THE TEAMSTERS LIFE INSURANCE TRUST FUND

Summary Plan Description

Plan C

Effective July 1, 2010

INTRODUCTION

This document constitutes your Summary Plan Description ("SPD") for Plan C of The Teamsters Life Insurance Trust Fund ("Trust") as required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Please read this document carefully. This SPD explains eligibility and coverage for life and accidental death and dismemberment insurance benefits for active employees and death benefits for eligible retirees in plain language. This SPD also provides information about claims and appeals procedures and other administrative and legally required information about the Plan. This document, together with the group insurance policies issued by MetLife, also serves as the plan document required by ERISA. If the terms of this document conflict with the terms of the group insurance policies or the Trust Agreement, the terms of the group insurance policies and/or Trust Agreement will control, unless superseded by applicable law. In the event of any conflict between the provisions of this Plan and the collective bargaining agreement between your union and your employer, the Plan shall prevail unless otherwise specifically noted. This document does not serve as a guarantee of continued employment or benefits. In addition, the Board of Trustees reserves the right to change or end the Plan by action at a regularly constituted Trustee meeting held according to the Trustees' established process. You will be notified if any material changes are made to the Plan or if the Plan is terminated.

Except as otherwise stated in this document, the Trust's Administrative Office—Health Services & Benefit Administrators—administers the Plan and provides information about the amount of benefits, eligibility and other provisions of the Plan. No union employee, including union officers and business agents, employer or employer representative, or any other organization except the Trust's Administrative Office, is authorized to give information or commit the Trustees on any matter. As a convenience to you, the Trust's Administrative Office may provide oral answers on an informal basis regarding coverage. However, no such oral communication is binding on the Board of Trustees. In all cases the provisions of the official Plan documents will govern.

Important Notice Regarding Eligibility. Your eligibility for benefits under this Plan depends on the continued receipt of employer contributions on your behalf. If your employer stops making contributions to the Trust, your eligibility for benefits will end as described in the Eligibility and Benefit Insert. Further, if you are a retired participant you will lose your coverage if your employer (including successors thereto) stops making contributions to the Trust, even if such contributions stop after you retired.

If you have any questions about your benefit coverage, contact the Trust's Administrative Office at 1 (925) 833-7315 and state that you are calling about Teamsters Life Insurance Trust benefits.

BOARD OF TRUSTEES

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SUMMARY OF BENEFITS

The Plan pays benefits to active employees or their beneficiaries based on the level of contributions made by the employer. The benefit paid upon your death is referred to as the "Standard Benefit Amount (SBA)." In some cases the Standard Benefit Amount for seasonally employed workers is different from the Standard Benefit Amount for full-time employees. In addition to benefits payable upon your death, benefits are also paid if you lose a limb or your eye sight. The benefit payable in these instances is expressed as a percentage of the Standard Benefit Amount. For example, the benefit paid when a limb or sight in one eye is lost is 50% of the Standard Benefit Amount. So, if your beneficiaries receive $4,000 when you die then the amount payable to you upon losing a limb or sight in one eye is $2,000. Under the Plan, once you retire, the death benefit is $1,000, regardless of your Standard Benefit Amount as an active employee. **For the Standard Benefit Amount applicable to your coverage see the Eligibility and Benefit Insert**.

Loss of life	100% of SBA
Accidental death and dismemberment (AD&D):	
Accidental death (in addition to benefit for loss of life)	100% of SBA
Loss of one limb or sight in one eye	50% of SBA
Loss of two limbs, sight in both eyes or one limb and sight in one eye	100% of SBA
Death when disabled	$1,000*
Retiree death benefit	$1,000

* Non-seasonal employees whose health benefits are paid by the employer while disabled will receive the Standard Benefit Amount if death occurs before the date employer-paid health coverage ends or 12 months after the date of disability, whichever occurs first.

SUMMARY OF ELIGIBILITY

Active Plan coverage:	
Initial and continuing employer-paid coverage	See Eligibility and Benefit Insert
When employer-paid life coverage ends	See Eligibility and Benefit Insert.
Self-pay rights	24 months
Conversion rights	If group coverage ends, you have the right, within a limited period of time, to convert your coverage to an individual policy
Retiree death benefit:	
120-month rule	Must be continuously covered for 120 months immediately prior to receiving a Qualified Pension (see page 12)
Grace period rule	Must begin receiving a Teamster pension within 24 months of completing a period of 120 months of continuous coverage under the Active Plan

ELIGIBILITY AND BENEFIT INSERT

While the eligibility rules and plan benefit provisions described in this Summary Plan Description are generally applicable to employees working at the employers listed below, different rules apply in some instances. The Eligibility and Benefit Insert included with the SPD will describe any different rules that may affect you.

LIST OF CONTRIBUTING EMPLOYERS

Bellingham Cold Storage
City of Burlington, Washington
Cowlitz County (WA), Sheriff Dept.
CSX Lines
Darigold Inc.
Lti, Inc.
Sanitary Service
Smith Frozen Foods, Inc.
Teamsters Joint Council #7
Teamsters Local 70
Teamsters Local 231
Teamsters Local 137
Teamsters Local 150
Teamsters Local 315
Teamsters Local 350
Teamsters Local 601
Teamsters Local 890
Teamsters Local 912
Teamsters Local 948
(1) Twin City Foods, Inc.

ESTABLISHMENT AND PURPOSE

The Teamsters Life Insurance Trust Fund ("Plan") was established effective February 1, 1973, to provide life, accidental death and dismemberment insurance benefits to active employees of Contributing Employers and death benefits to eligible retirees. The Plan is maintained for the exclusive benefit of eligible active employees and eligible retirees. The Plan is intended to be maintained on an indefinite basis but is subject to the amendment and termination provisions beginning on page 27. The Plan was amended and restated to read as set forth herein as of July 1, 2006.

