Teamsters Insurance Premium Reimbursement Fund

Summary Plan Description

Effective February 1, 2014

Chapter 1 How to use this Booklet

This booklet contains the Summary Plan Description (SPD) which describes your rights under the Teamsters Insurance Premium Reimbursement Fund (the "Fund"). This booklet explains how you and your spouse, if applicable, become eligible for benefits, what those benefits are, and how to file a claim for benefits.

The SPD is divided into numerous chapters.

- Chapter 1 contains general information about the Fund;
- Chapter 2 explains the Fund's eligibility rules for you and your spouse;
- Chapter 3 explains the benefits available to you and your spouse;
- Chapter 4 explains how to file a claim and tells you how a claim is paid.
- Chapter 5 explains what to do if you disagree with the payment or nonpayment of a claim;
- Chapter 6 provides you with the important information required by ERISA otherwise known as the Employee Retirement Income Security Act of 1974.

The questions and answers in the SPD are not intended to change in any way your rights under the Teamsters Insurance Premium Reimbursement Fund Plan Document. In the event there is a difference between the Plan Document and the SPD, the Plan Document will control. All benefits are determined under the terms of the Plan Document. Therefore, you must consult the actual Plan for a definitive answer to any question you have concerning your rights. Only the full Board of Trustees is authorized to interpret the Plan Document and SPD. No employer or union, nor any representative of any employer or union, is authorized to interpret the Plan Document or SPD, nor can any such person act as an agent of the Board of Trustees.

We urge you to read the SPD carefully in order to generally familiarize yourself with the benefits that are available to you under the Fund. If you have any questions after reading this booklet or if you would like to discuss the details further, contact the Fund Office. We will be glad to help you.

1. What is the name and purpose of the fund?

The full name of the fund is: Teamsters Insurance Premium Reimbursement Fund. Throughout this book it will be referred to as "the Fund". The purpose of the Fund is to collect contributions from employers that have agreed to withhold and remit to the Fund, post-tax contributions deducted from your paycheck on a voluntary basis. The contributions received are used to provide the benefits listed in Chapter 3 for those meeting the eligibility requirements listed in Chapter 2. No other funding source is used to provide the benefits.

2. What is the "Fund Office" and where is it located?

The Fund Office is the day-to-day administrator of benefits available from the Fund. The Fund Office is located at:

8814 Fargo Road, Suite 200
Richmond, VA 23229

Fargo Road is located in Henrico County off of Parham Road, just south of the Parham Road — Three Chopt Road Intersection.

3. What telephone numbers do I use to call the Fund Office?

For local telephone calls within the Richmond area use:

282-3131

For telephone calls outside of the Richmond area use:

1-800-852-0806

4. Who is the Fund Administrator?

The Fund Administrator is the Board of Trustees. It is their responsibility to administer the benefits for the good of all participants.

You may contact the Trustees through the Fund Office as follows:

Board of Trustees
Teamsters Insurance Premium Reimbursement Fund
8814 Fargo Road, Suite 200
Richmond, Virginia 23229

5. Who are the Trustees?

The Board of Trustees is made up of six individuals, three Union Trustees and three Employer Trustees.

Union Trustees	**Employer Trustees**
John D. Farrish Teamsters Local Union No. 29 12 Cedar Park Lane Verona, VA 24482	W. Robert Davidson 202 Winding River Road Eatonton, GA 31024
Kenneth L. Chism Teamsters Local Union No. 322 3705 Carolina Ave. Richmond, VA 23222	Jay Bowers United Parcel Service 55 Glen Lake Parkway, NE Atlanta, GA 30328
James R. Smith Teamsters Local Union No. 592 3705 Carolina Ave. Richmond, VA 23222	William A. Nations ABF Freight System, Inc 1165 Highway 66 South Kernersville, NC 27284

All communications with the Trustees should be made through the Fund Office.

6. Is the Fund maintained through collective bargaining and participation agreements?

Yes, the Fund is maintained currently through various collective bargaining agreements. The Fund originated through a collective bargaining agreement between the Teamsters and National Linen Service. ALSCO succeeded National Linen Service when ALSCO bought out National Linen's operations that involved the predecessor NLS-Teamsters Insurance Premium Reimbursement Fund in 2006. Other employers may join through the collective bargaining process or by signing a participation agreement.

Chapter 2 Eligibility

7. Explain the eligibility requirements of the Fund.

To be eligible for benefits from the Fund, you must:

- be retired and eligible for benefits as a retiree under your employer's pension or retirement plan;
- have had at least 312 weeks of contributions made to the NLS-Teamsters Insurance Premium Reimbursement Fund and/or Teamsters Insurance Premium Reimbursement Fund prior to retirement; and
- not be eligible for Medicare or Medicaid.

