SUMMARY PLAN DESCRIPTION / PLAN DOCUMENT
FOR THE
MICHAEL J. DAY MACHINISTS
RETIREE HEALTH INVESTMENT PLAN

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AMENDED, RESTATED, AND EFFECTIVE JANUARY 1, 2014

SUMMARY PLAN DESCRIPTION/ PLAN DOCUMENT FOR THE MICHAEL J. DAY MACHINISTS RETIREE HEALTH INVESTMENT PLAN

AMENDED, RESTATED, AND EFFECTIVE JANUARY 1, 2013

Administered By:

Associated Third Party Administrators
1640 South Loop Road
Alameda, CA 94502
Phone: 510-337-3050

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Introduction

The Michael J. Day Retiree Health Investment Plan ("RHIP," "the Plan" or "the Investment Plan") is designed to provide reimbursement of certain eligible expenses to eligible participants (defined in the Eligibility chapter) following retirement. The Plan allows you to receive reimbursement of eligible expenses on a tax-free basis. Note that the eligible expenses are retiree healthcare premiums, certain life insurance premiums and defined other medical expenses as explained in the Eligible Expenses chapter of this document.

The Plan is administered by Associated Third Party Administrators (ATPA). They may be reached at the following address and telephone number:

Associated Third Party Administrators (ATPA)
1640 South Loop Road
Alameda, CA 94502
Phone: 510-836-2484

ATPA is available to assist you with any of the following issues:

- Applications;
- Reimbursement for eligible charges;
- Contributions;
- Eligibility; and
- Benefit questions.

We recommend that you read this booklet carefully so that you will be familiar with the Plan's eligibility requirements and available benefits. If you have questions that the booklet does not answer or if you need clarification, please feel free to contact ATPA. As a courtesy to you, the claims administration staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Only the Board of Trustees is authorized to administer the Plan and to provide information relating to eligibility, benefits, and other provisions of the Plan. Statements by other persons, including union officers, your employer or individual Trustees, are not authorized and will not bind the Board of Trustees of the Plan.

About This Summary Plan Description

The Board of Trustees of the RHIP has established the Individual Retiree Spending Accounts with the intention that they qualify as a reimbursement Account within the meaning of Sections 105 and 106 of the Internal Revenue Code of 1986 (Code). This Plan is a collectively bargained Voluntary Employees' Benefit Association (VEBA) organized pursuant to Internal Revenue Code Section 501(c)(9). This document serves as both the Summary Plan Description (SPD)/Plan Document to describe the benefits, terms, and conditions of the Plan as it applies to you when you are eligible for participation in the Plan.

An Individual Retiree Spending Account ("Account") will be set up for you during your active employment with a contributing employer. Your Account will be credited with employer contributions made on your behalf. In addition, at the beginning of each year

all Accounts will be adjusted by a share of the Plan's investment earnings or losses, if any. See the section titled "Funding your Account" for more details.

The Board of Trustees reserves the right to amend, modify, or terminate the Retiree Health Investment Plan at any time.

Plan Highlights

The following items provide a brief description of some of the key facts about your Account:

- The Plan will establish your Account on the first valuation date after contributions are made by a contributing employer on your behalf. Employer contributions will be made to your Individual Retiree Spending Account ("Account") in accordance with the terms of your Collective Bargaining Agreement. Accounts may be increased by discretionary allocations of investment income and may be reduced by administrative expenses.
- Individual Retiree Spending Accounts are fully employer-funded; you cannot make contributions to your Account.
- Contributions to your Account are made by contributing employers each calendar quarter.
- The Plan invests the money in your Account so the money has the opportunity to grow and can help you pay a larger portion of healthcare premiums when you retire.
- You will receive a statement at the end of each Plan Year indicating your Account balance.
- You will become eligible for reimbursements from the Account when you retire.
- Reimbursement of eligible healthcare premiums incurred by you, your spouse, and eligible dependents are tax-free.
- Any balance in your Account at the end of the year will be carried forward into the next year.

Spanish Language Assistance:

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Fund Office en 510-337-3050.

