflict, whether declared as war or not, involving any country or government
6. Injury suffered while in the military service for any country or government

7. Injury which occurs when you commit or attempt to commit a felony
8. Use of any drug, narcotic or hallucinogenic agent—unless prescribed by a doctor—which is illegal—not taken as directed by a doctor or the manufacturer
9. Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

SURVIVOR INCOME INSURANCE

In the event you die while covered by this benefit, a monthly income will be paid to your beneficiary for a total of 60 months, starting on the first day of the month following the date you died. The survivor income insurance benefit payable to your beneficiary is shown on your Insert.

If you designate your spouse as primary beneficiary and your children as contingent beneficiaries, and your spouse dies before receiving 60 monthly benefit payments, the balance of the monthly payments will be paid to the surviving children who were designated as contingent beneficiaries. If there are no surviving children when your dependent spouse dies, the unpaid balance of the commuted value of the monthly benefit will be paid to your deceased spouse's estate.

If you designate your child or children as your beneficiaries, and a child who is receiving payments dies before 60 payments have been made, the balance of the monthly benefit will be divided equally among any other children who were designated as beneficiaries. If there are no surviving children, the balance remaining will be paid in a lump sum to the estate of the last child to die.

If the last designated beneficiary dies before a total of 60 payments have been made, the commuted value of the remaining monthly payments will be paid in a lump sum to the estate of that beneficiary.

FILING CLAIMS FOR LIFE, AD&D OR SURVIVOR INCOME INSURANCE

If you die, your family or beneficiary should notify the Fund Administrator immediately. To claim a dismemberment benefit, you or your representative should notify the Fund Administrator. The Fund Administrator will advise what forms and certificates need to be filed to apply for the life insurance benefit. The Fund Administrator will forward your claim to ReliaStar Life for processing. ReliaStar Life will make a decision, either making payment or issuing a denial of your claim within 90 days of receiving it. In some cases ReliaStar Life may require more than 90 days to make a decision, in which case it will extend its time to reach a decision by another 90 days, and will inform you of the reason for the extension.

APPEALING A DENIAL OF YOUR LIFE, AD&D OR SURVIVOR INCOME CLAIM

If ReliaStar Life denies your claim it will provide a notice of denial, which will contain the reason for the denial and refer to the provisions in the plan or policy on which the denial is based. If ReliaStar denies your claim, you may appeal the decision, but the appeal must be submitted directly to ReliaStar. In some cases ReliaStar Life may need additional information in order to decide your claim, in which case the denial letter will indicate the information you must provide. The notice will also inform you of your right to appeal the claim, and the manner and time in which you must do so.

If you decide to appeal, you or your authorized representative must submit a written letter of appeal to ReliaStar Life within 60 days from the date you receive the notice denying your claim (unless you have good reason for delay). You can also send an appeal letter to the Fund Administrator which will forward it to ReliaStar Life. You are entitled to review relevant documents related to your claim, and also to submit written comments, documents, records and other information relating to your claim.

After receiving your appeal, ReliaStar Life will review your claim and issue a decision within 60 days of receiving your appeal. ReliaStar Life will make all final decisions with respect to your claim for Life, AD&D and Survivor Income insurance benefits. The written decision will be written in an understandable way, will state the reason(s) for the decision, and will reference the provisions on which the denial is based.

If ReliaStar Life requires more time to decide your appeal, it will extend its time to respond for another 60 days, and will inform you of the reason for the extension. If you do not receive a decision within these time limits, the claim can be considered denied. For information regarding your rights under the benefits law known as ERISA, see "Your Federal Rights Under ERISA & HIPAA" on page 105 of this Booklet.

ReliaStar Life has final discretionary authority to determine all questions of eligibility and status to interpret and construe the terms of the Life, Survivor Income and AD&D Insurance policies.

WHEN LIFE, AD&D OR SURVIVOR INCOME COVERAGE ENDS

Your coverage under these policies ends on the earliest of the following:

- The date your eligibility for Fund benefits ends
- When premium payments or contributions to the Fund on your behalf end
- When your employer (or former employer) stops being a contributing employer
- With regard to AD&D or Survivor Income life insurance, the date you retire
- The date you enter active duty in any armed forces
- The date on which the Fund cancels the ReliaStar group policy applicable to your Plan

CONTINUATION OF COVERAGE FOR ACTIVE EMPLOYEES

Coverage may continue during certain periods of qualifying absence when it would otherwise end because you failed to meet the eligibility requirements (although not past age 65).

Family or Medical Leave of Absence. If you take an approved leave of absence under the federal Family and Medical Leave Act of 1993 (FMLA) or the California Family Rights Act (CFRA), coverage for you and your eligible dependents will continue during the approved leave, as required for the length of time and in the manner allowed under the applicable federal or state law.

During a Labor Dispute. If you stop work due to a labor dispute, you may continue coverage for you and your eligible dependents during the labor dispute if you make a payment each month for coverage under the rules described below, payments are collected from at least 75% of the employees who stop work because of the labor dispute and made to the insurance company in a timely manner. Here are the rules you and other contributing members must follow:

- You must make your monthly payments on each premium due date to the Fund.
- The amount of your monthly payment will be 120% of the amount you and your employer would have to pay to the trust on your behalf if you did not stop work.
- The continuation will end on the earlier of: (a) the date you start active full-time work with an employer other than the employer you stop working for due to the labor dispute; and (b) the last day of the sixth month that follows the date you stop working.

CONVERSION PRIVILEGE FOR GROUP LIFE & SURVIVOR INCOME INSURANCE COVERAGE

When your Fund coverage ends, you, and in certain cases your covered dependents, may be entitled to convert your group life insurance and group survivor income insurance coverage to an individual policy with the insurance company. You usually must elect this coverage within 31 days after coverage ends. You can get more information on conversion rights from the Fund Administrator.

EMPLOYEE SHORT-TERM DISABILITY INCOME COVERAGE

For Active Employees Only

In this chapter you'll find:
- A quick-reference guide to your benefits
- How the plan works
- Exclusions from coverage

The benefits described in this chapter are available only to active employees (not dependents or Retirees) and if you become totally disabled by a covered disability while you are eligible for the Employee Short Term Disability Income Coverage. ***Note that these benefits can be paid only for disabilities that are not work-related.***

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart. In addition, see your insert for the amount of your weekly benefit.

Summary of Employee Short Term Disability Income Insurance	
Schedule of Benefits	
Weekly Benefit	• Amount specified in your insert for the first 26 weeks of disability after the waiting period • Amount specified in your insert from the 27th week through 52nd week, if disability continues
Disability Waiting Periods	• 7 days for both injury and illness
Maximum Payment Period	• 52 weeks

HOW THE PLAN WORKS

A benefit will be paid to you if you become Totally Disabled while you are eligible. Benefit payments start once you satisfy the waiting period and continue for up to 52 weeks. No benefits will be paid after 52 weeks, even though you may still be disabled. For partial weeks, the daily benefit is 1/7 of the Weekly Benefit shown in the above chart. Don't forget that to receive benefits you must be Totally Disabled and you must be under the care of a physician.

The Disability Waiting Periods and the Maximum Payment Period apply separately to each covered Total Disability and are shown in the above chart.

More than one disability. Any two periods of Total Disability will be considered one period of disability unless:

- you returned to work on a full-time basis for at least two consecutive weeks between the two periods of disability, or
- the later disability is due to an injury or illness entirely unrelated to the causes of the earlier disability and begins after you have returned to work on a full-time basis.

EXCLUSIONS FROM COVERAGE

No disability benefit can be paid for:

1. a disability for which benefits are excluded by the "General Limitations and Exclusions" section of this SPD.
2. any period during which you are not under the care of a physician or allied health professional who may lawfully certify that you are totally disabled.
3. employment-related disabilities.

GENERAL LIMITATIONS AND EXCLUSIONS

This chapter provides important information on Fund limitations and exclusions.

- Duplicate Benefits Exclusion
- General Exclusions

This section explains the treatments and expenses that the Fund **does not cover;** in other words, they are **excluded** from the plan. You are responsible for paying any of the following excluded expenses. In addition to the general exclusions listed below, each type of benefit has additional exclusions that are specific to that benefit. These specific exclusions are listed in the applicable chapters (for example, medical). The exclusions listed below do not apply to *Life AD&D and Survivor Income Insurance Benefits*, but do apply to all other benefits under the Plan.

DUPLICATE BENEFITS EXCLUSION

The Plan will not make more than one payment for any charge.