Spouse eligibility:

Your spouse's eligibility for benefits is dependent on whether or not the spouse is legally married to you on the date of your retirement. If your spouse lives outside of either the US or Canada or is active duty military, they are not eligible for benefits. In such cases and once your spouse returns to the US or Canada or ceases to be active duty military, your spouse is eligible for benefits the month following the date of this change as long as they were legally married to you at the time of your retirement.

Chapter 3 Benefits

8. What benefits are paid from this Fund?

If you and/or your spouse meet the eligibility requirements, the Teamsters Insurance Premium Reimbursement Fund will reimburse you and your spouse, if appropriate, for each month in which you make a payment to your former employer's COBRA insurance program, your particular state's HIPAA program, or to the insurance company providing your Marketplace coverage under the Affordable Care Act. The Fund will reimburse you and your spouse for the amount of each COBRA or HIPAA payment(s) as appropriate according to Schedule A.

9. Is there a dollar limit on the amount of benefits payable from the Fund?

Yes, see Schedule A.

10. Can you explain what causes benefits to terminate?

Your benefits will cease when any of the following events occur:

- You turn 65. Benefits will be paid for the month that includes your 65th birthday.
- You become eligible for benefits under Medicare, Medicaid or any other group health planwith the exception of COBRA under your former Employer's group health plan, state HIPAA coverage or coverage available through the Marketplace as provided through the Affordable Care Act. Benefits will be prorated to the date eligibility begins under the other insurance program.
- You pass away. Benefits will be prorated to this date.
- The Fund has paid you and your spouse, if applicable, an amount equal to the lifetime maximum shown on Schedule A.

For your spouse, benefits will cease when any of the following events occurs:

- When they turn 65. Benefits will be paid for the month that includes their 65th birthday.
- When they become eligible for benefits under Medicare, Medicaid or any other group health plan with the exception of COBRA under their former Employer's group health plan, state HIPAA coverage or coverage available through the Marketplace as provided through the Affordable Care Act. Benefits will be prorated to the date eligibility begins under the other insurance program.
- The date you and your spouse divorce. Benefits will be prorated to this date. Please note that if you remarry this spouse, benefits will not be available to him/her.
- When your spouse passes away. Benefits will be prorated to this date.
- Three years after the termination of the Retired Employee's eligibility for benefits.
- The Fund has paid you and your spouse, if applicable, an amount equal to the lifetime maximum shown on Schedule A.

11. When are benefits paid?

Benefits are paid on the first business date of the month for all claims received prior to the 25th of the previous month. The below provides additional explanation.

Example: John Linen meets all the requirements necessary to qualify for benefits from the Teamsters Insurance Premium Reimbursement Fund. He pays his March COBRA bill on February 5. The Fund Office receives his application on February 12 for participation in the plan. Since his application was received prior to February 25, a check from the Fund will be sent to him on March 1 to reimburse him for a portion, if not all of his COBRA payment. If he remains eligible and again provides proof of his COBRA payment for April coverage prior to March 25, a reimbursement to cover the April COBRA payment will be issued on April 1.

Chapter 4 Claim Filing and Claim Payment

This chapter tells you how to file a claim. It also explains the time limits for filing, how benefits are paid, and the Fund's method of collecting overpayments.

12. What is a "claim" and why do I need it?
A "claim" is a request to the Fund for the reimbursement of health premiums. As a general rule, a claim needs to be filed with the Fund before benefits can be paid. To request your first monthly reimbursement, you need to fill out an application and provide it, along with a copy of your first COBRA,HIPAA, or Marketplace payment, to the Fund Office. For future reimbursement requests, only a copy of your COBRA,HIPAA, or Marketplace payment is necessary.

13. Can the date of the Fund's first payment be later than the first day of the month?
Yes. The Fund Office must first confirm your initial eligibility and your monthly COBRA,HIPAA, or Marketplace payment before providing reimbursement.

14. Who files claims with the Fund?
You or your spouse may file a claim by submitting an application and copies of the payment you issued to your COBRA, HIPAA, or Marketplace benefit provider. **15. Is there a time limit in which to file a claim?**
Yes. A claim must be received by the Fund within twelve months of paying COBRA,/HIPAA, or Marketplace premiums. The claim time limit may be waived by the Trustees if evidence is supplied, using the appeal process described in Chapter 5 that shows it was not reasonably possible to provide claim within 12 months and that such notice was supplied as soon as possible.

16. How will my benefits be paid?
Benefits will be paid directly to you, or in the case of your spouse, to him/her in check form.

