TEAMSTERS MULTI-BENEFIT TRUST

TRANSPORTATION INDUSTRY PROGRAM (TIP)

SUMMARY PLAN DESCRIPTION

EFFECTIVE
JANUARY 1, 2014

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A Message to All Participants

We are pleased to welcome you as a participant in the Teamsters Multi-Benefit Trust ("Trust"). This booklet, together with the evidence of coverage booklets prepared by each of the insurance providers describes the benefits available to you through the Trust's Teamster Transportation Program ("Plan"), and is intended to serve as your Summary Plan Description ("SPD") required by the Employee Retirement Income Security Act of 1974 ("ERISA"). This booklet includes important information to help you understand and appropriately access your benefits. The information in this booklet is effective January 1, 2014, 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. You may not be eligible for all of the benefits described in this SPD. Your eligibility is determined by the terms of your Collective Bargaining Agreement and the rules of the Trust.

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 contacts of insurance entered into by the Trust:

- Medical, Hospital and Prescription Drug Plans
- Mental Health and Chemical Dependency Plan
- Dental Plan
- Vision Plan
- Chiropractic/Acupuncture Coverage
- 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 the coverages provided to you and to your Dependents. The terms of these legal documents will control all questions concerning any subject matter covered in this booklet. Please see page 34 of this booklet under the section entitled "Insurers and Providers of Services to the Trust and Benefit Summaries" 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 Death and Accidental Death Benefit Plan SPD which is included with your enrollment packet. A copy may also be obtained by contacting Benefit Programs Administration at the number listed below.

The Joint Board of Trustees listed on page 3 of this booklet is the Plan Administrator. The Board has contracted with Benefit Programs Administration to perform routine

administration for the Plan as a third-party administrator. Benefit Programs Administration is responsible for the operation of the Trust Administrative Office which is sometimes referred to as the Fund Office or Trust Office. If you have any questions regarding any of the benefit programs or administration of Plan that are not fully answered by this booklet and the Evidence of Coverage booklet for each provider , please contact Benefit Programs Administration at the numbers and address listed below or the contact the specific provider who contact information is listed on page 34 of this booklet:

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

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

IT IS IMPORTANT that you inform the Trust Administrative Office promptly of any change in your name or your address, so you will 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 Office to find out how these events may affect your right 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 the eligibility rules. From time to time the Board of Trustees may find it necessary to change the provisions of the Plan or Plan's providers. If this occurs, you will be advised of any changes. If there are major amendments to the Plan you will receive updated information which should be kept as part of this booklet. Benefits are not vested. The Trustees have full authority to modify, limit or terminate health coverage at any time as they deem appropriate. Benefits shall be provided only so long as sufficient assets are available.

Board of Trustees

Summary Plan Description
General Information About the Plan

TRUST ADMINISTRATIVE OFFICE
TEAMSTERS MULTI-BENEFIT PLAN
Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906
(888) 410-1756; (562) 463-5040

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

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

LEGAL COUNSEL
WOHLNER KAPLON PHILLIPS YOUNG & CULTER
16501 Ventura Boulevard, Suite 304
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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

Employee Eligibility and Participation Requirements

Who is Eligible for Benefits?

You are eligible to participate in the Teamster Transportation Program ("Plan") if you are an Employee of an Employer who is required to make a contribution on your behalf to the Teamsters Multi-Benefit Trust pursuant to a Collective Bargaining Agreement between your Employer and any Union participating in the Trust. Your dependents who meet the definition of Dependent under the Plan may also be eligible to participate in the Plan.

There may be a waiting period described in your Collective Bargaining Agreement before contributions are required to be made on your behalf to the Trust. This may delay your eligibility for benefits because the hours worked during the waiting period do not count in establishing eligibility for benefits. Effective January 1, 2014, this waiting period cannot be more than 90 days from the date you are first employed, assuming you have met all other eligibility requirements specified in your Collective Bargaining Agreement.

