PENSIONERS' HEALTH BENEFITS

Plans

W-1 and W-102

SUMMARY PLAN DESCRIPTION AND RULES AND REGULATIONS

Bakery and Confectionery Union and Industry International Health Benefits Fund

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[The sixth, seventh and eighth trustee positions are vacant at the present time.]

EXECUTIVE DIRECTOR:	Robert J. Bergin
CONSULTANT AND ACTUARY:	The Segal Company
LEGAL COUNSEL:	Bredhoff & Kaiser, P.L.L.C.
	•
	Littler Mendelson, P.C.
ACCOUNTANTS:	Bond Beebe, P.C.

BAKERY AND CONFECTIONERY UNION AND INDUSTRY INTERNATIONAL HEALTH BENEFITS FUND

10401 Connecticut Avenue, Kensington, MD 20895-3960
(301) 468-3731

Dear Pensioner:

This booklet describes the health benefits by which you and your dependents will be covered under the Pensioners' Health Benefit Plan (the "Plan") if you meet the eligibility requirements, enroll at the proper time, and pay the applicable premiums, as explained in Article 2. If you are age 65 or older (or eligible for early Medicare), the Plan pays most benefits not covered by Medicare after you meet an annual deductible. If you are under age 65 (unless you are eligible for early Medicare), the Plan pays major medical benefits. You are generally limited to a lifetime maximum of $10,000 in benefits, but you may increase the maximum to $100,000 by paying additional premiums. The Plan also pays your prescription drug costs after you satisfy an annual deductible and required co-pays. Prescription drug benefits are not counted in determining whether you have used up your $10,000 or $100,000 lifetime maximum benefits.

If you are age 65 or older (or are eligible for early Medicare), instead of the coverage described above, which is known as "Plan W-1," you may elect coverage under a different program, known as "Plan W-102." You will pay more for routine medical expenses under Plan W-102 than you would under Plan W-1, but coverage for most catastrophic expenses is far better and the lifetime maximum benefits are $250,000, which is much higher than under Plan W-1. Under no circumstances will you be eligible to participate in more than one of the W-Plans at one time.

The Board of Trustees has had extensive deliberations with the consultants, administrators and counsel to the Fund to be sure that the Plan provides the best coverage possible for the monies available. You should be aware, however, that the Plan is not funded on a long-term basis. It is set up on a pay-as-you-go basis. The benefits are not guaranteed for your life or for any other period of time. Benefits may continue unchanged; they may increase, or regrettably, decrease; and coverage may be limited or discontinued. Each change is within the discretion of the Board of Trustees based on its review of the cost and the expected income of the Plan.

We hope you will have a long and happy retirement and that this Plan will help provide peace of mind during that time.

Sincerely,

Frank Hurt
Union Trustee and
Chairman of Board of Trustees

Richard B. Cook
Employer Trustee and
Secretary of Board of Trustees

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GENERAL INFORMATION

Your Pensioners' Health Benefits Plan is a part of the Bakery and Confectionery Union and Industry International Health Benefits Fund (the "Fund"), which is administered by a joint Board of Trustees consisting of eight Union representatives and eight Employer representatives. The Board of Trustees is the Fund Administrator and has been designated as the agent for the service of legal process. Its address is 10401 Connecticut Avenue, Kensington, Maryland 20895-3960. Service of process may also be made on any Trustee or on the Executive Director of the Fund, Robert J. Bergin.

Contributions to the Fund for benefits under this Plan are made by Employers in accordance with their collective bargaining agreements with Local Unions (or other written agreements with the Fund) at fixed rates per hour worked. Premiums are also paid by Pensioners in accordance with the appropriate schedule, which is available from the Fund Office. The Fund Office will provide you, upon written request, with information on the contribution rate for Pensioners, information as to whether a particular Employer is contributing to the Fund in accordance with a collective bargaining agreement and, at reasonable cost, a copy of any collective bargaining agreement requiring contributions to the Fund.

The premium rates for Pensioners and contribution rates for Employers are determined by the Board in its sole discretion, and may be revised by the Board from time to time.

