TEAMSTER MULTI-BENEFIT TRUST
HEALTH PLAN

SUMMARY PLAN DESCRIPTION

For Groups 1050/1100
Effective December 1, 2011

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An Important Message to Participants

We are pleased to welcome you as a participant in the Teamsters Multi-Benefit Trust Health Plan for Group Nos. 1050 and 1100 ("Plan"). This booklet, together with the evidence of coverage booklets prepared by each of the providers listed in this booklet describes the benefits available to you as a participant in the Plan and is intended to serve as your Summary Plan Description ("SPD"), required by the Employee Retirement Income Security Act of 1974 ("ERISA"). This SPD includes important information to help you understand and appropriately access your benefits. The information in this booklet is effective December 1, 2011 and supersedes and replaces all information previously provided to you.

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

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

- Medical, Hospital Plans
- Dental Plans
- Vision Plan
- Chiropractic – Acupuncture
- Employee Assistance Program (EAP)/Legal Benefit

This booklet should be read in conjunction with the Evidence of Coverage documents which contain full details for each of these coverages provided to you and your Dependents. The terms of these legal documents will control all questions concerning any subject matter covered in this booklet. Please see page 26 of this booklet under the section entitled "Insurers and Providers of Service to the Trust" for the contact information for each of the organizations providing benefits.

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

The Joint Board of Trustees listed at page 3 of this booklet is the Plan Administrator. The Board has contracted with Benefit Programs Administration Benefit Administrators, Inc. to perform routine administration for the Plan as a third-party administrator. Benefit Programs Administration is responsible for the operation of the Trust Administrative Office which is sometimes referred to as the Fund or Trust Office. If you have any questions regarding any benefit program or the administration of Plan which are not fully answered in this booklet, and the Evidence of Coverage booklets for each provider, please contact either Benefit Programs Administration at the address and numbers listed below or the specific provider whose contact information is listed on page 26 of this booklet.

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

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

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

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

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

Board of Trustees

Summary Plan Description

General Information About the Plan

ADMINISTRATIVE OFFICE
TEAMSTERS MULTI-BENEFIT PLAN
Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017
(562) 463-5040; (888) 410-1756

Office Hours: Monday through Friday, excluding holidays
8:30 a.m. to 4:30 p.m.

CONSULTANTS AND ACTUARIES
RAEL AND LETSON
35 North Lake Avenue, Suite 810
Pasadena, California 91101
(626) 432-7323

LEGAL COUNSEL
WOHLNER KAPLON PHILLIPS YOUNG & CULTER
16501 Ventura Boulevard, Suite 304
Encino, California 91436
(818) 501-8030

AUDITORS
MILLER KAPLAN ARASE & CO., LLP
Certified Public Accountants
4123 Lankershim Boulevard
North Hollywood, California 91602-2828
(818) 769-2010

BOARD OF TRUSTEES

LABOR TRUSTEES	MANAGEMENT TRUSTEES
Rick Middleton, Chairman	Tom Secrest
Lourdes Garcia	Elizabeth Sanchez

Eligibility Rules for Active Employees and Their Eligible Dependents

Employee Eligibility

Who Is Eligible for Benefits?
Eligibility for individual participants shall be determined according to the provisions of the Collective Bargaining Agreements between the various Unions and Employers participating in the Trust Fund. Please refer to your Collective Bargaining Agreement to determine the eligibility rules that apply to you.

What if I am an Employee of a Newly Participating Employer in the Trust?
If you are an Employee of an Employer on the first date the Employer becomes obligated to contribute to the Trust Fund, you will become eligible on the effective date of coverage of your Employer. *For Example:* You are working for the Employer on May 31, and your Employer enters into a Collective Bargaining Agreement with the Union effective June 1. Your coverage will begin on June 1, so long as the required contribution is made to the Trust on your behalf.

What if I Go to Work for an Employer Who Is Already Participating in the Trust?
If you are a newly hired Employee who goes to work for an Employer who is already participating in the Trust, you will become eligible for benefits in accordance with the terms of the Collective Bargaining Agreement requiring contributions to the Trust on your behalf. There may be a waiting period which is described in your Collective Bargaining Agreement before contributions are required to be made on your behalf. This may cause a delay in eligibility for benefits since ***any hours you work during a waiting period will not count toward establishing your Eligibility for benefits.***

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

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

Continuing Eligibility
Once you initially become eligible for benefits, you will remain eligible so long as you continue to satisfy the eligibility rules required to maintain coverage as provided in your Collective Bargaining Agreement. Please refer to your Collective Bargaining Agreement to determine these eligibility rules or contact the Trust Administration Office. Generally, this means that once you become eligible for benefits you will remain eligible so long as you are employed with a participating Employer and your Employer pays the required contribution on your behalf to the Trust Fund.

When Does My Eligibility for Benefits End?
Your eligibility as the Employee ends on the earliest of the following dates:

1. The date you fail to satisfy the eligibility rules required to maintain your coverage as provided in your Collective Bargaining Agreement.

2. The date coverage for which you are eligible is eliminated from the Plan.

3. The date the Plan terminates;

4. The date on which you enter full-time military service in the Uniformed Services of the United States which exceeds 31 days.

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

Am I Required to Enroll in the Plan?
Eligible Employees must complete an application form which is available from the Trust Administrative Office to enroll themselves and/or their eligible dependents. If you are a new employee you must enroll within certain time periods after being hired. Otherwise, enrollment is generally limited to the annual open enrollment period that occurs on the annual anniversary date of your Employer's participation in the Plan. However, please see pages 6-7 for a complete description of the Plan's Initial Enrollment Policy.

Neither you nor your Dependents will have coverage until you have submitted a completed enrollment application to the Trust Administrative Office, and have been notified that your enrollment is complete and your participation has been approved, or you have been enrolled pursuant to the Plan's Default Enrollment Policy. New Employees must enroll within 60 day from the date you become eligible. Once you are enrolled, you won't be able to change your enrollment until the next annual open enrollment period that occurs on the annual anniversary date of your Employer's participation in the Plan. If you have questions regarding enrollment you may contact each of the providers directly at the numbers listed on page 26 of this booklet under section entitled "Insurers and Providers of Service to the Trust" or contact Benefit Programs Administration at (562) 463-5040 or (888) 410-1756.

