Teamsters Managed

Health Care Trust Fund

Summary Plan Description

February 2022

INTRODUCTION

This *Guide to Your Benefits* explains the benefits provided through the Teamsters Managed Health Care Trust Fund. The booklet, along with the enclosed *Evidence of Coverage*, is technically known as a Summary Plan Description. Together, these materials provide an overview in simple language of the most important provisions and the most common situations associated with your benefits.

You'll be sent written updates from time to time as changes are made. Please read these announcements and keep them with your other Plan materials. You are welcome to read the official documents that govern your Plan by contacting the Plan Administrative Office.

Information about Plan Administration and your legal rights under the Employee Retirement Income Security Act (ERISA) may be found at the end of this guide.

Refer to your *Evidence of Coverage* for other details you need to know (such as your Plan name and amounts of copayments and maximums). If you have questions, contact the Plan Administrative Office at the numbers shown. When calling, you'll be asked for the name of your Plan (printed on the cover of the enclosed *Evidence of Coverage)* and your Social Security number.

The *Evidence of Coverage* is the binding document between the Health Plan and its members.

A Health Plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed and authorized, or directed by a Health Plan physician. You must receive the services and supplies at a Health Plan facility inside the Service Area, except where specifically noted to the contrary in the *Evidence of Coverage*.

Questions?

If you have questions about the Plan or eligibility for benefits, contact:

Teamsters Managed Trust Health Care Trust Fund
Plan Administrative Office

Mailing Address

P.O. Box 757, Pleasanton, CA 94566

Office Address

1181 Quarry Lane, Suite 400, Pleasanton, CA 94566

Customer Service Telephone Hours

9:00 a.m. to 4:30 p.m., Monday – Friday (except holidays)
(925) 426-3555 or (800) 924-1226

Office Hours
9:00 a.m. to 4:30 p.m., Monday – Friday (except holidays)

Fax Number

(925) 426-3565 or (877) 738-3815

To Participating Employees:

Your Local Union and your Employer have worked together to provide you with a comprehensive health plan under the Teamsters Managed Health Care Trust Fund.

The Plan is established as a result of collective bargaining and is financed primarily by Employer contributions to the Trust Fund. The Plan is administered by the Board of Trustees of the Teamsters Managed Health Care Trust Fund. The Board consists of an equal number of Employer and Union appointed Trustees. The Trust offers Medical, Prescription, Vision, Dental, Orthodontic, Chiropractic, Life, and Accidental Death and Dismemberment benefits. Your specific benefit package is based on what your Employer and Union have collectively bargained. If you have medical coverage, you have a choice of two benefit classifications, Class I or Class II. You may choose for the Plan to cover Medical, Prescription, and Vision (Life and Dental benefits provided if applicable) for you and your dependents (Class I) or, for the Plan to cover only Life and Dental benefits (if applicable) for you and your eligible dependents (Class II). By selecting Class II you will also participate in the Teamsters Managed Annuity Plan (Note: You can only choose Class II if you meet the qualifying guidelines).

ONLY THE PLAN ADMINISTRATIVE OFFICE, DMC INSURANCE ADMINISTRATORS, INC., REPRESENTS THE BOARD OF TRUSTEES IN ADMINISTERING THE PLAN AND PROVIDING INFORMATION ABOUT THE AMOUNT OF BENEFITS, ELIGIBILITY AND OTHER PROVISIONS OF THE PLAN. NO UNION EMPLOYEE, INCLUDING UNION OFFICERS AND BUSINESS AGENTS, NO EMPLOYER OR REPRESENTATIVE OF ANY OTHER ORGANIZATION EXCEPT THE PLAN ADMINISTRATIVE OFFICE IS AUTHORIZED TO GIVE INFORMATION, INTERPRET THE PLAN, OR COMMIT THE BOARD OF TRUSTEES ON ANY MATTER. AS A CONVENIENCE TO YOU, THE PLAN ADMINISTRATIVE OFFICE WILL 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 TERMS OF THE PLAN GOVERN.

From time to time, the Board of Trustees may be required to make changes in the benefit provisions of the Plan. You will receive a written notice of any change. Please keep this booklet and any notices of changes in a safe place.

Your dependents are to be designated on the Enrollment Application included in your information packet. (Applications can also be obtained from the Plan Administrative Office.) Only persons described in the "Eligible Dependents" section of this summary may be covered as dependents. This should be completed and returned to the Plan Administrative Office immediately. If you need to add additional dependents or wish to change your life insurance beneficiary, a new application must be submitted. **THE TRUST FUND REQUIRES THAT EACH COVERED EMPLOYEE HAVE A CURRENT ENROLLMENT APPLICATION ON FILE BEFORE ELIGIBILITY CAN BE PROCESSED. If you do not have an Enrollment Application on file or if a claim is submitted for a dependent not listed on the application, your claim may not be covered.**

The Trust Fund provides benefits through insurance policies. Medical, Prescription, Vision, Dental, Orthodontic, Life, Accidental Death and Dismemberment benefits are all insured.