Benefits are provided from the Fund's assets, which are accumulated in a separate account under the trust agreement establishing the Fund (the "Trust"). These assets are held in trust for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's assets and reserves are deposited in PNC, 2 Hopkins Plaza, Baltimore, MD 21203. Assets for the W-Plans are kept in a separate account and are not mixed with the assets for any of the Health Benefits Fund's other plans of benefits. All benefits for this Plan are paid from those assets. The assets in the account for W-Plans may be used only for W-Plan benefits and administrative expenses. (Similarly, the assets held in the Trust for other plans of benefits under the Health Benefits Fund may not be used to provide benefits under the W-Plans.)

All assets properly contributed to and held in the Trust are for the exclusive benefit of Fund participants and beneficiaries and may not inure to the benefit of a contributing employer or to any other party. The Fund may refund contributions made in error, as long as doing so would be consistent with the actuarial soundness of the Fund, in the exclusive discretion of the Fund's Board of Trustees.

Some of the Fund's contracts with Providers allow discounts, allowances, adjustments and settlements. These amounts are for the sole benefit of the Fund and the Fund will retain any payments resulting therefrom for the future benefit of all participants. All claims submitted to the Fund will have co-payments, coinsurance and deductible amounts calculated without regard to any such discounts, allowances or incentives.

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:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Fund 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.
- Receive a summary of the Fund's annual financial report. The Fund Administra¬tor is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review Article 7 of this summary plan description for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund. The people who operate the Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of you and other Plan partic-

ipants 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan 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 Fund 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal or state court. 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. If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Privacy Notice

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("HIPAA")

THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Information We Have. We receive enrollment information about you which includes your date of birth, sex, identification number and other personal information. We also receive bills, physician reports and other information about your medical care.

Our Privacy Policy. We care about your privacy and we guard your information carefully. We are required by law to maintain the privacy of that information and to provide you with this notice of our legal duties and our privacy practices. We will not sell any information about you. Only people who have both the need and the legal right may see your information. Unless you give us a written authorization, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so. Disclosures for treatment, payment and business operation may be made to our vendors and subcontractors.

Treatment. We may disclose medical information about you for the purpose of coordinating your healthcare. For example, we may notify your personal doctor about treatment you receive in an emergency room.

Payment. We may use and disclose medical information about you so that the medical services you receive can be properly billed and paid for. For example, we may ask a hospital emergency department for details about your treatment before we pay the bill for your care.

Business Operations. We may need to use and disclose medical information about you in connection with our business operations. For example, we may use medical information about you to review the quality of services you receive.

As Required By Law. We will release information about you when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

Authorizations. If you give us a written authorization to do so, we may use and disclose your personal information. If you give us a written

authorization, you have the right to change your mind and revoke that authorization.

Copies of this Notice. You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

Changes to this Notice. We reserve the right to revise this Privacy Notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. You will be advised as to any changes to our notice.

Your Right to Inspect and Copy. Upon written request, you have the right to inspect the information we have about you and to get copies of that information.

Your Right to Amend. If you feel that the information about you which we have is incorrect or incomplete, you can make a written request to us to amend that information. We can deny your request for certain limited reasons, but we must give you a written reason for our denial.

Your Right to a List of Disclosures. Upon written request, you have the right to receive a list of our disclosures of your information, except when you have authorized those disclosures or if the disclosures are made for treatment, payment or health care operations. We are not required to give you a list of disclosures made before April 14, 2003.

Your Right to Request Restrictions on Our Use or Disclosure of Information. If you do so in writing, you have the right to request restrictions on the information we may use or disclose about you. We are not required to agree to such requests.

Your Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we only contact you only at home or only at a certain address or only by mail.

How to Use Your Rights Under This Notice. If you want to use your rights under this notice, you may call us or write to us. If your request to us must be in writing, we will help you prepare your written request, if you wish.

Complaints to the Federal Government. If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to: Office of the Secretary, Department of Health and Human Services, 200 Independence Avenue,

S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint with the federal government.

Complaints and Communications to Us. If you want to exercise your rights under this Notice or if you wish to communicate with us about privacy issues or if you wish to file a complaint, you can write to: Bakery and Confectionery Union and Industry International Health Benefits Fund, 10401 Connecticut Ave., Kensington, MD 20895, Attn: Privacy Officer. You can also call us at 301-468-3731. You will not be penalized for filing a complaint.

