THE TEAMSTERS LIFE INSURANCE TRUST FUND

Summary Plan Description

California Cannery Plan A

Effective July 1, 2006

INTRODUCTION

This document constitutes your Summary Plan Description ("SPD") for California Cannery Plan A 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policies or the Trust Agreement, the terms of the group insurance policies and/or Trust Agreement will control, unless superseded by applicable law.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 Cannery Council/CPI Collective Bargaining Agreement, the Plan shall prevail. 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 on page 7 of this booklet. Further, unless your employer has agreed to be subject to withdrawal liability, 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) 449-7070 and state that you are calling about Teamsters Life Insurance Trust benefits.

BOARD OF TRUSTEES

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SUMMARY OF BENEFITS

	1400 Hour	Non-1400 Hour
Level of benefit:		
Loss of life	$5,000	$1,500
Accidental death and dismemberment (AD&D):		
Accidental death	$5,000	$1,500
Loss of one limb or sight in one eye	$2,500	$750
Loss of two limbs, sight in both eyes or one limb and sight in one eye	$5,000	$1,500
Death when disabled:		
Within the first 12 months of disability	$5,000	$1,000
Thereafter	$1,000	$1,000
Retiree death benefit:		
Last day of active coverage on or before June 30, 1997	$1,000	$1,000
Last day of active coverage on or after July 1, 1997	$2,000	$1,000

Eligibility:	
Active Plan coverage:	
Initial eligibility	30 days of employment
Continuing coverage	Covered during each month you work one day
When life coverage ends	31 days after the last day of the month you last worked one day (the extension period).* There is no employer-paid coverage when you are laid off or on medical leave
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 Teamster pension
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

* AD&D coverage ends on the last day of the month you last worked. There is no extension period.

LIST OF CONTRIBUTING EMPLOYERS

Campbell Soup (Stockton, Dixon)
Con Agra
Del Monte (excluding Hanford)
Escalon Packers
H. J. Heinz
Hormel Foods
Pacific Coast Producers
Seneca Foods Corporation
Silgan Containers (Modesto–Yosemite Avenue location and Kingsburg)
Stanislaus Foods
Unilever

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

When Coverage Begins

You are first covered for life insurance and accidental death and dismemberment (AD&D) benefits on the date you complete 30 days of employment (employment status for 30 calendar days not seniority as such) for a contributing employer in a covered classification of employment. For this purpose, "covered classification of employment" refers to a class of employment established in a collective bargaining agreement which provides for participation in this Plan. If you are not actively at work on the 30th day of employment, the start of coverage is deferred until you return to work.

Example You are hired on June 17th and therefore complete your 30th day in employment status on July 16th. However, you were laid-off from July 14th through July 20th and recalled on the 21st. Even though your 30th day of employment was on July 16th you are not eligible for coverage until July 21st, the date you returned to work.

The 30-day requirement is waived if you previously worked at the plant where you are now re-employed or have previous experience in the Northern California canning industry. If you meet this exception, your eligibility for benefits begins on the first day of the month you work one day in covered employment.

If your 30th day of employment falls on or before the 15th day of the month, your employer is required to make a contribution payment on your behalf for the month. If your 30th day of employment begins after the fifteenth, then even though you are covered, no contribution is required from the employer until the following month.

Classification Change

If your classification of employment changes (for example from Non-1400 Hour to 1400 Hour), your level of coverage changes effective with the first day of the month that coincides with or follows the date your employment classification changed.

How Long Employer-Paid Coverage Continues

After you have established eligibility for coverage, you are covered provided your employer continues to make the required contribution for each month during which you work one day, even if that day falls at the end of the month. (For 1400 Hour employees, vacation and sabbatical leave count as time worked.)

When Employer-Paid Coverage Ends

Employer-paid life insurance coverage ends 31 days after the last day of the month in which you last worked one day (the "extension period"). Employer-paid benefits do NOT continue because you have been laid-off or are on medical leave.

Example You worked at least one day in both January and February and no days in March. You are covered in January and February because you worked one day during each of these months. You are also covered by life insurance during March because of the 31-day "extension period." You are not covered in April.

Unlike your life insurance coverage, your AD&D coverage ends on the last day of the month in which you work one day. In the above example, your AD&D coverage would end February 28th.

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. (Non-1400 Hour employees may prepay for off-season coverage through payroll deductions while working during the season.) As explained on page 12, one of the requirements for the retiree death benefit is 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 qualify 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 ends and must be continuous. If you skip a month you cannot resume self-pay coverage without returning to covered employment and working at least one day. *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, 2006, the premium is $.85 per $1000 of coverage or:

Employee Classification	Monthly Premium	Benefit Level
1400 Hour	$4.25	$5,000
Non-1400 Hour	$1.275	$1,500

Based on these rates, a Non-1400 Hour employee who wants to purchase ten months of off-season coverage will ask to have $12.75 withheld while working.