This Summary Plan Description is intended to cover all plans. Please refer to your collective bargaining agreement for your specific benefit plan.

Important Notice Regarding Eligibility: Your eligibility for benefits under the Plan depends on the continued receipt of Employer contributions on your behalf. If your Employer stops making contributions to the Plan, your eligibility for benefits will end in accordance with Trust Fund rules. (See Employee Eligibility Rules on page 2).

If you have questions about your Plan, please contact the Plan Administrative Office at (925) 426-3555 or (800) 924-1226.

Sincerely,

The Board of Trustees

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PLAN ADMINISTRATOR

The Plan is administered by the Teamsters Managed Health Care Trust Fund Board of Trustees which contracts with DMC Insurance Administrators, Inc. for administrative services. If you need further information or assistance, contact the Plan Administrative Office:

Teamsters Managed Health Care Trust Fund
P.O. Box 757
Pleasanton, CA 94566
Phone: (925) 426-3555 or (800) 924-1226

ELIGIBILITY VERIFICATION

ONLY THE PLAN ADMINISTRATIVE OFFICE CAN VERIFY ELIGIBILITY. A statement of eligibility furnished by a Local Union, Employer or other source will not be honored if in error. **FOR ELIGIBILITY VERIFICATION PHONE (925) 426-3555 or (800) 924-1226.**

DEFINITIONS

PLEASE NOTE: Words or groups of words in bold lettering enclosed by quotation marks are defined under DEFINITIONS on page 11.

GENDER

The terms "he" or "his" as used in this booklet are also understood to mean "she" or "hers".

SCHEDULE OF BENEFITS FOR ACTIVES AND DEPENDENTS

Attached is a brief summary of plan benefits in accordance to your collective bargaining agreement. Please refer to the health care providers' Evidence of Coverage for detailed benefit information.

ENROLLMENT

GENERAL INFORMATION

1. Each covered **"employee"** must have a current Enrollment Application on file. If you have not filled out and returned an Enrollment Application to the Plan Administrative Office, you cannot receive any benefits. In addition, you must also have completed the applications for the specific providers you have chosen.

2. A Self-Directed Enrollment is available to plan participants. This allows you the option to change your medical and or dental providers at any time during the year in accordance with certain guidelines. They are as follows:

   - Plan participants can change medical providers one time within a twelve (12) month period.

   - Plan participants can change dental providers one time within a twelve (12) month period.

   - Plan participants can change benefit classifications one time within a twelve (12) month period. Those who select the Class II benefit option and later lose alternative coverage will revert back to the Class I benefit option so that there is no gap in coverage.

3. Complete the Enrollment Application and return it to the Plan Administrative Office. You must also report any changes in your address or dependents to the Plan Administrative Office. An Enrollment Application is included in your information packet, additional Enrollment Applications can be obtained from the Plan Administrative Office or your Local Union.

4. **The importance of having your current address on file cannot be overstated! It is the only way the Board of Trustees can keep you informed of any changes affecting your benefits.**

EMPLOYEE ELIGIBILITY RULES

INITIAL ELIGIBILITY

Only **"employees"** of a **"participating employer"** are eligible for coverage under the Plan. You become eligible for coverage under the Plan on the following date:

1. If you are an **"employee"** of a **"participating employer"** on the date your employer begins participation in the Teamsters Managed Health Care Trust Fund, you will become eligible for benefits on the first day of the month immediately following a month in which you work the hours required under the **"Collective Bargaining Agreement"** and your Employer makes the required contribution to the Trust Fund on your behalf.

Example: *Your Employer begins participation in the Teamsters Managed Health Care Trust Fund in January and, pursuant to the* ***"Collective Bargaining Agreement",*** *is required to contribute for any* ***"employee"*** *who worked 80 hours in the preceding month. If you worked 80 hours or more in December and your Employer makes the required contribution on your behalf for January coverage, your coverage begins January 1.*

2. If you are hired after your Employer has begun participation in the Trust Fund, you will become eligible for benefits on the first day of the month following the third month in any six consecutive months during which you work the hours required under the Collective Bargaining Agreement and your Employer makes the required contributions to the Trust Fund on your behalf.