If you have any difficulty understanding any part of this booklet, contact Mr. Robert J. Bergin, the Executive Director of the Fund, at 10401 Connecticut Avenue, Kensington, MD 20895-3960. You may also call the Fund Office at (301) 468-3731 for assistance. Office hours are from 8:00 A.M. to 4:00 P.M., Monday through Friday.

Employer Identification Number: 53-0227042
Plan Number: 501
Plan Year: January 1 - December 31

Este folleto contiene un resumen en Inglés del Plan de beneficios y derechos bajo el Bakery and Confectionery Union and Industry International Health Benefits Fund para los empleados retirados. Si tiene dificultad en entender alguna de las partes de este folleto, escriba al Sr. Robert J. Bergin, Director del Fondo, a 10401 Connecticut Avenue, Kensington, MD 20895-3960. También puede llamar a la oficina al teléfono (301) 468-3731. Las horas de la oficina son de 8:00 A.M. a 4:00 P.M., de lunes a viernes.

ARTICLE I
DEFINITIONS

Whenever the capitalized terms below are referred to in this booklet, they should be interpreted in accordance with the following definitions:

Section 1.1. Alcoholic, Drug or Psychiatric Treatment Facility. A facility that has been approved by the Joint Commission on the Accreditation of Hospitals for the purpose of providing treatment for alcohol or drug abuse, or for Mental and Nervous Disorders.

Section 1.2. Ambulatory Surgical Facility. An institution that:

(a) Is established primarily for the purpose of performing surgical procedures on an outpatient basis;

(b) Maintains diagnostic and therapeutic facilities;

(c) Provides full-time services of registered professional nurses for patient care; and

(d) Is operated under the supervision of a staff of qualified Physicians.

Section 1.3. Board. The persons from time to time who are acting collectively as the Board of Trustees of the Fund appointed to control and manage the operation and overall administration of the Fund.

Section 1.4. Covered Employment. Employment by an Employer under an agreement that requires the Employer to contribute to the Fund for benefits under the Plan, or by the Fund or the Pension Fund.

Section 1.5. Covered Expense. A charge that is allowable under the Fund. It is a charge incurred upon the recommendation and approval of the attending Physician for a service or supply that is Medically Necessary for the diagnosis, treatment, mitigation or cure of an Illness of, or an Injury to, a structure or function of the mind or body. No amount in excess of the actual charge for a service or supply shall be considered a Covered Expense. No amount in excess of the Maximum Allowable Charge shall be considered a Covered Expense.

Section 1.6. Covered Medical Expenses. The Covered Expenses described in Section 3.4.

Section 1.7. Dependent. A Dependent includes:

(a) a Participant's spouse,

(b) each of the Participant's unmarried children or stepchildren (or persons for whom the Participant has been appointed legal guardian) from birth until his or her 19th birthday (or 23rd birthday if living at home and registered as a full-time student of an accredited educational institution);

(c) each of the Participant's unmarried children or stepchildren who resides in the United States or Canada who is wholly dependent upon the Participant for support and who is incapable of self-support because of mental or physical incapacity that existed prior to reaching 19 years of age and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months; and

(d) any Alternate Recipient as identified in and as required by any Qualified Medical Child Support Order, but only to the extent required by such Qualified Medical Child Support Order.

Any Dependent (as defined in this section) who does not meet the age or support requirements applicable under Internal Revenue Code Section 106 for nontaxable health coverage, may be covered by the Fund only upon the timely payment of amounts set from time to time by the Fund Office as the amount that the Fund is required to withhold in taxes for the health coverage. A Dependent will be eligible for benefits only if he or she was enrolled as specified in Section 2.2(d) and if his or her eligibility for benefits has not been terminated as specified in Section 2.5.

Section 1.8. Employer. Any of the following:

(a) A signatory to a collective bargaining agreement with a Local Union that requires contributions to the Fund.