Please refer to your Collective Bargaining Agreement to determine the medical and dental plans available to your group or contact the Trust Administration Office. When you select the medical plan for yourself and your family, you must also complete the appropriate HMO enrollment form, which is supplied by your Employer or which can be obtained from the Trust Administration Office. Coverage will become effective the date you become eligible.

Can I Waive Participation in the Plan?
Participation in the Plan can be waived by you as the Employee if you complete and return to the Trust Office a signed Waiver of Coverage Form verifying that you are waiving coverage. In order to waive coverage you must meet all of the following conditions:

- You are required to make a premium contribution through payroll deduction by your Employer toward the cost of these benefits.
- You, as the Employee, are covered by another group plan, or you are listed as the Dependent of a spouse or domestic partner in the same employment covered by the same Collective Bargaining Agreement requiring contributions to the Trust who is already enrolled in the Plan. You, as the Employee, may waive coverage to avoid duplication of benefits, as provided by the Trust rules.
- You must provide proof in writing to the Trust of other group coverage or your spouse's or domestic partner's coverage in the Plan, along with a signed Waiver of Benefits Form provided by the Trust within 30 days of your employment.

Upon termination of the other group coverage, you must enroll in the Plan provided by your Collective Bargaining Agreement.

Participation in the Death and Accidental Death and Dismemberment Plan cannot be waived if this benefit is provided for in your Collective Bargaining Agreement.

Initial Enrollment Policy
What if I Fail to Enroll in the Plan as Required or Fail to Return the Waiver of Benefits?
Any eligible employee 1) who does not enroll in one of the medical plans offered pursuant to the bargaining agreement under which they are employed, or 2) who has not completed and returned the Trust Fund's approved Waiver of Benefits Form within thirty days of their initial eligibility, will be automatically enrolled for "Employee Only" coverage in the lowest cost medical plan pursuant to the following enrollment policy.

Employees have an additional sixty (60) days from the date of their default enrollment into the Lowest Cost Plan to enroll in another medical plan that is offered pursuant to the bargaining agreement and/or add Dependents to their coverage. The effective date of the selected coverage will be the first of the month following receipt of a completed Enrollment Form, and any other documents required by the Trust Fund to complete enrollment. You may have a special right to enroll your dependents under HIPAA (see HIPAA Special Enrollment Rights in your Summary Plan Description).

Employees, who do not enroll in a medical plan offered by the bargaining agreement and/or fail to add Dependents to their coverage within ninety (90) days of the date they are initially eligible, must wait until the next Open Enrollment opportunity to select a medical plan other than the Lowest Cost Plan and/or to add Dependents to their coverage.

When applicable, a change of medical plan will become effective the first of the month following the date the change was made and/or Dependents added. Any change of medical plan and/or addition of Dependents will not be applied retroactively.

To enroll dependents, each dependent must be listed on the initial enrollment form and provided to the Administrative office within the timeframe noted above. No dependent will be enrolled without proper documentation of dependent status (i.e. marriage certificate, birth certificate, etc.) which must be provided within the initial 90-days of the employee's eligibility. Dependent coverage will be effective the first of the month following receipt of required documentation.

Dependent Eligibility

How Do My Dependents Become Eligible for Benefits?
Your dependents who meet the definition of "Dependent" (see below) under the Plan become eligible for benefits on the date you become eligible. Eligible Dependents will be covered under the same medical, dental and vision programs that you select.

All eligible Dependents must be enrolled with the Plan to receive benefits. Services and reimbursements can be delayed, or denied to Dependents who are not properly enrolled. You may obtain the necessary forms to enroll Dependents, including newly-acquired Dependents, from your Employer or the Trust Administration Office. Coverage may be denied if you fail to request enrollment within 30 days from the date you acquire your new Dependent or you are initially eligible for benefits. If you are default enrolled in the Plan and you elect to enroll your Dependents, you will have an additional 60 days from the date of your default enrollment to add your Dependents and return documentation such as birth or marriage certificates to the Administrator. If you fail to enroll your Dependents or provide the documentation within these time periods coverage will be denied.

In order to enroll a dependent spouse, a copy of the marriage certificate is required. To add a Domestic Partner of either the same or opposite sex, please contact Benefit Programs Administration for the necessary documentation.

In order to add a dependent child, a copy of the birth certificate or other court-ordered documentation proving the child's dependent status will be required.

If the document establishing dependent status is received within twenty (20) days of it being requested, the dependent's health care coverage will become effective the first of the month in which the document is requested. If the document establishing dependent status is received more than twenty (20) days after it is requested, the dependent's health care coverage will become effective the first of the month following the receipt of the document. If the requested documents are not received, your dependents will not be enrolled in the Plan and may be denied access to health care.

Who Are My Eligible Dependents Under the Plan?

1. Your legal spouse.

2. Your same- sex Domestic Partner or your opposite sex Domestic Partner where one or more of the Domestic Partners is over age 62, who have provided the Trust with a Declaration of Domestic Partnership filed with the California Secretary of State or an equivalent document issued by a local agency of California or other state of local agency of another state.

   Domestic Partners who do not qualify for registration of their domestic partnership, but otherwise meet the Plan's definition of Domestic Partner and who sign an Affidavit of Domestic Partnership before a notary public under penalty of perjury and provide the required evidence of Domestic Partnership to the Plan Administrative Office.

3. Your natural children (born to you), adopted children, step-children, foster children, children of your Domestic Partner, or children placed for adoption who are less than 26 years of age.**.** Children for whom you or your spouse are the court-appointed Guardian, in limited circumstances when the employee's benefits are transferred from another Teamsters Trust Fund where the child had coverage immediately before the coverage was transferred.