   Example: *Your employer begins participation in the Trust Fund in January and you are hired in April. You work the hours required under your Collective Bargaining Agreement and your Employer makes the required contributions on your behalf for April, May and June work hours, your coverage begins July 1.*

Exceptions

If you have been eligible for benefits under another Teamsters Taft Hartley Health and Welfare Trust Fund within the last twelve (12) months, you will become eligible for benefits on the first day of the month immediately following a month in which you work the hours required under the "Collective Bargaining Agreement" and your employer makes the required contribution to the Trust Fund on your behalf.

CONTINUATION OF ELIGIBILITY FOR ACTIVE EMPLOYEES

Once you have established initial eligibility, you will remain eligible for benefits provided that you work the required hours and your Employer makes the required contributions to the Trust Fund on your behalf. Eligibility for benefits in any month is contingent upon receipt of the required contributions.

CONTINUATION OF COVERAGE FOR EMPLOYEES WHO ARE TOTALLY DISABLED

1. **If you are unable to work because you become totally disabled, the Plan will continue your coverage for up to three (3) months without self-payment.** In addition, your **"Collective Bargaining Agreement"** may require your Employer to make contributions on your behalf for an additional period.

2. If you remain totally disabled following the three (3) month extension described in paragraph 1 above or if you have left active employment due to temporary layoff or approved leave of absence, you may extend coverage by self-payment for **"COBRA"** continuation coverage. **"COBRA"** coverage does not include life insurance or disability benefits and is not available to participants entitled to **"Medicare"**. See page 6 for more information regarding **"COBRA"**.

3. The Plan's disability policy is not applicable to you while you are eligible for, and/or receiving, leave under the Family and Medical Leave Act (FMLA). However, if you remain totally disabled at the conclusion of your FMLA leave, the Plan will continue coverage for up to three (3) months in accordance with the Plan's disability waiver policy.

4. If you experience a second disabling condition during a period of extended eligibility, you will not be entitled to a further extension beyond the period described in paragraph 2.

5. **Proof of disability is required for extension of coverage due to disability. Contact the Plan Administrative Office for a *Proof of Disability Claim Form.***

6. See page 6 for COBRA rights.

TERMINATION OF ELIGIBILITY

Your eligibility for benefits will automatically terminate on the earliest of the following dates:

1. The Date on which you enter full-time military service; or

2. The first day of a month in which your Employer fails to make the required contribution to the Trust Fund on your behalf; or

3. The date the Plan terminates.

REINSTATEMENT OF ELIGIBILITY

If you become covered under the Plan, lose eligibility and then return to work for a **"participating employer"** your eligibility date will be the first day of the month immediately following a month in which you work the hours required under the **"Collective Bargaining Agreement"** and your Employer makes the required contribution to the Trust Fund on your behalf.

DEPENDENT ELIGIBILITY RULES

ELIGIBLE DEPENDENTS ARE:

1. Your lawful spouse.

2. Your children (including stepchildren, legally adopted children, and children for whom you or your spouse is the court appointed guardian) less than 26 years of age.

3. Your children age 26 or older, residing with and dependent upon you for support, which are incapable of self-support because of mental or physical disability that existed prior to reaching age 26.

4. Special Note Pertaining to Domestic Partners: The Plan does not offer domestic partner coverage. However, those plan participants who provided the Trust Fund Office a signed, notarized Declaration of Domestic Partnership and received coverage prior to January 1, 2016 will be "grandfathered" and allowed to continue the domestic partner's participation in the Plan.

EXCEPTIONS

1. The term dependent will not include any person who is in full-time service of the Armed Forces, who lives outside the Continental United States or who is eligible as an **"employee"**.

2. Foster children and children for whom you are not the legal guardian may not be eligible as dependents.

3. If both parents are eligible under the Plan as employees, a child may be included as a dependent of both.

INITIAL DEPENDENT ELIGIBILITY

Individual providers have their own rules on when a dependent first becomes eligible. See provider plan summaries for initial dependent eligibility rules.

QUALIFYING EVIDENCE IS REQUIRED

Each provider has their own requirements as to what proof is needed to show an adult child's incapacity or enrollment in an accredited school. You should check with the Plan Administrative Office to determine the specific requirements of your providers.

ENROLLING NEWLY ACQUIRED DEPENDENTS

To enroll newly acquired dependents including a newborn, contact the Plan Administrative Office, complete a new Enrollment Application within thirty-one (31) days and supply evidence of dependent status as may be required. You must also complete any applications or forms your providers require to enroll a new dependent.

TERMINATION OF DEPENDENT ELIGIBILITY

Dependents cease to be eligible on:

1. The day that eligibility for the **"employee"** ceases, or

2. The date the dependent ceases to be eligible as a dependent as set forth under definition of dependent.

   For Example: Your child ordinarily will lose eligibility at age 19 unless he is a full-time student.