(b) A Local Union that has signed a written agreement with the Fund agreeing to make contributions to the Fund on behalf of its full-time salaried employees, or that has executed a collective bargaining agreement with a labor organization providing for contributions to the Fund.

(c) The Union.

(d) The Fund.

(e) The Pension Fund.

(f) A Federal Credit Union that is affiliated with or sponsored by a Local Union, where a written agreement is in effect between such credit

union and the Fund providing for contributions to be made to the Fund on behalf of its employees.

Section 1.9. Fund. The Bakery and Confectionery Union and Industry International Health Benefits Fund.

Section 1.10. Hospice Care. Services provided at home, in a freestanding hospice facility or by a hospice team in a hospital for the terminally ill where there is a medical prognosis of six months or fewer to live, or the patient is in the final stages of an incurable illness.

Section 1.11. Hospital. An institution that:

(a) Is engaged primarily in medical care and treatment of sick and injured persons on an inpatient basis and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under supervision of qualified Physicians;

(b) Continuously provides twenty-four hours a day nursing service by or under the supervision of registered graduate nurses and is operated continuously with facilities for operative surgery; and

(c) Is not, other than incidentally, a place of rest, a place for the aged, or a nursing home.

Section 1.12. Illness. A disease, disorder or condition that requires treatment by a Physician.

Section 1.13. Injury. Damage to the body that requires treatment by a Physician.

Section 1.14. Local Union. Any local union affiliated with the Union.

Section 1.15. Maximum Allowable Charge. The Maximum Allowable Charge for any supply or service shall be the lesser of: a) the usual charge made by that Physician, or other provider of services or supplies; b) an amount stipulated by the Board as the maximum reasonable charge for that procedure, which is generally equivalent to what Medicare allows even if you are under age 65; and c) the amount normally charged by a selected segment of Physicians or other providers in that geographic area (such segment and area as defined by the Board).

Section 1.16. Medically Necessary. Services or supplies furnished, prescribed or ordered by a Physician to identify or treat an Illness or Injury, the furnishing of which is consistent with the diagnosis and treatment of the patient's condition in accordance with standards of good medical practice. That service or supply must be required for reasons other than

the convenience of the patient or Physician and must be the most appropriate level of service or supply that can be provided safely for the patient. When the term Medically Necessary is used to describe inpatient care in a Hospital, it means that the patient's medical symptoms and condition are such that the service or supply cannot be provided safely to the patient on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Physician does not necessarily mean that the services and supplies are Medically Necessary. The Board in its sole discretion shall determine whether services and supplies are Medically Necessary.

Section 1.17. Mental and Nervous Disorder. Neurosis, psychoneurosis, psychopathy, psychosis, or other emotional manifestation of any disease or disorder whether its cause is emotional, psychological or physical.

Section 1.18. Participant. A Pensioner who has met the requirements set forth in Sections 2.1 and 2.2 to receive benefits from the Plan, and whose eligibility for benefits has not terminated as specified in Section 2.5. When this Summary Plan Description uses the term "You," it means Participants or (as used in Article 2) employees who may become Participants.

Section 1.19. Pension Fund. The Bakery & Confectionery Union and Industry International Pension Fund.

Section 1.20. Pensioner. An individual who is receiving benefits from the Pension Fund or another pension plan sponsored by an Employer.

Section 1.21. Physician. A duly licensed medical doctor (M.D.), acting within the scope of his or her license, or certain duly licensed practitioners performing services that would be payable under the Fund if performed by a medical doctor. The Fund Office will provide you, upon request, a list of such licensed practitioners.

Section 1.22. Plan. This Pensioner's Health Benefits Plan, which is maintained under the Fund and which includes Plan W-1 and Plan W-102.

Section 1.23. Room and Board Charges. All charges for room, board, general duty nursing, and any other charges by whatever name such charges are called, which are made by the hospital as a condition of occupancy of the class of accommodations occupied. Charges for the professional services of Physicians are paid separately: they are not included as Room and Board Charges.

Section 1.24. Spouse. The person to whom a Participant is married in a legal union between one man and one woman as husband and wife,

which is recognized under the law of the state in which the Participant is domiciled.