For Example, if your Collective Bargaining Agreement states that your Employer is obligated to pay contributions on your behalf as of as of the first day of the month following the completion of 60 days of continuous employment, this sixty-day period is a waiting period during which you are not eligible for benefits. You will be eligible for benefits on the first day of the month for which an employer contribution is payable on your behalf after the sixty-day waiting period.

What If I am an Employee of New Participating Employer?

If you are an Employee working in covered employment on the date a new Participating Employer first becomes obligated to contribute to this Trust, you will become eligible for benefits on the effective date of the coverage for the Employer's Employees. *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 already participates in the Trust, and who is required to contribute on your behalf, you will be covered on the first day of the month following the month in which the first contribution is received by the Trust on your behalf. Please refer to your Collective Bargaining Agreement to determine whether there are eligibility requirements such as a waiting period which must be satisfied before your Employer is required to contribute to the Trust on your behalf.

Please refer to the Evidence of Coverage booklet issued by the organizations listed on page 34 of this booklet for additional information regarding eligibility for benefits and circumstances that may affect your benefits.

When Do I Become Eligible for Death and Accidental Death and Dismemberment Benefits, Prepaid Legal and Employee Assistance Benefits?

If your Collective Bargaining Agreement provides for contributions on your behalf for death and accidental death and dismemberment, prepaid legal and employee assistance benefits, you will be eligible on the first day of the month in which the first contribution is received by the Trust from your Employer for these benefits.

Continuing Eligibility

Once you 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 Administrative Office. Generally, this means that once you become eligible for benefits you will remain eligible so long as you are employed by a participating Employer and your Employer pays the required contribution on your behalf to the Trust.

When Does My Eligibility for Benefits End?

Your eligibility for benefits ends on the earliest of the following dates:

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

Please review the Termination of Coverage provisions contained in Evidence of Coverage booklets for of the organizations providing benefits listed on page 34 of this booklet for a complete description of events which may cause your eligibility for benefits or a particular benefit to terminate.

Am I Required to Enroll in the Plan?

All eligible Employees must complete an application form which is available from the Trust 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 which occurs on the anniversary date of your Employer's participation in the Plan. Please see page 7 for a 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 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. If you are a new Employee you must enroll within 60 days 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 anniversary date of your Employer's participation in the Plan. If you have questions regarding enrollment you may contact each provider directly at the number listed on page 34 of this booklet under the section entitled "Insurers and Providers of Service to the Trust" or contact Benefit Programs Administration at (888) 410-1756 or (562) 463-5040.

When you select a medical or dental plan you must also complete the appropriate HMO enrollment form, which is supplied by your Employer or which can be obtained from the Trust Office. If you timely enroll, coverage will become effective as of the date you become eligible for benefits under the Plan.

Can I Waive Participation in the Plan?

Participation in the Plan can be waived by you as the Employee if your Collective Bargaining Agreement requires an Employee contribution toward the cost of health care coverage or when you already have coverage under another Group Medical Plan, Retiree Plan, or Medi-Cal.

Coverage under the Plan can only be waived because of your enrollment in Medi-Cal when your Collective Bargaining Agreement requires that you make an Employee premium contribution.

If you wish to waive coverage you must complete and return to the Trust Office a signed Waiver of Coverage Form verifying that you are waiving coverage for one of the following reasons:

- You are required to make premium contribution through payroll deduction toward the cost of the coverages provided in your Collective Bargaining Agreement.

- You as the Employee are covered by another Group Health Plan not provided through your Collective Bargaining Agreement, or a Retiree Plan.

- Your spouse is in the same employment covered by the Collective Bargaining Agreement

- Your Spouse or Domestic Partner is in the same employment covered by the Collective Bargaining Agreement and you are waiving coverage to avoid duplication of benefits.

You must provide proof of the other coverage in writing, together with a fully signed Waiver of Benefits Form which can be obtained from the Trust Office. The signed Waiver of Benefits Form must be submitted to the Trust Office within thirty days of your employment. Upon termination of your other coverage you must enroll in the Plan as provided in your Collective Bargaining Agreement.

