TEAMSTERS LOCAL 1932
HEALTH AND WELFARE TRUST
RETIREE PLAN

SUMMARY PLAN DESCRIPTION
AND PLAN RULES RESTATEMENT

Effective January 1, 2025

THIS IS A GOVERNING PLAN DOCUMENT
FOR THE BENEFITS OUTLINED HEREIN

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Introduction

This Teamsters' Local 1932 Retiree Health Plan Summary Plan Description/Plan Rules ("Retiree SPD") describes the Teamsters' Local 1932 Retiree Health Care Plan ("Retiree Plan") in which you may be able to participate as a retiree of a Contributing Employer to the Teamsters' Local 1932 Health Care Trust.

The purpose of the Retiree Plan is to reimburse eligible retirees for certain health insurance premiums which are not otherwise reimbursed. This Plan is intended to be exempt from the Patient Protection and Affordable Care Act ("ACA") as a separate "retiree-only" plan pursuant to IRC Section 9831(a)(2).

Read this booklet carefully so you understand the provisions of the Retiree Plan and how you can use the Retiree Plan to your advantage.

This booklet describes the current provisions of the Retiree Plan which is designed to comply with applicable legal requirements. The Retiree Plan is subject to federal laws, such as the Internal Revenue Code (IRC), and other federal and state laws which may affect your rights. The provisions of the Retiree Plan are subject to revision due to changes in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. The Trustees may also amend or terminate the Retiree Plan. If the provisions of the plan described in this Summary change, you will be notified.

Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree.

How the Retiree Plan Works

A Medical Expense Reimbursement Plan is a reimbursement account the Trust establishes on your behalf. Each month, the Trust credits a specific dollar amount to your account to help cover the cost of eligible health care expenses for you. You can use the Plan to reimburse yourself for health insurance premiums you incur. You may not use the Plan to be reimbursed for expenses incurred by your domestic partner or your domestic partner's child(ren) unless they qualify as your tax dependent.

The purpose of the Retiree Plan is to provide a source of funds to reimburse you for some of the eligible insurance premiums you incur that are not otherwise reimbursable by other medical coverage. These expenses must be incurred while the Retiree Plan remains in effect, you are eligible, qualified, and participate in the Retiree Plan.

The Account is a bookkeeping account on the Teamster's Local 1932 Health and Welfare Trust records only, with all reimbursements being paid from the Trust Fund's general assets.

The account is not funded and cannot earn interest or earnings of any kind. Reimbursements under the Plan are paid from the Trust's general assets.

You do not pay taxes on the Plan contributions or the amounts you are reimbursed from the Plan for eligible premium reimbursements. Effective January 1, 2025 this Retiree Plan offers a Post-65 benefit for Eligible Retirees, and Surviving Spouses.

Your Eligibility

Eligibility for individual Participants shall be determined according to the provisions of the MOU between the various Unions and Employers participating in the Trust, and the rules described in this chapter. Coverage will become effective on the first day after active coverage ends due to retirement. To become eligible an individual must (1) retire from a Contributing Employer and (2) submit and have approval of an application for benefits. If there is any discrepancy between the terms in the MOU and these Plan Rules, the Plan Rules will govern.

The intent of the Trustees is to require that eligible participants either (1) have been a contributing member since the initial MOU that created the retiree plan or (2) have had contributions made on their behalf for a minimum of 10 years of Service Credit while in a Teamsters-represented bargaining unit, if retiring directly from a contributing employer.

For the purposes of this Retiree Plan, **Service Credit** means the service credit earned from hours worked in a participating employer's pension plan. Service Credit for this Retiree Plan does not include purchased service credit.

Generally, participation in the Retiree Plan will only be available to individuals who:

A. Retire (i.e. refrain from full time employment and be **immediately** eligible to receive a pension benefit payments from SBCERA or other Contributing Employer sponsored retirement plan) following the effective date of this Trust; **and**

B. Eligible retirees must have been:

   1. Service Requirement for individuals who retire between July 1, 2023 and July 1, 2024

      a. active County employees in a Teamsters-represented bargaining unit immediately preceding their retirement, provided they were in a Teamsters-represented bargaining unit from July 1, 2021 through July 1, 2023; or

      b. were active County employees immediately preceding their retirement but not in a Teamsters-represented bargaining unit, provided they were previously in a Teamsters-represented bargaining unit for a minimum of 10 years, and provided they were in a Teamsters-represented bargaining unit on July 1, 2021 through July 1, 2023; or

      c. previously worked for the County in a Teamsters-represented bargaining unit for at least 20 years and they retire, provided they were in a Teamsters-represented bargaining unit on July 1, 2021 through July 1, 2023.