Section 1.25. Union. The Bakery, Confectionery, Tobacco Workers and Grain Millers International Union.

Section 1.26. Urgent Claim. A claim for medical care or treatment where delay would (1) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (2) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

ARTICLE 2
ELIGIBILITY AND ENROLLMENT

Section 2.1. Eligibility. You will be eligible to become a Participant if you meet all of the following requirements in part (a) and either part (b) or (c) below:

(a) You must be a Pensioner—that is, you must be receiving pension benefits from the Pension Fund or from another pension plan sponsored by an Employer.

(b) You must generally become eligible to become a Pensioner no later than four months after leaving continuous Covered Employment (as defined below). However, if you have 15 or more years of pension credit under the Pension Fund (or an equivalent amount of pension credit under another pension plan to which your former Employer contributes, as determined by the Board), you must become eligible to become a Pensioner no later than three years (or five years, if you ceased Covered Employment as a result of a permanent reduction in workforce) after leaving continuous Covered Employment (as defined below).

For purposes of this subsection (b), continuous Covered Employment means 20 or more hours of Covered Employment per week, for a period of at least six months, including at least 504 hours for which your Employer contributed to the Fund for benefits under the Plan.

(c) If you are a Pensioner of a business unit or group purchased or otherwise acquired by an Employer, you will be eligible to be a Participant if all of the following conditions are satisfied:

(1) You are currently receiving retiree health benefits under another plan;

(2) When you were working for the unit or group acquired by the Employer, you worked in a job classification, or performed work, similar to the job classification or work of employees for whom the Employer makes contributions to this Plan; and

(3) The Employer enrolls you in this Plan within 91 days of the acquisition by paying the appropriate monthly premium established by the Trustees.

If you become eligible to be a Participant in this manner, you will not be required to enroll pursuant to Section 2.2, but you may be required to pay Participant premiums and Dependent premiums (if applicable), as provided by Section 2.4. You will remain a Participant for so long as the Employer continues to pay the monthly premium established by the Trustees for enrollments pursuant to this section, unless you cease to be a Participant for any of the reasons described in Section 2.5.

Section 2.2. Becoming a Participant. You will become a Participant in the Plan if you meet the eligibility requirements set forth in Section 2.1 and enroll in the Plan at the following times:

(a) Age 65 and Older. If you are age 65 or older when you become a Pensioner, you may enroll in the Plan at either of the following times: (i) when you receive your first pension check, or (ii) during the 90 days following the expiration of your coverage under the Fund or another employer health benefits plan (including coverage as a dependent, or COBRA continuation coverage). If you do not enroll in the Plan at one of these times, you will not be eligible to enroll at any other date.

(b) Under Age 65. If you are under age 65 when you become a Pensioner you may enroll in the Plan at any of the following four times: (i) when you receive your first pension check; (ii) during the 90 days following the expiration of your coverage under the Fund or other employer health benefits plan (including coverage as a dependent or COBRA continuation coverage); (iii) during the 90 days following the date on which you enroll in Medicare Part A and B prior to age 65 or (iv) if your pension began after December 31, 1988, when you reach age 65. If you do not enroll in the Plan at one of these four times, you will not be eligible to enroll at any other date.

(c) Once you select participation in either Plan W-1 or Plan W-102, that selection may be changed only in the following circumstances:

(1) If you enroll in Plan W-1 prior to age 65 and before you are eligible for Medicare, you will be given the opportunity to convert your coverage to Plan W-102 when you turn 65 or become eligible for early Medicare.

(2) If you first enroll in Plan W-1 but later convert that coverage to Plan W-102, you will be permitted to re-enroll in Plan W-1 during a period of 90 days beginning on the date when you converted your coverage to Plan W-102, but not at any time after that 90-day period.

(3) If you enroll in Plan W-102 when you are first eligible, you will be permitted to change your selection to Plan W-1 within a 90-day period beginning on the date of your enrollment in Plan W-102, but not at any time after that 90-day period.