GENERAL EXCLUSIONS

The Fund will not pay any benefits related to any:

1. Injuries or conditions caused by or resulting from your commission of an illegal act; provided, however, that this exclusion will not apply if the injury or condition resulted from an act of domestic violence or a mental health condition, to the extent that treatment for the injury or condition would otherwise be covered
2. Injuries or conditions that are intentionally self-inflicted unless due to a mental or physical condition
3. Injuries or conditions resulting from or arises out of any past or present employment or occupation for compensation or profit
4. Injuries or conditions covered by any workers' compensation or occupational disease law
5. Injuries or conditions that resulted from an act of war, declared or undeclared, including armed aggression
6. Charges for treatment of accidental bodily injury or sickness that occurs while in the armed services and determined by the Secretary of Veterans Affairs to be service connected
7. Charges for treatment of illness or injury or for dental services or supplies that are not reasonably necessary for medical or dental health
8. Charges for treatment of illness or injury that are in excess of the Usual, Customary and Reasonable charges or are in excess of charges that would have been made for this care and treatment in the absence of benefits provided by the Plan. The Plan will not pay any expenses the participant is not obligated to pay, such as expenses incurred under HMO coverage for which no charge would otherwise be made to the patient.

9. Charges for which you are not personally obligated to pay the charge (or part of a charge) for the services, or you would not have been billed for the charge if you were not otherwise covered by the Plan (e.g. expenses covered by an HMO for which no charge would otherwise be payable)
10. Charges for services that were provided by a person who ordinarily lives in your home or by your spouse, child, parent, or sibling or your spouse's child, parent or sibling
11. Investigational or experimental treatment
12. To the extent permitted by federal or state law, any condition for which care or treatment is obtained from a federal government agency or from any state or political subdivision where this care is available without cost to the individual. To the extent permitted by federal law, any period of confinement in, or any medical care and treatment received from a Veteran Administration Hospital. In addition, any confinement or care in a Hospital owned or operated by a state or political subdivision is excluded from coverage, unless there is an unconditional requirement to pay for this care or confinement without regard to the rights of others, contractual or otherwise.
13. Services or supplies furnished for the treatment of a condition for which the Plan participant is not under the care of a Doctor

In addition to the general exclusions listed above, each benefit type has additional exclusions that are specific to it. Additional exclusions under the medical plan are listed on page 36, exclusions specific to prescription drug benefits are listed on page 45, and exclusions from dental coverage are listed on page 51.

GLOSSARY

In this section you'll find definitions for important Plan terms.

- Contact the Fund Administrator if you have a question about a term that isn't included here.
- Only the Board of Trustees is authorized to interpret the Plan.

While some medical benefit terms are defined in the text of this booklet, other terms are defined in this section.

ACCIDENT

An event that caused a physical injury; was caused by a sudden, violent, and external force; was not expected and could not have been reasonably foreseen; and could not have been avoided.

ACCREDITED SCHOOL OR COLLEGE

Accredited school or college means any accredited high school, college, university, or other bona fide educational institution, such as a nursing school or trade school that provides a curriculum for full-time students. Correspondence schools, night schools, or other institutions requiring less than full-time attendance do not qualify.

ACTIVE EMPLOYEE

You are an active employee if your continued participation in the Plan is based on the number of hours you work for a Participating Employer bound by a collective bargaining agreement with a Participating Local Union that calls for contributions to be made to the Fund on your behalf. You remain an active employee if you are on leave or otherwise not actively working provided that the collective bargaining agreement requires your employer to continue to make contributions to the Fund while you are on such leave, and such contributions are in fact made.

ALLIED HEALTH PROFESSIONAL

A person shown in the following list of allied health professionals, but only if the person is licensed and practices within the scope of the license:

- a dentist
- a psychologist
- a physical therapist (considered an allied health professional only if the patient is referred to the physical therapist by a physician)
- a speech therapist (considered an allied health professional only if the patient is referred to the speech therapist by a physician)
- a chiropractor
- a podiatrist
- an optometrist

- an optician
- a certified acupuncturist
- a registered nurse or physician's assistant (RN or PA)

If you are receiving care from a type of provider who is not listed above and intend to make a claim for benefits for such care, please call the Fund Administrator to determine if the care is covered.

BAY AREA DELIVERY DRIVERS SECURITY FUND

The trust established to sponsor health benefit plans pursuant to the collective bargaining agreements and the Trust Agreement.

BENEFICIARY

The person or persons you have designated to receive certain Plan benefits that are payable if you die.

BENEFIT MAXIMUM

The maximum amount of benefits that the Plan will pay for a specified type of covered charges over a specific period of time. Once the Plan has paid the benefit maximum, additional charges will not be paid by the Plan.

CALENDAR MONTH AND CALENDAR YEAR

The 12 named months of a calendar year. A calendar year is a period that starts on January 1 and ends on December 31 of each year.

CHIROPRACTIC TREATMENT

Treatment provided, supervised, or directed by a licensed chiropractor (including neuromuscular physical medicine) and incurred while under the care of a chiropractor.

COLLECTIVE BARGAINING AGREEMENT

The most recent collective bargaining agreement between your participating employer and your local Union which has been approved by the Fund's Board of Trustees.

COMPLICATION OF PREGNANCY

Medically necessary cesarean section; spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible; or a condition that requires hospital confinement (when the pregnancy is not terminated) whose diagnosis is distinct from pregnancy but is caused or adversely affected by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity.

The term "complication of pregnancy" does <u>not</u> include false labor, occasional spotting, physician-prescribed rest during a pregnancy, morning sickness, pre-eclampsia, or similar conditions that are associated with a difficult pregnancy but do not constitute classifiable distinct complications of pregnancy.

CONFINED

Due to sickness or bodily injury, you are an inpatient in a medical facility. Confined includes confinement in a hospital, skilled nursing or rehabilitation facility, alcoholism or drug abuse treatment facility, mental health treatment center, hospice, or any other facility engaged in the treatment of sickness or bodily injury.

CONTRIBUTING EMPLOYER (AND EMPLOYER)

Any employer party to a collective bargaining agreement providing for health and welfare payments to the Fund, or that has executed a subscriber agreement to be bound to the terms of the Trust Agreement establishing the Bay Area Delivery Drivers Security Fund.

CONTRIBUTION

The payment required to be made to the Fund by any employer in accordance with the provisions of the Trust Agreement and applicable collective bargaining agreement.

COSMETIC

Surgery or other treatment performed to alter and reshape normal body structures primarily for the purpose of improving an individual's appearance.

COVERED CHARGE LIMITS

The covered charge limits that apply to each service or supply not subject to a Plan exclusion are:

- the usual, customary and reasonable charge for the service or supply
- any limit specified in the Basic Medical or Major Medical lists of covered services
- any maximum determined from the Relative Value Schedule

Just because an expense is covered does not mean that it will be paid in full by the Fund: coverage may be subject to specific Plan restriction.

CUSTODIAL CARE

Care that consists of services and supplies that are given mainly to help a person meet the activities of daily living, whether or not the person is disabled, and that are not rendered mainly for their therapeutic value in the treatment of an injury or disease. Custodial care includes, but is not limited to, care mainly to provide room and board, preparation of special diets, supervision of the administration of medications that can normally be self-administered, and personal care such as helping a person walk, get in or out of bed, bathe, dress, eat, or use the toilet.

DEDUCTIBLE

An amount of covered charges that must be incurred by a covered person before Major Medical benefits (other than for hospice care or home health care) will be paid. No benefits will be paid for the charges applied toward a deductible.

DENTAL SERVICES

All diagnosis, treatment and repair to the teeth or gums for disease or injury, except tumors, including but not limited to a procedure related to a prosthetic device.

DENTAL SUPPLY

All provisions used for or in conjunction with the replacement or repair of the teeth or gums including but not limited to prosthetic devices.

DENTIST

A Doctor of Dental Science or Doctor of Dental Surgery (D.D.S) or a Doctor of Dental Medicine (D.M.D.) licensed to practice dentistry in the state, country or other jurisdiction in which he or she renders treatment.

DOMESTIC PARTNER

A person who meets all of the conditions for and has been recognized as a domestic partner under the laws of the State of California (and summarized beginning on page 5 of this booklet).

DRUG OR PRESCRIPTION DRUG

Drug or prescription drug means medication that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendments thereto, only upon a written or oral prescription of a dentist or physician (other than a psychologist or chiropractor) licensed by law to administer it.

DURABLE MEDICAL EQUIPMENT

Equipment that is designated for repeated use, is mainly and customarily used for medical purposes, and is not generally of use to a person in the absence of a disease or injury. Durable medical equipment includes, but is not limited to, equipment such as hospital beds, wheelchairs, iron lungs, traction apparatus, intermittent positive pressure breathing machines, braces, and crutches.

EXPERIMENTAL

Any accommodations, services, supplies, or other items or combination of the foregoing that are determined by the Fund Administrator to be a medical or health care procedure or treatment:

- that is not recognized as conforming to safe and accepted medical or health practice
- in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness established
- for which the required approval of a governmental agency has not been granted at the time the services are rendered

The Fund Administrator will make such determination. To determine whether a particular accommodation, service, supply, or other item is experimental, the Fund Administrator may review established utilization review procedures, and refer to the current applicable literature and federal and state laws and regulations, and consider any

other information it deems relevant or appropriate. Such determination will be conclusive and binding with respect to all concerned parties.

FUND

The Bay Area Delivery Drivers Security Fund (BADDSF).