   2. Service Requirement for individuals who Retire on or after July 1, 2024 and prior to July 1, 2031:

      a. Be an active County employee in a Teamsters-represented bargaining unit immediately before retirement, with continuous Service Credit earned in such a unit from July 1, 2021, until Retirement, and with corresponding contributions to the Fund from employment in such a unit; or

3. Service Requirements for Individuals who Retire After July 1, 2031:

    a. Be an active County employee in a Teamsters-represented bargaining unit immediately before retirement, who has earned at least 10 years of Service Credit while in a Teamsters-represented bargaining unit, with corresponding contributions to the Fund from employment in such a unit; or

    b. Be an active County employee at retirement (not in a Teamsters-represented bargaining unit), but have accrued at least 10 years of Service Credit while in a Teamsters-represented bargaining unit with corresponding contributions to the Fund; or

    c. Retire after having accrued at least 20 years of Service Credit while in a Teamsters-represented bargaining unit with corresponding contributions to the Fund from employment in a Teamsters-represented bargaining unit.

Retire/Retirement for purposes of eligibility under this Retiree Plan means withdrawing from and **refraining from full time employment** for wage or profit and meeting the eligibility requirements for a distribution from a Contributing Employer sponsored retirement plan.

If you defer retirement, you may still be considered retired for purposes of eligibility under this Retiree Plan. **However**, if you **defer your retirement for more than 2 years**, your eligibility for this Retiree Plan **will cease and no further benefits will be payable**.

Continuing Eligibility

Once you initially become eligible for benefits, you will remain eligible so long as you continue to satisfy the eligibility rules required to maintain coverage as provided in your MOU. Please refer to your MOU to determine these eligibility rules or contact the Trust Administration Office. Generally, this means that once you become eligible for benefits you will remain eligible **until you no longer meet the definition of retired or the Plan terminates**.

Spouse Eligibility

If you, the Participant in this Retiree Plan, have a Spouse, who meets the definition of "Spouse" as described below, **and he/she is Retired as defined above**, he/she may become eligible for benefits on the date you become eligible.

If your Spouse is not eligible for Medicare or other employer-sponsored group coverage, he/she will become eligible the first of the month following your enrollment and will remain eligible until the earliest of the following:

A. He/she becomes eligible for Medicare

B. He/she engages in full-time employment, or

C. He/she loses eligibility.

The Spouse benefit ends at age 65, when the Spouse becomes entitled to Medicare. The Spouse may regain eligibility for a Post-65 benefit if the Spouse later qualifies as a Surviving Spouse.

Surviving Spouse Eligibility

If you, the Participant in this Retiree Plan, pass away while covered by the Plan, your Surviving Spouse, who meets the definition of "Spouse" as described below, becomes eligible for benefits on the date you lose eligibility due to death.

If you die prior to retirement, and as of the date of your death you could have retired and met the other eligibility rules above, you will be deemed to have retired as of the date of your death and your Surviving Spouse would be eligible.

If your Surviving Spouse survives your death and is not eligible for other employer sponsored group coverage, he/she will become eligible the first of the month following your death and will remain eligible until the earliest of the following:

A. He/She engages in full time employment, or

B. He/She remarries.

Definition of Spouse

This Plan defines Spouse as an Eligible Retiree's:

A. Same or opposite sex spouse; or

B. Same sex or opposite sex Domestic Partner having registered with the California Secretary of State pursuant to a Declaration of Domestic Partnership (Form NP/SF DP-1 or DP-1A); or

C. Same sex or opposite sex Domestic Partner having completed, signed and filed an official Affidavit of Domestic Partnership with the appropriate city or county of the State of California in which they reside; or

D. Same sex or opposite sex Domestic Partner with whom you reside in a California city or county which does not provide official Affidavits of Domestic Partnership, having completed and signed the Affidavit of Domestic Partnership obtainable from the Trust Administration Office.