3. **See page 7 for COBRA continuation rights.**

REMEMBER IT IS YOUR RESPONSIBILITY TO NOTIFY THE PLAN ADMINISTRATIVE OFFICE WHEN A CHANGE OCCURES IN YOUR FAMILY WHICH AFFECTS THE ELIGIBILITY OF YOUR DEPENDENTS.

CONTINUED HEALTH PLAN COVERAGE
STATEMENT OF "COBRA" SELF-PAY RIGHTS

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason; or
- You become divorced.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason;
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after your loss of coverage due to the qualifying event. You must provide this notice to**:**

Teamsters Managed Health Care Trust Fund
c/o DMC Insurance Administrators, Inc.
1181 Quarry Lane, Suite 400
P.O. Box 757
Pleasanton, CA 94566

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.
There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To get this extension you must send a copy of the Social Security Award within 60 days from the latest of (1) the date of the Social Security Disability Award, (2) the date that the qualified beneficiary loses coverage, or (3) the date on which the qualified beneficiary is informed of the obligation to provide the disability award, but in no event later than the expiration of the first 18 months of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

TERMINATION OF COBRA CONTINUATION COVERAGE

Coverage under COBRA Self-Payment through this Plan will terminate earlier than the stated maximum period under any one of the following circumstances:

- failure to make the monthly payment on time;
- the date you or your dependent(s) become covered under another group health plan (unless the other plan excludes or limits coverage for a pre-existing condition affecting you or your dependent, and such exclusion or limitation is enforceable under the Health Insurance Portability and Accountability Act);
- the date you or your dependent become entitled to Medicare;
- the date the Plan is terminated; however, if the Plan is replaced, coverage may be continued under the new Plan;
- the date your employer ceases to maintain any group health plan; and
- the date your employer withdraws as a participating employer from the Teamsters Managed Health Care Trust Fund.

IF YOU HAVE ANY QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

The group health plan's official name and address are:

Teamsters Managed Health Care Trust Fund
c/o DMC Insurance Administrators, Inc.
1181 Quarry Lane, Suite 400
P.O. Box 757
Pleasanton, CA 94566

The Plan's contact person at the foregoing address is:

Name : Mario Guerrero, Fund Manager
Phone : (925) 426-3555
Fax: (925) 426-3565

SUBJECT TO REVISION

COBRA requirements are subject to change according to federal law. Please direct any COBRA eligibility questions to the Plan Administrative Office.

EXTENSION OF MEDICAL BENEFITS DURING "TOTAL DISABILITY"

1. If an eligible individual becomes totally disabled, the Plan will continue coverage for up to three (3) months in any twelve (12) month period, for all disabilities combined, without self-payment. In addition, your "Collective Bargaining Agreement" may stipulate additional extension of coverage or may require your Employer to make contributions on your behalf for an additional period.

2. If you remain totally disabled following the three (3) month extension described in paragraph 1 above you may extend coverage by self -payment for "COBRA" continuation coverage. COBRA coverage does not include life insurance or disability and is not available to participants entitled to "Medicare". See page 6 for more information regarding COBRA.

EXTENDED COVERAGE UNDER
THE FAMILY AND MEDICAL LEAVE ACT

Your employer must continue to pay for your health coverage during any approved leave under the federal Family and Medical Leave Act (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1. Your employer has at least 50 employees;

2. You worked for the employer for at least 12 months and for a total of at least 1250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

   (a) birth or placement of a child for adoption or foster care

   (b) to care for your child, spouse or parent with a serious medical condition, or

   (c) your own serious health condition. Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the health plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self payments. If the dispute is resolved in your favor, the health plan will obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

If your employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the Health Plan for your coverage during the leave.

CERTIFICATE OF COVERAGE

The certificate of former group health plan coverage provides evidence of your health coverage under the Teamsters Managed Health Care Trust Fund. If you become covered under a new group health plan that has a waiting period for coverage, excludes coverage for certain medical conditions, or has a pre-existing condition clause, you may need to furnish the certificate to the new plan administrator.

You may also need to provide this certificate if you are buying insurance for yourself or your family, which excludes coverage for certain medical conditions, or has a pre-existing condition clause.

If you or your dependents lose coverage under the Teamsters Managed Health Care Trust Fund, you will be provided with a certificate of former group health plan coverage. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may request a certificate within 24 months after losing coverage.

MATERNITY NOTICE

Health Plans and health insurance issuers offering group health coverage generally may not restrict benefits for any hospital length stay in connection with childbirth for the mother or newborn to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Reconstructive breast surgery expenses incurred by a covered person as the result of a mastectomy on one or both breasts, and in a manner determined in consultation between the attending physician and the patient, are covered as shown below. Any exclusion of benefits for cosmetic surgery does not apply to this benefit. This coverage is subject to the deductibles and/or co-payments which apply to your other medical coverage.