FUND ADMINISTRATOR

The entity that administers the BADDSF plans of benefits. The Fund Administrator is appointed by the Trustees to perform the day to day administration of the Fund and its benefit plans and regularly engages in the business of providing claims administration, adjustment and payment and claims review services to employee welfare benefit plans. Note that the Fund Administrator does not have authority or discretion to interpret the Plans or the terms of this booklet, only the Board of Trustees has that authority. The current Fund Administrator is Health Services Benefit Administrators. The Fund Administrator's address is:

Fund Administrator
Bay Area Delivery Drivers Security Fund
P.O. Box 2358
Livermore, CA 94551-2358
800-654-1824
925-449-7070

GENERIC DRUGS

Prescription medication which is equivalent to a brand name drug and meets the same Food and Drug Administration (FDA) requirements for purity, strength and safety, but is not protected by trademark registration.

HOME HEALTH CARE

Services and supplies provided in lieu of the services which would have been covered if you were confined in a hospital or convalescent hospital, including skilled nursing care and home health aide services. Home health care does not include housekeeping or custodial care.

HOME INFUSION THERAPY

Medicine taken at home through a pump or intravenously that can be maintained by the patient after specific instruction by a registered nurse.

HOSPICE

An alternate type of treatment for terminally ill patients. A hospice facility or program focuses on trying to make death less painful, less stressful, and less fearful for the patient and his or her family. Hospices provide both home and inpatient care, including, but not limited to:

- physician services
- home health care services
- physical therapy

- rental of hospital beds, wheelchairs, and other equipment
- homemaker services
- pain control
- bereavement and emotional support services for the patient's family

HOSPITAL

An institution that meets all of the following requirements:

- It mainly provides medical treatment to inpatients
- It maintains facilities for diagnosis
- It provides treatment only by or under a staff of physicians, and has a doctor in regular attendance
- It maintains permanent and full-time facilities for bed care of five or more resident patients
- It provides care by registered nurses 24 hours a day
- It maintains permanent facilities for surgery
- It maintains a daily medical record for each patient
- It complies with all licensing and other legal requirements, and is operated lawfully in the jurisdiction where it is located
- It is not a skilled nursing facility or a specialized facility
- It is not, other than incidentally:
    - a place for custodial care
    - a place for the aged
    - a place for the care of persons addicted to or dependent on a drug or chemical, including alcohol
    - a place for the care of persons with mental, nervous, or emotional disorders or conditions (unless licensed by the State of California as an Acute Psychiatric Hospital)
    - a place of rest, rest home or convalescent home
    - a nursing home, a hotel, or a similar institution

INPATIENT

Care furnished to a person while the person is confined in a hospital as a registered bed patient.

INSERT (OR SUMMARY AND SUPPLEMENTAL INFORMATION)

A summary which describes benefit limits and other provisions specific to your Plan and which, alongside this booklet, is your *Summary Plan Description.*

INTENSIVE CARE UNIT

A separate, clearly designated service section that is part of a hospital and that meets all of the following tests:

- It is solely for treatment of patients who are in a critical condition
- It provides constant special nursing care and observation not available in the other sections of the hospital
- It contains special life-saving equipment that is ready for immediate use
- It contains at least two beds for critically ill patients
- It has, at all times, at least one registered nurse who is in constant attendance
- It meets the standards set for an intensive care unit by the Joint Commission on Accreditation of Hospitals

The term "intensive care unit" shall include a burn unit or cardiac care unit that meets all of the above tests. The term shall not include a unit for intensive alcoholism or psychiatric treatment.

LEGAL GUARDIANSHIP

The term "legal guardianship" refers to the court-ordered relationship between a child and a person other than the legal parent resulting in the termination of parental rights and the assumption of responsibility over the child by a non-parent guardian.

LICENSED PHARMACIST

A person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

LICENSED PSYCHIATRIC HEALTH FACILITY

An institution that meets all of the following tests:

- It mainly provides psychiatric treatment to inpatients
- It maintains facilities for diagnosis
- It provides treatment only by or under a staff of physicians
- It provides care by registered nurses 24 hours a day
- It maintains psychology and social work departments
- It maintains a daily medical record for each patient
- It complies with all licensing and other legal requirements
- It is not, other than incidentally:
    - a place for custodial care
    - a place for the aged
    - a place for the care of persons addicted to or dependent on a drug or chemical, including alcohol
    - a place of rest
    - a nursing home, a hotel, or a similar institution

MAINTENANCE MEDICATIONS

Prescription drugs otherwise covered under the terms of the Plan required to stabilize an illness or symptoms of illness. Examples of maintenance medications include, but are not limited to, medications taken for

- attention-deficit hyperactivity disorder (ADHD) and attention-deficit disorder (ADD),depression, anxiety, insomnia, psychosis or schizophrenia
- diseases of the central nervous system including epilepsy or seizures, Parkinson's disease, dementia, Alzheimer's disease or similar memory problems, etc.
- diabetes, thyroid problems or osteoporosis
- heart, circulatory or blood conditions including heart failure, high cholesterol, high blood pressure, stroke, heart attack, blood clots, anemias, etc.
- some respiratory or lung conditions such as allergies, asthma, etc.
- certain stomach, bowel or digestive problems including ulcers, heartburn or reflux disease, etc.
- urinary or prostate problems including, enlarged prostate, etc.
- some painful conditions such as migraine headaches, gout, some types of arthritis, etc.
- Medications to treat conditions of the eye such as glaucoma, etc.
- skin or skin-related conditions such as acne, psoriasis, etc.
- prevention of rejection of transplanted organs or tissues
- certain infectious disease such as tuberculosis and viral diseases such as HIV, hepatitis, etc.

MEDICALLY NECESSARY

With respect to each service and supply, the term "medically necessary" means that the service or supply meets all of the following tests:

- It is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects, and birth defects
- It is appropriate for the symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards
- It is not mainly for the convenience of the covered person or the covered person's physician or other provider
- It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in an acute care hospital or other facility, this test means that the covered person needs to be confined as an inpatient due to the nature of the services rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through outpatient treatment.

MEDICARE

The benefits provided under Title XVIII of the Social Security Act and all amendments to the Act.

MENTAL, NERVOUS, OR EMOTIONAL DISORDER OR CONDITION

A disorder or condition that affects thinking, perception, mood, and/or behavior. Such disorders or conditions are recognized by psychiatric symptoms that appear as distortions of normal thinking and/or perception, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior, highly agitated or manic behavior, physical manifestations or other mental or nervous disorders.

Any disorder or condition meeting this definition is a mental, nervous, or emotional disorder or condition regardless of whether the psychiatric symptoms are caused by a psychiatric disorder, by a physical disorder, or by a combination of physical and psychiatric causes. Any disorder or condition meeting this definition is included in it regardless of whether it produces only emotional symptoms or only physical symptoms such as headaches, sweats, trembling, nausea, hysterical paralysis or a combination of physical and psychiatric causes. Plan limits on the treatment of mental, nervous, or emotional disorders or conditions apply to the treatment of all disorders and conditions meeting this definition.

Some examples of mental, nervous, or emotional disorders or conditions are schizophrenia, manic depression, and other disorders or conditions usually classified in the medical community as psychosis; depressive, phobic, manic, and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive and compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial, and borderline); dementia and delirious states; post-traumatic stress disorder; organic brain syndrome; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; and anorexia nervosa and bulimia.

MORBID OBESITY

Morbid obesity that has persisted for at least 5 years, defined as either:

- Body Mass Index (BMI) exceeding 40; or

- BMI greater than 35 in conjunction with ANY of the following severe co-morbidities:
  a) coronary heart disease
  b) type 2 diabetes mellitus
  c) clinically significant obstructive sleep apnea (as determined by the Plan Administrator or its designee)
  d) high blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management)

NURSE

A person who is a registered nurse (R.N.), a licensed vocational nurse (L.V.N.), or a licensed practical nurse (L.P.N.).

OPEN ENROLLMENT PERIOD

The month of July, with coverage effective August 1.

ORTHODONTIA

The removal and/or straightening of teeth to correct malocclusion.

OUTPATIENT

Care furnished to a person while the person is not confined in a facility as a registered bed patient.

PARTICIPATING EMPLOYER

Any employer or successor in interest to such employer that subscribes to the Trust Agreement and is obligated to contribute to the Plan, contributes to the Plan, and is accepted for Plan participation by the Board of Trustees.

PARTICIPATING LOCAL UNIONS

A Union affiliated with the International Brotherhood of Teamsters that has entered into a collective bargaining agreement with a participating employer, if the agreement provides for the provision of benefits under the Plan.

PERCENTAGE PAYABLE

The factor by which an amount of covered charges is multiplied to calculate a benefit under the group policy.

PERIOD OF DISABILITY

For purposes of hospital or surgical benefits, period of disability means the time period beginning with the first day of hospitalization or the first surgery for a particular disorder and ending with a return to work (if you are an eligible employee). If you are a dependent, a period of disability ends when you have not been confined to an inpatient facility for a period of six months.

Periods of Disability that follow each other and are due to totally unrelated causes will be considered separate periods of disability.