Once you have elected to waive participation in the Plan you may not enroll in coverage under the Plan until your Employer's annual open enrollment period; however, if you have waived coverage because you are enrolled in other group health coverage, you must enroll in the Plan provided by your Collective Bargaining Agreement within 30 days of the date of termination of the other coverage.

Participation in the Teamsters Multi-Benefit Trust Death and Accidental Death Benefit Plan cannot be waived if the benefit is provided in your Collective Bargaining Agreement.

Initial Enrollment Policy

What Happens if I Fail to Enroll in the Plan or Fail to Return the Waiver of Benefits?

If you fail to enroll in the Plan as required or have not completed and returned a Waiver of Benefits Form within thirty (30) days from the date of your initial eligibility for benefits you will automatically be enrolled for "Employee Only" coverage in the lowest cost medical plan provided by the Trust.

You will have an additional sixty-day period from the date of your default enrollment to enroll in another medical plan, if any, offered pursuant to the your Collective Bargaining Agreement and/or to add Dependents. The effective date of the coverage you select during this period will be the first day of the month following receipt of a completed Enrollment Form, and any other documents required by the Trust to complete your enrollment. Any change in your medical plan and/or addition of Dependents will not be applied retroactively. If you do not enroll in a medical plan offered under your Collective Bargaining Agreement and/or fail to add Dependents to your coverage within ninety (90) days of the date you are initially eligible for coverage, you must wait until the next Open Enrollment opportunity to select a medical plan other the lowest cost plan/or to add Dependents to your coverage. Please note, you may have a special right to enroll your Dependents under HIPAA which is separate from this enrollment opportunity. A copy of the Trust's Initial Enrollment Policy and Waiver of Benefits Forms are included with your enrollment packet. Copies can also be obtained without charge by contacting Trust Office at (888) 410-1756 or (562) 463-5040.

Dependent Eligibility and Participation Requirements

How Do My Dependents Become Eligible for Benefits?

Your Dependents who meet the definition of "Dependent" under the Plan become eligible for benefits on the date you become eligible. Please refer to the section entitled "Definitions" at pages 30 - 34 for complete description. Eligible Dependents will be covered under the same medical, dental and vision programs that you select.

Who Are My Eligible Dependents?

Your eligible Dependents are:

- Your Legal Spouse
- Your Registered same-sex Domestic Partner or your Registered 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 another jurisdiction.
- Domestic Partners who are not Registered Domestic Partners, but who 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 Trust Administrative Office.

Your natural born children, stepchildren, children of your Domestic Partner, legally adopted children or children placed for adoption, who are less than 26 years of age. Children for whom you, your Spouse or Domestic Partner are the court appointed Legal Guardian are not Dependents. Children who are enrolled in the Plan as of November 12, 2013, based upon an Order of Guardianship, will remain eligible for coverage under the Plan until such time as their coverage would otherwise terminate under the Plan.

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 which existed prior to reaching age 19. Proof of 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.

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, and submit an Affidavit of Domestic Partnership, enrollment is limited to the initial eligibility enrollment period or the annual open enrollment period.

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: (888) 410-1756 or (562) 463-5040
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.) Coverage will commence the first day of the month following approval of the enrollment by the Plan Administrator.

Who Is Not an Eligible Dependent under the Plan?

- A Dependent who is serving in the Uniformed Services of the United States is not eligible as Dependent under this Plan.
- 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.
- An Employee's Domestic Partner shall cease to be a Dependent under this Plan on the date of termination of the Domestic Partnership

When Will Eligibility for My Dependents End?

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

Eligibility ends for:

- Legal Spouse, the date of entry of a decree of dissolution or legal separation;
- Registered Domestic Partner at the end of the sixth month after a Notice of Termination of Domestic Partnership is filed with the California Secretary of State or the date of entry of a judgment that dissolves, nullifies or legally separates the Domestic Partnership;
- For a non-Registered Domestic Partnership the date on which the 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.
- The date your Dependent enters full-time military service.

Please review Termination of Coverage provisions contained in Evidence of Coverage booklets for each of the organizations providing benefits listed at page 34 of this booklet for a complete description of events which may lead to termination of coverage for your Dependents.