A Spouse for purposes of this Retiree Plan must have been married to the Eligible Retiree for a period of two years prior to Retirement.

Eligibility for Post-65 Benefit for Individuals who Retired Between July 1, 2023 and January 1, 2025.

If you retired after July 1, 2023, and were over age 65 at the time of retirement or turned 65 after retirement, you may still be eligible for the Post-65 benefit, if you otherwise met the eligibility requirements for the Retiree Plan at the time of Retirement. Please contact the Trust Administration Office for more information:

Zenith American Solutions
421 N. Sierra Way
San Bernardino, California 92410
Telephone (866) 484-1337 or (909) 494-2916
e-mail: Teamsters1932eligibility@zenith-american.com

When Participation Begins

Retiree Enrollment

Eligible Retirees must complete an Enrollment Form either online or available from the Trust Administration Office to enroll themselves and/or their eligible Spouse or Surviving Spouse. Neither you nor your Spouse or Surviving Spouse will be eligible for benefits until you have submitted a completed Enrollment Form to the Trust Administration Office and have been notified that your enrollment is complete and your participation has been approved. If you have questions regarding enrollment, you may contact the Trust Administration Office at (866) 484-1337 or (909) 494-2916.

An Eligible Retiree shall have benefits commence on the earlier of the following dates:

A. The date on which his/her eligibility as an active employee in a Contributing Employer Plan terminates, if he/she is eligible as a Retiree as of such date.

B. The first day of the month in which pension benefits from a plan sponsored by a Contributing Employer become payable to such Eligible Retiree.

Notwithstanding the foregoing, if an individual otherwise eligible for the benefits so elects, the individual may defer entry into the Retiree Plan until the first day of the month elected.

An Eligible Retiree **must** complete the necessary written application and submit it to the Administrative Office of the Fund within 60 days of retirement or within 60 days of a Pension award. If a Retiree fails to affirmatively enroll or properly elect to defer benefits, such Retiree will not be eligible for this Retiree Plan.

Filling the Gap Between Active Coverage and other Coverage

For Eligible Retirees that lose coverage under an active employee plan due to retirement, the Retiree Plan will pay the daily COBRA rate between the date your active coverage ends until the first of the month following. In no event will this gap-in-coverage benefit be more than $750. This benefit is intended to allow Eligible Retirees to bridge the gap in coverage created by retiring on a date that does not coincide with the monthly benefit.

Spouse/Surviving Spouse Enrollment

A Spouse or Surviving Spouse must be enrolled to receive benefits. Services and reimbursement can be delayed, or denied to Spouses or Surviving Spouses who are not properly enrolled. You may obtain the necessary forms to enroll as a Spouse or Surviving Spouse from the Trust Administration Office. Verification of Spouse or Surviving Spouse status (e.g. marriage certificate, Affidavit of Domestic Partnership, or California State Declaration of Domestic Partnership) is required to complete the enrollment process. Coverage may be denied if the necessary forms are not received by the Trust Administration Office **within sixty (60) days** from the date your Spouse or Surviving Spouse becomes eligible.

In order to enroll a Spouse or Surviving Spouse, a copy of the state-issued marriage certificate is required, for Domestic Partners of either the same or opposite sex, please contact the Trust

Administration Office for the necessary documentation.

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Maximum Monthly Benefit – Premium Reimbursement

Each Eligible Retiree, Spouse, or Surviving Spouse (a "Participant") is entitled to reimbursement of certain Eligible Expenses, as determined in the sole discretion of the Trustees each month.

The Trust will reimburse Eligible Expenses for each Eligible Retiree, Spouse, or Surviving Spouse on the first day of each month, up to the amounts in the chart below.

Individual Category	Maximum Monthly Benefit Amount
Pre-65 Eligible Retiree	$750
Post-65 Eligible Retiree	$200
Pre-65 Spouse	$375
Pre-65 Surviving Spouse	$750
Post-65 Surviving Spouse	$200

Each month, the amount of any eligible health care expenses that are reimbursed under the Plan will be reimbursed up to the Maximum Benefit Amount listed in the chart above.