(d) Dependents. You must generally enroll Dependents at the same time that you enroll yourself, with the following exceptions:

(1) If you have a Dependent who is eligible for coverage under the Fund as an active employee or dependent of an active employee, that Dependent is not eligible for coverage under the Plan. You may enroll your Dependent in the Plan at any time during the 90 days following the date on which the Dependent's coverage under the Fund as an active employee or a dependent of an active employee (including any extension of coverage that your Dependent elects under COBRA) ceases.

(2) If you have a Dependent who is covered under another plan of group health insurance sponsored by an employer, you may enroll that Dependent in the Plan at any time during the 90 days following the date on which that Dependent's coverage under the other group health insurance (including any extension of coverage that your Dependent elects under COBRA) ceases.

(3) If you become a Pensioner and enroll in the Plan before you reach age 65, you may defer enrolling your Dependents until you reach age 65.

(4) If an employee becomes a Pensioner before age 65, elects to defer enrollment, and dies before reaching age 65, the Pensioner's surviving spouse may enroll himself or herself

(and any Dependents that were the employee's Dependents when the employee died) in the Plan upon reaching age 65 or, if he or she is already age 65, within 90 days following the Pensioner's death.

(5) If, after you enroll in the Plan, you marry or re-marry, or acquire a new Dependent child under the age of 19, you may enroll your new Dependent in the Plan no later than 90 days from the date that person becomes a Dependent. If you do not enroll your Dependent in the Plan during this 90-day period, you will not be eligible to enroll your Dependent at any later date.

Section 2.3. Special Rule for Spouses of Individuals who Die Before Becoming a Pensioner. If an employee of an Employer dies after reaching age 55 with 15 or more years of pension credit under the Pension Fund (or an equivalent amount of pension credit under another pension fund to which the Employer contributes, as determined by the Board), and the requirements in Section 2.1(b) are met as of the date of death, the employee's spouse may enroll either: (i) upon beginning to receive a qualified pre-retirement survivor annuity from the Pension Fund or other plan; or (ii) upon reaching age 65. Other Dependents who were the employee's Dependents when the employee died must be enrolled at the same time as the spouse unless Section 2.2(d)(1) or (2) authorizes a later enrollment.

Section 2.4. Payment of Premiums. The Board may change the applicable monthly premiums that you must pay (or have deducted from your pension check) in order to maintain coverage under the Plan for yourself and your Dependents, if applicable. You will be notified in advance of any change in the premium.

Section 2.5. Termination of Participation. Once you have enrolled in the Plan, you will be entitled to benefits for as long as the Plan is continued, unless you cease to be a Participant for any of the reasons described in this Section. If you are still a Participant when you die, benefits will continue to be provided to your spouse and any other Dependents who were covered as of the date of your death unless their eligibility is terminated for any of the reasons described in this section.

(a) Non-payment of Participant or Dependent Premiums.

(1) You will cease to be a Participant, and benefits under the Plan to you and your Dependents will cease, on the first day of the first month for which you fail to pay (or have de-

ducted from your pension check) your full monthly premium in a timely manner.

(2) If you are paying an additional premium for the supplemental coverage described in Section 3.2(b)(2), you and your Spouse will cease to be eligible for such supplemental coverage on the first day of the first month for which you fail to pay (or have deducted from your pension check) your full monthly supplemental premium in a timely manner.

(3) Benefits for a Spouse or other Dependent will cease on the first day of the first month for which the full monthly premium for that person is not paid or deducted from your pension check in a timely manner. After the Participant's death, if the full monthly premium for the Spouse is not paid or deducted from the Spouse's pension check in a timely manner, benefits for the Spouse and for all other Dependents will terminate.

Neither you nor your Dependents will be allowed to re-enroll in the Plan after losing coverage because of failure to pay your premiums, except as provided in Section 2.6.

(b) Non-payment of Employer Contributions. You will cease to be a Participant, and benefits under the Plan to you and your Dependents will cease, on the last day of the first month for which your last Employer ceases to make contributions to the Plan. The only exception is that if your last Employer paid at least 48 months of contributions to the W-1 Plan, and then goes out of business or closes the plant at which you last worked, as defined below, you can maintain your coverage under the Plan by paying an additional premium. The Board of Trustees shall have the sole discretion to determine the amount of the additional premium. The Employer will be considered to have closed the plant at which you last worked if there is a reduction of 70% or more of hours reported under the plant's account or collective bargaining agreement within a 180-day period. If you become a Participant pursuant to Section 2.1(c) and the Employer stops paying the established monthly premium for *any* reason, you will immediately cease to be a Participant and will have no further right to benefits under the Plan.