ACTIVE PLAN–LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Eligibility

Employer-paid Coverage

To be covered under the Plan by your employer, generally speaking you must:

(a) be covered under a collective bargaining agreement between your local union and your employer or covered under the terms of a subscriber agreement between the employer and the Trust; and
(b) and be working in an employee classification eligible for benefits (i.e. normally a full-time employee).

In addition, most agreements providing for coverage require that you meet a work or compensation test. For example, your collective bargaining agreement may require that you work 80 hours in the preceding month. The specific work, compensation or other tests that are applied to determine your eligibility for life coverage are described in the Eligibility and Benefit Insert. Keep this Insert with your SPD.

When Employer-paid Coverage Ends

Employer-paid life insurance coverage ends 31 days after the last day of the month in which you do not meet the work, compensation or other requirements contained in your collective bargaining agreement. This additional 31 days of coverage is referred to as the "extension period."

Example Your bargaining agreement states that you will be covered for life and accidental death and dismemberment insurance in the month following each month you worked 80 hours. You worked 80 hours in January and February but only 40 hours in March and no hours in April. You are covered in February because of the 80 hours you worked in January and in March because of the 80 hours you worked in February. Although you failed to meet the work test for April coverage (you did not work 80 hours in March) you are nevertheless covered for life insurance during April because of the 31-day "extension period." You are not covered in May.

There is no 31 day "extension period" coverage for Accidental Death and Dismemberment coverage. In the example above, unlike your life insurance coverage, your AD&D coverage ends on the last day of the month following the month you last worked 80 hours or March 31st.

When employer-paid coverage ends you may only continue coverage by making self-payments or by converting your group coverage to an individual plan (see sections below).

Continuing Group Coverage by Making Self-Payments

If you are laid-off or go on an approved leave of absence, you may continue your life and AD&D coverage for up to 24 months by making self-payments. As explained on page 13, one of the requirements for the retiree death benefit is 120 months (ten years) of continuous coverage prior to retirement. Therefore, if you fail to self pay for coverage when you are not working, you will not preserve the continuity of your coverage and, as a result, may fail to meet the 120-month test that would otherwise qualify you for the retiree death benefit.

Self-payments must be made to your employer who will submit them to the Trust together with premiums for working employees. Self-payments must begin the month after employer-paid coverage (**excluding the "extension period**" discussed on page 6) ends and must be continuous. If you skip a month you cannot resume self-pay coverage without returning to covered employment and regaining eligibility. *Payments are due on the first day of the month for which coverage is being purchased. Payments are considered late if they are not received within 30 days of the due date.* **There is no grace period. If a payment is late, self-pay coverage is cancelled.** As of July 1, 2010, the premium is $.85 per $1000 of coverage. See your Eligibility and Benefit Insert for your self-pay premium rates.

Example Cont. The last contribution made by your employer paid for March coverage. Although life is extended an additional 31 days (the extension period), if you want to continue group coverage by making self-payments, you must begin by paying for April coverage. Your first self-payment is due on April 1st and must be made by April 30th to avoid being late. There is no grace period. If the payment for April is not received by the end of the month, your life coverage will end April 30th (AD&D coverage will end March 31st) and you will have lost the right to continue coverage by making self-payments.

YOU DO NOT HAVE THE RIGHT TO MAKE SELF-PAYMENTS IF YOU QUIT, RETIRE OR ARE TERMINATED FROM EMPLOYMENT. (However, you may be able to continue life coverage by converting to an individual policy—see page 8.)

When Self-Pay Coverage Ends

Self-pay life coverage ends 31 days after the end of the month in which you:

- make your last self-payment;
- terminate employment; or
- come to the end of your 24-month self-pay period,

whichever is earliest. Once the 24-month period expires, you cannot self pay for coverage until you earn coverage again based on hours worked.

Example Cont. Because of lay-off or personal leave, your employer does not provide coverage during April, May and June and July. You self pay for April and May but make no payment in June. Your AD&D coverage will end on May 31st. Because of the 31-day "extension period," your life coverage will not end until July 1st (i.e. 31 days after May 31st). Because a timely payment was not made for June, you cannot later self pay for June or any subsequent month.

Total Disability (Disability Waiver Coverage)

If, while covered by the Active Plan, you become Totally Disabled before your 65th birthday then your life insurance coverage, but not AD&D, will continue so long as you remain Totally Disabled. You do not need to make self-payments (i.e. premiums are waived while you are Totally Disabled). However, you do need to file a claim giving proof of your disability within 12 months of the date the disability began. And, whenever requested by the Administrative Office, you will need to furnish continuing proof of your disability. For more information on how to apply for a waiver so you will not have to pay premiums while you are disabled, see page 18.

If, while you are Totally Disabled, you become eligible for the retiree death benefit—see description beginning on page 12—your disability benefit will be replaced by your retiree benefit.

Totally Disabled	Means that because of sickness or injury you are completely and continuously unable to engage in any occupation or business for an income or profit, for which you are qualified by reason of education, training or experience.