4. Your unmarried children, regardless of age, who are financially dependent upon you for support and who are incapable of self-support because of mental or physical incapacities that existed prior to reaching age 19. Proof of such incapacity must be presented to the Trust Administrative Office within 30 days of the date coverage would otherwise end due to age and thereafter periodically at the request of the Board of Trustees.

Who Is Not an Eligible "Dependent" Under the Plan?

1. A dependent who is serving in the Uniformed Services of the United States is not eligible as a Dependent under this Plan.

2. An Employee's Spouse shall cease to be a Dependent under this Plan on the date set forth for termination of marriage in the Judgment of Dissolution or Nullity.

3. An Employee's Domestic Partner shall cease to be a Dependent under this Plan on the date of termination of the Domestic Partnership.

When Can I Enroll a Newly Acquired Dependent?

If you acquire a new dependent because of marriage, domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, Registration of Domestic Partnership,

birth, adoption, or placement for adoption. For Domestic partners who do not qualify for registration, enrollment is limited to the initial eligibility enrollment period or open enrollment. To request special enrollment or obtain more information, contact the Trust Administration Office at:

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

For those persons who have a special enrollment right but fail to exercise that right within the required time period, they may enroll by completing the enrollment form and providing the required documentation (i.e. marriage certificate, birth certificate, etc.) Benefits will commence the first day of the month following approval of the enrollment by the Plan Administrator.

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

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

1. The date your eligibility, as the Employee, terminates for any reason;
2. The date your Dependent no longer qualifies as an eligible Dependent as defined by the Plan;
3. For your legal spouse, the date of entry of a decree of dissolution or legal separation.
4. For your Registered Domestic Partner eligibility terminates at the end of the sixth month after a Notice of Termination of Domestic Partnership is filed with California Secretary of State or the date of entry of a Superior Court judgment is entered that dissolves, nullifies or legally separates Domestic Partnership.
5. The date on which your non –registered domestic partnership ends. You or your former Domestic Partner must immediately notify the Plan in writing of the end of your domestic partnership and execute the Plan's Affidavit of Termination of Domestic Partnership.
6. The date your Dependent enters full-time military service in the uniformed services of the United States.
7 The date the Plan terminates or no longer provides coverage for Dependents of active Employees**.**

However, when the Dependent's eligibility terminates, the Dependent may have the right to elect COBRA coverage under the Trust. See the section entitled "Continuation Coverage under COBRA.

Please review Termination of Coverage provisions contained in Evidence of Coverage booklets for a full description of events which may lead to termination of coverage. You may also have individual conversion rights explained in your Evidence of Coverage booklets.

Special Enrollment - Health Information Portability and Accountability Act of 1996

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

Special Enrollment Rights Under "SCHIP"

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

Extensions of Coverage During Leaves of Absence

Military Leave

Continuation of coverage may be available to you under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA was enacted by Congress to provide protections to individuals who are members of the "Uniformed Services." "Uniformed Services" is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency.

If you take a military leave for 30 Days or less, you will continue to receive benefits for up to 30 days. If you take a military leave for more than 30 days, USERRA permits you to continue coverage for you and your Dependents at your own expense, at a cost of 102% of the cost of coverage for up to 24 months. The maximum period of continuation coverage for health care under USERRA is the lesser of: (1) 24 months (beginning from the date you leave work due to your military leave) or (2) the day after the date you fail to timely apply for or return to a position of employment with an Employer participating in the Plan.

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

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

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

Family and Medical Leave Act

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

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

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

Continuation Coverage Under COBRA

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

If you or your Dependent lose coverage under the Plan as a result of a Qualifying Event described below, coverage may be continued for a limited period under COBRA Continuation

Coverage by making monthly payments to the Trust Fund. ***If you do not take advantage of COBRA coverage, you may have limited coverage under a new insurance plan if you have a break in coverage of more than 63 days.***

COBRA Continuation Coverage is not available to Domestic Partners; however the Plan recognizes Domestic Partners as Dependents and will extend continuation coverage under the Plan for the period during which your coverage is extended under COBRA. Your Domestic Partner has no independent rights to elect or extend COBRA Continuation Coverage. Please contact the Trust Administrative Office for more information including the cost of extending coverage for your Domestic Partner.

What Benefits Are Available Under COBRA Continuation Coverage?
You, your Legal Spouse or your Dependent Children have the option of electing COBRA coverage to continue the coverages provided through the Trust described in this booklet. If you choose COBRA continuation Coverage, you will be entitled to the same coverage that you had on the day before the event that caused your coverage under end.

COBRA Eligibility (COBRA Qualifying Events)

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

Qualifying Events for the Employee:

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

Qualifying Events for your Dependent Spouse are:

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

Qualifying Events for your Dependent Child are:

1. Parent-Employee dies;
2. Parent-Employee's hours of employment are reduced;
3. Parent-Employee's employment ends for any reason other than his or her gross misconduct;
4. Parents divorce or legally separate; or
5. Your child is no longer eligible for coverage under the Plan as a "Dependent child."

Who Is Eligible for COBRA Continuation Coverage?

COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who will lose coverage under the Plan because of a "Qualifying Event." Depending on the type of qualifying event, Employees and their spouses or Dependent children may be Qualified Beneficiaries. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Please note that Domestic Partners are not Qualified Beneficiaries.

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

Who Can Elect COBRA Coverage?

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

How Do I Obtain COBRA Continuation Coverage?

Benefit Programs Administration administers COBRA continuation coverage for the Plan. Your Employer has the responsibility for notifying the Benefit Programs Administration within 30 days of the Qualifying Event or loss of coverage, whichever is later, if the Qualifying Event is your death, reduction of your hours, termination of employment or your entitlement to Medicare.

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

If you do not provide written notice to the Trust Office of the Qualifying Event within the 60-day period after the Qualifying Event, you and your Dependents will lose the right to continue your coverage through self-payments under COBRA. Notice should be sent to Teamsters Multi-Benefit Trust c/o Benefit Programs Administration at the address listed on page 2 of this booklet. Please contact Benefit Programs Administration at (562) 463-5040 or (888) 410-1756 regarding the required information for the written notice.