PHYSICIAN OR DOCTOR

A person who is licensed and practices within the scope of the license as a doctor of medicine (M.D.) or as a doctor of osteopathy (D.O.). This term will also include any Allied Health Professional as defined above, who upon referral from a physician, performs services that are covered under the plan and within the scope of his license or certificate.

PHYSICAL THERAPY

The prevention and management of movement disorders arising from an illness or injury administered by a licensed Physical Therapist pursuant to the orders of the physician treating said illness or injury.

PLAN PARTICIPANT (OR PARTICIPANT)

An individual employed by a Contributing Employer on whose behalf contributions are made to this Plan who has met the Plan's eligibility requirements.

PLAN YEAR

The twelve-month period beginning each August 1 and ending July 31 of the succeeding calendar year.

PREGNANCY

Any pregnancy, a complication thereof, or the termination of a pregnancy.

PROFESSIONALLY RECOGNIZED STANDARDS

The term "professionally recognized standards" means professionally recognized standards of quality, as determined by the Board of Trustees for this Fund in consultation with inside or outside medical professionals with expertise in the particular area of medicine. To determine such standards, the Fund may use such groups as: the American Medical Association; the American Dental Association; their affiliates and successors; peer review groups; professional review groups; and similar groups.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Qualified Medical Child Support Order (QMCSO) means a medical support order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law under that state, and which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Plan participant is eligible. The Plan must determine that the order is qualified under the terms of ERISA and applicable state law.

RELATIVE VALUE SCHEDULE

Base Plan benefits shall be determined by multiplying the number of units specified in the California Relative Value Studies (CRVS 1974 version) for a covered service or supply by a factor determined by the Board of Trustees from time to time in their sole discretion.

RETIREE

An individual who formerly received benefits under the Plan as an Active employee, and who has enrolled and meets the eligibility criteria to participate in the Retiree Plans as set forth on page 2.

SKILLED NURSING FACILITY AND REHABILITATION HOSPITAL

An institution that meets all of the following tests:

- It mainly provides skilled nursing care or rehabilitation care to registered inpatients
- It provides care that is supervised, 24 hours per day, by a physician or a registered nurse
- It has available at all times a physician who is a staff member of an acute care hospital
- It has a registered nurse, licensed vocational nurse, or licensed practical nurse on duty 24 hours per day and has a registered nurse on duty at least 8 hours per day
- It maintains a daily medical record for each patient
- It complies with all licensing and other legal requirements
- It is not a specialized facility

- It is not, other than incidentally:
  - a place for custodial care
  - a place for the aged
  - a place for the care of persons addicted to or dependent on a drug or chemical, including alcohol
  - a place for the care of persons with mental, nervous, or emotional disorders or conditions
  - a place of rest
  - a nursing home, a hotel, or a similar institution

TOTALLY DISABLED OR TOTAL DISABILITY

You are Totally Disabled, or suffer from a Total Disability, when: (1) you are unable, due to illness, injury or health complications due to pregnancy, to perform your regular and customary work, and (2) you are not working in any gainful employment.

Your dependant is Totally Disabled, or suffers from a Total Disability, when he or she is completely unable to engage in the normal activities of a person of the same sex or age.

Any two periods of disability will be considered one period of disability, unless you returned to work on a full-time basis for at least two consecutive weeks between the two periods of disability, or the later disability is due to an injury or illness entirely unrelated to the causes of the earlier disability and begins after you have returned to work on a full-time basis.

For purposes of COBRA extended disability coverage, disabled means the Social Security Administration's determination of disability.

TRUST AGREEMENT

The Agreement and Declaration of Trust establishing the Bay Area Delivery Drivers Security Fund and any modification, amendment, extension or renewal thereof.

TRUSTEES OR BOARD OF TRUSTEES

Trustees or Board of Trustees means the Board of Trustees of the Bay Area Delivery Drivers Security Fund.

UNION

A local union affiliated with the International Brotherhood of Teamsters that has entered into an agreement with a contributing employer which provides for the provision of benefits under the Plan.

USUAL, CUSTOMARY AND REASONABLE CHARGE

Usual, customary and reasonable charge means an amount charged by a provider of services or supplies that does not exceed the fair and reasonable value of the service or supply. When determining whether a charge is usual, reasonable and customary, the following criteria apply:

- "Usual" means the fee that is regularly charged and accepted as payment in full by the provider of the service or supply
- "Customary" means the charge is within the range of prevailing fees charged by providers of similar training or experience, within the same geographic area, for the performance of a specific service or procedure
- "Reasonable" means the fees are customary and justified considering medical complications or special circumstances requiring additional time, skill or experience in connection with the performed service or procedure
- Any limit contained in the Basic Medical or Major Medical lists of covered services
- Relative Value Schedule: any maximum determined from the Relative Value Schedule is used to determine maximum Basic Medical benefits for surgical and anesthesia procedures

FILING A CLAIM FOR BENEFITS AND CLAIM APPEALS PROCEDURES

In this section you'll find information on:

- Filing a claim for benefits
- Appealing a denied claim

This chapter explains how to submit a claim for benefits.

The discussion below applies to "post-service claims" only, which are claims you submit <u>after</u> you have received a service. However, requests for pre-authorization are considered claims, and if denied are subject to the appeals procedure outlined below. **If you do not comply with the pre-authorization procedures, your claim for benefits may be denied.** Procedures for obtaining preauthorization vary depending on the type of benefit; these procedures are explained above on pages 24 (Medical), 40 (Chemical Dependency), 48 (Dental) and 58 (Vision). Procedures for appealing a denial of a request for preauthorization are explained on page 90.

HOW TO FILE A POST-SERVICE CLAIM FOR MEDICAL BENEFITS

When you go to a hospital or other facility, show your Blue Cross ID card and remind the admitting office that your claim must be submitted electronically to Blue Cross. All other claims can be submitted on claim forms that are available from your Union, your Employer, or the Fund Administrator. If you use a participating provider, the provider must submit claims for you, and the Fund will usually accept the forms provided by your participating provider. Show your Blue Cross identification card to your participating provider.

All claims except hospital and facility claims, whether submitted by you or your provider, and if not submitted electronically by your provider, should be sent to:

Bay Area Delivery Drivers Security Fund
P.O. Box 2358
Livermore, CA 94551-2358

A non-participating provider will usually submit claims for you as well. If the non-participating provider will not submit your claims, you will need to file a claim yourself. Check the claim form to be certain that all applicable portions of the form are completed and that the following information is included:

- your name and ID number
- the patient's name, date of birth, and relationship to you
- the date of service
- the CPT-4 codes—the codes for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association or HCPC code

- the ICD-9 codes—the diagnosis codes found in the *International Classification of Diseases, 9th Edition, Clinical Modification*, as maintained and distributed by the U.S. Department of Health and Human Services
- the billed charges (bills must be itemized with all dates of physician visits shown)
- the number of units (for anesthesia and certain other claims)
- the federal taxpayer identification number (TIN) of the provider
- the provider's billing name, address, telephone number, and professional degree or license
- the provider's signature
- if treatment is due to an accident, accident details (you may be required to sign a third-party liability agreement to reimburse the Plan if you recover damages)
- information on other insurance coverage, if any, including coverage that may be available to your spouse through his or her employer

You must file your claim with the Fund Administrator within the time frames described below.

HOW TO FILE A CLAIM FOR DENTAL BENEFITS

You or your dentist's office may submit a claim form to the fund for services rendered. You can obtain claim forms from the Union, or the Fund Administrator. Your dentist's office should also have standard claim forms that can be used.

Complete your part of the claim form and have your dentist's office complete the rest of the claim form. The completed claim should be sent to the Fund at the following address:

Bay Area Delivery Drivers Security Fund
P.O. Box 2358
Livermore, CA 94551-2358

HOW TO FILE A CLAIM FOR ALCOHOLISM AND CHEMICAL DEPENDENCY BENEFITS

INPATIENT DETOXIFICATION CLAIMS

When you are admitted, show your Blue Cross identification card to the admitting office and tell the admitting office that the claim must be submitted directly to Blue Cross electronically. You must notify TAP within 48 hours and rehabilitation must begin immediately following detoxification treatment, or you will not be reimbursed for detoxification.

INPATIENT REHABILITATIVE TREATMENT CLAIMS

When you are admitted, show your Fund identification card to the admitting office and tell the admitting office to send the claim to TAP at the following address:

Teamsters Assistance Program of Northern California
300 Pendleton Way
Oakland, California 94621

Any questions should be directed to TAP at 510-562-3600.

OUTPATIENT TREATMENT CLAIMS

As you will be referred to a provider by TAP you do not need to submit a claim. The provider will send the bill directly to TAP.

HOW TO FILE A CLAIM FOR PRESCRIPTION DRUG BENEFITS

You will need to file a claim only if you have used a nonparticipating retail pharmacy.

A claim form is not necessary. You need only send in the tag that accompanies your prescriptions, that shows the name and identification number of the member, name of the patient, the date of purchase, the drug's name and strength, the quantity, and the price. You must file your claim within 90 days.