Conversion from Active Plan Coverage to an Individual Policy

So long as MetLife underwrites the group policy, if your life insurance coverage terminates, you have the right to purchase an individual policy from MetLife. You must apply for this coverage in accordance with the following deadlines:

Written Notice of Option To Convert Received	**Application Deadline**
15 days before or after coverage ends	31 days after life insurance coverage ends (excluding extension period)
More than 15 days after coverage ends	25 days from the date you receive the notice or 91 days after coverage (excluding extension period) ends, whichever is earlier
No notice received	91 days after coverage ends (excluding extension period)

Contact the Administrative Office to obtain an application. If you convert to an individual policy, you will make your premium payments directly to MetLife. The cost of the policy will depend on your sex and age. If you return to covered employment in the industry within two years, you must surrender your individual conversion policy (and you will be paid the cash surrender value thereof) before you can resume coverage under the Active Plan. Note, the time you are covered by the conversion policy does not count in meeting the 120-month requirement for coverage under the retiree plan—see page 13.

Retirees who lose Retiree Plan coverage may also convert their group coverage to an individual policy.

Benefits

Standard Benefit Amount

The Plan pays benefits to active employees or their beneficiaries based on the level of contributions made by the Employer. The benefit paid upon your death is referred to as the "Standard Benefit Amount" (SBA). In addition to benefits payable upon your death, benefits are also paid if you lose a limb or your eye sight. This benefit, referred to as the Accidental Death and Dismemberment (AD&D) benefit, is based on a percentage of the Standard Benefit Amount, depending on your loss. For example, the benefit paid when a limb or sight in one eye is lost is 50% of the Standard Benefit Amount. So, if your beneficiaries receive $4,000 when you die then the amount payable to you upon losing a limb or sight in one eye is $2,000. Under the Plan, once you retire the death benefit is $1,000, regardless of your Standard Benefit Amount as an active employee. Retirees are not eligible for AD&D. **SEE THE ELIGIBILITY AND BENEFIT INSERT FOR THE STANDARD BENEFIT AMOUNT FOR YOUR COVERAGE.**

Disability Benefit

As described under Total Disability (Disability Waiver Coverage) on page 8 your life insurance coverage continues if you are totally disabled. Except as described below, the death benefit under disability waiver coverage is $1,000 regardless of your Standard Benefit Amount as an active employee. **Exception:** If you are in a non-seasonal job or seniority classification AND under the collective bargaining agreement with your employer you are entitled to employer-paid health coverage while off work because of a disability ("Disability Health Care Coverage Protection") then your disability waiver death benefit is equal to the Standard Benefit Amount during the period while you are disabled and continue receiving employer-paid health care coverage (but in no event longer than 12 months). Thereafter your disability waiver coverage benefit is $1,000.

Example You are a full-time year-round employee. After working more than 80 hours in February 2006, you are disabled and remain so for more than one year. The collective bargaining agreement between your union and employer provides for employer-paid health coverage during the month that follows each month you work 80 hours. In addition, the agreement

also requires that the employer continue to pay for health and welfare coverage for up to six months while you are disabled. In this example, you have health coverage in March 2006 because of your 80 hours of work in February. In addition, you have employer-paid health coverage from April 2006 through September 2006 because of your Disability Health Care Coverage Protection. If you pass away on or before September 30, 2006 your beneficiaries will receive the Standard Benefit Amount. After September 2006, the benefit is $1,000.

If your employer provides 12 months of Disability Health Care Coverage Protection your disability waiver death benefit is the Standard Benefit Amount up through March 31, 2007. Thereafter, the benefit is $1,000, even if your employer provides health care for a longer period.

CONSULT YOUR ELIGIBILITY AND BENEFIT INSERT. IF YOU HAVE DISABILITY HEALTH CARE COVERAGE PROTECTION IT WILL BE DESCRIBED THERE.

Summary of Benefits

The chart below shows the benefit (expressed as a percentage of the Standard Benefit Amount) for each type of loss covered under the Plan for Active employees.

Loss of life	100% of SBA
Accidental death and dismemberment:	
Accidental death (in addition to life insurance benefit)	100% of SBA
Loss of hand (permanently severed above wrist and below elbow)	50% of SBA
Loss of foot (permanently severed above ankle and below knee)	50% of SBA
Loss of sight in one eye (permanent uncorrectable acuity of 20/200 or worse or a field of vision of less than 20 degrees)	50% of SBA
Loss of one limb or sight in one eye	50% of SBA
Loss of any combination of hand, foot or sight in one eye	100% of SBA
Loss of sight in both eyes	100% of SBA
Death when disabled	
Full-time employees while covered by Employer-paid health insurance (but no longer than 12 months, see Disability Benefit)	100% of SBA
Participants in seasonal employment and full-time employees not covered by Employer-paid health coverage, see Disability Benefit)	$1,000

To qualify for benefits under the accidental death and dismemberment policy, the accidental injury must occur while you are covered under that policy and the loss must occur within 12 months of the accidental injury and must be the direct result of the accidental injury, independent of any other cause.

Exclusions

No accidental death and dismemberment benefits are payable if the loss of life or injury is caused or contributed to by any of the following:

- Suicide or attempted suicide;
- Service in the armed forces of any country or international authority, except the United States National Guard;
- War, whether declared or undeclared, or act of war, insurrection, rebellion, riot or terrorist act;
- Committing or attempting to commit a felony;
- Intentionally self-inflicted injury;
- Intoxication while operating a vehicle or other device when the incident occurs. (Intoxication means your blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.)
- Voluntary intake or use by any means of:
  - any drug, medication or sedative unless it is either taken or used as prescribed by a physician or it is an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication or sedative;
  - poison, gas or fumes.
- Aircraft travel:
  - as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - in an aircraft or device used for testing or experimental purposes or by any military authority or for travel or designed for travel beyond the earth's atmosphere.
- Parachuting or otherwise exiting from an aircraft while in flight except for self-preservation;
- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound.

These exclusions do not apply to the life insurance benefit.