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

COBRA continuation coverage will be offered to each eligible Qualified Beneficiary. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage.

For example, Your Spouse may elect coverage even if you do not, you may elect COBRA continuation coverage on behalf of your Spouse and Dependents, and parents may elect COBRA continuation coverage on behalf of any Dependent child who is a Qualified Beneficiary**.**

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

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

When Do COBRA Coverage and Self-Payments Begin?
Although you have up to 60 days to make an election, COBRA coverage must begin the first day of the month in which full coverage would otherwise terminate. Payment of the first contribution must be received by the Trust Administrative Office within 45 days of the date that the Administrative Office receives notification from a Qualified Beneficiary that the Qualified Beneficiary chooses COBRA Continuation Coverage. If a Qualified Beneficiary waits until the end of the election and the payment period, payment for each full month which has passed since the date the Plan coverage terminated must be included with the first payment. Subsequent payments will be due the first day of each month. If payment is not received within 30 days of the due date, COBRA Continuation Coverage will be terminated and all rights to continue coverage will cease.

For How Long Will COBRA Coverage Continue?
COBRA Continuation Coverage can continue for up to 18, 29 or 36 months depending on the COBRA qualifying event.

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

29 Months – (You and Your Dependents)
COBRA Continuation Coverage continues for an additional 11 months (up to a total of 29 months) if within the first 60 days of COBRA coverage you or an eligible Dependent is or

becomes permanently disabled (as determined by the Social Security Administration). In this event, you or your Dependent must notify the Trust Office of the Social Security determination no later than 60 days after it is received and before the end of the initial 18-month COBRA continuation period to be eligible for this COBRA extension**.**

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

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

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

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

If you elect continuation coverage any extension of coverage under COBRA and, if available under USERRA (described below) will run concurrently.
Can COBRA Coverage Be Extended Because of Disability?
If you, your Spouse or Dependent are entitled to the COBRA Continuation Coverage for the 18-month period, that period can be extended for the person who is determined to be entitled to Social Security Disability Income benefits, and/or any other covered family members for up to 11 additional months so long as all the following conditions are met:

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

To qualify for this additional period of coverage, you must provide Benefit Programs Administration at the address listed at page 3 of this booklet with written notice of the disability determination within the 60-day period. The written notice must be accompanied with a photocopy of the entire Social Security

Administration determination. If you do not submit written notice to the Administrator within the 60-day period you will not be eligible for this extension under COBRA.

When Does an Extension of COBRA Coverage Due to Disability End?
The extension of COBRA Continuation Coverage up to 29 months will end the earlier of

1. The last day of the month during which the Social Security Administration has determined that you and /or your Dependent is no longer disabled.
2. The end of the 29-month period after the Qualifying Event.
3. The date the disabled individual first becomes entitled to Medicare after electing COBRA**.**

If at a subsequent date, the Social Security Administration determines that you are no longer disabled, you must provide the Trust Office with written notice of the Social Security Administration's final determination that you are no longer disabled within 30 days of the final determination or within 30 days of the date you received this Summary Plan Description, whichever is later. This written notice must be addressed to Benefit Programs Administration at the address listed on page 2 of this booklet. The Notice must contain the following information: the Plan name, the Employer's name, the names and social security numbers of the Employee and Dependents and the date the Social Security Administration determined that the individual is no longer disabled. The written notice must be accompanied with a photocopy of the entire Social Security Administration determination and submitted to the Trust Administrative Office.

What Happens in Cases Where There Are Multiple Qualifying Events?
If you lose coverage because your employment terminates or your hours are reduced within 18 months after becoming entitled to Medicare, your Spouse and eligible Dependents may continue coverage for up to 36 months from the date of your Medicare entitlement**.**

If you die, divorce or legally separate or become entitled to Medicare, or if your Dependent child ceases to be a Dependent under this Plan during the 18-month period of COBRA coverage, your family has experienced a second Qualifying Event which may allow them to continue COBRA coverage for up to a maximum of 36 months from the date of the first Qualifying Event. To be eligible for this extension of coverage under COBRA either you, your Spouse and/or Dependent or any representative acting on their behalf must provide written notice to the Trust Administrative Office listed on page 2 of this booklet of the second Qualifying Event within 60 days after the date of the second Qualifying Event.

Can COBRA Coverage End Early? (Before the 18, 29, or 36 month periods)
Even though you may have elected COBRA Continuation Coverage and have been advised that it is available for a certain period, your coverage may be terminated if there is any of the following happens:

1. The first day of the month for which a timely payment is not received by the Trust Office;
2. The day on which this Plan is terminated;

3. The first date, after the date of the COBRA election on which either you or your eligible Dependent(s) first become covered by another group health plan (including a retiree health plan), and that Plan does not contain any legally applicable exclusion or limitation with respect to pre-existing conditions that the Qualified Beneficiary may have. If such a limitation or exclusion for such pre-existing condition exists, coverage will not terminate until the date the condition is covered under the new plan, or the maximum time allowed under COBRA has been reached, whichever occurs first;

4. The first date, after the date of the COBRA election, on which you or your eligible Dependent(s) (the Qualified Beneficiary) first become entitled to Medicare benefits under Title XVIII of the Social Security Act;

5. The date the Employee's Employer stops making contributions to the Plan on behalf of its active employees, and provides alternative coverage to those employees under another plan; or

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

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

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

When Does COBRA Coverage End?

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

1. The occurrence of any of the events described above; or

2. At the end of the last day of the maximum coverage period (18, 29, 36 months) applicable to the Qualified Beneficiary under COBRA.

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

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

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

If new Dependents are acquired through marriage, birth, or placement for adoption after COBRA Continuation of Coverage has begun, they may be added by contacting Benefit Programs Administration at the address and telephone numbers listed on page 2 of this booklet. Newborn and adopted children or children placed for adoption may have separate COBRA rights.
To enroll a new Dependent (newborn, child placed for adoption, etc.) for COBRA coverage, you must notify the Trust Administrative Office within 31 days of acquiring the new Dependent. There may be a change in the COBRA premium as a result of the addition of a new Dependent.