Participants may receive reimbursement for eligible health care premium expenses up to the amount in the chart above at any time. No more than the amount listed in the above applicable Monthly Benefit Amount may be reimbursed in a given month.

Unused contributions remaining in the notional account at the end of the plan year will be available to reimburse eligible health care expenses incurred during the previous plan year until July 1st of the following plan year.

Remaining amounts cannot be paid out in cash or any other form of distribution. They can only be used to reimburse eligible health care premium expenses incurred while you are eligible.

Eligible and Ineligible Expenses

Eligible Expenses

Health care expenses include the premiums you pay for insurance. **You may not use the Plan to be reimbursed for expenses incurred by your domestic partner or your domestic partner's child(ren) unless they qualify as your tax dependent.**

Premium expenses for: medical, prescription drug, dental, vision, incurred while you are eligible for your funding program can be submitted for reimbursement.

Ineligible Expenses

Health care expenses do not include the following types of expenses under this Plan:

Out of Pocket expenses for: Health care, prescription and over-the-counter drugs and supplies, dental, vision, and hearing incurred while you are eligible for your funding program cannot be submitted for reimbursement.

The following are examples of ineligible health care expenses when they are incurred by you and are not reimbursed under another health plan:

- Acupuncture services related to the diagnosis, cure, mitigation, treatment, or prevention of disease.
- Ambulance expenses
- Chiropractor fees
- Cosmetic surgery – only if directly related to a congenital abnormality, a personal injury from an accident or trauma or a disfiguring disease
- Dental care
- Diagnostic services, including laboratory and X-ray services
- Eyeglasses and contact lenses
- Inpatient and outpatient hospital fees
- Insulin
- Medical appliances, such as artificial teeth or limbs, crutches, elastic stockings and hearing aids
- Prescription drugs
- Over-the-counter medicines or drugs that are legally purchased, such as antacids, allergy medicine, vitamins, pain relievers and cold medicine
- Nurse fees
- Oxygen equipment and oxygen
- Physician fees
- Psychiatric care
- Psychologist fees
- Surgical fees
- Travel related to your health care
- The cost of most types of cosmetic surgery, including breast augmentation, face lifts, hair transplants, hair removal (electrolysis) and liposuction (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident, or disfiguring disease)
- Certain vitamins

- Health spas, health club dues and exercise classes; (with a Letter of Medical Necessity stating the medical condition and the exercise program designed to treat the condition, the expenses may be reimbursable)
- Weight reduction classes, (except as part of the treatment of a specific disease diagnosed by a physician, such as obesity, hypertension, or heart disease)
- Babysitting expenses to enable you to get to a doctor's appointment
- Controlled substances (such as marijuana, laetrile, etc.) that aren't legal under federal law, even if such substances are legalized by state law
- Massage therapy
- Funeral or burial expenses
- Household and domestic help
- Cosmetics, toiletries, toothpaste, etc.

The following expenses are not reimbursed from the Plan:

- expenses incurred for covered Part D prescription drugs;
- expenses incurred *prior to the date* that you became a Participant in the Plan.
- expenses incurred *after the date* that you cease to be a Participant in the Plan.
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- Any other expense that is not a health care premium.

If you need more information regarding whether an expense is an eligible health care expense under the Retiree Plan, contact the Third-Party Administrator listed in the Plan Information Appendix of this Retiree SPD. The Plan Administrator (and its delegates) solely determine what qualifies as an eligible health care expense.

Only eligible health care expenses incurred while you are a Participant in the Retiree Plan may be reimbursed from the Plan.

Similarly, only eligible health care expenses incurred while your Surviving Spouse is a Participant in the Retiree Plan may be reimbursed from the Plan.

Health insurance premiums are incurred on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the premium is paid even if the covered individual paid the premium for the coverage prior to the first day of the plan year.

The federal government permits you to take a deduction on your income tax return for certain health care expenses. You should remember that you cannot claim the same expense twice, once through the Plan and also as a tax deduction. For specific advice about your situation, you may want to consult a tax advisor. The Trust cannot advise you regarding tax, investment or legal considerations relating to the Plan.