17. What happens if the Fund makes an overpayment?
In cases where an overpayment is made by the Fund to you or your spouse, the Fund Office will attempt to recover the overpayment by withholding benefit payments on all of the Participant's and Spouse's claims until repaid in full. If repayment is not made through this means, the Fund Office will issue up to four repayment requests. If either of these methods fails to recoup the full overpayment, the matter will be referred to the Board of Trustees.

Chapter 5 Appeals

18. What can I do if I disagree with the Fund's payment or nonpayment of my claim?

If you disagree with the Fund's decision, you may ask to have it reviewed. Your written request for review must be received by the Fund Office within 180 days from the date you receive an "Adverse Benefit Determination" or denial notice. Also, your request must be addressed to the Board of Trustees in care of the Fund Office and must state the following:

- Your name and address;
- The fact that you are appealing a decision of the Fund Office and the date of the decision;
- The basis of your appeal, i.e., the reason why you feel that your claim should not be denied; and
- The provisions of the Plan on which you base your claim.

IMPORTANT: If your appeal is not filed within the required 180 day period, you lose your right to a review of the denial and the decision of the Fund Office will become final and binding.

19. Can someone else submit an appeal on my behalf?

Yes, as long as you provide the Fund Office a letter naming your "authorized representative" in writing, the Fund's Trustees will accept their appeal on your behalf.

20. Do I have any rights to collect or supply information from or to the Fund Office related to the claim(s) for which I am appealing?

Yes, as follows:

- You may submit written comments, documents, records and other information you feel is important to your claim for which you are appealing;
- You may request and receive reasonable access to all documents, records or other information related to you and the claim for which you are appealing. Copies of documents you desire will be provided free of charge.

21. Is everything the Fund Office has relating to the claim considered a "document, record or other information?"

If the item

- was relied upon in making the original benefit payment decision;
- was submitted, considered or created during the claim review by the Fund Office whether or not the item was relied upon when processing the claim;
- shows that claim payment decisions are made as required by the plan document and that such requirements are consistently applied; or
- is a policy or guideline that covered the Fund Office's decision to deny, then it will be considered a "document, record or other information."

22. Who reviews and rules on an appeal?

The Board of Trustees, together with their advisers, reviews appeals. In doing so, they will take into account all comments, documents, records and other information submitted, whether or not such information was considered when the claim was originally processed by the Fund Office.

In addition, the Trustees will ignore the conclusion reached by the Fund Office when originally processing the claim.

23. When should I expect a decision on my appeal from the Board of Trustees?
The Board will render a decision within 60 days unless their meeting schedule provides for quarterly meetings. In such a case, they will render a decision for all appeals received less than 30 days prior to the previous Trustee meeting date unless special circumstances require an extension.

24. Is the Board's decision concerning my appeal final and binding?
Yes, unless you elect to take the matter to court as described below.

25. If I don't agree with Board's decision, what can I do?
If you have followed the entire appeal process, and don't agree with the Board's decision, then you may take your claim denial to court but you must do it within 180 days after the Board of Trustees' decision on your appeal. Refer to "Important Information Required by ERISA" for details.

Chapter 6 Important Information Required by ERISA

ERISA requires that certain information be furnished to each participant in an employee benefit plan. This booklet is your Summary Plan Description (SPD). Contributions to the Fund are made by participating employers and, under certain circumstances, by the participant. Contributions are based on negotiated contributions as set forth in the collective bargaining agreements. Benefits provided by the Fund are determined by the Board of Trustees. The Board is empowered to amend the Fund at any time, and to impose any conditions, fees, or cost-sharing structure on eligibility or on the provision of benefits, as they deem advisable. All determinations by the Board of Trustees are final and binding on all parties. This Booklet is effective February 1, 2014.

The following is more important information you should know about the Fund:

- The Board of Trustees is the Administrator of the Fund. The Board of Trustees consists of an equal number of union and employer representatives, selected by the union and the employers who have entered into collective bargaining agreements which relate to the Fund. Inquires may be sent to the Trustees in care of the Fund Office at 8814 Fargo Road, Suite 200, Richmond, Virginia, 23229, (804) 282-3131;
- The Board of Trustees is both the plan sponsor and the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information about the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974;
- The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 504556299;
- The Fund's agent for service of legal process is:
  Michael M. McCall
  Teamsters Insurance Premium Reimbursement Fund
  8814 Fargo Road, Suite 200
  Richmond, Virginia, 23229
- The names and addresses of the Trustees are listed beginning on page 2 of this booklet;
- All assets are held in trust by the Board of Trustees;
- The Plan Year begins on January 1 and ends on December 31 of each year.
  See Chapter 4 for information on filing claims for benefits and Chapter 5 for information on appealing denied claims.

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

As a participant in the 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

- examine, without charge, at the plan administrator's 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;
- obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.