What if My Spouse or Dependent Is Covered under another Plan and Loses Coverage While I am Making Self Payments for COBRA Continuation Coverage?
If, while you are enrolled in COBRA Continuation Coverage, your Spouse or Dependent child loses coverage under another group health plan, you may enroll the Spouse or Dependent child in this Plan for coverage for the balance of the period of your COBRA Continuation Coverage so long as the following conditions are met**:**

1. Your Spouse or Dependent child must have been eligible for COBRA Continuation Coverage at the time of your Qualifying Event, but not enrolled;
2. When COBRA Coverage enrollment under this Plan was offered and declined, the Spouse or Dependent child must have been covered under another group health plan or had other health insurance coverage;
3. The loss of coverage must be due to: exhaustion of COBRA continuation coverage under another plan; termination as a result of loss of eligibility for coverage; or the termination of the employer's contributions toward the other coverage;
4. Loss of eligibility cannot be due to the failure of your Spouse to pay premiums on a timely basis or termination of coverage for cause**.**

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

What If I Have Questions Regarding Coverage Under COBRA?
If you have any questions regarding COBRA continuation coverage under this Plan or need information regarding notices required to be given, you should contact: the Trust Office at the telephone numbers and address listed at page 2 of this booklet.

You may also contact the United States Department of Labor, Employee Benefits Security Administration (EBSA) at the address listed on page 28. The addresses and phone numbers of the Regional and District Offices are also available through the EBSA's website www.dol.gov/ebsa.

California COBRA Option

If you have a qualifying event that results in less than 36 months of coverage, and you have maintained that coverage for the maximum period of time, you may be eligible to continue your medical benefits for an additional period of time under California COBRA. This coverage is

only available to Participants enrolled in an HMO medical plan. You can receive additional information regarding your "Cal-Cobra" rights directly from your HMO plan (Please refer to your Evidence of Coverage booklets for telephone numbers for your HMO Plan)

The Trade Act of 2002

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

Medi-Cal Health Insurance Premium Program (HIPP)

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

*http://www.dhcs.ca.gov/services/Pages/HIPPOnlineForms.aspx***.**

Individual Conversion Privilege Option

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

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

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

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

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

Certificate of Group Health Coverage

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

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

Information Regarding HIPAA Privacy Statement and Notice of Privacy Practices.

As a participant in the Plan you have certain rights under HIPAA with respect to your health information. HIPAA requires that employee welfare plans such as the Teamster Multi-Benefit Trust Health Plan protect the privacy of your personal health information ("PHI"). A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices which is included in your enrollment materials. You may also obtain a copy free of charge by contacting Benefit Programs Administration at the numbers listed on page 4 of this booklet.

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

Summary of Plan Benefits

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

Prior Notice of Plan Changes

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

Benefits Are Fully Insured

Plan benefits are fully insured and provided to Employees and their eligible Dependents under group health contracts entered into between the Trust Fund and the insurance issuers and providers listed at page 26 of this booklet. Summaries of the benefits for each insured option which available to you under your Collective Bargaining Agreement are provided along with and should be considered as part of this booklet. . A complete copy of the Evidence of Coverage for each of these benefits may be obtained free of charge directly from the insurance company or by calling the Trust Administrative Office at (562) 463-5040 or (888) 410-1756.

The Women's Health and Cancer Rights Act

Special Notice Regarding Mastectomy Coverage

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

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

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

Newborns' and Mothers' Health Protection Act of 1996

Special Notice Regarding Maternity Coverage

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Death and Accidental Death and Dismemberment Benefits

A description of benefits which are available to you and your Dependents in the event of either your or your Dependent's death or accidental death and dismemberment is contained in the Teamsters Multi-Benefit Trust Death and Accidental Death Benefit Plan and Summary Plan Description. A copy may can be obtained free of charge from the Trust Administrative Office.

Claims Procedures

Except for Death and Accidental Death Benefit Claims

For a description of the claim procedures, including the time limits for Death an Accidental Death Benefit claims, and appeal procedures in the event a claim is denied, please refer to the Teamsters Multi-Benefit Trust Death and Accidental Death Plan and Summary Plan Description. A copy can be obtained free of charge by contacting the Trust Administrative Office.

Your health and welfare benefits are fully insured by the companies listed in this booklet at page 26. These companies will decide your claim in accordance with a reasonable claims procedure required by ERISA. Generally, you will not be required to submit a claim. If you need to file a claim or if you have received an adverse benefit determination you will be required to follow the claims procedures detailed in your Evidence of Coverage booklet issued by the insurance company that provides your insured benefits.

Please see the Evidence of Coverage booklets issued by the insurers listed at page 29 of this booklet for information about how to file a claim and for details regarding the particular insurance company's claims procedures.

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

Important Appeal Deadlines

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

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

External Review

Under certain circumstances, you may have the right to obtain external review (that is, review outside of the Plan) if your claim is denied by your health insurance carrier. Please refer to the Evidence of Coverage booklet for details regarding this right to external review.

Acts of Third Parties - Third Party Liability

Your Evidence of Coverage booklet contains information about your insurance provider's right to subrogation or reimbursement of benefits paid on your behalf when either you or your Dependent is injured or becomes ill as the result of the actions of a third-party. Although your insurance carrier will pay your medical expenses you may be obligated to reimburse the insurance carrier from the monies you receive from the third-party up to the amount of benefits the carrier paid on your behalf. If you are injured or become ill it is very important that you review the Evidence of Coverage – Acts of Third Parties provisions to determine your rights and obligations with respect to your insurance carrier.

Disclosure Information

Important Information About the Plan Required by ERISA

Name of the Plan

The Plan is officially known as the Teamsters Multi-Benefit Trust Health Plan for Groups 1050/1100. The Death and Accidental Death and Dismemberment benefits are provided through the Teamsters Multi-Benefit Death and Accidental Death Plan formerly known as the South Bay Teamsters and Employers Health and Welfare and Related Benefits Trust Fund Death and Accidental Death Benefit Plan.