Send your claim to the Fund at the following address:

Bay Area Delivery Drivers Security Fund
P.O. Box 2358
Livermore, CA 94551-2358

HOW TO FILE A CLAIM FOR VISION BENEFITS

If you use a VSP provider, you do not need to file a claim form. You will pay the amount due at the end of your visit, and your provider will take care of billing VSP for the remainder.

If you use a non-VSP provider, you will need to file a claim for reimbursement of the applicable amount. Call VSP at 800-877-7195 to have an Out-of-Network Reimbursement Form mailed or faxed to you (*you can also fill out the form online at www.vsp.com and print it out*). Mail the completed form with your itemized receipt to VSP at the following address:

Vision Service Plan
Attn: Out-of-Network Provider Claims
P.O. Box 997105
Sacramento, CA 95899-7105

If you have any questions about submitting your claim, contact VSP directly.

HOW TO FILE A CLAIM FOR LIFE, AD&D, AND SURVIVOR INCOME INSURANCE BENEFITS

Claims for Life, Survivor Income Insurance or AD&D benefits may be sent to the Fund Administrator, on forms available from the Fund Administrator. The claims and appeal process is described above, in the Life, AD&D and Survivor Income section of this booklet, beginning on page 59.

HMO CLAIMS PAYMENT

If you are enrolled in the Kaiser HMO plan, Kaiser has its own procedures for making claims and filing appeals, which are explained in Kaiser's *"Your Health Plan Coverage"* booklet.

TIMELY SUBMIT YOUR CLAIMS

All claims must be submitted as soon as possible after you receive your services. Medical and dental claims received more than **12 months** after the date of service will be denied as untimely. Prescription drug claims will be denied if not filed within **90 days** of purchase. If your claim is for Life, AD&D or Survivor Income benefits, a claim filed more then twelve months from the date the benefit accrued will be denied unless you can show that there was reasonable cause for your delay. In such cases, ReliaStar Life may require you to provide proof substantiating the reason for delay.

In no event, unless because of no fault of your own, will a claim be accepted later than one year after the date services were first received. For information on what to do if you disagree with the decision made in regard to your claim, see *"Appeal Procedure" beginning on page 89.*

DECISION ON YOUR CLAIM

The claims procedure you follow will depend on whether your claim for benefits is a claim involving urgent care, a pre-service claim, or a post-service claim.

A pre-service claim is any claim for services not yet performed, which are not for urgent care. An urgent care claim is a claim for medical care or treatment if delays could seriously jeopardize your life or health or your ability to regain maximum function, or would, in the opinion of your physician, subject you to severe pain that can only be effectively managed through the requested course of treatment. Any claim for health care benefits under the Plan that is not an urgent care claim, a pre-service claim, or a concurrent care claim (see below) is considered a post-service claim.

PRE-SERVICE CLAIMS

The Fund will issue a decision within 15 days after receipt of the claim. If an extension is necessary, then a decision will be issued within 30 days. You will receive written

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

URGENT CARE CLAIMS

The Fund will issue a decision as soon as possible and within 72 hours after receipt of the claim. If more information is required to determine the claim, you will be notified as soon as possible but within 24 hours, and given at least 48 hours to provide the requested information. If you do not provide the requested information within the 48-hour period, your claim will be denied.

POST-SERVICE CLAIM

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

CONCURRENT CARE CLAIMS

In the case of a concurrent care claim, where health care treatment is reduced or terminated before the end of the approved period of time or number of treatments, the Fund will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision if you choose to do so and have the appeal decided before the benefit is reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies. If the request involves urgent care, any claim to extend a course of treatment will be decided as soon as possible but within 24 hours, provided the claim is submitted at least 24 hours prior to the prescribed end of the course of treatments.

CLAIMS FOR DISABILITY BENEFITS

The Fund will issue a decision within 45 days after receipt of the claim. This period may be extended twice, up to 30 days for each extension. Written notice of the extension will be provided to you before the end of the initial 45-day period and will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the

required information, and you will have 45 days to provide the requested information. The time period in which a decision will be issued is delayed from the date the request is made until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

CLAIMS FOR LIFE INSURANCE AND AD&D INSURANCE BENEFITS

ReliaStar Life will issue a decision within 90 days after receipt of the claim, unless an extension is necessary, in which case a decision will be issued within 180 days. Written notice of the extension will be provided to you before the end of the initial 90-day period and will state the reason(s) for the extension and the date you can expect a decision.

EXPLANATION FOR DENIAL OF A CLAIM FOR MEDICAL, PRESCRIPTION DRUG OR DENTAL BENEFITS

After you file a claim or request pre-authorization (following the procedures listed in the preceding chapters) the Fund may deny all or a part of your claim or request (in the case of prescription drugs, your claim will be reviewed directly by Prescription Solutions. You may seek review of that decision by Prescription Solutions, and in the event the claim is still denied, you may then appeal the decision to the Board of Trustees as described below). There are a number of reasons why the Fund may deny your claim, most frequently because the individual receiving treatment is not eligible under the Fund, the claim is submitted late, or because the treatment provided is not covered under the terms of the Plan.

If your claim or request is denied, the Fund will send you a letter stating the reason your claim was denied and informing you of the steps you must take to appeal the denial. This letter is referred to as a "notice of adverse decision." The notice will inform you of:

- the reason for the denial of your claim or request, with a reference to the Plan provision(s) that requires denial of your claim
- any additional information that the Plan requires before it can make a final determination of your claim or request and an explanation of why the Plan needs the information
- the steps you must take if you choose to appeal the denial, including the applicable time limits for submitting an appeal and your right to submit written comments, documents and other information relating to the claim
- your right to request, free of charge, access to any copies of any records or documents that it has in its possession that are relevant to your claim
- your right to request from the Plan a copy of any internal rule, guideline or protocol that it relied on to decide your claim
- if your claim is denied because of a lack medical necessity or the use of experimental or investigational treatment, or other similar exclusion or limit, an explanation that you will be provided free of charge an explanation of the scientific or clinical judgment for the determination as applied to the Plan or your claim
- a description of the expedited review process if you were denied an urgent care or urgent pre-authorization request
- your rights under ERISA to bring a civil action following a denial of a claim on appeal

APPEAL PROCEDURE

If you disagree with the Fund's reason(s) for denying your claim or request, you may appeal the decision. When you appeal a decision it means the Board of Trustees will review and reconsider the Plan's initial determination.

To appeal a claim or request denial you must send a written statement to the Fund Administrator within **180 days** of receiving a notice of adverse decision on your claim for benefits and/or request for pre-authorization. If you (or your authorized representative) do not appeal the decision within 180 days, you lose your right to appeal the decision and also your right to sue because you have not exhausted your administrative remedies. If you have a good reason for failing to appeal a decision within the period, you may file an appeal for up to one year after the denial, but you must show in your appeal that you had good cause for filing a late appeal.

Your written statement of appeal must describe in detail your claim for benefits and the reason why you believe your claim was improperly denied. In addition, the statement must include any documents you believe are pertinent to your appeal (and were not already provided to the Fund with your original claim).

All claims other than Pre-service or Urgent Care claims will be decided at the next regularly scheduled meeting of the Board of Trustees if the Plan receives your appeal at least thirty days in advance of the next Board Meeting. If your appeal is not received within thirty days of the next Board of Trustees meeting, your appeal will be decided at the second regularly scheduled Board of Trustees meeting following receipt of your appeal. If the Board requires additional time because of exceptional circumstances, within sixty days of receiving your appeal, the Plan will send you a notice extending the time to decide your appeal. Even with an extension of time, the Board will not take longer than **120 days** to decide your appeal.

The Board of Trustees will make a decision on your appeal, and may appoint at least one Employer Trustee and one Union Trustee to hear your appeal, who will then make a recommendation to the entire Board of Trustees for final determination. The Board of Trustees will not defer to the initial adverse benefit determination and will consider all comments, documents and records and other information you timely provide, even if they were not received or considered during the initial claim decision. The Board of Trustees' decision on your appeal will be made on the basis of the record, including any additional documents and comments you send. If the Plan denied your claim on the basis of medical necessity, the Trustees will consult a health care professional with training and expertise applicable to the relevant field of medicine. Upon request, you can obtain the name of any health care professional consulted and the advice given, if any, concerning your claim.

APPEALING PRE-SERVICE AND URGENT CARE CLAIMS

Different procedures apply to **pre-service** and **urgent care health claims**. For Pre-Service claims, the Board will decide your appeal within 30 days. You may also request expedited review of urgent care claim denials by telephone or in writing and submit information in support of your appeal by facsimile and/or telephone, as appropriate.

For such claims you may appeal an adverse decision by calling the Fund Administrator at 800-654-1824 or 925-449-7070, and by faxing your letter of appeal or supporting documents to 925-443-2035.

You will receive notice of the decision within 72 hours of receipt of the appeal.