RETIREE PLAN–DEATH BENEFIT

Eligibility

When you die, your beneficiaries are eligible for a death benefit if you meet either of the following two tests and are not affected by any exclusion.

Test 1 You retired prior to January 1, 1983 AND EITHER:

(1) Began receiving a pension from a pension plan maintained under a collective bargaining agreement with a Teamsters Union organization (a Qualified Pension) within 24 months (or 11 months for retirees who died before July 1, 2000) of the last day you were covered under the Active Plan (grace period rule),

OR

(2) You were age 65 when you retired.

Test 2 You retired on or after January 1, 1983 AND

You were continuously covered by the Active Plan for 120 months (120-month rule) AND EITHER

(1) Began receiving a Qualified Pension within 24 months (or 11 months for retirees who died before July 1, 2000) of completing a period of 120 months of continuous coverage under the Active Plan (grace period rule),

OR

(2) You are covered under the Active Plan for a reason other than disability waiver on or after your 65th birthday.

Exclusions Even if you meet test 1 or test 2, you are NOT eligible for a retiree death benefit if:

- You retired prior to February 1, 1973, the date the Trust started, or the date your employer first participated in the Trust, whichever is later.
- You retired on or after January 1, 1983 and your employer (or a successor to that employer) no longer contributes to the Trust.

The following guidelines are used in applying Tests 1 and 2.

120-month rule

The 120-month rule requires that you have ten years of continuous coverage under the Active Plan without a break (with your last day of continuous coverage ending within your grace period as described above). The 120-month period begins anew after any month in which you are without coverage. **Exception:**

IF You are a full-time employee forth in your collective bargaining agreement

AND You lose Active Plan coverage under this Trust because of a medical disability or lay-off

AND Your employer continues to provide at least three months of employer-paid health care coverage during your lay-off or disability

THEN You will **not have a break** in your continuous coverage provided that your lapse in Active Plan coverage (due to your lay-off or disability) is three or fewer months in any twelve-month period.

Active Plan life insurance coverage (but not AD&D coverage) continues while you are Totally Disabled (see page 8). However, for any single period of disability, no more than 24 months of disability waiver coverage count towards meeting the 120-month rule requirement.

Coverage during the 31-day extension period (see page 6) does not count towards meeting the 120-month rule requirement. Neither does coverage under the individual policy you receive if you exercise your option to convert.

Preventing a Break in Coverage through Self-Payment

You may be able to prevent a break in your continuous coverage when you are not working by exercising your right to continue your coverage through self-payment. For example, if you are in a job or classification that provides seasonal employment and you are not working due to seasonal lay-off, you can prevent a break in coverage by self paying the required premiums. Contact your employer to make arrangements.

If you are a full-time employee you also need to be careful about breaks in coverage. Unless described differently in the Eligibility and Benefit Insert, there is no lay-off

protection for life insurance. If, because of lay-off, illness or injury, you fail to work in covered employment at least nine out of 12 months in each of the last ten years you are covered by the Active Plan, you will have to make self-payments to prevent a break in your continuous coverage.

The rules governing when and for how long you can continue coverage through self payment are summarized on page 7.

Grace period rule The 24-month grace period (or 11-month grace period for retirees who died prior to July 1, 2000) starts the first month after the last month in an uninterrupted sequence of 120 consecutive months during which you were continuously eligible under the Active Plan and ends with the last month before you start receiving your Qualified Pension. For this purpose, coverage during the 31-day extension period is NOT counted as Active Plan coverage nor is coverage under a disability waiver.

You are deemed to start receiving your Qualified Pension on the effective date of your pension, even if actual payment is delayed due to processing.

Examples of how these two tests work.

Example Test 1 You worked continuously in covered employment for five years from 1977 through 1981. You retired on January 1, 1982 and started to receive a Qualified Pension on July 1, 1983. You qualify for the retiree death benefit under Test 1 because:

(a) You retired before January 1, 1983 (so the 120-month rule does not apply); and
(b) You began receiving a Qualified Pension within 24 months of the last day you were covered by the Active Plan (Active Plan coverage ended December 31, 1981, pension effective date 18 months later on July 1, 1983).

In this example if you waited to start your pension until February 1, 1984 you would not qualify for the retiree death benefit because more than 24 months would have elapsed between your last day of Active Plan coverage and the start of your pension payments.

Example Test 2

You worked continuously in covered employment from January 1, 1991 through September 30, 1999 (105 months). On October 1, 1999, you were laid-off but continued your Active Plan life insurance coverage by making self-payments. On March 31, 2001, (18 months later) you retired and your name was removed from the seniority list. Because you are no longer an employee you lost the right to continue to make self-payments under the Active Plan at the end of March 2001. On April 1, 2003, you started to receive a Qualified Pension. You qualify for the retiree death benefit under Test 2 because:

(a) You were continuously covered by the Active Plan for at least 120 months (105 months of employer contributions plus 18 months of self-payments = 123 months); and

(b) You started receiving Qualified Pension benefits within 24 months of when you completed your 120-month period of continuous eligibility under the Active Plan. (Your most recent 120-month period of continuous eligibility was April 1991 through March 2001. You started receiving your Qualified Pension on April 1, 2003—24 months later.)

Note, in this example you are not covered by life insurance from April 1, 2001 through March 31, 2003 because you are no longer eligible for the Active Plan and, because your pension has not started, you are not yet covered under the Retiree Plan.

Conversion from Retiree Plan Coverage to an Individual Policy

If you lose retiree coverage (because, for example, your former employer no longer contributes to the Trust) you have the right to purchase an individual policy from MetLife. See "Conversion from Active Plan Coverage to an Individual Policy" on page 8 for conditions and deadlines.