Plan Sponsor's Employer Identification Number and Plan Number

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

Plan Year End Date

The Plan operates on a Plan year ending December 31.

Type of Plan:

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

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

Board of Trustees of the Teamsters Multi-Benefit Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017
(562) 463-5040, (888) 410-1756

Type of Administration:

The Teamsters Multi-Benefit Trust formerly known as the South Bay Teamsters and Employers Health and Welfare and Related Benefits Trust Fund was established and is maintained pursuant to collective bargaining agreements between participating Local Unions of the International Brotherhood of Teamsters and various Employers signatory to these collective bargaining

agreements. It is a Joint Trusteed Labor-Management Trust which was created to provide health and welfare benefits to Employees and their eligible dependents.
The Board of Trustees is the Plan Administrator. However, the Board of Trustees has contracted with a third-party administrator, Benefit Programs Administration to provide day to day administrative services for the Trust Fund. Benefit Programs Administration maintains and manages the office which is referred to as the Trust Fund Office, or Trust Administrative Office and whose mailing address if 1200 Wilshire Blvd., Fifth Floor, Los Angeles, California 90017.

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

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

Name and Address of Agent for Service of Legal Process
The person designated as the Plan's agent for service of process is:

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

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

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

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

Tom Secrest
Vice-President Labor Relations
First Student
600 Vine Street, Suite 1400
Cincinnati, Ohio 45202

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

Elizabeth Sanchez
Vice-President
First Student
13200 Crossroads Parkway, Suite 450
City of Industry, California 91746

Source of Funding for the Plan
The Plan is funded by contributions made by Employers signatory to collective bargaining agreements requiring payment of contributions to the Teamsters Multi-Benefit Trust. Death and Accidental Death and Dismemberment Benefits are paid directly from the Trust assets. All other benefits are funded through group insurance contracts with organizations listed at pages 26 of this booklet.

Insurance Contracts Control
Benefits hereunder are provided solely pursuant to contracts of insurance entered into between the Teamsters Multi-Benefit Trust and the respective insurance companies and health and dental maintenance organizations. If the terms of this document conflict with the terms of the such contracts, the terms of the insurance contracts, group health, vision and dental agreements will control, unless superseded by applicable law.

Names and Addresses of Plan Insurers and Service Providers
The following is the current list of Plan service providers:

INSURERS AND PROVIDERS OF SERVICE TO THE TRUST

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Teamsters Multi-Benefit Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017

DENTAL BENEFITS

Dental Health Services
3833 Atlantic Ave.
Long Beach, CA 90807-3505

Liberty Dental Plan
3200 El Camino Real, Suite 290
Irvine, CA 92602

United Concordia
21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367

HOSPITAL, MEDICAL, SURGICAL AND PRESCRIPTION DRUG BENEFITS

Health Net Corporate
P.O. Box 9103
Van Nuys, CA 91409-9103

Kaiser Permanente,
Regional Administration, Northern California
1800 Harrison Street, 13th Floor
Oakland, California 94162

Kaiser Permanente
Regional Administration, Southern California
3100 Thornton Avenue
Burbank, CA 95104

SIMNSA Health Plan
303 H Street, Suite 6040
Chula Vista, CA 91910

VISION BENEFITS

Davis Vision Plan
159 Express Street
Plainview, NY 11803

UniDent
SIMNSA Health Plan
303 H Street, Suite 6040
Chula Vista, CA 91910

CHIROPRACTIC/ACUPUNCTURE BENEFITS

Landmark Healthplan, Inc.
1750 Howe Avenue, Suite 30
Sacramento, California 95825

MEMBER ASSISTANCE AND PRE-PAID LEGAL

Health Management Concepts, Inc. (HMC)
HMC Companies - Administrative Office
32 Hampden Street, 2nd Floor
Springfield, MA 01103-1398

Benefit Plan Service Providers

Benefit	*Healthcare Provider*	*Member Services Phone Number*
Medical & Prescription Drug	Health Net of California	(800) 522-0088
	Kaiser Permanente	(800) 464-4000
	SINMSA	(800) 424-4652
Chiropractic	Landmark	(800) 638-4557
Dental	DHS	(800) 637-6453
	United Concordia (HMO))	(866) 357-3304
	United Concordia (PPO)	(800) 332-0366
	Liberty Dental	(888) 703-6999
	SINMSA/UniDent	(800) 424-4652
Vision	Davis Vision	(800)783-6872
	SINMSA/Vision	(800) 424-4652
Chiropractic/Acupuncture	Landmark Healthplan	(800) 638-4557
Legal Benefit	HMC/APS Healthcare	(877) 225-2267
Member Assistance Plan	HMC/APS Healthcare	(800) 633-1231

Amendment and Termination

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

1. Terminate or amend either the amount or conditions with respect to any benefits or provisions of the Plan even though such termination or amendment affects claims in process and/or expenses already incurred; and

2. Alter or postpone the method of payment of any benefit; and

3. Amend any provisions of these rules and regulations.

Your Rights Under the Employee Retirement Income Security Act of 1974, as Amended ("ERISA")

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

Receive Information About Your Plan and Benefits

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

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

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

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

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

Prudent Action by Plan Fiduciaries

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

No one, including your employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

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

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

DEFINITIONS

COBRA means the federal legislation Consolidated Omnibus Reconciliation Act of 1986, as amended, requiring the right to continue health coverage upon loss of eligibility.

Collective Bargaining Agreement shall mean a written contract by and between any Employer and Union which provides for contributions to be made to this Trust Fund. It shall also include any and all extensions, renewals or any new collective bargaining agreement entered into by the Union and the Employer which provides for contributions to be made to this Trust Fund.

Contribution or ***Contributions*** or ***Employer Contributions*** means the contributions specified in a Collective Bargaining Agreement to be made by Employers to the Trust for each Employee.
Covered Employment means employment or work covered by the terms of a Collective Bargaining Agreement or other agreement pursuant to which Contributions are required to be made to the Trust.

