TEAMSTERS MISCELLANEOUS SECURITY TRUST FUND

Opt-Out Rules Under Active Coverage When Other Group Health Insurance is Available

If you are eligible or enrolled in health and welfare coverage as an active employee under the Teamsters Miscellaneous Security Trust Fund (Plan) and your employer does not pay contributions on behalf of active employees for future retiree health coverage to the Plan, you may elect to opt-out of your health and welfare coverage for the reasons listed below:

- **If You or Your Spouse (or Domestic Partner) Have Other Group Health Coverage**
- **If You Have Other Group Health Coverage through a Parent as an Adult Dependent up to the age of 26**
- **If You or Your Spouse (or Domestic Partner, if applicable) Both Work for Contributing Employers to this Plan and are Both Covered by Said Plan**

How To Opt-Out of Coverage

➢ If You or Your Spouse (or Domestic Partner) Have Other Group Coverage

If you, your spouse or domestic partner currently have or obtain other employment-related group health and welfare coverage, you can opt-out of your health and welfare coverage under this Plan until that other group coverage ends. **To be eligible to enroll or re-enroll in the Plan, there cannot be any lapse in coverage from the time you opt-out of your coverage under this Plan until you re-enroll in this Plan**.

Your spouse, domestic partner, and/or dependent children may opt-out of coverage if you are participating in the Plan and he or she has other employment-related group health and welfare coverage. You and your spouse, domestic partner, and/or dependents may also jointly opt-out of your coverage for the same time period if you both have other employment-related group health and welfare coverage. Please note that your spouse, domestic partner, and/or dependents cannot continue participating in the Plan if you, as the Employee, opt-out of your health and welfare coverage.

The notification requirements outlined below also apply to your spouse, domestic partner, and/or dependents.

To Opt-Out:

- You must inform the Administrative Office of the other group health coverage; either at the time you are eligible for Plan coverage, or when you obtain the other group health coverage if you are already participating in this Plan.

- You will be required to complete the attached "Request to Opt-Out of Coverage" and send it to the Administrative Office of this Plan along with documentation (deemed acceptable to the Plan) from your other carrier. If the information is in order, the Plan's Administrative Office will notify you, in writing that your coverage under this Plan will be postponed or suspended, effective on the first of the second month following approval and remain suspended until such time as the other employment-related group health coverage is terminated.

- The Administrative Office must receive all the required information at least 15 days before the end of the month for your opt-out to be effective on the first of the following second month. For example, you must submit all the required information by April 15th for your opt-out to be effective on June 1. However, if for instance, you submit all the required information between April 16th through the 30th, your opt-out will be effective on July 1.

- **The opt-out of your Plan coverage is not effective until verified in writing by the Administrative Office.**

- **Once you opt-out of your coverage under this Plan, you must remain in that other group health coverage for a minimum of one year, except if your eligibility in that other group health coverage terminates. You will not be allowed to opt back in to this Plan for one year unless your eligibility in that other group health coverage terminates.** If such occurs, you will be required to submit within 60 days documentation that is acceptable to the Plan that you have had continuous coverage in order for you to be enrolled retroactive to the termination date of your other health coverage.

- However, once your coverage has been suspended for a minimum of one year, you will be allowed to opt back in to this Plan without having a loss in your other group health coverage. A written request for reinstatement must be submitted to the Administrative Office along with documentation (deemed acceptable to the Plan) from your other carrier providing proof of continuous coverage from your Opt-Out effective date to the date of request for reinstatement into this Plan.

- Once your opt-out request is approved, no contribution will be required from your employer and no benefits will be provided by the Plan (after the Opt-Out effective date) even if your other group health coverage does not offer comparable benefits.

- Once you opt-out of your coverage under this Plan, your other group health coverage must be maintained on a **continuous basis**. Any interruption of your other coverage, for whatever reason, will be a termination of that coverage and the full employer contributions for all applicable health and welfare benefits will be required from your employer from the effective date of the termination of that coverage.