No Guarantee of Tax Consequences

Neither the Fund Office nor the Board of Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of a Retiree under this Plan will be excludable from the Retiree's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Retiree to determine whether each payment under this portion of the Plan is excludable from the gross income for federal, state, and local income tax purposes, and to notify the Fund Office if the Retiree has any reason to believe that such payment is not so excludable.

Participation and Eligibility

Retiree Participation

Participation in the Fund begins on the last day of the month in which a contributing employer first contributes to the Trust on your behalf.

Retiree Eligibility

You are eligible to receive benefits from your account after you meet the following conditions:

1) You are receiving retirement benefits from the Automotive Industries Pension Plan, the I.A.M. National Pension Fund or such other retirement Plans approved by the Board of Trustees;

2) You have a positive Account Balance; and

3) You have submitted a full and complete approved written application for benefits under the Plan.

If you think that the Plan has incorrect information about you and/or your dependents, contact ATPA or your local union office.

Dependent Eligibility

A “dependent” for the purposes of this Individual Retiree Spending Account means any person who is your tax dependent as defined in Code Section 152 including your lawful spouse, tax qualified domestic partner and eligible dependent children up to age 26. Eligible dependent children includes natural children, stepchildren, adopted children (including children placed for adoption), children of domestic partners and children of divorced parents where either you or your ex-spouse have custody of the children for more than one-half of the calendar year and you work together with your ex-spouse to provide more than one-half of the child’s support for the calendar year.

Dependent also includes a Disabled Adult Child (meaning an unmarried Dependent Child age 26 and older who is permanently and totally disabled with a disability that existed prior to the attainment of the Plan’s age limit and who is eligible for tax-free coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c)or 152(d) or who will be claimed as a dependent on the retiree’s federal income tax return for each Plan Year for which coverage is provided..

Expenses incurred by a child who is the subject of a Qualified Medical Child Support Order (QMSCO) or a National Medical Child Support Order may be reimbursed under the Individual Retiree Spending Account even if the child does not otherwise meet the definition of a dependent” as described above.

Qualified Medical Child Support Orders (QMCSO)

In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient" to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

Please contact ATPA for additional information (free of charge) regarding the procedures for administration of QMCSOs.

Initial Application for Benefits

Before you are eligible to be reimbursed for any benefits under this Plan, you must submit a written application for the benefit in a form and at times prescribed by the Board of Trustees.

You will become eligible the first day of the month following the date that the Board of Trustees approves your application for benefits. Please note that you do not have to apply for benefits at the earliest time that you are eligible.

Please contact ATPA or your local union for help with your initial application.

Ongoing Verification Form

In order to receive continued payment of benefits under this Plan, you may be asked to submit verification of continued eligibility in a form and at times prescribed by the Board of Trustees.

Please contact ATPA or your local union for help with a continued verification forms.

Obligation to Furnish Information to the Board of Trustees

You are obligated to cooperate with the Board of Trustees and to provide any information to assist with eligibility verification when requested within 30 days of the request. If you fail to cooperate with requests for information from the Board of Trustees, they have the authority not to pay benefits under the Plan.

The Board of Trustees may request the following information including but not limited to:

- Your retirement status;

- Tax forms and records from the Social Security Administration concerning employment;
- Your marriage certificate;
- Birth certificates for an eligible Dependent;
- Proof of domestic partners eligibility; and
- A death certificate.

Death

In the event of your death, any remaining balance in your Account will be distributed as a death benefit. The “death benefit” will only be paid after any expenses incurred before your death are paid.

After notice and satisfactory proof of your death has been provided to the Administrative Office and the payment of all eligible expenses incurred before your death are paid (plus any Account expense charges), any remaining Account balance (the death benefit) will be distributed to the following person or persons listed on file with the Plan according to this order:

- surviving spouse, or if none,
- tax eligible domestic partner, or if none,
- to the surviving children in equal shares.

After 180 days, your Account will be forfeited if your surviving dependents (noted above) cannot be identified and located after a reasonable effort has been made to do so.

The provision outlined above applies whether you die during active employment or when you are a covered retiree.