Benefits

Unless a different amount is set forth in the Eligibility and Benefit Insert, the death benefit under the Retiree Plan is $1,000.

If, after the effective date of your Qualified Pension you return to work, your death benefit will be the higher of your Active Plan benefit or your Retiree Plan benefit (but not both). Once your Active Plan coverage ends, you will continue to have coverage under the Retiree Plan.

NAMING BENEFICIARIES

Completing The Beneficiary Designation Form

It is important that you name one or more beneficiaries when you first become eligible for Active Plan coverage. You can do this by filling out the Trust's Beneficiary Designation Form and mailing it to the Administrative Office. **BE SURE TO SIGN AND DATE the beneficiary form.** Unsigned forms or forms received by the Trust after you die are not valid. Beneficiary designation forms can be obtained at your union local or by calling the Administrative Office. You may change your beneficiary any time you want by filling out a new form. **You cannot change your beneficiary by calling the Administrative Office**. **The change must be made in writing on a form approved by the Trust.**

Preference Beneficiary Rule

If you do not designate a beneficiary, your death benefit under either the Active or Retiree Plan will be paid to beneficiaries in the following order:

1. To your spouse (a domestic partner registered as such with the State of California is considered to be a spouse).
2. To your children, equally, if you have no spouse.
3. To your parents, equally, if you have no children.
4. To your brothers and sisters, equally, if you have no parents.
5. To your estate.

ANY PAYMENT MADE IN GOOD FAITH TO ANY OF THE ABOVE BENEFICIARIES DISCHARGES THE TRUST'S LIABILITY TO THE EXTENT OF SUCH PAYMENT.

CLAIMING BENEFITS
AND
REQUESTING A DISABILITY PREMIUM WAIVER

How To File A Claim Or Request A Disability Waiver

Life Claim and Retiree Plan Death Benefit

If you are a beneficiary of an active or retired employee who has passed away, you or your authorized representative may claim your benefit by contacting the union local or the Administrative Office and requesting a claim form.

1. Fill out the Claimant's section. Be sure to list any other beneficiaries (name, address, Social Security number).
2. Attach a CERTIFIED copy of the deceased employee's death certificate. (Photocopies will not be accepted.)
3. If the benefit is to be shared (for example by the children of the deceased) and one of the beneficiaries has died, attach a photocopy of the deceased beneficiary's death certificate.
4. If you are applying on behalf of the deceased employee's estate, attach a certified certificate of appointment or other document appointing the estate representative.

Forward this package of material to the union local. The Union will fill out the section of the claim form covering work history and then forward the entire application to the Administrative Office for processing.

The Administrative Office will check work history and process the claim. If there is no card on file naming a beneficiary you will be sent a "Claimant's Affidavit." This form must be completed and returned before the preference beneficiary rules are used to distribute the death benefit.

Benefits are normally paid within 90 days of receiving a fully completed claim. If you file a claim and have not received a response from the Administrative Office within 90 days, please call.

Accidental Death and Dismemberment Claim

If you or your authorized representative are filing an accidental death claim, in addition to the death certificate you will need to furnish the Administrative Office with a copy of the police report, if there is one. The insurance carrier, MetLife, may also request a toxicology report.

If the claim is for the accidental loss of your hand, foot or eyesight, you will need to furnish the Administrative Office with a statement from your doctor.

Disability Premium Waiver Application

To retain coverage when you are Totally Disabled, you or your authorized representative MUST file a request for premium waiver. If the request is approved, you are covered without having to self pay the premium (i.e. the premium is waived) for as long as you remain Totally Disabled.

Deadline YOU MUST SUBMIT THE APPLICATION FOR PREMIUM WAIVER WITHIN 12 MONTHS OF THE DATE YOUR DISABILITY BEGAN.

The request for premium waiver form can be obtained from your union local or the Administrative Office. Complete and sign the claimant's portion and forward the form to your physician who must complete the sections describing your disability. Your physician must then file the request for premium waiver form with the Administrative Office.

The Plan reserves the right to require ongoing proof of your continuing Total Disability. If you receive a request for an update on your condition, fill out your portion and forward it to your doctor. If you do not respond within 90 days, coverage under the Total Disability provisions of the Active Plan will be cancelled.

Responding To Filed Claims

Responding to Life, AD&D and Retiree Death Benefits

Within 90 days after the date the Administrative Office receives a fully completed claim for benefits, including any required attachments or requested additional information, the Administrative Office will:

a. Pay the claim; or

b. Send written notice to the claimant explaining that special circumstances require additional time (up to 90 days) to process the claim and give the date by which a decision is expected to be made; or

c. Send written notification to the claimant that the claim has been denied, in whole or in part. This notice will include:
   - Specific reasons for the denial;
   - Specific references to the Plan provisions upon which the denial is based;
   - A description of any information or material necessary to perfect the claim and reasons why that information is necessary;
   - An explanation of how the claimant may appeal the denial, including applicable time limits; and
   - A statement of the claimant's right to bring a civil action under ERISA §502(a) following an adverse benefit determination on review.

Responding to Application for Disability Premium Waiver

Within 45 days after the date the Administrative Office receives a fully completed application for a disability premium waiver, including any required attachments or requested additional information, the Administrative Office will:

a. Grant the disability waiver; or

b. Send written notice to the claimant explaining that special circumstances require additional time (up to 30 days) to process the application and give the date by which a decision is expected to be made. If additional information is needed to decide the claim, the notice will specify the needed information. The Administrative Office may request no more than two extensions.