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery on and reconstruction of the non-diseased breast to produce symmetry between the breasts.
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of a mastectomy.

COORDINATION OF BENEFITS

If you or your eligible dependents are also covered by another group plan, the benefits payable by your provider under this Plan may be reduced. Check with the Plan Administrative Office for your provider's Coordination of Benefit rules.

RIGHT OF RECOVERY

1. Whenever payments have been made by your provider under this Plan with respect to "covered expenses" in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the provider shall have the right to recover such payments, to the extent of such excess, from among one or more of the following; any persons to or for whom such payments were made, any insurance companies or any other organizations. Failure to invoke this provision for any claims shall not waive the providers' right to invoke it for subsequent claims.
2. Your provider under this Plan may pay benefits for care or services, pending a determination of whether or not such care or services are covered, without waiving any Plan exclusions. In the event it is determined that such care or services are not covered, the provider under this Plan shall be entitled to recoup and recover the amount paid from the employee or the entity that provided services. You and your eligible dependents must execute and deliver to the Plan, all assignments and other documents necessary or useful to the Plan or provider for the purpose of enforcing its rights under this provision.

RIGHT OF RECOVERY AGAINST THIRD PARTIES

Your provider may be entitled to reimbursement from any recovery of proceeds for damages from any source up to the amount of payments made by the provider on account of any expenses related to, or arising out of any injury, illness, disease or other physical or psychiatric condition, and or resulting death for which a third party is or may be legally responsible. Check with the Plan Administrative Office for your provider's right of recovery rules.

DEFINITIONS

1. **ACTIVE WORK** means: The **"employee"** is performing all the regular duties of his employment.

2. **COLLECTIVE BARGAINING AGREEMENT** means: A labor agreement between an Employer and a Local Union providing for contributions to the Plan which has been approved by the Teamsters Managed Health Care Trust Fund Board of Trustees.

3. **DISABILITY:** See Total Disability.

4. **DURING ANY DISABILITY:**

   a. **FOR YOU,** the term means all periods of disability arising from the same cause except that if you completely recover or return to active employment, any subsequent period of disability from the same cause will be considered a new disability.

   b. **FOR YOUR DEPENDENT** the term means all periods of disability arising from the same cause; except in case of recovery for a period of six (6) months during which he is capable of resuming the normal activities of a person in good health and of the same age and sex, any subsequent period of disability from the same cause will be considered a new disability.

5. **EMPLOYEE** means: The common law employees of a participating employer.

6. **MEDI-CAL** means: The Medical Care for Public Assistance Recipients program under California Welfare and Institutions Code Sec. 14000 et. seq., as amended.

7. **MEDICARE** means: The Health Insurance for the Aged program under Title XVIII of the Social Security Act, as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), as amended.

8. **PARTICIPATING EMPLOYER** means: Any Employer or successor in interest to such Employer who is party to a **"Collective Bargaining Agreement"** requiring contributions to the Trust Fund.

9. **TOTAL DISABILITY** means: that you are unable because of illness or injury to carry on the regular and customary activities of a person in good health of the same age and sex and are not, in fact, engaged in any employment or occupation whatsoever for compensation, gain or profit. Disabilities resulting from purposefully self-inflicted injuries, participation in the commission of a felony and injuries or illness due to service in the Armed Forces and for which the **"employee"** received a military pension are excluded.

APPEALS PROCEDURE WHEN CLAIMS ARE DENIED

All initial appeals to denied claims must first go through the appeals procedures as set forth by the provider that denied the claim. If after exhausting the provider's appeals procedures without satisfaction a participant may then follow the following procedures to appeal the denied claim to the Board of Trustees.

1. **Application for Review may be made by you or your authorized representative by filing a written application for review within 60 days after you receive the written notification of the denial from your provider.** Your written application for review should be addressed to the Board of Trustees. The Board of Trustees may consider a late application if it concludes the delay in filing was for a reasonable cause. As part of the review procedure, you or your authorized representative may review pertinent documents and submit issues and comments in writing, but have no right to appear personally before the reviewing group, unless the Board of Trustees concludes that such an appearance would be of value in enabling it to review and decide on your claim.

2. The Board of Trustees will promptly review your claim and appeal. You will be advised of the Board's decision within 90 days after the receipt of your written appeal or within 180 days if there are special circumstances requiring delay. If no decision is reached within the applicable time period the appeal is deemed denied.

3. **The decision of the Board of Trustees, with respect to any appeal, shall be final and binding on all persons, subject only to any civil action you may bring under §502(a) of ERISA. A civil action arising from the denial of benefits must be filed within one year from the date on which the Board of Trustees provides notice that your appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.**

4. By participating in the Fund, to the fullest extent permitted by law, you waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy, and you agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

5. Neither your claim nor any rights, interests, or obligations under the Fund shall be assigned, in whole or in part, by operation of law or otherwise, to any third parties. Any such purported assignment shall be void.