THE DECISION ON APPEAL

After the Board decides your appeal, the Plan will send you a written notice of the decision, which will include:

- the reasons for the decision and references to the Plan's rules that justify the Board's decision
- a statement of your right to receive, upon you request and free of charge, access to and copies of all documents, records and other relevant information
- your right to file suit under section 502(a) of ERISA
- if your claim is for medical or disability benefits, you will be notified if an internal rule, guideline, or other similar criterion was relied on by the Board and will be provided with a copy of such rule, guideline, or other criterion free of charge at your request
- if your claim is denied based on a medical necessity or other similar exclusion or limit, at your request you will be provided, free of charge, an explanation of how that exclusion or limit and any clinical judgments apply to your medical circumstances, including information relating to medical or vocational experts whose advice was obtained on behalf of the Board in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination

You will be notified of the Trustees' decision on your appeal as soon as possible, but no later than five days after the Board has made its decision.

AUTHORIZED REPRESENTATIVE

You can act on your own behalf in filing and/or appealing your claim, or you may ask another person to act as your Authorized Representative. If you designate an Authorized Representative, he or she will receive all communication about your claim or appeal.

RIGHT TO SUE

A lawsuit to obtain benefits is considered untimely before you appeal a denied claim, or before the time period for filing an appeal ends, or while your appeal is still pending. No action may be brought to enforce any right under the Plan until a claim has been submitted to and determined by the Board of Trustees and all rights of appeal have been exhausted. The decision of the Board of Trustees is final and binding upon all parties, and is subject to judicial review only for abuse of discretion.

COORDINATION OF BENEFITS AND PLAN'S RIGHT TO RECOVERY

In this section you'll find:
- The Fund's rules on coordination of benefit payments from two or more plans.
- The Fund's subrogation/ reimbursement policy, under which it may recover duplicate benefit payments.

This chapter explains how benefits are paid if you and/or your dependent are covered by this Plan and another plan (including Medicare). In such cases the two plans will *coordinate* their payment of benefits under the rules described below. This chapter also explains the Fund's right to seek reimbursement from you and your dependents if you receive compensation for injuries for which the plan has paid benefits.

COORDINATION OF BENEFITS

If you or your dependent is entitled to any benefits under another group health plan, the various plans will *coordinate* payment of your benefits to ensure that you or your dependent do not receive more than 100% of the expenses incurred. This Coordination of Benefits provision will determine when the Bay Area Delivery Drivers Security Fund is the *primary* payer of your benefits, and when it pays *secondary* benefits. The plan that is determined to be the primary payer under these rules will pay benefits first – as if there were no other group plans involved. Then, if your expenses have not been fully covered, any secondary plans coordinate their payments to ensure that (1) you receive all of the benefits to which you are entitled, and (2) you do not receive double payments or benefits for more than the actual cost of your covered expenses. *Note that different rules apply depending on whether you or your dependent is entitled to Medicare.*

If you are **not** entitled to Medicare, the following rules determine if the Bay Area Delivery Drivers Security Fund or another group plan will be the primary payer of your benefits:

- A plan without a coordination of benefits provision or with a provision that bars or substantially restricts (as determined by the Board of Trustees) coordination with this Plan is primary
- The plan covering the patient directly, *e.g.* the plan that covers the patient as an employee rather than a dependent, is the primary payer
- The plan that covers you or your dependent as an active employee is primary to a plan that covers you or your dependent as a laid-off or retired employee, or that covers you under COBRA continuation coverage
- In the case of a dependent child, when both parents have direct coverage, the plan that insures the parent whose birthday (month and day) occurs earlier in the calendar year will pay benefits first. When parents have the same birthday (month and day), the plan that has covered the dependent longer pays first (this rule does not apply if the other plan does

not have this provision; in such case, the other plan shall determine the order of benefit payments)

- An HMO or pre-paid plan will pay benefits first for all participants, including an active employee under this plan
- If you are separated or divorced or have terminated your domestic partnership, the order of payment for your dependent children is:
    - The plan of the natural or adoptive parent with custody is the primary payer, or if a Qualified Medical Child Support Order ("QMSCO" see "definitions" on page 80) designates a parent to be financially responsible for health care expenses of the child, that parent's plan is the primary payer
    - The plan of the stepparent with custody pays benefits before the plan of a natural or adoptive parent without custody
    - The plan covering the natural or adoptive parent without custody then pays

If these rules do not determine which plan is the primary payer, then the plan that has covered the person for the longest time will be primary.

In the event of coordination with a plan that contains a substantially restrictive coordination of benefits provision, the Trustees in their sole discretion may determine to pay benefits only in amount that would have been paid had the other plan not contained the substantially restrictive coordination of benefits provision. A substantially restrictive coordination of benefits provision is a provision in a coordinating plan, the purpose of which is to avoid payment of benefits that would otherwise be paid by application of the above coordination of benefits rules. The Trustees have sole discretionary authority to determine whether a coordination of benefits provision is substantially restrictive.

The Plan has the right to release to (and obtain from) any insurance company, claims administrator, organization, or person, any benefit information necessary to apply this coordination of benefit provision.

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provision, if you are covered under the Medical Plan and have coverage under a prepaid program of another plan (e.g., as the spouse of someone covered by an HMO) and you incur expenses normally owed under the prepaid program, this Plan will only reimburse your copayments required by the prepaid plan, and only if copayments are required of every person covered by that program. This Plan will not pay expenses covered by prepaid programs.

These coordination of benefits rules apply to any group insurance coverage or other method of group coverage, which provides medical or dental benefits or services on an insured or uninsured basis. The rules also apply to any plan that is required by law, including a no-fault vehicle plan, to provide medical or dental payments. In the case of a no-fault vehicle plan, a person subject to such a law who has not complied with the law will be considered to have received the benefits required by the law. If you or your dependents are insured under an individual health plan or insurance program for which

you pay premiums directly to the insurance company, the Fund will pay the full benefits to which you are entitled.

END STAGE RENAL DISEASE (ESRD)

ESRD coordination may differ and is subject to federal guidelines. Contact the Fund Administrator if you have questions about ESRD coordination issues.

EFFECT OF MEDICARE PART A & B ON COORDINATION OF BENEFITS

If you (or your spouse) are eligible for coverage under Medicare Part A or B while still receiving coverage under this plan, your benefits may be affected.

In general, Medicare is the primary payer only for retirees age 65 or over or those receiving Social Security disability benefits for 24 months. **If you are enrolled in plans 11A or 11B, the Fund's retiree plans, then Medicare is your primary plan if you are eligible for Medicare Part A or B either by age or disability status. Note that retirees eligible for Medicare Part B must enroll in Part B. If you don't enroll in Part B, claims under this plan will still be processed as if you were enrolled in Part B, and you will be required to pay the difference.** *Remember that if you are receiving prescription drug benefits you should not enroll in Medicare Part D.*

Coordination with Medicare Part A and B for you:

The Plan is primary and you file claims with the Plan first if:

- You are covered under the Plan because of your current employment status, or
- You are eligible for Medicare benefits because you have end-stage renal disease (ESRD) unless you became eligible for Medicare benefits due to age or Disability prior to becoming eligible for Medicare benefits due to ESRD, and the Plan is already paying secondary because you are not covered on the basis of your current employment status. In general, the Plan remains primary for the first 30 months if either (1) ESRD is the first reason for Medicare-eligibility, or (2) Medicare eligibility is first due to age or Disability and the Plan has already been paying on a primary basis because coverage is provided by virtue of current employment status. At the end of the 30-month period, Medicare will be primary.

Medicare is the primary payer and you file claims with Medicare first if you do not have ESRD and you are not in "current employment status."

"Current employment status" means an individual is actively working—or is not actively working and:

- Is receiving employer-provided Disability benefits that are subject to FICA taxation (i.e., the first six months of Disability benefits)—or
- Retains employment rights in the industry (for example, as a seasonal employee), has not had membership in an employee organization terminated, has group health plan coverage other than COBRA coverage, is not receiving Social Security Disability benefits, and has not received Disability benefits from an employer for more than six months.

If you are age 65 or older, you may choose to elect Medicare as the primary plan; if you do, benefits under the Plan will end.

Coordination with Medicare Part A and B for your dependents:

If your dependent is eligible to receive Medicare benefits—whether or not he or she has actually applied for Medicare benefits—the following rules apply:

The Plan is primary if:

- Your dependent is covered under the Plan because of your current employment status, or
- Your dependent is eligible for Medicare benefits due to ESRD, **unless**:
    - Your dependent becomes eligible for Medicare benefits due to age or Disability before becoming eligible for Medicare benefits due to ESRD, and
    - The Plan is already permissibly paying secondary because your dependent is not covered on the basis of your current employment status.
      The Plan is primary payer for the first 30 months your dependent is eligible for Medicare due to ESRD; at the end of the 30-month period, Medicare will be the primary payer.
- Your dependent is Disabled and eligible for Medicare—and you are covered under the Plan because of your current employment status.

The Plan is the secondary (and Medicare is primary) if:

- your dependent does not have ESRD and you are not in current employment status
- your dependent is age 65 or older, he or she may elect Medicare as the primary plan; if he or she does, benefits under the Plan will end

The Plan does not pay Medicare Part B premium reimbursements for active employees. Contact your local Social Security office for more information.