   If additional information is requested, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, a decision will be made on the basis of the previously submitted information: or

c. Send written notification to the claimant that the claim for disability waiver has been denied, in whole or in part. This notice will include:
   - Specific reasons for the denial;
   - Specific references to the Plan provisions upon which the denial is based;
   - A description of any information or material necessary to perfect the claim and reasons why that information is necessary;
   - An explanation of how the claimant may appeal the denial, including applicable time limits; and
   - A statement of the claimant's right to bring a civil action under ERISA §502(a) following an adverse benefit determination on review.
   - The notice may also specify:
     - Whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, and either the specific rule, guideline, protocol, or other similar criterion or a statement that such information is available upon request free of charge; or
     - Whether the determination was based on an exclusion or limit, and either an explanation of the scientific or clinical judgment for the determination or a statement that such information is available upon request free of charge.

How To Appeal A Denied Claim Or Premium Waiver Request

Appealing a Denied Life, AD&D or Retiree Death Benefit Claim

If a claim for Life, AD&D or retiree death benefits is wholly or partly denied, the claimant or his or her authorized representative may submit a request for a review of the claim. The request for review will be considered by a Review Panel designated by the Board of Trustees which shall consist of an equal number of Employer Trustees and Union Trustees. Requests for review must be sent to the Administrative Office which will refer the appeal to the Review Panel. This appeal must be filed within 60 days after the date the claim is denied. The claimant may submit written comments, documents, records, etc., with regard to his or her claim to the Administrative Office which will forward such information to the Review Panel. The claimant will also have an opportunity to review and obtain copies of all documents, records, and other information relevant to his or her claim, free of charge from the Administrative Office. The review by the Review Panel will take into account all information submitted by the claimant, regardless of whether it was reviewed as part of the initial determination. The Review Panel will render a decision within 60 days of receiving the appeal from the Administrative Office unless special circumstances require an extension of time of up to an additional 60 days. If such an extension is required, the claimant will be notified in writing by the Review Panel before the initial 60-day period ends.

If the appeal is denied, a notice of determination will be provided to the claimant that will include:

- Specific reasons for the denial;
- Specific references to the Plan provisions upon which the denial is based;
- A statement regarding the claimant's right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
- A statement of the claimant's right to bring a civil action under ERISA § 502(a) following an adverse benefit determination on review.

The decision of the Review Panel on appeal is FINAL AND BINDING on all persons.

Appealing a Denied Request for Disability Premium Waiver

If a claim for a disability premium waiver is denied, the claimant or his or her authorized representative may submit a request for a review. The request for review will be considered by a Review Panel designated by the Board of Trustees which shall consist of an equal number of Employer Trustees and Union Trustees. Requests for review must be sent to the Administrative Office which will refer the appeal to the Review Panel. Appeals regarding a disability premium waiver must be filed within 180 days after the date the claim is denied by the Administrative Office. The claimant may submit written comments, documents, records, etc., relating to his or her claim to the Administrative Office which will forward such information to the Review Panel. The claimant will also

have an opportunity to review and obtain copies of all documents, records, and other information relevant to his or her claim, free of charge from the Administrative Office.

The Review Panel will take into account all information submitted by the claimant, regardless of whether it was reviewed as part of the initial determination. Where an appeal is based on a medical judgment, the Review Panel will consult with a properly trained health care professional. The health care professional will not be the same individual who was consulted in connection with the initial determination nor a subordinate of that individual. The identity of any medical or vocational expert whose advice was obtained in connection with the appeal will be provided upon request.

Within 45 days after the Review Panel receives a request for review, the Review Panel will:

a. Grant the disability premium waiver; or

b. Send written notice to the claimant explaining that special circumstances require additional time (up to 45 days) to process the claim and give the date by which a decision is expected to be made. If additional information is needed to decide the claim, the notice will specify the needed information.

   If additional information is requested, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, a decision will be made on the basis of the previously submitted information; or

c. Send written notification to the claimant that the appeal has been denied, in whole or in part. This notice will include:
   - Specific reasons for the denial;
   - Specific references to the Plan provisions upon which the denial is based;
   - A statement regarding the claimant's right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
   - A statement of the claimant's right to bring a civil action under ERISA § 502(a); and
   - The notice may also specify:
     - Whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, and either the specific rule, guideline, protocol, or other similar criterion or a statement that such information is available upon request free of charge; or
     - Whether the determination was based on an exclusion or limit, and either an explanation of the scientific or clinical judgment for the determination or a statement that such information is available upon request free of charge.

The Review Panel's decision on appeal is FINAL AND BINDING on all parties.

Authority of Board of Trustees

The Board of Trustees and the Review Panel designated by the Board of Trustees have the exclusive and discretionary right to interpret and construe the provisions of the Plan, and decide any and all matters arising there under, including the right to remedy possible ambiguities in any relevant Plan document, or this Summary Plan Description or the application of ERISA, as well as to determine factual matters.

Right to Sue

No legal action may be taken to gain benefits from the Plan until you have:

- Submitted a written claim for benefits; and
- Been notified by the Administrative Office that the claim is denied; and
- Filed a written request for a review of the denied claim by the Review Panel designated by the Board of Trustees; and
- Been notified in writing that claim denial has been affirmed by the Review Panel designated by the Board of Trustees.

The ERISA Statement of Rights, beginning on page 24, provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

Benefits Not Subject To Alienation

Plan benefits shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person.

Payments Made In Error

In the event the Plan erroneously (1) makes benefit payments to a participant or beneficiary in excess of amounts provided for by this Plan; (2) makes benefit payments to a participant or beneficiary for which benefits are not payable under this Plan; or (3) erroneously makes benefit payments to an individual who fraudulently participates in the Plan based on a misrepresentation of facts, the amount so paid shall be repaid to the Trust by the participant, beneficiary, estate or individual. If such amounts are not repaid, the Trustees may file suit to recover any amount due.