INFORMATION REQUIRED BY ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. That information, as not otherwise included in this Booklet, is as follows:

NAME OF THE PLAN:

The full name of the Plan is Teamsters Managed Health Care Trust Fund.

PLAN ADMINISTRATION:

The Plan is administered by the Board of Trustees of the Teamsters Managed Health Care Trust Fund which consists of equal numbers of Employer Trustees and Union Trustees. The Board of Trustees contract for administration services with:

DMC Insurance Administrators, Inc.
P.O. Box 757
Pleasanton, CA 94566
Phone (925) 426-3555 or (800) 924-1226

NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR SERVICE OF LEGAL PROCESS:

DMC Insurance Administrators, Inc. has been designated as agent for purposes of accepting legal process on behalf of the Plan. Legal process may also be served on any member of the Board of Trustees.

BENEFITS:

All of the types of benefits provided by the Plan are through insurance policies or service agreements. The complete terms of the benefits provided are set forth in the group insurance policies or service agreement with the following organizations:

Delta Dental
100 First Street
San Francisco, CA 94105
(415) 972-8300
Provides prepaid dental benefits, with guaranteed payment of these benefits.

Liberty Dental Plan
340 Commerce, Suite 100
Irvine, CA 92602
(888) 703-6999
Provides prepaid dental benefits, with guaranteed payment of these benefits.

UnitedHealthcare Dental
5701 Katella Ave
Cypress, CA 90630
(877) 816-3596
Provides prepaid dental benefits, with guaranteed payment of these benefits.

Prudential Life Insurance Co. of America
2049 Century Park East, Suite 2300
Los Angeles, CA 90067
(310) 284-3871
Fully insures life and accidental death and dismemberment benefits for eligible participants.

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195
(510) 562-3600
Provides prepaid vision benefits, with guaranteed payment of these benefits.

Kaiser Permanente
Northern California Region
1800 Harrison Street
Oakland, CA 94612
(800) 731-4661
Provides prepaid medical benefits, with guaranteed payment of these benefits.

UnitedHealthcare
5701 Katella Ave
Cypress, CA 90630
(800) 999-3367
Provides prepaid medical benefits, with guaranteed payment of these benefits.

Teamsters' Assistance Program (TAP)
80 Swan Way, Suite 420
Oakland, CA 94621
(510) 562-3600
Provides assessment and referral services for drug and alcohol treatment.

PhysMetrics
1080 West Shaw Avenue
Suite 105
Fresno, CA 93711
(877) 519-8839
Provides access to chiropractic and acupuncture physicians.

NAMES AND ADDRESSES OF TRUSTEES :

Labor Trustees

Efren Alarcon
Teamsters Local 853
7750 Pardee Lane
Oakland, CA 94621

Don E. Garcia
Teamsters Local 315
2727 Alhambra Avenue
Martinez, CA 94553

Stacy Murphy
Teamsters Local 853
7750 Pardee Lane
Oakland, CA 94621

Management Trustees

Jim Beard
Beard Affiliates, LLC
5 Thomas Mellon Circle, Suite 111
San Francisco, CA 94134

Bruce Heid
I.E.D.A.
1181 Quarry Lane, Suite 400
Pleasanton, CA 94566

TYPE OF PLAN

The Teamsters Managed Health Care Trust Fund is a collectively bargained, jointly trusteed welfare plan that provides hospital, medical, prescription drug, dental, orthodontic and vision for eligible employees and dependents and life insurance, disability and accidental death and dismemberment benefits for eligible employees.

PLAN FUNDING

The Plan is funded by monthly contributions from participating Employers paid on behalf of eligible employees and their eligible dependents. A list of participating Employers is available from the Plan Administrative Office. The amount of contributions is determined by the Board of Trustees under the authority of provisions contained in the Collective Bargaining Agreements and Trust Fund Agreement. In some cases, employees may be able to self-pay for a period of time when they are not covered by Employer contributions (See COBRA Self-pay Rights). Assets of the Plan are held in Trust Fund and benefits are funded through insurance companies

FUTURE OF THE PLAN

1. The Teamsters Managed Health Care Trust Fund is established and maintained through collective bargaining. The Board of Trustees anticipates that the Plan will continue as long as Collective Bargaining Agreements so provide or until the bargaining parties elect to discontinue the Plan or the Trust Fund. The Board of Trustees reserves the right, to the extent not explicitly reserved by the Bargaining parties, to change or modify the Plan at any time for any reason without the specific approval of any person. Any change or modification of the Plan will not affect a claim incurred by a participant or covered dependent before the effective date of such change or modification.