You may not submit a claim for an amount that was incurred prior to the time the Plan became

effective (typically the first day of the plan year or the first day your election for Plan coverage is effective, if later). In addition, you cannot submit a claim for any expenses that have been paid in-full through any other health insurance plan, Section 125 "cafeteria" plan or other similar health care expense reimbursement arrangement.

How to Use the Benefit

When you pay for an eligible health care expense, you want to put your Plan to work right away. Via Benefits gives you several options to use your money the way you choose.

Using Your Smartphone or Mobile Device

Using the Via Benefits mobile app, you can submit claims, upload, and submit receipts, and check your account balance any time.

To use the Via Benefits mobile app:

- Visit iTunes or Google Play Store to download the Via Benefits Accounts mobile app.
- Log in to your account.
- Check your balance, request reimbursement, upload receipts and check claim status, among other activities. All activities are easily accessible from the app home screen.

Using the Via Benefits Website

Using the Via Benefits website means you will never need to fill out a paper claim form again. It's quick, easy, secure, and available 24/7/365.

Once you've logged in, you'll be asked to provide details about the claim, including date of service, reimbursement/payment amount, and provider. You'll also choose whether to reimburse yourself or pay the provider and you'll upload/attach your receipt or EOB.

Paper Claim

You can also download the Via Benefits claim form from viabenefitsaccounts.com and fax or mail your claim to the address on the form.

What to Include in a Claim

Regardless of the method you choose to submit a claim, make sure your documentation includes the five following pieces of information required by the IRS:

- Date of purchase.
- Participant name.
- Detailed description.
- Patient portion or amount owed.
- Provider or merchant name.

You may submit a claim for reimbursement for an eligible health care expense arising during the

plan year at any time during the year. Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

Pre-Tax Premium Expense Reimbursement

The Retiree Plan will allow for reimbursement of premiums paid with pre-tax-income. For example, the portion of premium paid with payroll deductions by your Spouse for family coverage may be reimbursed. However, in this circumstance the IRS requires the Plan to issue a Form 1099 to the Plan participant to show that he or she has received taxable income from the Trust. Please contact the Trust Administration Office for the necessary information on submitting a claim for a Pre-Tax Premium Expense.

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Enhanced Claims Services

For Eligible Retirees that are Teamsters Members, Via Benefits can offer additional services. Via Benefits will have concierge service to help Teamsters Members find and select a health care plan that is tailored to your needs. In addition, the Third-Party Administrator may establish an automatic premium reimbursement process for the payment of certain health insurance premiums for Teamsters Members. Automatic premium reimbursements shall not be considered to be claims for benefits and shall not be subject to the procedures described in the "Claims and Appeals Procedures" section of this SPD. In establishing and operating any automatic premium reimbursement process, the Third-Party Administrator may establish a process to remove and/or prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements shall also not be considered to be claims for benefits and shall not be subject to the procedures described in the "Claims and Appeals Procedures" section of this SPD.

More About Claims

Via Benefits: Via Benefits will process your claim, and if the request is for eligible health care premium expenses, Via Benefits will deduct the money from your account and pay you via direct deposit or check. If your claim request is denied, you will be notified of this denial under procedures described below.

You should submit requests for reimbursement of Eligible Health care Expenses within 6 months following the plan year in which the expense is incurred. Any claims submitted after that date will not be reimbursed.

Initial Claims Process and Timing

If you make a claim for health care expenses under the Retiree Plan, the following timetable for claims decisions applies (references to "days" below indicate calendar days):

Notification of whether claim is denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim	15 days
Notification to Participant	15 days
Response by Participant	45 days
Response to claim	15 days

If a claim under the Retiree Plan is denied in whole or in part, the Participant will receive electronic or written notification based on the Participant's setting. The notification will include:

- The specific reason(s) for the denial.
- Reference to the specific plan provisions on which the denial was based.
- A description of any additional material or information needed to further process the claim, and an explanation of why such material or information is necessary.
- A description of the Plan's internal review procedures, and time limits applicable to such procedures, available external review procedures, as well as your right to bring a civil action following a final appeal.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- A description of any internal rule, guideline, protocol, or similar criteria used in the decision OR statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon request.
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge.