Physical Exams

A written statement from your doctor will normally be required in support of a claim for an accidental dismemberment benefit or a disability premium waiver. If after reviewing your doctor's statement, the Plan concludes that more information is needed to determine your benefit, the Plan has the right to condition payment of your benefits on an examination by a physician(s) designated by the Plan (at the Plan's expense) as often as is reasonably necessary to process the claim.

Autopsy

The Plan has the right to make a reasonable request for an autopsy where permitted by law and to condition payment of benefits on the results of any such autopsy. Any such request will set forth the reasons the Plan is requesting the autopsy.

YOUR ERISA RIGHTS AND PLAN ADMINISTRATIVE INFORMATION

ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all The Teamsters Life Insurance Trust Fund participants are entitled to:

Receive Information about Your Plan and Benefits

- You can examine, without charge, at The Teamsters Life Insurance Trust Fund's Administrative Office and at other specified locations (such as worksites and local unions) all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain, upon written request to the Board of Trustees or the Administrative Office, copies of all 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 an updated Summary Plan Description. (A reasonable charge may be made for copies.)
- You should receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide a copy of this summary annual report to each Plan participant.

Prudent Actions by 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. These people, called "fiduciaries" of the Plan, have a duty to operate your Plan 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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules, see Claiming Benefits and Requesting A Disability Premium Waiver starting on page 17) to know why this was done, to obtain copies of the documents relating to the decision without charge, and to appeal any denial.

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 your copies within 30 days, you may file suit in 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court if Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights.

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 (for example, if it finds your claim is frivolous).

Assistance with Your Questions
If you have 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 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 Benefits 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 at 1 (866) 444-3272.

Administrative Information

Name of Plan
The full name of this Plan is The Teamsters Life Insurance Trust Fund.

Type of Plan
This is a welfare plan that provides group life and accidental death and dismemberment insurance to Active Participants and a death benefit to Retired Participants.

Collective Bargaining
This Plan is maintained pursuant to a labor agreement between your employer and a Teamster Union as described in the Eligibility and Benefit Insert. A copy of the labor agreement is available for examination during normal business hours by Plan participants and beneficiaries at the Administrative Office. Copies will be provided to Plan participants and beneficiaries upon written request to the Administrative Office.

Plan Numbers

The Teamsters Life Insurance Trust Fund Employer Identification Number: 23-7316778
Plan Identification Number: 501

Plan Year

The Plan Year starts on February 1 and ends on January 31.

Plan Funding and Source of Contributions

The Plan is funded by monthly contributions from participating employers, paid on behalf of eligible active employees. A list of participating employers is available from the Administrative Office. The amount of the contribution is determined by the Board of Trustees of The Teamsters Life Insurance Trust Fund acting under the authority of collective bargaining agreements. In some cases, as described beginning on page 7, employees may be able to self pay for a period of time when they are not covered by employer contributions. Assets of the Plan are held in trust and benefits are funded through The Teamsters Life Insurance Trust Fund. Eligibility for benefits under the Plan (except in circumstances where you are entitled to extended coverage or coverage through self payment) depends on continued receipt of employer contributions on your behalf. If your employer stops making contributions to The Teamsters Life Insurance Trust Fund, you lose your eligibility for Active Plan benefits. Further, as noted on page 12, you lose your right to retiree plan benefits if your employer (or a successor thereto) stops making Active Plan contributions to the Trust, even if you retired before your employer ceased making contributions. In addition, the Trust's obligation to provide benefits is limited to the extent that the collective bargaining agreements provide for funding of the Trust sufficient to provide benefits.

Active Plan benefits (life insurance and accidental death and dismemberment) are funded through a contract with the Metropolitan Life Insurance Company ("MetLife"). Under this contract, MetLife assumes the risk of payment of claims.

Retiree death benefits are on a year-to-year basis under an "experience-rated" contract with MetLife. The Trust's ability to pay premiums to MetLife to provide these benefits is ultimately dependent on the adequacy of its reserves in relation to the actuarial obligation these benefits represent.

Benefits are payable only to the extent of the insurance coverage described above or assets held by the Trust.

No Guarantee of Continued Benefits

The benefits described in this booklet are not guaranteed and may be modified or eliminated at any time by action of the Board of Trustees. (See amendment under "Future of the Plan" below.) No individual shall have any right to benefits under the Plan or in the assets of the Trust except as and only to the extent expressly provided in the plan documents and the applicable insurance contracts.

Future of the Plan

Amendment

The Plan was established and is maintained through collective bargaining. The Trustees anticipate that the Plan will continue as long as the collective bargaining agreements so provide or until the bargaining parties elect to discontinue the Plan. The Trustees reserve the right, to the extent not explicitly reserved for the bargaining parties, to change or modify the Plan at any time for any reasons without specific approval of any person. Such modifications to the Plan shall be enacted through a formally approved resolution at a regularly constituted Trustees meeting held according to the established process of the Trustees. A change or modification of the Plan shall not affect a claim incurred by a participant before such change or modification is adopted.