2. If the Trust Fund or Plan are terminated, the remaining assets will be used to continue to provide benefits under the Plan until there are no assets remaining or will be used in a manner consistent with the purpose of the Plan. In no event will termination of the Trust Fund or Plan result in a reversion of assets to any Employer.

DISCRETIONARY AUTHORITY OF BOARD OF TRUSTEES:

The Board of Trustees reserves the right to make any determination of fact necessary or proper to the Administration of this Trust Fund. Further, the Trustees shall have the power to construe and interpret the provisions of the Trust Agreement and Plan of Benefits relating to eligibility of employees or retired employees, their dependents and beneficiaries to receive benefits. Such determinations shall be final and binding upon all parties, including employees, retired employees, their dependents and beneficiaries.

PARTICIPATING EMPLOYERS:

A list of participating Employers may be obtained from the Plan Administrative Office.

EMPLOYER IDENTIFICATION NUMBER:

94-3138275

PLAN IDENTIFICATION NUMBER:

501

PLAN YEAR:

The plan year ends each December 31.

EFFECTIVE DATE OF THE PLAN:

The Plan became effective May 21, 1991.

YOUR LEGAL RIGHTS AND ADMINISTRATION INFORMATION ABOUT THE PLAN

STATEMENT OF ERISA RIGHTS

Rights of Participants and Beneficiaries

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrative Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and 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 Pension and Welfare Benefit Administration.

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

Receive a summary of the plan's annual financial report. The Plan Administrative Office is required by law to furnish each Participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrative Office and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

COMPLIANCE WITH HIPAA PRIVACY REGULATIONS

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Department of Health and Human Services has adopted regulations for group health plans to treat health information of participants and beneficiaries as protected information.

Information regarding a person's past, present or future physical or mental health, the provision of health care to that person, or past present or future payment for that person's health care, known as "Protected Health Information" (PHI), can be disclosed only to certain individuals for specific purposes.

The Plan Sponsor for the Teamster Managed Health Care Trust Fund is the Board of Trustees of the Plan. The Board of Trustees consists of an equal number of Union and Management Trustees whose Unions, Companies and Associations are party to collective bargaining agreements that provide for participation in the Plan. The Plan Sponsors have final authority over Plan Administration and operations, and in order to meet their obligations in this regard, must have access to PHI.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration and Operations

The circumstances and purposes for which the Plan Sponsor may have access to PHI regarding you or your covered dependents are as follows:

1. Deciding appeals of benefit denials and eligibility; establishing contribution rates; making determinations regarding benefits, including whether or not to offer certain benefits and making plan design decisions; monitoring services provided by, and contracting with, HMOs, insurers, provider networks, and providers themselves (i.e., doctors and hospitals).

2. Dealing with subrogation and reimbursement claims involving third parties and participants; addressing coordination of benefit issues with other plans; purchasing stop-loss insurance and/or insurance to cover any of the benefits offered by the Plan.

3. Making decisions regarding the interpretation of plan documents as they relate to specific benefit claims, including decisions regarding medical necessity, disease management, standards of practice, and experimental treatments.

4. Providing for the collection of contributions from participating employers, including the auditing of such employers and the subsequent review of compliance audits to determine which employees and dependents an employer has contributed for and if there are any for whom contributions are delinquent.

5. Addressing issues and appeals involving participants' legal rights, such as COBRA continuation coverage, HIPAA special enrollment periods, and HIPAA certificates of creditable coverage.

Disclosure of PHI to Plan Consultants

The Board of Trustees acting as Plan Sponsor, undertake their responsibilities to the Plan on a voluntary basis. They are not employed by the Plan, nor does Plan or the trust fund have any employees. The Trustees and the Plan therefore utilize outside consultants to assist in all aspects of plan Administration and operations, which requires the Plan to disclose PHI to them.

The consultants retained by the Plan include attorneys, benefit consultants, accountants, auditors, and the third party administrator that administers the plan. Any or all of them may require access to PHI in order to advise and assist the Trustees. For example, the third party administrator for the Plan, which processes all claims and verifies eligibility, will have access to PHI in carrying out these administrative functions. The auditor for the Plan determines if contributions have been correctly paid for all covered employees, and if ineligible persons were covered, whether claims were paid for them based on improper employer contributions.