Qualified Medical Child Support Orders

The Plan provides benefits in accordance with ERISA section 609(a) for any Dependent added to the Plan under a qualified medical child support order (QMCSO).(a). A QMCSO is a court order requiring the Plan to provide health coverage for a child of a Participant. A copy of the Plan's procedures for determining whether an order qualifies as a QMCSO is available, without charge, to Participants and beneficiaries and may be obtained by contacting the Trust Office at the numbers listed on page 3 of this booklet.

Special Enrollment Rights

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).

What if I Have a Newly Acquired Dependent?

If you have a new Dependent as a result of marriage, 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, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Trust Administration Office at (888) 410-1756 or (562) 463-5040 for assistance.

Special Enrollment Rights under "SCHIP"

If you decline enrollment for yourself or your Dependents (including your spouse) because of coverage under a state Medicaid Plan or a State Children Health Insurance Plan "SCHIP," such as Medi-Cal in California, 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 - Self-Payment under the Uniformed Services Employment and Re-Employment Rights Act (USERRA)

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 at pages 11-19. If you elect continuation coverage under USERRA, the COBRA and USERRA coverage periods will run concurrently.

For more information regarding your rights under the USERRA, contact the Trust Administrative Office at:

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

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 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.

If you take FMLA leave and you fail to return to work you may be eligible to continue your coverage by self-payment through COBRA.

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 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 loses 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.

What Benefits Are Available Under COBRA Continuation Coverage?

You, your Spouse or your Dependent Children have the option of electing COBRA coverage to continue the benefits provided through the Teamsters Transportation Program described in this booklet and the Evidence of Coverage booklets for each provider 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 the Plan to 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;
3. The Employee's becoming qualified for Medicare (Part A, Part B or both);
4. Employee's employment ends for any reason other than the Employee's gross misconduct; or
5. Divorce or legal separation from the Employee.

Qualifying Events for your Dependent Child are:

1. parent-employee dies;
2. parent-employee's hours of employment are reduced;
3. The Employee's becoming entitled to Medicare (Part A, Part B or both)
4. Parent-employee's employment ends for any reason other than his or her gross misconduct;

5. Parent divorces or legally separates;
6. or your child ceases being eligible for coverage under the Plan as a "Dependent child."

Who Is Eligible for COBRA Continuation Coverage?

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

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

Who Can Elect COBRA Coverage?

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

How Do I Obtain COBRA Continuation Coverage?

Benefit Programs Administration the COBRA Continuation Coverage for the Plan**.** Your Employer has the responsibility for notifying the Trust Administrative Office 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 Benefit Programs Administration 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 -Teamster Transportation Program
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017

Please contact Benefit Programs Administration 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 the 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 Trust 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 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 (see pages 10) 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 18 months of COBRA Continuation of 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.

You Must Provide a Copy of Your Disability Determination

To qualify for this additional period of coverage, you must provide the Trust Administrative Office 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 Terminate?

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

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

If at a subsequent date, the Social Security Administration determines that you are no longer disabled, you must provide the Trust Office with written notice of the Social Security Administration's final determination that you are no longer disabled within 30 days of the final determination or within 30 days of the date you received this Summary Plan Description, whichever is later. This written notice must be addressed to Benefit Programs Administration at the address listed on page 3 of this booklet. The Notice must contain the following information: the Plan name, the Employer's name, the names and social security numbers of the Employee and Dependents and the date the Social Security Administration determined that the individual is no longer disabled. The written notice must be accompanied with a photocopy of the entire Social Security Administration determination and submitted to the Trust Administrative Office.

What Happens in Cases Where There Are Multiple Qualifying Events?

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

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

A second qualifying event for purposes of extending COBRA coverage only qualifies as such if it would have caused the Dependent to lose coverage under the Plan in the absence of the first 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 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 number listed on page 3 of this booklet. Newborn and adopted children or children placed for adoption may have separate COBRA rights.