(c) Suspension of Pension Benefits. If your pension benefits are suspended because you return to work, you will cease to be a Participant, and benefits under the Plan to you and your Dependents will cease, beginning on the date that your pension

benefits are suspended. When your pension benefits resume, you may re-enroll yourself and your Dependents in the Plan so long as you are otherwise eligible and you re-enroll at one of the times provided in Section 2.2(b).

(d) Changes to the Plan. You will cease to be a Participant, and benefits under the Plan to you and your Dependents will cease, if the Board decides to terminate the Plan or the Fund. The Board may also make changes to the Plan that change or discontinue your (and your Dependents') benefits.

(e) Termination of Dependent Coverage. Benefits to your non-spouse Dependents will cease when they are no longer your Dependents. If you die and your former non-spouse Dependents are covered by the Plan as your Spouse's Dependents, their benefits will cease when they are no longer your Spouse's Dependents or, if earlier, when your Spouse dies or ceases to be covered under the Plan. If a non-spouse Dependent loses coverage because he or she is no longer your Dependent or your Spouse's Dependent, he or she may re-enroll in the Plan if he or she becomes a Dependent again, but only within the 90-day period beginning when he or she becomes a Dependent. If a non-spouse Dependent loses coverage after your death because your Spouse has died or is not covered by the Plan, re-enrollment will not be permitted.

Section 2.6. Re-Enrollment.

(a) Except as noted below, if your enrollment in the W-Plans ceases for any reason, you will not be permitted to re-enroll at a later date.

(b) On or after December 3, 1998, (i) if you had previously ceased enrollment in the W-Plans due to enrollment in a Medicare HMO, and the HMO subsequently ceases doing business in the geographic area in which you reside, you may re-enroll in the W-Plans if you elect to do so within 90 days of your loss of coverage under the HMO; (ii) if you become a Participant before age 65 and after December 31, 1988 and you stop paying premiums before age 65, you will have an opportunity to re-enroll at age 65.

(c) If you re-enroll in the W-Plans in either circumstance set forth in subsection (b) above, your W-Plans claims experience will be applied against all applicable coverage limitations. In the case of re-enrollment under subsection (b)(i), you will be per-

mitted to re-enroll only in those W-Plans in which you were enrolled prior to your enrollment in a Medicare HMO.

Section 2.7. Qualified Medical Child Support Orders. The Fund pays benefits to alternate recipients as identified in and required by a Qualified Medical Child Support Order (QMCSO). If you need information regarding the qualification of a QMCSO, or the Fund's Rules and Procedures governing QMCSOs, contact the Fund Office, and copies of these documents will be provided to you without charge.

ARTICLE 3
BENEFITS

Section 3.1. General Description of Plan W-1 and Plan W-102. There is one plan of benefits for Participants and Dependents who are not yet eligible for Medicare, and two plans of benefits available to Participants and Dependents who are eligible for Medicare. It is therefore possible that you and your Dependents may be covered under different plans of benefits.

(a) Plan W-1. All Participants and Dependents may be covered by Plan W-1, regardless of whether they are eligible for Medicare. If you are not yet eligible for Medicare, Plan W-1 pays major medical benefits. If you are age 65 or over (or eligible for early Medicare), Plan W-1 pays most medical benefits not covered by Medicare. You and your covered family members are generally limited to a lifetime maximum of $10,000 each in benefits, but you may increase the maximum to $100,000 by purchasing additional coverage. Plan W-1 also provides coverage for prescription drugs as described in Article 4. The prescription drug benefits do not count against the lifetime maximum.

(b) Plan W-102. The other plan - Plan W-102 - is available to those Participants and Dependents who are age 65 or older (or are eligible for early Medicare). You must specifically choose to be covered by Plan W-102 instead of Plan W-1. If you choose Plan W-102, you will pay more for routine medical expenses than you would under Plan W-1, but coverage for most catastrophic expenses is far better and the lifetime maximum, at $250,000, is much higher. The prescription drug coverage under Plan W-102 is described in Article 4.