- The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793

Claims Appeals Process

If you receive a claim denial, you will have 180 days following the receipt of the notification in which to appeal the decision, by making a written request for consideration to Via Benefits. You have the right to:

× Submit written comments, documents, records, and other information relating to the reimbursement claim for benefits

× Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim request if it:

  - Was relied upon in making the benefit determination
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record, or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination

- A review that takes into account, all comments, documents, records, and other information related to the claim that you submitted, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate
- If the appeal involves a denial based on a medical judgment, a review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

If sufficient information is available to decide the first level appeal, Via Benefits will resolve your first level appeal within a reasonable period of time, but not later than 30 days from receipt of the first level appeal request. If more information is needed to make a decision on your appeal, Via Benefits shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 days of the appeal request, Via Benefits shall

conduct its review based upon the available information. The review shall be completed within a reasonable period of time, but not later than 30 days from receipt of the first level appeal request.

The first and second level of appeal will not take more than 60 days combined to resolve, from the receipt of each written appeal to the notice of decision for each appeal.

Notice of an adverse benefit determination on appeals will contain all of the following information:

- The specific reasons for the denial,
- Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable),
- The specific Retiree Plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the plan's standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision,
- A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary,
- A description of the Retiree Plan's external review procedures and a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; including your right to bring a civil action in federal court following a claims denial on review,
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material, will be provided upon request, free of charge.
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge, and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

If you have any questions about a denied claim, you should contact Via Benefits. Via Benefits' decisions are conclusive and binding.

If you are not satisfied with the decision made on the first level appeal, you may request in writing, within 90 days of receipt of the notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative to the Plan Administrator. To initiate a second-level appeal, you can provide all information from the first level of appeal, and additional information or statements that you feel are relevant, to the Plan Administrator. You have the same rights with the second level appeal as you do with the first level appeal and all responses will follow the same time period. Instructions for contacting your Plan Administrator will be included in the notice of adverse benefit determination.

You and the Plan may also have the right to other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance

regulatory agency.

You cannot bring any legal action relating to this Retiree Plan against the plan, Plan Administrator, or Claims Administrator, for any reason unless you first complete all non-voluntary steps in the appeal process as described in this "Claims Appeals Process" section. (However, you may be treated as having completed all these steps with respect to a claim if the plan fails to comply with its obligations at any point in the claims and appeals process, unless the plan's failure to comply is de minimis, non-prejudicial, attributable to good cause, or matters beyond the plan's control, in the context of an ongoing, good-faith exchange of information, and not reflective of a pattern or practice of non-compliance). After completing the claims and appeals process, if you want to bring such a legal action you must do so within 24-months of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action.

Overpayments

If it is later determined that you and/or your, covered spouse, or surviving spouse received an overpayment or a payment was made in error, you (or your covered eligible surviving spouse) will be required to refund the overpayment or erroneous reimbursement to the Retiree Plan. An example of an overpayment is being reimbursed for an expense under the Plan that is later determined to be ineligible or paid for by some other health care plan.

If you do not refund the overpayment or erroneous payment, the Retiree Plan reserves the right to offset future reimbursements from the Plan equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on an IRS Form 1099 as income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under the Retiree Plan.

Unclaimed Payments

Any Plan payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) will automatically forfeit 18 months from the date set forth on the check or from the date the payment was otherwise approved.

If the participant or other authorized person does not contact Via Benefits prior to the 18-month forfeiture time frame, the unclaimed reimbursement will be voided.

If the Participant or other authorized person contacts Via Benefits within six months, Via Benefits may cancel and void the original check or payment and re-issue a new check or as otherwise determined by Via Benefits.

If the Participant or other authorized person contacts Via Benefits after six months, Via Benefits will cancel and void the original check or payment and shall re-issue the payment by direct deposit, or as otherwise determined by Via Benefits.\

Continuation of Coverage under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Retiree Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you, and what you need to do to protect the right to receive it.**

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 coverage under the Plan.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Retiree Plan coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You could become a qualified beneficiary if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the "Paying for COBRA Continuation Coverage" section.