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

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

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

1. Your Spouse or Dependent child must have been eligible for COBRA Continuation Coverage at the time of your Qualifying Event, but did not enroll;
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; and
4. Loss of eligibility cannot be due to the failure of your Spouse to pay premiums on a timely basis or termination of coverage for cause**.**

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

What if I Have Questions Regarding Coverage under COBRA?

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

You may also contact the United States Department of Labor, Employee Benefits Security Administration (EBSA) at the address listed on page 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 (See the telephone numbers listed in your Evidence of Coverage booklet.)

Medi-Cal Health Insurance Premium Program (HIPP)

You may qualify for the Health Insurance Premium Payment Program (HIPP) offered by the state of California. Under HIPP, the California Department of Health Services will pay your COBRA premium if you meet all eligibility requirements established by the California Department of Health Services.

To enroll in HIPP, or to find out more information, you should call the California Department of Health Services' HIPP toll-free number at **(866) 298-8443.**

Notice Regarding Health Insurance Marketplace

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family if you lose coverage under the Plan. Effective January 1, 2014, you will be able to purchase coverage through the Health Insurance Marketplace through what is called a "special enrollment period". In the Marketplace you may be eligible for a new kind of tax credit that lowers your monthly premiums right way, and you can see what your premiums, deductibles and out of pocket costs will be before you make a decision to enroll. As of January 1, 2014, being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Information regarding your Insurance

Marketplace options is available at:
http://www.dol.gov/ebsa/publications/dislocated_workers_brochure.html?advisorid=321990

Individual Conversion Privilege Option

Once your continuation coverage under the Plan 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 in the Evidence of Coverage booklet from your insurance provider which can be obtained free of charge from the Trust Administrator. Generally, you must submit your conversion application to your insurance provider and initial premium 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 provider.

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

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

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

The health plans offered through the Trust do not contain any pre-existing condition exclusions. When you become eligible for benefits under this Plan all covered benefits become effective on the date you become eligible for benefits. However, each of the medical plans do have certain plan limitations and exclusions which are described in the Evidence of Coverage booklets for each insurance carrier listed on page 34 of this booklet..

Certificate of Group Health Coverage

HIPAA requires the Plan to provide a "Certificate of Group Health Plan Coverage". The primary purpose of the Certificate is to show the amount of Credible Coverage that you and /or your Dependents had under the Plan. The Credible Coverage is used to reduce or eliminate the length of time that any pre-existing condition limitation might apply in a new plan. If you or your Dependent's coverage under the Plan ends prior to December 31, 2014, you or your Dependent will automatically receive a Certificate of Credible Coverage upon termination of coverage. If you do not receive this Certificate after coverage terminates, or if you want to request a Certificate, please contact the Trust Administrative Office. Pre-existing limitations are prohibited in group plans beginning on or after January 1, 2014. Effective December 31, 2014, the Plan will no longer issue Certificates to individuals whose coverage terminates under the Plan.

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 – Transportation Industry Program 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 as required by the HIPAA Privacy Rule issued on December 28, 2000, and modified on August 14, 2002 and February 17, 2010 by contacting the Trust Administrative Office at the numbers listed on page 3 of this booklet.

Please address your request to:
Lance Phillips
Teamsters Multi-Benefit Trust
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906

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

The Plan provides health insurance to eligible Employees and their eligible Dependents through group insurance contracts entered into between the Plan and the companies listed at page 34 of this booklet. Please refer to the Evidences of Coverage issued by each of these companies for a summary of the benefits. The Trustees may from time to time enter into new contracts of insurance and benefits may be modified. In the event there is a change in either the provider or the benefit design you will be notified in advance of such change in accordance with the provisions of the Affordable Care Act and you will receive a new summary of benefits which should be kept are part of this booklet.

This booklet should be read in conjunction with the Evidence of Coverage booklets which contain full details for each of the benefit plans. The terms of these legal documents will control all questions concerning any subject matter covered in this booklet.

We urge you to read and review this booklet, including the Evidence of Coverage booklets carefully so you will be fully aware of the benefits which are available under Plan. The

information in this booklet will help you understand your rights and responsibilities as a participant, as well as the Plan's procedures for obtaining benefits.

Benefits 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").