Funding Your Account

An Account will be established in your name during your active employment with a contributing employer. After you retire, eligible healthcare premiums for you and your eligible dependents may be reimbursed from the balance in your Account at the time a claim is submitted. This section of the SPD describes how your Account is funded and how it is administered.

Employer Contributions

Your Account is funded exclusively through contributions made by your employer as negotiated through a Collective Bargaining Agreement or other contribution agreement that has been approved by the Board of Trustees. Contributions received by the Plan will be held in a trust for the purpose of reimbursing healthcare premiums of eligible retirees and their dependents. The assets of the Account are held in trust and are invested by an investment manager appointed by the Board of Trustees.

Accounts will be established for each eligible Participant on the first Valuation Date after the date contributions are made by a contributing employer on behalf of a Participant under the terms of a Collective Bargaining Agreement or contribution agreement accepted by the Board of Trustees. Accounts shall be valued on a quarterly basis.

If your active employment under the Collective Bargaining Agreement ends for any reason, including retirement, contributions to your Account will stop at that time. Contributions made to the Account during any COBRA continuation will not be accepted.

Employee Contributions

You are not permitted to make contributions to your Account. In general, this means no pre-tax, salary reduction contributions under a cafeteria plan (e.g., flex credits) or after-tax employee contributions will be accepted by the Plan. The only contributions that are permitted to the Account are employer contributions.

Account Balances

All reimbursements payable from the Plan will be paid from the assets of the Plan that are held in the Michael J. Day Machinists Retiree Health Investment Trust ("Trust). Your Account is a bookkeeping record to track in writing any contributions and investment gains credited to your Account and losses debited to the Account such as reimbursements, investment losses, and administrative expenses.

The balance in your Account will be determined as of December 31st of each Plan Year. Your balance will be computed by looking at:

1. the balance in your Account on January 1st of the previous year; plus

2. the amount of employer contributions and net investment income credited to your Account during the Plan Year; minus

3. the benefit payments, administrative expenses (including Account expense charges), and investment losses (if any) debited to your Account during the Plan Year.

Account Expense Charge

The **Account expense charge** (how much it has cost to administer the Trust over the past year) will be determined as follows:

1. Determine the total of all operating expenses (net of forfeitures and liquidated damages) incurred by the Plan during the current valuation period (excluding all investment manager and brokerage fees).

2. Determine the number of Accounts that are in existence on the current valuation date.

3. Divide number 1 by number 3. The result is the **Account expense charge** for the valuation period.

Investment Income Factor

The **investment income factor** (the total of the gains and losses on investments that have been applied to the Account over the past year) will be determined as follows:

1. Determine the total net investment income (including gains and losses) for the valuation period, including all realized and unrealized capital gains or losses less any investment manager or brokerage fees. Should the forfeitures and liquidated damages for a year exceed the Plan's operating expenses for that year, the excess will be included in total investment income.

2. Determine the sum of the Account balances on the preceding valuation date, add total Contributions to individual Accounts for the current valuation period, and subtract total Plan payments made since the last valuation date.

3. Divide number 1 by number 3. The result is the **investment income factor.**

The net investment income, including gains and losses, to be allocated to the Participant's Account for the valuation period is obtained by multiplying the investment income factor by the Account balance. This is determined by taking the Account Balance on the preceding valuation date, add total contributions made to the Participant's Account since the last valuation date, and subtract payments made from the Participant's Account since the last valuation date.

Since contributions, investment earnings and expenses are posted to your Account quarterly, during the time between quarterly postings, the Plan will pay up to 80% of your Account balance as of the last valuation date. Any additional amount reimbursable from the Plan will be paid after the next following valuation is made. The valuation date is the last day of each calendar quarter, when the value of the Plan’s investments is determined.

The fact that Accounts are established and valued as of each valuation date will not give any Retiree or Dependents any right, title or interest in the Trust or its assets, or in the Account, except at the time or times and upon the terms and conditions provided in this SPD/Plan Document.

Investment of your Account Balance

The money in your Account is invested conservatively with the goal of the investments being preservation of the principal sum with modest growth. In an environment with low interest rates, the principal sum could go down. The Trustees monitor the Trust closely and can change investments if needed.