COBRA Qualifying Event

If you are a covered retiree, you will become a qualified beneficiary if you lose coverage under the Retiree Plan because the following qualifying event happens:

× There are no instances where an Eligible Retiree could experience a qualifying event.

Giving Notice that a COBRA Qualifying Event Has Occurred

The Retiree Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred.

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to the qualified beneficiaries.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of Retiree Plan coverage.

Electing COBRA Continuation Coverage

You must choose to continue coverage under the Retiree Plan within 60 days after the later of the following dates:

- The date you would lose coverage under the Retiree Plan as a result of the qualifying event; or
- The date the Trust notifies you (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost of Retiree Plan coverage.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all contributions due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Retiree Plan. Payment is considered made on the date it is sent to the Retiree Plan.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The contribution due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Retiree Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period – respectively – for that coverage period, you will lose all rights to COBRA continuation coverage under the Retiree Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any qualified beneficiary will end when the first of the following occurs:

- Any required premium is not paid on time
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as a retiree or otherwise) under another group health Plan (not offered by the Trust)
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (that is, enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA continuation coverage if bankruptcy is the qualifying event

COBRA continuation coverage may also be terminated for any reason the Retiree Plan would terminate coverage of a participant not receiving COBRA continuation coverage (such as fraud).

Marketplace Coverage as an Alternative to COBRA.

As explained above, when you lose your coverage under the Retiree Plan by reason of a COBRA qualifying event, you temporarily can elect to continue that coverage under the applicable health plan at your own expense at group rates (known as COBRA coverage). You also may have special enrollment rights to enroll under another group health plan (such as your spouse's employer plan). You also have viable purchasing options for individual health insurance policies through the Health Insurance Marketplace ("Public Marketplace") or through other commercial insurance issuers outside of the Public Marketplace. The Public Marketplace may offer you less expensive premiums and out-of-pocket costs than any other health care coverage options, including COBRA coverage, especially in the event that you qualify for governmental subsidies (i.e., tax credits) that help you pay for your coverage purchased from the Public Marketplace.

You should carefully and timely review all of your coverage options before making a final decision. If you decide to purchase other health coverage (e.g., through your spouse or through the Public Marketplace or other commercial insurance) and do not elect COBRA within the 60-day election period, you will no longer have the right to elect COBRA coverage under the health plans.

If you decide to elect COBRA coverage, you also should be aware that you are restricted in when you can enroll in an individual health insurance policy. For example, if you enroll in COBRA medical coverage under the plan but decide mid-year that you want to drop that coverage because it is not affordable to you, most insurance carriers will not permit you to enroll in an individual health insurance policy until the next open enrollment period. This restriction applies even though COBRA is no longer affordable to you (e.g., when your financial situation changes).

More information regarding COBRA coverage is included above and in the COBRA Notices available from the plan administrator. Additional information regarding Public Marketplace coverage is available by visiting www.healthcare.gov and also in the health plans' COBRA Notices.

If You Have Questions

Questions concerning your Retiree Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the California Department of Managed Health Care at 1-888-466-2219.

Additional Information

Keep Your Plan Informed of Address and Contact Changes

In order to protect your rights, as well as the rights of your spouse/domestic partner, you should keep the Service Center informed of any changes in the addresses of your spouse/domestic partner. You should also keep a copy for your records of any notices you send to the Service Center.

Plan Accounting

VIA benefits will periodically furnish you with a statement of your benefits and reimbursements so you can track your reimbursements during the year. You may also submit a written request to the plan administrator to receive a copy of your benefit information at any time.

Your Rights

As a participant in the Retiree Plan, you are entitled to certain rights and protections under the law.

All plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations such as work sites, all documents governing the plan, including insurance contracts.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, applicable laws impose 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 all other Plan participants and beneficiaries.

Enforce Your Rights

If your claim for a Retiree Plan 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 the Retiree Plan, there are steps you can take to enforce the above rights.