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 through your health insurance provider. If you have any questions about Plan coverage of mastectomies or reconstructive surgery or if you would like more information on WHCRA benefits, please call the Trust Administration Office at: (888) 410-1756 or (562) 463-5040.

Newborns' and Mothers' Health Protection Act of 1996

Special Notice Regarding Maternity Coverage

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

Benefits which are available to you and your Dependents in the event of either your or your Dependents' death, accidental death or dismemberment are described in Teamsters Multi-Benefit Trust Death and Accidental Death Benefit Summary Plan Description. A copy is available free of charge from the Trust Office.

Claims and Appeals Procedures for All Claims

Except Death and Accidental Death and Dismemberment Claims

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

Filing a Claim for Benefits

Your health and welfare benefits are fully insured by the companies listed in this booklet at page 34. These insurance companies will decide your claim in accordance with a reasonable claims procedure required by ERISA and Patient Protection and Affordable Care Act (as amended by the Health Care and Education Reconciliation Act of 2010). Generally, you will not be required to submit a claim. If you need to file a claim or if you have received an adverse benefit determination you will be required to follow the claims procedures detailed in the Evidence of Coverage booklets issued by each of these companies.

Appealing Your Claim for Benefits:

If your claim is denied in whole or in part you may appeal to the insurance company for a review of the denied claim who will decide your appeal in accordance with the reasonable claims procedures required by ERISA and by the Patient Protection Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

You should refer to your Evidence of Coverage booklet for details on how to appeal a denied claim and 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

External Review

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

Filing a Claim for Eligibility to Participate in the Plan

Any person who believes that he or she is eligible to participate in the Plan may file a claim with Trust Administrative Office. All claims must be submitted in writing. Eligibility claims are only claims for eligibility for coverage, and not claims for particular benefits under the Plan. All claims for benefits must be submitted to applicable claims administrators for the insurance company listed at page 34.

The Plan Administrator must notify you of its eligibility determination within 30 days after the claim for eligibility to participate is received. The initial 30-day period can be extended by another 15 days if the Plan Administrator determines that an extension is necessary due to circumstances beyond the Plan's control. The Plan Administrator will provide you with notice of the extension within the initial 15-day period. This notice will explain why an extension is necessary and tell you when the Plan Administrator expects to make a decision. The notice shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In this case the time period allowed for making the eligibility determination is tolled from the date the notice is sent to you until the date you respond to the notice. If you initially fail to provide sufficient information to determine whether you are eligible for coverage under the Plan, the Plan Administrator shall notify you as soon as possible but not later than 5 days after receipt of the claim.

Appealing a Denial of Eligibility or a Revocation of Eligibility

A participant, or their duly authorized representative, has a right to appeal a denial of eligibility and/or revocation of eligibility (i.e. decision to rescind participatory status by the Plan) to the Board of Trustees. A denial or revocation of eligibility includes the Plan's denial of a participant's or his/her Dependent's request for late enrollment. The appeal MUST BE MADE IN WRITING. The participant (or their authorized representative) may review pertinent documents and may submit comments in writing.

Any appeal from a denial or revocation of eligibility must be filed, in writing, with the Trust Administrator's Office no later than 180 days from the date on which the participant received notice from the Plan that he/she is not eligible to participate in the Plan or that her/his eligibility has been revoked.

The Trustees shall decide the appeal at their next regularly scheduled quarterly meeting. Provided, however, that if appeal is received less than 30 days prior to the next Trust meeting, the appeal may be decided at the following quarterly Trustees' meeting.

In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. You also have the right to request copies of all relevant documents free of charge. The relevant documents that must be made available to you include documents, records and other information that:

- were relied on in deciding your claim;
- were submitted, considered or generated in the course of deciding your claim; or
- demonstrate that the decision complied with the Plan's administrative procedures or safeguards.

The appeal will be considered by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker will not give any deference to the initial decision and will consider all information relevant to the

claim, not just information relied upon (or available) when the original decision was made. The decision maker must also consider any information submitted by you.