Certifications, Restrictions and Limitations on the Use of PHI

The Plan, and the Plan Sponsor, hereby certify that they will:

a) Disclose PHI to the Plan Sponsor and its consultants only as set forth above and only the minimum amount necessary to enable them to fulfill their obligations to the Plan and its participants.

b) Report to the Plan any unauthorized disclosure of PHI or any use of PHI that is contrary to the purposes set forth herein. If the Plan Sponsor wishes to obtain access to PHI for purposes other than those set forth herein, it will seek written authorization from the participant(s) whose PHI is involved before the Plan allows access to the information.

c) Ensure that all consultants, attorneys, accountants, auditors, third party administrators, HMOs, insurers, or other Business Associates of the Plan agree in writing not to disclose or use PHI for any purpose contrary to law or to the terms of such written agreement with the Plan, and to otherwise comply with the requirements of the Privacy Standards with regard to the use and disclosure of PHI.

d) Make the PHI of any participant available to them pursuant to Section 164.524 of the Privacy Standards (45 CFR 164.524).

e) Not use or disclose PHI for employment related actions or decisions or in connection with any other non-group health employee benefit plan of the plan sponsor.

f) Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526).

g) Make available an accounting of disclosures of PHI to any participant in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528).

h) Make the Plan's internal practices, books and records relating to the use or disclosure of PHI available to the Secretary of HHS for audit purposes.

i) If feasible, return or destroy all PHI received from the group health plan that the plan sponsor retains in any form when no longer needed for the purpose for which the disclosure was made.

j) Ensure that adequate separation between the group health plan and the plan sponsor exists to ensure the confidentiality of PHI.

k) Make no other disclosures or uses of PHI besides those permitted or required by the Plan Documents or as required by law.

Privacy Officer

The Plan has appointed a Privacy Officer, who is designated to ensure that this policy is followed and to address any issue or complaint regarding access to PHI for the Plan. Any participant or beneficiary who has a question or concern regarding the use of their PHI may direct their question or concern to: Privacy Officer, Teamsters Managed Health Care Trust Fund c/o DMC Insurance Administrators, Inc., P.O. Box 757, Pleasanton, CA 94566. The telephone number is (925) 426-3555 or (800) 924-1226. Participants and beneficiaries are also entitled to obtain an accounting of any disclosures of their PHI by the Plan. If they are not satisfied after communication with the Privacy Officer, they may direct any problem, concern or request to the Board of Trustees, who will treat it as an appeal to the Board and respond accordingly.

FOREIGN LANGUAGE NOTICE

This booklet contains a summary in English of your rights and benefits under the Teamsters Managed Health Care Trust Fund. If you have any difficulty in understanding any part of this booklet, you may contact the Plan Administrative Office, Inc., P.O. Box 757, Pleasanton, CA 94566. The telephone number is (925) 426-3555 or (800) 924-1226. Office hours are from 9:00 a.m. to 4:30 p.m., Monday through Friday.

AVISO EN ESPAÑOL

Este Folleto contiene un resumen en ingles de sus derechos y beneficios bajo el Teamsters Managed Health Care Trust Fund. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede contactar a la oficina administrativa del plan, P.O. Box 757, Pleasanton, CA 94566, o llamar al numero telefonico (925) 426-3555 or (800) 924-1226. Las horas de la oficina son de 9:00 a.m. a 4:30 p.m., de Lunes a Viernes.

RETIREES

The Teamsters Managed Health Care Plan also provides a self-pay voluntary retiree plan for eligible retired employees.

ELIGIBLE RETIREES ARE:

A person who has retired from active employment under the Teamsters Managed Health Care Trust Fund is eligible for benefits under the plan if the following conditions are met:

1. He/She is at least 55 years of age (see Note (a) below) or has qualified under Federal Social Security for monthly benefits; and
2. He/She is not eligible as an active employee under any plan of group insurance or group coverage; and
3. He/She makes timely self-payments (see Note (d) below) in an amount as determined by the Board of Trustees; and
4. There is no gap in coverage between eligibility as an active employee covered under the Trust Fund, and eligibility as a retiree (see Note (b) below); and
5. He/She was employed at the time of retirement by an employer who contributes to the Trust Fund or was employed at the time of retirement by an employer who contributed to a different Trust Fund which then contributes to this Trust Fund (see Note (c) below).

Note (a): The minimum age requirement will be waived for retirees younger than 55 receiving a monthly pension from the Western Conference of Teamsters (WCT) Pension Fund or any other pension plan approved by the Board of Trustees.

Note (b): A gap in coverage will be waived in cases of disability retirement so long as the application for benefits is made on a timely basis, after receipt of notice of entitlement to Social Security and the relevant Pension Fund. Copies of both the notice of Social Security eligibility and certification of pension entitlement are required to establish eligibility in this plan.

Note (c): If the retired individual's former employer ceases to make contributions to the Trust Fund, he/she will cease to be eligible for benefits, except in the event of a plant closure.

Note (d): In some specific and exceptional situations, these payments may be remitted by an employer**.**