Interest on your Account Balance

Any interest accrued from the investments on the money in your Account (after administrative expenses incurred by the Fund are paid) will be allocated to your Account.

Annual Statements

You will receive a statement at the end of each Plan Year reflecting the balance of your Account.

Carryover of Account Balance

Any unused amounts in your Account at the end of a Plan Year will be carried over into the next Plan Year.

Forfeitures

If you leave covered employment before you retire, your Account may be forfeited . Forfeitures will be used by the Board of Trustees to reduce Plan administrative expenses and/or may be reallocated to the Accounts of other participants.

Also, any benefit payments that are unclaimed (e.g., unclaimed benefit checks) within the 12-month period after the close of the Plan Year in which the claim expense was incurred will be forfeited.

Eligible Expenses

You may use the available funds in your Account to pay for "Eligible Medical Care Expenses," as described below. To be considered an "Eligible Medical Care Expense" that qualifies for reimbursement, an expense must:

- be incurred and claimed while you are eligible for reimbursement in accordance with all provisions of the Plan; and
- be substantiated by filing a written claim with the Fund Office and providing evidence that an Eligible Medical Care Expense was Incurred; and
- not be reimbursable from any other health plan or insurance; and
- be incurred by you and/or your eligible Dependents for "medical care," as defined in Internal Revenue Code Sections 105 and 213(d).

Medical Care Expenses

You may use some or all of the money in your Account to pay for certain healthcare premiums and life insurance including premiums for health coverage (medical including acupuncture and physical therapy, dental, vision, prescription drug, orthodontia coverage and life insurance up to $50,000 in coverage). In addition, covered expenses include amounts for such services as hospitalization, doctors and dentists, prescription drugs and amounts you pay for deductibles, copays or coinsurance, However, not all medical care expenses will be considered "Covered Expenses" that qualify for reimbursement under the Fund. Generally, only expenses within the meaning of Section 213 of the Internal Revenue Code are eligible.

Common Medical Care Expenses include: acupuncture, contraceptives, chiropractic services, contact lenses/eyeglasses, crutches, dental treatment but not teeth whitening, diabetic supplies, eye examination by an optometrist, device to measure blood pressure, fertility treatment, surgical dressing supplies, elastic bandages like an Ace wrap, hearing aids, immunizations and flu shots, laboratory tests, LASIK eye surgery, tobacco cessation drugs, orthodontia treatment/dental braces, walker/wheelchair and weight loss programs/weight loss drugs only if recommended by a Physician to treat a specific medical condition (e.g. diabetes, obesity, heart disease), and for retirees, the premiums for Medicare medical and prescription drug coverage.

However, not all Medical Care Expenses will be considered "Eligible Medical Care Expenses" that qualify for reimbursement under the Fund. Generally, only Medical Care Expenses within the meaning of Section 213 of the Internal Revenue Code are eligible.

If you have any questions as to whether an expense is reimbursable, call the Fund Office.

Note: The Account can be used for eligible expenses for you, your spouse (or domestic partner) and your eligible dependents.

Excludable Expenses

The following expenses are examples of the kinds of expenses that are not reimbursable, as they do not meet the definition of "medical care" under Code Section 213. This is not intended to be a complete list of all services that are not payable under the Plan, but an example of more commonly submitted services that are not reimbursed

from the Plan. The Plan does not pay for/reimburse any item that does not constitute "medical care" as defined under Internal Revenue Code §213.

1. Long-term care (LTC) services.
2. Cosmetic surgery/services, ear piercing, hair removal or other similar cosmetic procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
3. Funeral and burial expenses.
4. Massage therapy to improve general health.
5. Custodial care.
6. Babysitting and child care expenses.
7. Costs for sending a problem child to a school for benefits that the child may receive from the course of study and/or disciplinary methods.
8. Health club or fitness program dues.
9. Social activities, such as dance lessons and swimming lessons to improve general health.
10. Cosmetics, toiletries, toothpaste, etc.
11. Vitamins, food supplements, diet food, even if prescribed by a physician.
12. Uniforms or special clothing, such as maternity clothing.
13. Automobile insurance premiums.
14. Transportation expenses except in certain circumstances where transportation is necessary to receive medical care.
15. Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
16. Premiums paid through salary reduction contributions under the terms of a Code Section 125 Plan or any Plan that provides for premium payment with pre-tax dollars.
17. COBRA premiums that an Employee pays on an after-tax basis.
18. Over-the-Counter drugs and medicine unless prescribed by a health care provider or physician.