Termination

The Plan shall, except as modified below, continue in full force and effect for the duration of the collective bargaining agreements and any amendments, extensions, or renewals thereof by which it is required that a participating employer make payments into the Trust for the purpose hereinbefore set forth. If the Trust Agreement and Plan are not voluntarily extended by the participating employers and the union, the Trust shall be applied and disbursed by the Trustees so as to:

- Pay any and all outstanding debts and obligations of the Plan or Trust.
- Apply any remaining surplus in a manner best able to effectuate the purposes contemplated by the Trust Agreement, and then upon disbursement of the entire Trust, The Teamsters Life Insurance Trust Fund and the Plan shall terminate. However, if prior to the disbursement of the entire Trust, a new collective bargaining agreement is entered into between the participating employers and unions that provides for contributions to a benefit trust, and the Board of Trustees concludes that continuation of the Trust is actuarially sound, the Trust Agreement and Plan shall continue in full force and effect, and there shall be no further action taken toward termination of The Teamsters Life Insurance Trust Fund or the Plan. Thereafter, all disbursements shall be made as provided for by the Trust Agreement and the Plan.

In no event shall Plan termination result in a reversion of assets to any Participating Employer. A termination of the Plan shall be enacted through a formally approved resolution at a regularly constituted Trustees meeting held according to the established process of the Trustees.

Plan and Trust Agreement Control

Benefits of this Plan are subject to and controlled by the provisions of The Teamsters Life Insurance Trust Fund Trust Agreement and this Plan. In the event of any conflict between the provisions of this Plan and the collective bargaining agreement that covers you, the Plan shall prevail.

Administrative Responsibilities

Unless otherwise delegated by the Trustees, the Trustees shall be the named fiduciaries with the absolute discretionary authority to control and manage the operation and administration of the Plan and to interpret or construe all provisions of the Plan, including the discretionary authority to determine eligibility for benefits. These fiduciaries shall be deemed to have properly exercised their authority unless they have abused their discretion hereunder by acting arbitrarily or capriciously. The Trustees shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Trustees may deem appropriate. The rules, interpretations, computations and actions of the Trustees shall be binding and conclusive on all persons. In administering the Plan, the Trustees shall at all times discharge their duties with respect to the Plan according to the standards set forth in section 404(a)(1) of ERISA.

Performance of Duties and Responsibilities

The Trustees may engage such attorneys, actuaries, accountants, consultants, investment managers or other persons to render advice or to perform services with regard to any of its responsibilities under the Plan as it shall determine to be necessary or appropriate. The Trustees may designate by written instrument (signed by both parties) one or more persons or entities as fiduciaries to carry out, where appropriate, fiduciary responsibilities of the Trustees. The Trustees may rely on the actions of an administrative service organization or the written opinion or advice of counsel or any actuary prudently retained by the Trustees.

Recordkeeping and Authorization of Benefit Payments

The Trustees shall cause to be kept full and accurate accounts of receipts and disbursements of the Plan.

Administrative Office

The Administrative Office shall be appointed by the Trustees to administer claims under the Plan. The Trustees shall periodically review the performance and methods of the Administrative Office and may appoint, remove or replace The Teamsters Life Insurance Trust Fund's Administrative Office at any time for any reason.

Payment of Plan Expenses

The expense of administering the Plan, including (1) the fees and expenses of The Teamsters Life Insurance Trust Fund's Administrative Office, (2) the expenses incurred by the Trustees in the performance of duties under the Plan (including reasonable compensation for legal counsel, certified public accountants, actuaries, investment managers, consultants and agents, and the cost of other services rendered with respect to the Plan), and (3) all other proper charges and disbursements by the Trustees (including settlements of claims or legal actions approved by counsel to the Plan) will be paid from the general assets of the Trust. In estimating costs under the Plan, administrative costs may be anticipated.

Administration and Financing of Plan Benefits

This Plan is administered by the Board of Trustees of The Teamsters Life Insurance Trust Fund, which contracts for administrative services for processing claims submitted under the Active and Retiree Plans with:

Health Services & Benefit Administrators (HS&BA)
4160 Dublin Boulevard, Suite 400
Dublin, California 94568-7756

Correspondence may be addressed to:

The Teamsters Life Insurance Trust Fund
4160 Dublin Boulevard, Suite 400
Dublin, California 94568-7756

Appeals of claims filed with and processed by Health Services & Benefits Administrators should be addressed to the Board of Trustees, The Teamsters Life Insurance Trust Fund, care of Health Services &Benefit Administrators.

The Trust provides active life insurance, accidental death and dismemberment benefits under Group Policy No. 109913-1-G and retiree death benefits under Group Policy No. 109913-2-G issued by:

Metropolitan Life Insurance Company
200 Park Avenue,
New York, NY 10166

Life, accidental death and dismemberment, and retiree death insurance benefits are administered by MetLife, which has discretionary authority to interpret and construe the terms of the insurance contract and to resolve ambiguities in the contract. MetLife is the fiduciary regarding these insured benefits and is solely responsible for paying benefit claims. Notwithstanding the foregoing, the Trustees have the discretionary authority to determine who is eligible to participate in the plan.

Board Of Trustees

Union Trustees:
Jerry Hammack
4160 Dublin Blvd., Suite 400
Dublin, CA 94568

Darrell Pratt
4160 Dublin Blvd., Suite 400
Dublin, CA 94568

Employer Trustees:
Richard Muto
4160 Dublin Blvd., Suite 400
Dublin, CA 94568

John Hurley
4160 Dublin Blvd., Suite 400
Dublin, CA 94568

Agent For Service Of Legal Process

The Plan's agent for service of legal process is:

David Haumesser
Health Services & Benefit Administrators
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756
Telephone (925) 833-7300

Legal process may also be served on any Plan Trustee.

Participating Employers

A complete list of currently Participating Employers who sponsor the Plan may be obtained by participants and beneficiaries from the Plan Administrator upon written request to the Administrative Office. The list is also available for examination by participants and beneficiaries at The Teamsters Life Insurance Trust Fund's Administrative Office during normal business hours.