- While your Plan coverage is suspended, you must complete and submit an attestation form (provided by the Plan) on an annual basis. If you fail to do so before your opt out anniversary, the Plan will require your employer to pay the full contribution (e.g. for medical, prescription drug, dental, vision, mental health/substance abuse benefits or life insurance benefits, if applicable) effective with the first of the month after your opt out anniversary date. You must also provide annually documentation that is acceptable to the Plan that you are maintaining other continuous health coverage.

- When your other group health coverage is terminated you must notify the Administrative Office. **The notice must be received no later than 60 days after your other group health coverage terminates**. You will also be required to submit documentation that is acceptable to the Plan that you have had continuous coverage in order for you to be enrolled retroactive to the termination date of your other health coverage. **If timely notice is not given, your option to return to the Plan will be available on a prospective basis only**.

- After your timely notice is received, the Administrative Office will then notify you, in writing, of any enrollment forms and paperwork it needs to enroll or re-enroll you in the Plan.

- Once the Administrative Office receives your completed enrollment forms and paperwork, you will be enrolled in this Plan, retroactive to the termination of your other coverage.

- **After you re-enroll in this Plan, you will not be allowed to opt out of this Plan for one year.**

➢ **If You Have Other Group Health Coverage through a Parent as an Adult Dependent up to the age of 26**

If you currently have or obtain other employment-related group health and welfare coverage through a Parent through the age of 26 as an Adult Dependent, you can opt-out of your health and welfare coverage under this Plan until that other group coverage ends. **To be eligible to enroll or re-enroll in the Plan, there cannot be any lapse in coverage from the time you opt-out of your coverage under this Plan until you re-enroll in this Plan**.

Your spouse, domestic partner, and/or dependent children may opt-out of coverage if you are participating in the Plan and he or she has other employment-related group health and welfare coverage. You and your spouse, domestic partner, and/or dependents may also jointly opt-out of your coverage for the same time period if you both have other employment-related group health and welfare coverage. Please note that your spouse, domestic partner, and/or dependents cannot continue participating in the Plan if you, as the Employee, opt-out of your health and welfare coverage.

The notification requirements outlined below also apply to your spouse, domestic partner, and/or dependents.

To Opt-Out:

- You must inform the Administrative Office of the other group health coverage; either at the time you are eligible for Plan coverage, or when you obtain the other group health coverage if you are already participating in this Plan.

- You will be required to complete the attached "Request to Opt-Out of Coverage" and send it to the Administrative Office of this Plan along with documentation (deemed acceptable to the Plan) from your other carrier. If the information is in order, the Plan's Administrative Office will notify you, in writing that your coverage under this Plan will be postponed or suspended, effective on the first of the second month following approval and remain suspended until such time as the other employment-related group health coverage is terminated.

- The Administrative Office must receive all the required information at least 15 days before the end of the month for your opt-out to be effective on the first of the following second month. For example, you must submit all the required information by April 15th for your opt-out to be effective on June 1. However, if for instance, you submit all the required information between April 16th through the 30th, your opt-out will be effective on July 1.

- **The opt-out of your Plan coverage is not effective until verified in writing by the Administrative Office.**

- **Once you opt-out of your coverage under this Plan, you must remain in that other group health coverage for a minimum of one year, except if your eligibility in that other group health coverage terminates. You will not be allowed to opt back in to this Plan for one year unless your eligibility in that other group health coverage terminates.** If such occurs, you will be required to submit within 60 days documentation that is acceptable to the Plan that you have had continuous coverage in order for you to be enrolled retroactive to the termination date of other health coverage.

- However, once your coverage has been suspended for a minimum of one year, you will be allowed to opt back in to this Plan without having a loss in your other group health coverage. A written request for reinstatement must be submitted to the Administrative Office along with documentation (deemed acceptable to the Plan) from your other carrier providing proof of continuous coverage from your Opt-Out effective date to the date of request for reinstatement into this Plan.

- Once your suspension request is approved, no contribution will be required from your employer and no benefits will be provided by the Plan (after the Opt-Out effective date) even if your other group health coverage does not offer comparable benefits.

- Once you opt-out of your coverage under this Plan, your other group health coverage must be maintained on a **continuous basis**. Any interruption of your other coverage, for whatever reason, will be a termination of that coverage and the full employer contributions for all applicable health and welfare benefits will be required from your employer from the effective date of the termination of that coverage.