DEBIT CARD

Eligible Health Care Expenses under the Plan may be paid or reimbursed with a Debit Card that ATPA will provide to you when you become eligible for benefits. Prior to receiving the care, you must agree, in writing, to:

- only use the Debit Card to pay for eligible expenses incurred by the Employee, or his or her spouse or Dependents;
- not use the Debit Card for any medical expense that has already been reimbursed;
- not seek reimbursement under any other health Plan for any expense paid for by the Debit Card; and
- acquire and maintain documentation, such as invoices and receipts, to substantiate any expenses paid for with the Debit Card.

The Plan will limit use of the Debit Card to:

- physicians, dentists, vision care offices, hospitals, or other medical providers (as identified by their merchant category code);
- stores with a merchant category code for drugstores and pharmacies that comply with applicable IRS regulations;
- stores that have implemented an inventory information approval system consistent with applicable IRS regulations.

All claims for eligible expenses paid with your Debit Card need to be substantiated in a manner consistent with IRS guidance.

Correction Procedures for Improper Debit Card Payments

If a Covered Employee receives payments under this Plan via a Debit Card that exceed the amount of Eligible Health Care Expenses substantiated by the retiree, ATPA will immediately notify the retiree in writing of any such improper payment and de-activate the Debit Card until the full amount of the improper payment is recovered.

Claims and Appeals Procedures

The following procedures must be followed in order to receive a reimbursement from your account.

Filing a Claim for Reimbursement

Claims Submission

To be reimbursed for your eligible expenses, you must complete a claim form and submit it to ATPA within 12 months of the date the expense was incurred. The eligible expense cannot exceed your Account balance at the time reimbursement is requested.

Incurred expenses must total at least $100 before they can be submitted for reimbursement. You may include multiple Eligible Medical Care Expenses to be included in a claim in order to reach the $100 minimum. If your claim(s) do not meet or exceed the $100 limit, you may submit one claim per quarter.

Claim forms are available from ATPA.

Substantiation (Supporting Documentation)

As part of the process to substantiate reimbursement for eligible expenses, you must submit a properly completed claim form with any required supporting documentation, in accordance with the Plan's claim procedures as described in this SPD/Plan Document. The claim for the eligible expenses must be incurred on or after the date your Account became effective and demonstrate that:

- You have not been, and will not be, reimbursed for these expenses by any other health plan, insurance, or other source or entity;
- You have not deducted, and will not deduct, any of the expenses reimbursed through the Plan on your individual income tax return; and
- Premiums submitted for reimbursement were not made through salary reduction contributions under the terms of an IRC Section 125 Plan.

Along with the claim form, you must provide any of the following, as applicable:

- Proof of the amount, the name of the covered person, date paid, and coverage period for other insurance premiums, such as a spouse's group health coverage premiums, and verification that the premium was not paid or eligible for payment under an IRC Section 125 Plan.
- Bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that ATPA may request.
- Any additional documentation requested by the Plan.

Where to File a Claim

To file a claim for reimbursement, send your completed claim form and supporting documentation to:

Michael J. Day Machinists Retiree Health Investment Plan
Associated Third Party Administrators
Post Office Box 23263
Oakland, CA 94623

Claims Decisions

Within 30 days of the date you submitted your claim and supporting documentation, you will either be reimbursed or provided with a notification that your claim has been denied. If additional time for reimbursement is needed, due to matters beyond the control of the Plan, you will be informed of the extension within this 30-day deadline. If additional information is needed before your claim can be processed, you will be notified within the 30-day period. You will then have up to 45 days to provide the requested information. After 45 days or the date information is received, whichever is earlier, the Plan will notify you of its decision within 15 days.