If you are enrolled in an active Plan, and you reach age 65 and are still an active employee, Medicare will be considered the secondary payer of benefits and this Plan will be primary.

If you are entitled to Medicare benefits (either as result of turning age 65 or due to total disability) and are covered under this Plan, you may choose to have Medicare as the primary plan by notifying the Fund Administrator. If you do so, your medical coverage under this Plan will end.

RIGHT OF RECOVERY AGAINST THIRD PARTIES

THE FUND PAYS CLAIMS FOR EXPENSES INCURRED BECAUSE OF AN ILLNESS OR INJURY FOR WHICH A THIRD PARTY IS (OR MAY BE) RESPONSIBLE, BUT BY SUBMITTING THE CLAIM FOR PAYMENT BY THE FUND YOU (AND A COVERED DEPENDENT IF HE OR SHE SUFFERS THE ILLNESS OR INJURY) ARE DEEMED TO AGREE TO EACH OF THE FOLLOWING CONDITIONS:

- The Fund holds an equitable lien on any recovery received by you (or your dependent, legal representative or agent)
- You will notify any third party responsible for your illness or injury of the Fund's right to reimbursement for any claims related to your illness or injury
- You will hold any reimbursement or recovery received by you (or your dependent, legal representative or agent) in trust on behalf of the Fund to cover all benefits paid by the Fund with respect to such illness or injury and to reimburse the Fund promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss
- The Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or dependent is made whole) and that the Fund's claim has first priority over all other claims and rights
- You will reimburse the Fund in full up to the total amount of all benefits paid by the Fund in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Fund as reimbursement up to the full amount of the benefits paid.
- The Fund's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise
- In the event you elect not to pursue your claim(s) against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims
- You will assign, upon the Fund's request, any right or cause of action to the Fund
- You will not take or omit to take any action to prejudice the Fund's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Fund in obtaining reimbursement
- You will cooperate in doing what is necessary to help the Fund recover the benefits paid or in pursuing any recovery
- You will forward any recovery to the Fund within ten days of disbursement by the third party or to notify the Fund as to why you are unable to do so
- You will permit the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your or your dependents' behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Fund's attorney's fees and costs

If you or your dependents have uninsured motorist or under-insured motorist coverage under an automobile liability insurance policy that applies to an illness or injury caused or contributed to by a third party, the conditions described above also apply to your rights under that insurance policy.

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

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

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

If you have questions about how to meet these third party liability rules, contact the Fund Administrator.

OVERPAYMENT OF BENEFITS

The Fund reserves the right to recover claim payments made on your or your dependents' behalf if the Fund has overpaid a claim. If the Fund makes an overpayment, you or your dependent are obligated as a condition of coverage under the Fund to reimburse the Fund for the amount of the overpayment. The Fund may recover the overpaid amount by making deductions from any future benefit payments payable to you or assigned by you or by taking appropriate legal action.

WORKERS' COMPENSATION

Benefits are not payable for any injury, illness, disease or other physical or psychiatric condition and/or death caused by or resulting from any employment, occupation or work for wage or profit. If you incur such a loss, you should file a workers' compensation claim with your employer. However the Fund may provide provisional coverage subject to a lien on any workers' compensation benefits awarded. This provisional coverage is subject to the terms and conditions described above under the heading "Right to Recovery Against Third Parties."

In the event your workers' compensation claim is denied by your employer, you must appeal the denial through your employer's workers' compensation carrier. The Appeals Board will then issue an application for adjudication.

For your claim to be considered for payment under the Plan you must submit a copy of the denial letter and the application for adjudication to the Fund. A notice and request for allowance of lien will then be issued for signature for the charges that were submitted to the Fund for medical services rendered as a result of the alleged workers' compensation injury or illness. Upon receipt of the executed request for allowance of lien, payment will be made on the pending claims and the Fund will file the lien claim with the Workers' Compensation Appeals Board.

IF YOU CLAIM COVERAGE FOR SOMEONE WHO IS NOT ELIGIBLE

If you claim coverage for a dependent or other person who does not meet the Plan's eligibility requirements, the Fund reserves the right to take any legally permissible actions to recover any amounts wrongly paid, including withholding payment on future claims submitted by you and/or your eligible dependents or filing a lawsuit against you and/or any person who has wrongfully received benefits. The Fund will withhold benefit payments for covered expenses until it has fully recovered the amount paid for expenses incurred by ineligible dependents. The Fund shall also be entitled to recover its costs of recovery of any amounts wrongly paid, including its attorney fees and court costs. Anyone who submits a claim for a person who is not eligible should be aware that insurance fraud is a crime subject to criminal prosecution. The Trustees may also, in their sole discretion, terminate the participation of anyone found to have willfully defrauded the Fund.

GENERAL & ADMINISTRATIVE INFORMATION

In this section you'll find important information on:

- Administration of the Fund
- Funding of benefits
- The Board of Trustees

FUND NAME AND ADDRESS

The name of this Fund is the Bay Area Delivery Drivers Security Fund.

THE TRUST FUND

The benefits provided under the Bay Area Delivery Drivers Security Fund are financed entirely by contributions from employers in accordance with the collective bargaining agreement between the employers and the participating local unions. The amount of the contributions is determined through the collective bargaining process.

TYPE OF FUND

The Fund is an employee welfare benefit Fund and provides medical, dental, vision, prescription drug, mental health, alcohol and chemical dependency treatment and life insurance benefits for eligible employees and dependents, plus accidental death and dismemberment and weekly disability benefits for eligible employees. The benefits are funded and maintained through monthly contributions from participating employers paid on behalf of eligible employees and their covered dependents pursuant to a collective bargaining agreement.

FUTURE OF THE FUND

The Fund and all of the Plans it sponsors are established and maintained through the collective bargaining process. The Board of Trustees anticipates that the Plan under which you are covered will continue as long as the collective bargaining agreements so provide or until the Trustees decide to end the Plan or the Fund.

Subject to any maintenance of benefits requirements contained in the applicable collective bargaining agreements, the Board of Trustees reserve the right to change or discontinue any Plan at any time for any reason without need for prior approval by any person, employer or union. Such amendments may change benefit levels, eligibility requirements or any other provision of the Plan.

The Board of Trustees may update the Plan to reflect changes in laws and regulations as well as for other reasons. Any changes to the Plan will not lower amounts already payable for claims incurred before the Plan changes become effective.

Federal law prohibits use of Fund assets for any purpose other than providing benefits and paying the reasonable administrative expenses of the Fund and the Plans it sponsors. If the Fund or Plan(s) end, the remaining assets will continue to provide Plan benefits until there are no more assets left, or will be used in a way that is consistent with the purpose of the Plan or the Fund.

In no event will termination of the Plan and Trust result in the reversion of trust assets to any employer.

BENEFITS AND SOURCE OF BENEFITS

All of the benefits provided by the Plan are summarized in this document. The complete terms of the benefits provided are set forth in the group insurance policies or service agreements with the following organizations:

- Kaiser Foundation Health Plan, Inc.
- Vision Service Plan
- Prescription Solutions
- Teamsters Assistance Program of Northern California
- ReliaStar Life Insurance Company

Contributions to the Plan are made by employers in accordance with their collective bargaining agreements with the participating local unions and by certain other employers pursuant to the provisions of the Trust Agreement.

There is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts the Trust Fund collected and has available for health care benefits by payment of premiums for the coverage provided by any HMO, insurer listed above.

THE BOARD OF TRUSTEES

The Board of Trustees is responsible for the operation of the Fund and is made up of three Trustees appointed by the contributing employers and three Trustees appointed by the local unions.

Union Trustees	Employer Trustees
Jack Bookter Retail Delivery Drivers Local 278 5 Thomas Mellon Circle, Suite 130 San Francisco, CA 94134	Rich Murphy United Parcel Service 2574 Barrington Court Hayward, CA 94545
Dennis Hart Teamsters Local No. 78 492 "C" Street Hayward, CA 94541	Frank Cademarti United Parcel Service 2222 – 17th Street San Francisco, CA 94103
Richard Rodriguez c/o HSBA 160 Airway Blvd Livermore, CA 94551	Debbie Field DS Waters 5660 New Northside Drive, Suite 500 Atlanta, GA 30328

AGENT FOR SERVICE OF LEGAL PROCESS

Jeffrey Chapman is designated by the Board of Trustees as the Agent of the Trust Fund for the service of legal process, and can be reached at the same address as the Fund Administrator, 160 Airway Boulevard, Livermore, CA 94550. Legal process may also be served on any Trustee.

ASSIGNMENT OF BENEFITS

Except as authorized by federal law, your benefits under the Fund cannot be assigned and are not subject to garnishment or attachment.

INFORMATION ABOUT TAXES

The Plans described in this guide provide benefits to eligible employees and retirees in keeping with federal law and governing documents. With the exception of benefits provided to domestic partners, it is intended that the value of coverage generally be non-taxable for federal income tax purposes.