- While your Plan coverage is suspended, you must complete and submit an attestation form (provided by the Plan) on an annual basis. If you fail to do so before your opt out anniversary, the Plan will require your employer to pay the full contribution (e.g. for medical, prescription drug, dental, vision, mental health/substance abuse benefits or life insurance benefits, if applicable) effective with the first of the month after your opt out anniversary date. You must also provide annually documentation that is acceptable to the Plan that you are maintaining other continuous health coverage.

- When your other group health coverage is terminated you must notify the Administrative Office. **The notice must be received no later than 60 days after your other group health coverage terminates**. You will also be required to submit documentation that is acceptable to the Plan that you have had continuous coverage in order for you to be enrolled retroactive to the termination date of your other health coverage. **If timely notice is not given, your option to return to the Plan will be available on a prospective basis only**.

- After your timely notice is received, the Administrative Office will then notify you, in writing, of any enrollment forms and paperwork it needs to enroll or re-enroll you in the Plan.

- Once the Administrative Office receives your completed enrollment forms and paperwork, you will be enrolled in this Plan, retroactive to the termination of your other coverage.

- **After you re-enroll in this Plan, you will not be allowed to opt out of this Plan for one year.**

➢ If You or Your Spouse (or Domestic Partner, if applicable) Both Work for Contributing Employers to this Plan and are Both Covered by Said Plan

- If you or your spouse (or Domestic Partner, if applicable) both work for Contributing Employers to this Plan, either one of you may opt-out of your health and welfare coverage as an active employee under this Plan as long as one of you enrolls (or continues to be enrolled) in this Plan as an active employee. However, the employee who opts-out of his coverage as an active employee must still be covered as a dependent for such benefits.

- Coverage under this Plan, however, for the employee who suspends his health and welfare coverage as an active employee must be continuous as a dependent under this Plan for the time he suspends as an active employee under this Plan.

- **Once you opt-out of your coverage under this Plan, you must remain in that other group health coverage for a minimum of one year, except if your eligibility in the other group health coverage terminates. You will not be allowed to opt back in to this Plan for one year unless your eligibility in that other group health coverage terminates.** If such occurs, you will be required to submit within 60 days documentation that is acceptable to the Plan that you have had continuous coverage in order for you to be enrolled retroactive to the termination date of your other health coverage.

- However, once your coverage has been suspended for a minimum of one year, you will be allowed to opt back in to this Plan without having a loss in your other group health coverage. A written request for reinstatement must be submitted to the Administrative Office along with documentation (deemed acceptable to the Plan) from your other carrier providing proof of continuous coverage from your opt-out effective date to the date of request for reinstatement into this Plan.

- While your Plan coverage is suspended, you must complete and submit an attestation form (provided by the Plan) on an annual basis. If you fail to do so before your opt out anniversary, the Plan will require your employer to pay the full contribution (e.g. for medical, prescription drug, dental, vision, mental health/substance abuse benefits or life insurance benefits, if applicable) effective with the first of the month after your opt out anniversary date.

- Once coverage ends for the employee who is enrolled as an active employee under this Plan, the employee, who suspended his coverage as an employee, must contact the Administrative Office within 60 days to enroll or re-enroll as an active employee under the Plan. **If timely notice is not given, your option to return to the Plan will be available on a prospective basis only**

- After your timely notice is received, the Administrative Office will then notify you, in writing, of any enrollment forms and paperwork it needs to enroll or re-enroll you as an active employee in the Plan.

- Once your completed enrollment forms and paperwork are received, you will be enrolled in this Plan, retroactive to the termination of your other coverage.

- **After you re-enroll in this Plan, you will not be allowed to opt out of this Plan for one year.**

➢ COBRA – Continuation of Your Group Health Coverage

As a participant in this Plan, you have a right to continue your coverage if you lose your group health coverage because of a qualifying event such as a reduction in your hours of employment or the termination of your employment. Remember though that you may only continue the health coverage which you were receiving before you experienced the qualifying event. In this case, since you opted out of the coverage under this Plan and no benefits were being provided to you and/or your eligible dependents, COBRA continuation coverage is not available.