Denied Claims

If your claim is denied, the Plan will notify you within 30 days of the date the claim was submitted. The denial notice will provide:

- The specific reason(s) for the decision;
- Any references to provision(s) in the Plan on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of why it is needed;
- A copy of the Plan's review procedures and time periods to appeal your claim;
- A statement that a copy of any rule, guideline, or protocol relied upon by the Plan in denying your claim is available for your review; and
- A statement that a copy of any scientific or clinical judgment used by the Plan in denying your claim is available for your review.

You, or your authorized representative, have the right to appeal a denial of your claim and have your claim reviewed again by the Board of Trustees. An appeal must be filed with the Plan no later than 180 days after the date the claim was initially denied.

Your appeal must be in writing and explain the reasons you disagree with the decision on your claim. When filing an appeal, you may:

- Submit additional materials, including comments, statements, or documents in support of your appeal;
- Request a review of all relevant information pertaining to claim (free of charge);

- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and

- Request a copy of any explanation of the scientific or clinical judgment (if any) on which the denial was based.

Where to File an Appeal: Send your written appeal to:

Michael J. Day Machinists Retiree Health Investment Plan
Associated Third Party Administrators
1640 South Loop Road, Alameda, CA 94502
Post Office Box 23263, Oakland, CA 94623

Appeals Decisions: If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made by the Board of Trustees. The Trustees will not consider or defer to the initial decision in making their determination about the appeal.

A determination will be made at the Trustees' next regularly scheduled quarterly meeting following receipt of your appeal.

If the Trustees' deny your appeal, you will receive a notice providing:

- The specific reason(s) for the decision;

- The reference(s) to Plan provision(s) on which the decision was based;

- A statement that you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA); and

- A statement that you have the right to look at and/or copy (free of charge) any rule, guideline, protocol, or similar criteria, any scientific or clinical judgment, and any documents, records, or other information relevant to your claim.

Following issuance of a decision on appeal, there is no further right under these procedures to appeal or arbitrate the decision.

If you are not satisfied with the appeal decision after the Plan's appeals process has been exhausted, you have the right to file a civil action against the Plan in accordance with Section 502(a) of ERISA. However you must exhaust your administrative remedies as outlined in this SPD. Failure to exhaust your administrative remedies will preclude further judicial review.

Authorized Representative

You may appoint in writing an authorized representative to act on your behalf in pursuing a claim or appeal, including a healthcare professional with knowledge of your medical condition. There is no required signed form for this purpose. In the case of a claim involving urgent care, a healthcare professional with knowledge of your medial condition will be permitted to act as an authorized representative without written authorization.

Contact APTA to appoint an authorized representative.

Rights of the Board of Trustees

The Board of Trustees possesses full authority and discretion to interpret the terms of the Trust Agreement and this SPD/Plan Document. The Board retains the right to interpret and amend these claims procedures. Furthermore, if these procedures are ambiguous or do not provide an explicit procedure for a specific circumstance, the Board is authorized to adopt such rules as it in its discretion deems necessary and appropriate to provide Claimants with appropriate initial determinations and an opportunity for a full and fair review of any adverse benefit determination.

The Board of Trustees expressly reserves the right in its sole discretion at any time and from time to time to:

1) Increase, decrease, or modify the conditions that have to be met before a benefit is payable and such changes may be made applicable to claims in process or which are made in the future;
2) Amend, alter, or modify any eligibility requirement for benefits under this Plan;
3) Amend any provision of the SPD/Plan Document; or
4) Terminate the Plan in full.

Limitations of Liability

Neither the establishment of the Plan or the Trust nor any modifications thereto, nor the payment of any benefits shall be construed as giving any person any legal or equitable right of action or recourse against the Board of Trustees or its agents or employees, except as provided in the Plan and in the Trust Agreement.

Non-Affiliation

The health insurer or health plans to which the Trust makes payments are separate and distinct from the Trust and are not agents of the Trust.