Day means a calendar Day, not a business Day.

Death Benefits means any and all payments payable upon the death of an eligible participant or other person as provided for under the benefits plans developed and established by the Trustees pursuant to the Restated Declarations of Trust and as required by a Collective Bargaining Agreement.

Dependent means any of the following:

a. The legal spouse of an Active Employee.

b. Effective January 1, 2001, the same-sex Domestic Partner of an Employee and effective January 1, 2002, Dependent shall include the opposite-sex Domestic Partner of an Employee.

c. The Employee's Spouse's or the Domestic Partner's children under age 26.

d. The Employee's Spouse's or Domestic Partner's Dependent children regardless of age who are incapable of self-sustaining employment by reason of mental retardation or physical handicap who were covered under the Plan prior to reaching age 19. Such child will continue to qualify as an eligible Dependent so long as the Disability continues, and the Dependent remains unmarried, and the child is Dependent on the Employee or Retiree for support and maintenance. Proof of continued Disability satisfactory to the Board of Trustees must be furnished to the Trust Fund when requested.

e. An Employee's spouse shall cease to be a ***Dependent*** on the date of entry of a final judgment of dissolution of marriage or legal separation between the Employee and spouse. For Domestic Partners registered with the State of California, the Employee's Domestic Partner shall cease to be a Dependent on the date the Domestic Partnership terminates in accordance with California law. For Domestic Partners not registered with the State of California, the Employee's Domestic Partner shall cease to be a Dependent on the date the Affidavit of Termination of Domestic Partnership is filed with the Trust.

The term ***Dependent*** does not include any person who is in full-time military service.

Domestic Partners means two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring and who share a common residence. Neither Domestic Partner is married to someone else or a member of another Domestic Partnership with someone else that has not been terminated, dissolved or adjudged a nullity and neither is related

by blood closer than the laws of the state would permit for a legal marriage. Each Domestic Partner must be at least 18 years or older, must be capable of consenting to the Domestic Partnership at the time the Domestic Partnership began, and if the Domestic Partner resides in jurisdiction which permits registration as Domestic Partners, the Domestic Partnership must be registered.

Employee and ***Member*** will be interchangeable and will mean any person covered by a Collective Bargaining Agreement and employed by an Employer. The term Employee will also include members in good standing and officers and Employees of the Union which make Contributions to the Plan on behalf of such Employees, officers and Members in good standing, provided the inclusion of such persons is not a violation of any existing law or statute.

Employer means, for purposes of the Plan, any employer or any successor in interest of said Employer who has signed or who is bound by a Collective Bargaining Agreement or other agreement, requiring that Contributions be made to the Teamsters Multi Benefit Trust Fund, and shall include the Union which makes Contributions on behalf of its Members in good standing and its officers and Employees, provided the inclusion of said Union as an Employer is not a violation of any existing law or statute.

Health and Welfare Benefits shall mean any and all benefit payments to Employees or their Dependents as required by a Collective Bargaining Agreement, and provided through a Plan developed and established by the Trustees pursuant to the Restated Declarations of Trust. Said Health and Welfare Benefits may include life, accidental death and dismemberment, dental, medical, surgical, hospital, supplemental accident, prescription drug, maternity and vision care benefits.

Injury means an accidental bodily Injury resulting from an occurrence which is not expected, foreseen, or intended.

Medicare means the insurance program established by Title XVIII, United States Social Security Act of 1965, as originally enacted or as subsequently amended.

Non-medical Claim means any Claim for Death or Accidental Death and Dismemberment Benefits provided under the Plan, which follows the Plan's procedures for filing of a Claim.

Participant means each eligible Employee or Dependent.

Participating Employer means (a) an Employer who is obligated to make Contributions to the Trust pursuant to a Collective Bargaining Agreement; or (b) an Employer who has agreed to contribute to the Trust to provide coverage under the Plan.

Plan or ***Plan Document*** means the plan or program of benefits provided for in the Summary Plan Description, as amended from time to time (including the Evidence of Coverage booklets for insured benefits), which is adopted by the Board of Trustees pursuant to the Amended Agreement and Declaration of Trust providing for the Teamsters Multi-Benefit Trust Fund.

Pre-Paid Legal Services means legal services provided to eligible Employees and Dependents as required by a Collective Bargaining Agreement and provided through a prepaid legal services plan developed and established by the Trustees pursuant to the Restated Declarations of Trust, for the purpose of defraying the costs of legal services. Legal services provided for shall be limited by the provisions of Section 302 of the National Labor Relations Act, as amended.

Pre-service Claim means any Claim which requires the approval of the Claim in advance of obtaining medical care.

Post-service Claim means any Claim or benefit under the Plan which is not a Pre-service Claim.

Registered Nurse (R.N.) means a person licensed under the appropriate laws who is not the Employee, Retiree, Dependent or is related by blood, marriage, or Domestic Partnership to the Employee, Retiree, or Dependent and does not have the same legal address as the person receiving the nursing care.

Sickness means a Sickness or disease for which the individual is not entitled to benefits under any Workers' Compensation Law or similar legislation

Total Disability means an Injury or Sickness, which completely prevents an Employee from engaging in any business or occupation for remuneration or profit and, in the case of a Dependent, from engaging in normal activity. Nothing in this definition of Total Disability is intended to alter any requirement for extending coverage to the Employee's or Retiree's mentally or physically handicapped children, age 26 years and older, who are incapable of self-sustaining employment and were covered under the Plan prior to reaching the age of 19.

Trust Administrator as used in this Summary Plan Description shall mean the third-party administrator with whom the Board of Trustees has contracted to perform Day-to-Day operations of the Plan.

Trust Administrator's Office or ***Trust Office*** means the offices maintained by the third party administrator for the administration of the Trust Fund which is Benefit Programs Administration

Trust Agreement or ***Declaration of Trust*** means the Restated Agreement and Declaration of Trust Providing for Teamsters Multi-Benefit Trust, effective October 1, 2010, and any modification, amendment, extension or renewal thereof.