Appeal Decision. The final decision concerning the appeal shall include:

1. information sufficient to identify the claim involved (i.e. date of service and claim amount, etc.);
2. the specific reason or reasons for the decision;
3. reference to the specific Plan provisions upon which the decision is based;
4. a statement that at no charge and upon your request, you may have reasonable access to, and copies of, all documents, records and other information relevant to your claim;
5. either a copy of any internal rule, guideline, protocol or similar criterion that was relied on in making the decision, or a statement that such a document was relied upon and that a copy will be furnished free of charge upon request; and
6. a statement that the claimant has the right to bring a civil action under ERISA Section 502(a) following a denial upon appeal.

The decision of the Board of Trustees on appeal is final and binding upon you or anyone claiming eligibility or benefits through you. You have the right to bring a civil action under §502 of the Employee Retirement Income Security Act of 1974, as amended, in either state or federal court. If you wish to contest the determination on appeal, under the provisions of the Plan, no action may be commenced with respect to a claim of eligibility or for benefits against the Plan or the Board of Trustees more than 180 days after you are first given notice of the decision on your appeal. This Plan is governed by ERISA.

Acts of Third Parties - Third Party Liability

The Evidence of Coverage booklets issued by the companies listed at page 34 of this booklet contain information about your insurance carrier's right to subrogation or reimbursement of benefits where either you or your Dependent is injured or becomes ill because of the actions of a third-party. Although your insurance carrier will cover your medical expenses you may be obligated to reimburse the amount of benefits paid by the carrier r from the funds you receive from the third- party up to the value of the accident related benefits you received.

Disclosure Information

Required by the Employee Retirement Income Security Act of 1974, as Amended

Name of the Plan:
The Plan is officially known as the Teamsters Multi-Benefit Trust - Teamsters Transportation Program. Death and accidental death and dismemberment benefits are provided through the Teamsters Multi-Benefit Trust Death and Accidental Death Benefit 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 benefit welfare plan subject to the provisions of ERISA which provides medical, hospital, prescription drug, dental, vision, chiropractic, mental health substance abuse and employee assistance benefits through contracts of insurance, and self-funded death and accidental death and dismemberment benefits.

Name, Address, of the 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
(888) 410-1756; (562) 463-5040
Facsimile: (562) 463-5894

Type of Administration
The Teamsters Multi-Benefit Trust, formerly known as the South Bay Teamsters and Employers Health and Welfare and Related Benefits Trust Fund. which was established and is maintained pursuant to collective bargaining agreements between participating Local Unions affiliated with the International Brotherhood of Teamsters and various Employers signatory to these Collective Bargaining Agreements. It is a Joint Trustee Labor-Management Trust which was created to provide health and welfare and death and accidental death and dismemberment benefits to employees and their eligible Dependents.

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 the records of the Trust and manages the office which is referred to as the Trust Administrative Office, Trust Office or Fund Office.

Right to a 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.

Mailing Address and Office Location for Benefit Programs Administration:
Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906

Name and Address of Agent for Service of Legal Process
The person designated by the Plan as agent to receive legal process is:
Lance Phillips, Administrator
Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017-1906

Service may be made upon the agent or upon a member of the Board of Trustees at the address of each Trustee 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
Sr. Vice-President Labor Relations
FirstGroup America, Inc.
600 Vine Street, Suite 1400
Cincinnati, Ohio 45202

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

Elizabeth Sanchez
Sr. Vice President
First Student, Inc.
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 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 the companies listed at page 34 of this booklet:

Death and accidental death and dismemberment benefits are self-funded through the Trust, and are detailed in a separate Summary Plan Description which can be obtained free of charge from the Plan's Third-Party Administrator, Benefit Programs Administration.

Insurers and Service Providers:
For the name and contact information for each insurer providing benefits, please see list at page 34 of this booklet.

Please see page 34 of this booklet for a list of the Trust's service providers.