Non-Assignment of Benefits

You do not have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payments (except in the case of a Qualified Child Medical Support Order). The benefits of this Trust are not subject to levy or execution or attachment or garnishment.

Extent of Liability

The benefits provided by this Plan are not insured by any contract of insurance, and there is no liability on the Board of Trustees or other individual or entity to provide payment over and beyond the amount in the Trust collected and available for purposes of the Plan.

Privacy Policy

The Board of Trustees of the Retiree Health Investment Plan and its Business Associates are required to protect the confidentiality of your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

- Receive confidential communications of your protected health information, as applicable;
- See and copy your health information;
- Receive an Accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact ATPA or your local union.

General Provisions and Information Required by ERISA

Plan Sponsor

The Plan is sponsored by the Board of Trustees of the Michael J. Day Machinists Retiree Health Investment Plan. The Board of Trustees consists of employer and union representatives selected by your employers and unions that have entered into Collective Bargaining Agreements that relate to this Plan.

The Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of ERISA.

To contact the Board of Trustees, you may use the address and phone number below:

Michael J. Day Machinists Retiree Health Investment Trust
c/o Associated Third Party Administrators
1640 South Loop Road, Alameda, CA 94502
Post Office Box 23263, Oakland, CA 94623
Phone: 510-836-2484

Names and addresses of the Trustees

Employer Trustees

Ms. Denise Gasti
United Parcel Service, Inc. (UPS)
8475 Pardee Drive
Oakland, CA 94621

Mr. John Rosselle
SSA Terminals, LLC
1717 Middle Harbor Road
Oakland, CA 94607

Union Trustees

Mr. James Beno
IAM & AW District Lodge 190
7717 Oakport Blvd., Suite 1
Oakland, CA 94621

Mr. Donald D. Crosatto
Automotive Machinists Local No. 1546
10260 MacArthur Boulevard
Oakland, CA 94605

Discretion and Authority of Board of Trustees

The Board of Trustees has full discretion and authority to interpret the terms of all documents establishing this Plan, including but not limited to, the rules of eligibility. Benefits are only provided if the Trustees (or their delegate) decide, in their discretion, that the individual is entitled to them under the Plan's terms. You will receive written notice of any Plan amendments.

The Board of Trustees also decides any factual question related to eligibility for and amount of benefits. The decision of the Board of Trustees is final and binding and will receive judicial deference to the extent that they do not constitute an abuse of discretion.

No Guarantee of Continued Employment

Your coverage by this Plan does not constitute a guarantee of your continued employment or participation in this Plan and you are not vested in the benefits described in this SPD/Plan Document. The Trustees reserve the right to amend, modify, or terminate the Plan or any of its benefits at any time.

Plan Administrator

The Board of Trustees has delegated administrative responsibilities of the Plan to ATPA, an independent third party administrator.

Plan Funding

The Plan is funded exclusively through employer contributions and benefits are paid from the assets of the Trust.

Parties to the Collective Bargaining Agreement

The Plan is maintained pursuant to Collective Bargaining Agreements. The Collective Bargaining Agreements determine the amount of contributions and employees on whose behalf an Employer is required to contribute. Participants and dependents may obtain, upon written request to the Plan Administrator, information as to the address of a particular employer and whether an employer is required to pay contributions to the Fund.

You may obtain a copy of the Collective Bargaining Agreement under which you are covered, at a reasonable charge, upon written request to the Plan Administrator. You may also review these agreements, at no charge, at the Plan Administrator's Office, at the principal office of each participating Union, and at employer worksites at which 50 participants customarily work.

Plan Name

The name of the Plan is the Michael J. Day Machinists Retiree Health Investment Plan.

Name of Trust

The name of the Plan is the Machinists Retiree Investment Trust ("Trust").

Plan Number

The Plan Number is 501.

Plan Sponsor EIN

The employer identification number of the Fund, which is the Plan Sponsor, is 41-2061777.

Plan Year

The Plan Year begins on January 1 and ends on December 31.