RIGHT TO EXAMINE PERSON AND RECORDS

The Fund, at its own expense, shall have the right and opportunity to examine the medical records and person of any participant when and as often as it may reasonably require while a claim is pending, and also reserves the right and opportunity to conduct an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Fund.

ADMINISTRATION OF THE TRUST FUND

The Bay Area Delivery Drivers Security Fund is administered by the Board of Trustees, which contracts with Health Services Benefit Administrators for administrative services. You may write to the Board of Trustees at the following address: Bay Area Delivery Drivers Security Fund, P.O. Box 2358, Livermore, California 94551-2358.

FUND ASSETS

The assets of the Fund are held in trust for the sole purpose of funding benefits and paying the costs of administration of the Fund and its Plans. In no event will Fund assets revert to contributing employers.

TRUST FUND RECORDS/PLAN YEAR

The financial and claim experience records of the Fund are kept on a fiscal year basis, ending July 31st of each year.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Fund's Employer Identification Number is: 94-6072965. The Plan Number is 501.

FUNDING AND CONTRIBUTIONS

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

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

In certain circumstances, employees may be able to self pay for a period of time when they are not covered by employer contributions.

Life and Accidental Death and Dismemberment benefits are paid through a contract with ReliaStar Life Insurance Company. Vision benefits are paid through a contract with Vision Services Plan and the prescription drug benefits are paid through a contract with Prescription Solutions. HMO benefits are insured through the Kaiser Permanente HMO plan. All other benefits are funded directly by the Trust Fund.

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

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

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

AUTHORITY OF THE BOARD OF TRUSTEES

The Trust Agreement gives the Board of Trustees the authority to make any determination of fact necessary and proper to the administration of the Fund and the Plans. It also gives the Board of Trustees the power to construe and interpret the rules of the Plan and the Trust Agreement relating to eligibility of covered employees and retirees, their dependents and beneficiaries to receive benefits.

The Trustees shall have the exclusive right, power and authority in their sole and absolute discretion to administer, apply, interpret and/or terminate any provisions of the Plan, this Summary Plan Description, and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the foregoing, the Trustees shall have the sole and absolute discretionary authority:

- to take all actions and make all decisions with respect to eligibility for, and the amount of, benefits payable under the Plan
- to formulate, interpret and apply rules, and policies necessary to administer the Plan in accordance with its terms
- to decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan
- to resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents
- to process, and approve or deny, benefit claims, and rule on any benefit exclusions

All determinations made by the Trustees with respect to any matter arising under the Plan, this Summary Plan Description, and any other Plan documents shall be final and binding on all parties. The Trustees have delegated their authority to determine matters arising under the life, accidental death and disability and survivor income insurance benefit coverage to ReliaStar life and under the Kaiser HMO Plan to Kaiser.

ONLY THE FULL BOARD OF TRUSTEES IS AUTHORIZED TO INTERPRET THE PLAN OF BENEFITS DESCRIBED IN THE BOOKLET AND NO INDIVIDUAL TRUSTEE, UNION REPRESENTATIVE OR EMPLOYER REPRESENTATIVE IS AUTHORIZED TO INTERPRET THIS PLAN ON BEHALF OF THE BOARD OR TO ACT AS AN AGENT OF THE BOARD. THE TRUSTEES HAVE AUTHORIZED THE FUND ADMINISTRATOR TO RESPOND IN WRITING TO WRITTEN INQUIRIES FROM PLAN PARTICIPANTS AS A CONVENIENCE TO PARTICIPANTS, THE FUND ADMINISTRATOR WILL PROVIDE ORAL ANSWERS REGARDING COVERAGE ON AN INFORMATIONAL BASIS. HOWEVER, NO SUCH ORAL COMMUNICATION IS BINDING UPON THE BOARD OF TRUSTEES.

FUNDING OF BENEFITS

Some benefits under the Plan are self-funded by the Bay Area Delivery Drivers Security Fund, others are funded through an insurance contract between the Fund and a third party, as described in the chart below.

Type Of Benefit	Name Of Provider	Type of Funding
Indemnity Medical Plan	BADDSF	Self-Funded
HMO medical benefits	Kaiser Permanente	Insured
Prescription Drugs	Prescription Solutions	Self-Funded
Dental	BADDSF	Self-Funded
Vision	Vision Service Plan	Self-Funded
Life, AD&D, Survivor Income	ReliaStar Life Insurance Co.	Insured
Alcohol/Chemical Dependency	If enrolled in Indemnity Medical Plan: Teamsters Assistance Plan (TAP)	Self-Funded
Alcohol/Chemical Dependency	Kaiser Permanente, if enrolled in HMO medical option	Insured
Short-term Disability	BADDSF	Self-Funded

YOUR FEDERAL RIGHTS UNDER ERISA & HIPAA

In this section you'll find information on your rights under two important federal laws:

- ERISA
- HIPAA

YOUR RIGHTS UNDER ERISA

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 to protect the interests of participants and beneficiaries in certain employee benefit plans. As a participant in the Plan, you have certain rights and protections under ERISA. ERISA provides that you, as a participant or beneficiary in each Plan, are entitled to:

- receive information about your Plan and benefits
- continue group health Plan coverage after losing coverage
- prudent actions by Plan fiduciaries
- enforce your rights
- assistance with your questions

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

- Examine, without charge, at the Plan/Fund Administrator's principal office—and at other specified locations such as worksites and union halls—all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration
- Obtain copies of documents governing the operation of the Plan and other Plan information by writing to the appropriate Fund Administrator (there may be a reasonable charge for the copies)
- Receive a summary of the Plan's annual financial report (if any) — the Fund Administrator is required by law to furnish each Plan participant with a copy of this summary annual report
- Continue health care coverage (either for yourself, or your spouse and/or dependent children) if there is a loss of coverage under the Plan due to a Qualifying Event, though you or your dependents will have to pay for this coverage
- A reduction in, or elimination of, exclusionary periods of coverage for preexisting conditions that apply under your medical Plans, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or 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.

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

No one—neither your employer nor any other individual—may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. However, this rule neither guarantees continued employment, nor affects your employer's right to terminate your employment for other reasons.

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

Under ERISA, there are steps you can take to enforce the rights listed above. For instance, if you request a copy of the Plan document or the latest annual report from the Fund Administrator 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 Fund Administrator to provide the materials and pay you up to $110 a day until you receive them, unless they were not sent because of reasons beyond the Administrator's control.

If your claim for benefits is denied in whole or in part, and you have been through the Plan's appeals procedure, you may sue in a state or federal court. In addition, if you disagree with the Fund Administrator's decision concerning the qualified status of a domestic relations order or medical child support order, you may file suit in a federal court after exhausting appeals.

Similarly, if you believe that any Plan fiduciary is misusing Fund money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you win, the court may order the person you sued to pay these legal expenses. If you lose, the court may order you to pay the court costs and legal fees (if, for example, it finds your claim is frivolous).

If you have questions about one of the Plans, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C., 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR HEALTH INFORMATION AND PRIVACY

The health benefit options offered under the Fund use health information about you and your covered dependents only for the purposes of providing treatment, paying claims, and related functions. A copy of the Fund's Privacy Notice appears below.

To protect the privacy of health information, access to your health information is limited to such purposes. Effective **April 14, 2003**, the health benefit plan options offered under the Fund will comply with the applicable health information privacy requirements in Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the applicable federal regulations issued by the Department of Health and Human Services.

PRIVACY NOTICE

USE AND DISCLOSURE OF HEALTH INFORMATION

The Fund may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

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

To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

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

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

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

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

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

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

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

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

For Disclosure to the Plan Sponsor. The Plan sponsor represents that adequate separation exists between the Plan and Plan sponsor so that Protected Health Information (PHI) will be used only for Plan administration. As a jointly trusteed multiemployer trust fund which contracts with a third party administrator, the Plan sponsor has no employees. No person under the control of the Plan sponsor has access to your PHI. The Fund may disclose your health information to the Plan sponsor for Plan or Fund administration functions performed by the Plan sponsor on behalf of the Fund and Plans. Such administration shall include, but is not limited to, the following purposes: appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits, and Plan design. The Fund also may provide summary health information to the Plan sponsor so that the Plan sponsor may solicit premium bids from other health Plans or modify, amend or terminate the Plan.

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

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

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

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

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

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Fund may disclose your health information in the course of any

judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Fund makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

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

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

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

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

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

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

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

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Officer at the Fund Administrator.

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

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

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

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Officer at the Fund Administrator. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Privacy Notice at any time, even if you have received this Privacy Notice previously or agreed to receive the Privacy Notice electronically. To obtain a paper copy, please contact the Privacy Officer at the Plan Administration Office.

DUTIES OF THE FUND

The Fund is required by law to maintain the privacy of your health information and to provide to you this Privacy Notice of its duties and privacy practices. The Fund is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it

maintains. If the Fund changes its policies and procedures, the Fund will revise the Privacy Notice and will provide a copy of the revised notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Privacy Officer at the Plan Administration Office. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Officer by calling 800-654-1824 or 925-449-7070.

EFFECTIVE DATE

The Fund's privacy policies and procedures became effective April 14, 2003.