Trust or ***Trust Fund*** means the entire trust estate under "Teamsters Multi-Benefit Trust," and shall include all monies, assets of every kind and nature and Contributions which belong to or are part of the trust estate.

Trustees and/or ***Board of Trustees*** means the named fiduciaries of the Trust who have the joint authority to control and manage the operation and administration of the Trust and Plan in accordance with the provisions of the Trust Agreement.

Union means those labor organizations that are parties to the Restated Trust Agreement and any other labor organization participating in the Trust which has an agreement with an Employer providing for payments into the Trust and which agreement and parties have been accepted by the Trustees.

Urgent Care Claim means a Pre-service Claim for medical care or Treatment that, if the normal Pre-service Claim standards of the Plan were to be applied for processing a Claim either (a) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function as determined by applying the judgment of a prudent layperson with an average knowledge of health and medicine, or (b) would in the opinion of a Physician familiar with the Claimant's condition subject the Claimant to severe pain that cannot be adequately managed without the care or Treatment that is the subject of the Claim. An "Urgent Care" Claim may be filed by the Claimant, or by a Doctor or other health professional authorized to act on behalf of the Claimant.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

You or y***our*** means the eligible Employee.

TEAMSTERS MULTI-BENEFIT TRUST
HEALTH PLAN GROUPS 1050 AND 1100

Effective Date
December 1, 2011

SUMMARY OF BENEFIT OPTIONS

Choice of Medical Plans

As a new Employee, when you become eligible for coverage for the first time, you must complete an enrollment form designating the Health Maintenance Organization (HMO) of your choice. These medical plans are described in separate booklets called Evidence of Coverage. It is important you understand the benefits provided under the medical plans before you make your selection and complete the necessary enrollment forms. In addition, you MUST complete the appropriate HMO enrollment form in full. You must select Participating Medical Group or Independent Physician Association for the HMO plans offered.

The Evidence of Coverage booklets and the HMO provider directories can be obtained free of charge, by contacting the Trust Administration Office.

It is important you send the completed enrollment form to the Trust Administration Office. Your eligible Dependent(s) will be covered under the same medical plan you select for yourself. Services can be delayed or denied unless you have made your selection in writing, and all the required information has been correctly filled in. The Evidence of Coverage booklet for each plan contains the benefit provisions, including applicable limitations and exclusions for each program. If you have any questions regarding your medical plan coverage, please contact the Trust Administration Office.

Types of Medical Plans (HMO)

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

Except for certain medical emergencies or authorized referrals, you must use physicians or Hospitals affiliated with the HMO. If you do not use physicians or Hospitals authorized by your HMO, neither the Trust not the HMO will be responsible for the charges you incur.

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

We encourage you to contact the Trust Administration Office to determine the plan that applies to you.

See the Addendum in the back of this booklet for a summary of benefits under these different plans.

Choice of Dental Plans

Dental Benefits

The Trust offers several prepaid dental plans. Under each of these dental plans, you must receive services from a network provider in order to receive coverage. Many of the services offered by these dental plans require no copay. In addition, there is no annual deductible to satisfy. Please refer to your Collective Bargaining Agreement to determine the plan(s) that apply to you.

Enrolling in one of these dental plans is similar to enrolling in the medical plans previously described. You must complete the appropriate enrollment form and select the appropriate dental plan available to you according to your Collective Bargaining Agreement.

Vision Benefits

Employees enrolled in the vision plan have the choice of seeing a network or out-of-network licensed optometrist or ophthalmologist; however, most services are covered in full, less any applicable copay, when received from a network or contracted provider. If you obtain services from an out-of-network provider, you will be reimbursed by the vision plan in accordance with the allowance schedule, less any applicable copays, once the appropriate claim form is submitted to your vision plan carrier.

The Trust Administration Office can provide you with information regarding the vision plan available to you.

Member Assistance Program

Enrollment in the Member Assistance Program (MAP) will occur upon enrollment in one of the health plans offered by the Fund and selected by your Employer. The benefits include problem assessment, education, information, and assistance with initial crisis management is provided. Such personal problems may include, but are not limited to, family or relationship problems, parenting difficulties, work related problems, substance use and abuse, grief and loss, emotional and physical abuse, and anxiety and depression. The plan of assistance may include a referral to an outside agency for further support or assistance. Fees incurred by any member or family member at agencies other than HMC/HMC/APS are not included in the MAP coverage and are the full responsibility of the member or eligible family member.

Counseling sessions including an initial evaluation to identify problems, with follow-up contact as deemed appropriate by the counselor. HMC/APS agrees to provide a maximum of **three (3)** counseling sessions (hours) per incident per year for each eligible member and their family members. HMC/APS shall determine what constitutes a separate incident. A counselor may deem it necessary to hold longer sessions to facilitate the needs of the client. If session length is extended, the number of sessions is reduced to equal a maximum of counseling hours.

HMC/HMC/APS shall make MAP masters or doctoral level consultants available telephonically 24 X 7. As appropriate, the MAP telephonic consultant will facilitate an in-person MAP assessment.

Prepaid Legal and Financial Services Program

Prepaid legal and financial Services are included as a benefit under the Member Assistance Program.

Legal Services
3 free 30-minute phone or in-person consultation per issue is available to help answer basic legal questions and simplify the process of obtaining legal help. Clients are eligible for a 25% discount if they decide to retain the attorney.

Financial Services
Employees facing financial challenges or in need of advice about a specific issue such as tax preparation, may call the Employee Assistance Program for a 30-minute consultation by phone with a licensed or credentialed financial advisor.

NOTE: Not all benefit options may be available through your employer. See the benefit addendum for the benefits available to your employer group.

The Summary of Benefits and Coverages for the medical, as well as the benefit summaries for any ancillary benefit options available to your employer group, is attached as an addendum to this document.

Addendum

Schedules of Benefits

Teamsters Multi-Benefit Trust

General Industries Program