Agent for Service of Legal Process

The agent, for the purpose of accepting service of legal process on behalf of the Trust is:

Saltzman & Johnson Law Corporation
44 Montgomery Street, Suite 2110
San Francisco, California 94104

However, such documents may also be served upon any individual Trustee of the Plan.

Plan Type

This Plan is a welfare Plan which consists of individual Retiree spending Accounts to be used to provide financial assistance to eligible retirees and their eligible dependents by paying for certain eligible expenses (as described in this SPD/Plan Document).

Circumstances Which May Result in Ineligibility or Denial of Benefits

A Participant who has not satisfied all of the eligibility requirements will not receive any benefits under the Plan.

Use of Assets upon Termination of Plan

The Board of Trustees possesses the authority to terminate any of the Trust's Plans. In the event this Plan is terminated, any and all remaining Trust monies and assets, after payment of expenses, shall be used for the continuation of the benefits provided by the then existing Plan or similar benefits, until such monies and assets have been exhausted.

ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

Receive Information About Your Plan And Benefits: As a Plan Participant, you have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies); and

- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each participant.

Continue Group Health Plan Coverage: Also, you have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan because of a qualifying event. (You or your dependents may have to pay for such coverage; review this Summary Plan Description and any documents governing the Plan on the rules governing your COBRA continuation coverage rights.); and

- Reduce or eliminate 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;

  - become entitled to elect COBRA continuation coverage; or

  - lose COBRA continuation coverage.

  In addition, you may request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to preexisting 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a 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 the Plan Documents or the latest annual report from the Plan 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. 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 federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been 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 Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA. For single copies of publications, contact the EBSA brochure request line at (800) 998-7542 or contact the EBSA field office nearest you.

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the Web site of the EBSA at www.dol.gov/ebsa.

"Account" means the Account established on your behalf after contributions are made by a contributing employer. Employer contributions will be made to your Account in accordance with the terms of your Collective Bargaining Agreement. Your Accounts may be increased by discretionary allocations of investment income and may be reduced by administrative expenses.

"Account Balance" refers to the value of the Account established for you under the Plan to receive contributions and to be credited or debited with its share of Plan earnings, losses and expenses.

"Board of Trustees" refers to the Board of Trustees of the Michael J. Day Machinists Retiree Investment Trust.

Collective Bargaining Agreement (or Participation Agreement) refers to the agreement between contributing employers and the Board of Trustees. Contributions are accumulated under the provisions of the Collective Bargaining Agreement for the purpose of helping retirees pay for the cost of retiree healthcare premiums and be reimbursed for Qualified Medical Expenses.

"Dependent" refers to:

- Your legal spouse (as determined by the Federal Defense of Marriage Act (DOMA) regulations);
- Tax-qualified Domestic partner that is registered with a governmental agency.
- Unmarried children up to age 26 (including natural children, adopted step-children, adopted children, children of a domestic partner, children placed for adoption and children of divorced parents where either you or your ex-spouse have custody of the children.)
- Disabled Adult Child: This includes an unmarried Dependent Child age 26 and older who is permanently and totally disabled with a disability that existed prior to the attainment of the Plan's age limit and who is eligible for tax-free coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c)or 152(d) or who will be claimed as a dependent on the retiree's federal income tax return for each Plan Year for which coverage is provided.

"Domestic Partner" is a tax qualified adult person who has registered as a domestic partner of an unmarried Participant on a governmental agency registry for that purpose and who satisfies the requirements of that agency for being a domestic partner.

"Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 105 and 213(d) (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs). Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents will be charged against the Participant's HRA Account.

- "Medical Care Expenses" will not include (1) health insurance premiums for individual policies or for any other group health plan (including a Plan sponsored by

the Employer); and (2) the expenses listed as exclusions for this Plan. Notwithstanding the foregoing, an HRA account may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health Plan sponsored by the Employer.

- Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Plan.

"Participant" refers to a person on whose behalf a contribution has been received.

"Plan" refers to the Trust's Plan, entitled Michael J. Day Machinists Retiree Health Investment Plan.

“Surviving spouse” refers to an individual lawfully married to a Participant at the time of the Participant’s death.

“Valuation Date” refers to the last day of each calendar quarter.