Please refer to the Consolidated Omnibus Budget Reconciliation Act (COBRA) section in your Summary Plan Description to learn more about your rights and obligations under this law.

TEAMSTERS MISCELLANEOUS SECURITY TRUST FUND

Request to Opt-Out of Coverage under the Plan as an Active Employee

Please submit proof of current Other Group Health Coverage with your request
(ID Cards are not acceptable proof of coverage)

1. Employee's Name:_____
   SS#:_____
   Employer:_____

2. Which individuals are covered by the request?
   Employee's Name:_____

   Spouse's Name:_____

   Domestic Partner's Name (if applicable):_____

   Dependent Children (Name(s) and Date(s) of Birth):_____

   _____

3. Date you wish to opt-out of health and welfare coverage (must be at the beginning of the month):_____
   _____

4. Type of Suspension or Postponement:

   ☐ Have other employment-related group health and welfare coverage – complete question 5.

   To postpone or suspend coverage each individual must be covered under the other group health plan. Also, your spouse, domestic partner, and children cannot continue to participate in the Plan if only you, as the Employee, postpone or suspend coverage for such benefits.

   ☐ Opt-Out of Coverage Because Both You and Your Spouse (or Your Domestic Partner, if applicable) Work for Contributing Employers to the Plan and are Both Covered by said Plan – complete question 6.

5. Information about other employment-related group health care coverage:
   a. Name of Employer:_____
   b. Type of Plan/Group #:_____
   c. Effective Date of Other Coverage:_____
   d. Who is covered under other insurance (You/Spouse or Domestic Partner/Dependent Children):

   _____

   _____

   e. Plan Administrator Name/Insurance Name, Address, Phone Number (if applicable):

   _____

   _____

6. Information about Contributing Employers to this Plan:
   a. Name of Employer:_____
   b. Address of Employer:_____
   c. Name of Employer:_____
   d. Address of Employer:_____
   e. Who do you want to be covered as an Active Employee under the Plan (You –or– Spouse – or Domestic Partner, if applicable):_____
   f. State Relationship Status between Employee and Individual Selected in item 6.e.: (e.g., Self, Spouse or Domestic Partner)_____
   g. Who do you want to be covered as the Dependent under the Plan (You –or Spouse – or Domestic Partner, if applicable):_____
   h. State Relationship Status between Employee and Individual Selected in item 6.g.: (e.g., Self, Spouse or Domestic partner)_____
   i. Who are the other Dependents who you want to be enrolled under the Plan?

_____

The employment-related group health coverage for any individual that postpones or suspends Plan coverage must be continuous. Once you opt-out of your coverage under this Plan, you must remain in that other group health coverage for a minimum of one year, except if your eligibility under that other group health coverage terminates. Once your coverage has been suspended for a minimum of one year, you will be allowed to opt back in provided proof of continuous coverage is provided. While your Plan coverage is suspended, you must annually complete and submit a Plan attestation form and documentation deemed acceptable to the Plan that you are maintaining other continuous group health coverage. If you fail to do so before your opt out anniversary, the Plan will require your employer to pay the full contribution (e.g. for medical, prescription drug, dental, vision, mental health/substance abuse benefits or life insurance benefits, if applicable) effective with the first of the month after your opt out anniversary date.

Any interruption of that coverage for any reason will be deemed a termination of coverage. If that happens, you must notify the Administrative Office no later than 60 days following the termination of your other group health coverage. If timely notice is not given, your option to return to the Plan will be available on a prospective basis only. The Administrative Office will notify you in writing of what enrollment forms and paperwork that you must complete to enroll or re-enroll in the Plan coverage and the due date.

I hereby certify, the above information is true and I have read the Plan provisions governing "Opt-Out Rules" under the Active Plan that are attached.

_____
Signature of Employee Date

_____
Print Name

_____
Signature of Spouse/Domestic Partner/Parent Date
Circle one: Spouse, Domestic Partner or Parent

_____
Print Name

Please remit completed form to:

Northwest Administrators, Inc.
225 South Lake Avenue, Suite 1200
Pasadena, CA 91101