Example You work at least one day in January and February. You are laid-off in March but wish to continue your coverage by making self-payments. Your first self-payment is due on March 1st and must be made by March 30th to avoid being late. This self-payment covers you for the month of March.

As in the example above, if you do not pay by March 30th, your AD&D coverage will end on February 28th and, because of the 31-day "extension period," your life coverage will end on March 31st.

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 9.)

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 Continued Your lay-off continues through April and May. You self pay for April but make no payment in May. Your AD&D coverage will end on April 30th. Because of the 31-day "extension period," your life coverage will not end until May 31st. Because no payment was made for May, you cannot self pay for June or any subsequent month. Coverage will begin again on the first day of the month in which you return and work at least one day.

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 11—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 to 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 12.

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

Benefits

Benefits are paid in accordance with the following schedules:

	Benefit Paid	
	1400 Hour	Non-1400 Hour
Type of Loss		
Life insurance—loss of life	$5,000	$1,500
Accidental death and dismemberment:		
Accidental death (in addition to life insurance benefit)	$5,000	$1,500
Loss of hand (permanently severed above wrist and below elbow)	$2,500	$750
Loss of foot (permanently severed above ankle and below knee)	$2,500	$750
Loss of sight in one eye (permanent uncorrectable acuity of 20/200 or worse or a field of vision of less than 20 degrees)	$2,500	$750
Loss of any combination of hand, foot or sight in one eye	$5,000	$1,500
Loss of sight in both eyes	$5,000	$1,500
Disability:		
Within the first 12 months of disability	$5,000	$1,000
Thereafter	$1,000	$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 Teamster 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 Teamster 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. (This exclusion does not apply to certain employers who have agreed to be subject to the withdrawal liability provisions of the Trust. A list of such employers is available from the Administrative Office.)

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 Employees Plan without a break (with your last day of continuous coverage ending within your grace period as described above). While you are a 1400 Hour employee, you will have a break in your continuous coverage if you have fewer than nine calendar months of life insurance under the Active Plan in any twelve-month period. While you are a Non-1400 Hour employee, you will have a break in your continuous coverage if you go one or more calendar months without having life insurance coverage under the Active Employee Plan.

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 7) 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 a Non-1400 Hour employee who is seasonally laid-off, you can prevent a break in coverage by self paying the required premiums. The easiest way to do this is to have the cost of off-season life coverage withheld during the work season. Contact your employer to make arrangements.

If you are a 1400 Hour employee you also need to be careful about breaks in coverage. There is no lay-off protection for life insurance. If 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 Teamster 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 Teamster Pension on the effective date of your pension, even if actual payment is delayed due to processing.

A "Teamster Pension" is any pension plan maintained under a collective bargaining agreement with a local union or council affiliated with the International Brotherhood of Teamsters.

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 Teamster 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 Teamster 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 Teamster 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 Teamster 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 Teamster 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 To 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 to Individual Policy" on page 9 for conditions and deadlines.

Benefits

Benefits are paid in accordance with the following schedule:

Retirement Date	Death Benefit 1400 Hour	Death Benefit Non-1400 Hour
Last day of Active Plan coverage on or after July 1, 1997	$2,000	$1,000
Last day of Active Plan coverage on or before June 30, 1997	$1,000	$1,000

If, after the effective date of your Teamster 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). For example, if you are a retired 1400 Hour employee eligible for the $2,000 benefit who returns to seasonal employment, your life insurance benefit will be $2,000, not $1,500, the Active Plan benefit while working as a seasonal Non-1400 Hour employee. 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 thereunder, 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 the California Processors, Inc./Teamsters California State Council of Cannery and Food Processing Unions ("Cannery Council/CPI Collective Bargaining Agreement") and other collective bargaining agreements, copies of which are 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 11, unless your employer agreed to the Trust's withdrawal liability provisions, 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" on page 27.) 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 Cannery Council/CPI Collective Bargaining Agreement, 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 (HSBA)
160 Airway Boulevard
Livermore, California 94551

Correspondence may be addressed to:

The Teamsters Life Insurance Trust Fund
160 Airway Boulevard
Livermore, California 94551

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
160 Airway Blvd
Livermore, CA 94551

Jim Hammack
160 Airway Blvd
Livermore, CA 94551

Employer Trustees:
Richard Muto
Vice President, Personnel
Del Monte U.S.A.
Steuart Street Tower, 6th Floor
San Francisco, CA 94105

John Hurley
President
California Processors, Inc.
Harvey Milk Plaza
425 Military East, Suite J
Benicia, CA 94510

Agent For Service Of Legal Process

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

David Haumesser
Health Services Benefit Administrators
160 Airway Boulevard
Livermore, CA 94551
Telephone (925) 449-7070

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.