If you have a claim for benefits that is denied, or ignored, in whole or in part, you may file a suit in court but only after you have exhausted the Plan's claims and appeals procedure as described in this Retiree SPD. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in a federal court. Any action at law or in equity must begin within three years after the denial of any appeal from an initial adverse benefit determination, regardless of any state or federal statutes establishing procedures

relating to limitations of actions.

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 California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC), or you may file suit in court. The court will decide who should pay court costs and 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.

Qualified Medical Child Support Order

The Retiree Plan will comply with all the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under a health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage under the plan pursuant to a medical child support order will not become effective until the plan administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact

Zenith American Solutions
421 N. Sierra Way
San Bernardino, California 92410
Telephone (866) 484-1337 or (909) 494-2916

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Retiree Plan is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The Trust is required to provide notice of the ways that Protected Health Information (PHI) may be used in accordance with HIPAA. A copy of the HIPAA notice of privacy practices can be obtained by contacting:

Zenith American Solutions
421 N. Sierra Way
San Bernardino, California 92410
Telephone (866) 484-1337 or (909) 494-2916

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, or if you need assistance in obtaining documents from the plan administrator, you should contact the California Department of Insurance (CDI) at 1-800-927-4375 or the Department of Managed Health Care (DMHC) at 1-888-466-2219.

Plan Information Appendix

Details About Plan Administration	
Plan Sponsor/Plan Administrator	Name: Board of Trustees of the Teamsters Local 1932 Health and Welfare Fund Address: 421 North Sierra Way San Bernardino, CA 92402 Phone Number: (909)-494-2916
COBRA Administrator	Name: Zenith American Solutions Address: 421 North Sierra Way San Bernardino, CA 92402 Phone Number: (909)-494-2916
Employer Identification Number	84-7018438
Official Plan Name and Number	Teamsters Local 1932 Retiree Plan 502
Plan Year	July 1 through June 30
Type of Plan	Welfare benefit plan providing health care premium reimbursements.
Agent for Service of Legal Process	Name: Zenith American Solutions Address: 421 North Sierra Way San Bernardino, CA 92402 Phone Number: 909-494-2916 Legal process can also be served on the plan administrator
Third Party Administrator	Via Benefits 10975 South Sterling View Drive South Jordan, UT 84905 (866) 630-9466 My.ViaBenefits.com/funds
Claims Submission Information	Name: Via Benefits Mobile App: Search for Via Benefits Accounts where you download apps URL VIAbenefits.com Online: my.viabenefits.com/funds Mail: P.O. Box 981156, El Paso, TX 79998-1156 Fax: (866) 886-0878

Plan Administrator's Discretionary Authority to Interpret the Plan

The administration of the Retiree Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretionary authority to determine all matters relating to the Retiree Plan, including eligibility, coverage, and benefits, to the extent permitted under the applicable collective bargaining agreement.

The Plan Administrator will also have the exclusive discretionary authority to determine all matters relating to interpretation and operation of the Retiree Plan. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

Plan Document

This SPD and Plan Rules Restatement is intended to be the combined SPD and plan document that governs the operation of the Retiree Plan. That document sets forth the provisions concerning the Retiree Plan and is subject to amendment.

The Trust's Right to Amend or Terminate the Plan

It is the Trustee's intent that the Retiree Plan will continue indefinitely. However, the Trustees reserve the right to amend, modify, suspend, or terminate the Retiree Plan, in whole or in part, by action of the Board of Trustees. Any such action would be taken in writing and maintained with the records of the Retiree Plan. Plan amendment, modification, suspension, or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the Retiree Plan to the extent permitted by law, and to the extent permitted under the applicable collective bargaining agreement.

The Trustee's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, third-party administrators, etc., at any time, and the right to revise the amount of Trust contributions. Participants will be notified of any material modification to the Retiree Plan.

If the Retiree Plan is terminated, there will not be any plan assets that would need to be distributed.

Limitation on Assignment

Your rights under the Retiree Plan cannot be assigned, sold, or transferred to your creditors or anyone else. However, you may assign any benefit payments you may be entitled to the health care provider who provided the covered services.

Your Employment

This SPD provides detailed summary of the Trust Fund's Retiree Plan and how it works. This SPD does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the Retiree Plan or any of its component plans should not be interpreted as an implied or express contract or guarantee of employment.