Documents Governing Plan Benefits

Your right to benefits is governed by the terms of this Summary Plan Description, the Plan Document, and the Agreement and Declaration of Trust as well as the policies, contracts and Evidences of Coverage issued to the Plan by the companies listed at page 34 of this booklet If there are any differences or conflicts between this booklet and the Declaration of Trust or policies, contracts or Evidences of Coverage issued to the Plan, the terms and conditions of the Declaration of Trust, Contract or Evidences of Coverage shall prevail unless superseded by applicable law. Copies of these governing documents are available at the offices of Benefit Programs Administration.

Amendment or Termination

There is no vested right to receive Plan benefits. The Board of Trustees reserves the right to amend, modify, or discontinue all or part of any Plan at any time whenever, in their sole judgment and discretion, conditions so warrant. The Plan may be amended or terminated by a written instrument duly adopted and signed by the Trustees**.**

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

As a participant in the Teamsters Multi-Benefit Trust Transportation Industry Program 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) is filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

EBSA Los Angeles Regional Office
1055 East Colorado Blvd, Ste 200
Pasadena, CA 91106-2357
Tel (626) 229-1000
Fax (626) 229-1098

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.

Continue Group Health Plan Coverage

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

Affordable Care Act or ACA means the Patient Protection Affordable Care Act and Health Care and Education Reconciliation Act ("Affordable Care Act").

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 Teamsters Multi-Benefit Trust. 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.

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 Agreement and Declarations of Trust Providing for the Teamsters Multi-Benefit Trust and as required by a Collective Bargaining Agreement.

Dependent means any of the following:

a. The Legal Spouse of an Employee. The term Legal Spouse or Spouse means any individual who is lawfully married to the Employee under the state law, including same-sex couples who are legally married to the Employee in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages.

b. Same-Sex Domestic Partner of an Employee or the opposite sex Domestic Partner where one of the Domestic Partners is age 62 or older who have provided the Trust with a Declaration of Domestic Partnership registered with the California Secretary of State, or an equivalent document filed with another state or local jurisdiction.

   Effective January 1, 2002, Domestic Partner includes Domestic Partners who sign the Plan's Affidavit of Domestic Partnership before a notary public under penalty of perjury and provide the Affidavit and required evidence of Domestic Partnership to the Trust Administrative Office.

c. The Employee, Spouses or Domestic Partners' natural born children, stepchildren, legally adopted children or children placed for adoption who are less than 26 years of age. Children for whom an Employee, Spouse or Domestic Partner is the Court Appointed Legal Guardian are not Dependents under the Plan, however, Children who are enrolled in the Plan as of November 12, 2013, based upon an Order of Guardianship, will remain eligible for coverage under the Plan until such time as their coverage would otherwise terminate under the Plan.

d. The Employee, Spouse or Domestic Partners' 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 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 or nullity 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 of termination of the Domestic Partnership as evidenced by the Affidavit of Termination of Domestic Partnership required to be 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.

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 Trust Agreement. 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 are 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 Trust Agreement, 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.
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 Administrative Office, Trust Office or Fund Office means the offices maintained by the third-party administrator for the administration of the Trust 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 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.

Insurers and Providers of Services to the Trust

Benefit	*Healthcare Provider*	*Member Services Phone Number*
Medical & Prescription Drug	Kaiser Permanente	(800) 464-4000
	SIMNSA	(800) 424-4652
Dental	Liberty Dental	(888) 703-6999
	SIMNSA/UniDent	(800) 424-4652
Vision	Vision Service Plan (VSP)	(800) 877-7195
	Davis Vision	(800)783-6872
Chiropractic	Landmark HealthPlan	(800) 638-4557
Member Assistance Plan	Optum Health	(877) 225-2267
Legal Benefit	Optum Health	(877) 225-2267

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. You may not be eligible for all of the benefits described in this SPD. Your eligibility is determined by the terms of your Collective Bargaining Agreement and the rules of the Trust.

TEAMSTERS MULTI-BENEFIT TRUST
(Transportation Industry Program)

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Effective Date
January 1, 2014

TEAMSTERS MULTI-BENEFIT TRUST

TRANSPORTATION INDUSTRY PROGRAM (TIP)

SUMMARY PLAN DESCRIPTION

Effective Date

JANUARY 1, 2014