To assist you in choosing between the Plan W-1 and the Plan W-102, the charts on pages 15 and 16 summarize the benefits available un-

der Medicare, Plan W-1 and Plan W-102. Please remember that the charts are only intended as summaries, and are subject to the additional rules contained in this booklet, such as the rule limiting benefits to Covered Medical Expenses. Also, please remember that, once you have elected to participate in either Plan W-1 or Plan W-102, you may not change that election at a later date unless you elect to participate in Plan W-1 prior to age 65, in which case you will be given an opportunity to convert your coverage to Plan W-102 when you turn age 65.

Section 3.2. Plan W-1 Benefits.

(a) The Deductible. You must pay $300 in Covered Medical Expenses during each calendar year before you are eligible for benefits under Plan W-1. Each covered person in your family must satisfy the $300 deductible before medical expenses are payable for that person in that year. The deductible does not apply to prescription drug expenses.

(b) Lifetime Maximum.

(1) General. There is a lifetime maximum on Plan W-1 benefits of $10,000 for each covered person. If you use a portion of your maximum benefits in any particular year, up to $1,000 of the benefits you have used will be restored to the maximum the following January 1. However, the lifetime maximum may never exceed $10,000 (unless you buy supplemental coverage as described below). The lifetime maximum does not apply to prescription drug benefits, which have their own annual maximum.

(2) Supplemental. If the effective date of your pension is in 1989 or later, you may elect supplemental coverage to increase your lifetime maximum benefits to $100,000 by paying an additional monthly premium. The amount of the premium is determined by the Board and varies from time to time.

The rules for electing this coverage are as follows:

(A) The time to elect supplemental coverage depends on your age when you first enroll in Plan W-1. If you are 65 or older when you first enroll in Plan W-1, you must elect supplemental coverage at that time. If you are not yet 65 when you enroll in Plan W-1, you may elect supplemental coverage either at that time, at age 65, or

SUMMARY OF BENEFIT CHOICES

Provision or Coverage	Medicare	W-1 Plan	W-102 Plan
Lifetime Maximums	N/A	Lifetime maximum of $10,000 (or $100,000 if supplemental coverage is in effect) not including prescription drugs.	Lifetime maximum of $250,000 including prescription drugs

SUMMARY OF BENEFIT CHOICES – Hospital Coverage

(Refer to appropriate section of booklet for complete provision)

Provision or Coverage	Medicare Part A–Hospital*	W-1 Plan	W-102 Plan
Hospital			
Deductible	$1,024 for first day of each benefit period.	After the $300 annual deductible has been met, the Plan pays 100% of Medicare Part A Hospital deductible.	The Plan pays 80% of the Medicare Part A Hospital deductible.
Hospital Stays			
1st–60th days	After deductible, covered in full.	N/A	N/A
61st–90th days	You must pay $256 per day.	After deductible, the Plan pays 80% of expenses not covered by Medicare.	Covered in full.
91st–150th days (60 Lifetime Reserve Days)	You must pay $496 per day.	After deductible, the Plan pays 80% of expenses not covered by Medicare.	Covered in full.
After 60 reserve days	Not covered.	After deductible, the Plan pays 80% of expenses not covered by Medicare.	Covered in full up to 365 days.
Emergency Room Care in Foreign Countries	Not covered.	After deductible, the Plan pays 80% of expenses not covered by Medicare.	Covered in full.
Blood	Covered in full after first 3 pints of blood.	After deductible, the Plan pays 80% of expenses.	Covered in full.
Skilled Nursing Care Facility			
Days 1–20	Covered in full.	N/A	N/A
Days 21–100	You must pay $128 per day.	After deductible, the Plan pays 80% of expenses not covered by Medicare.	Covers in full the $128 Medicare co-pay up to the 100th day. No coverage after the 100th day.

SUMMARY OF BENEFIT CHOICES – Medical Coverage

(Refer to appropriate section of booklet for complete provision)

Provision or Coverage	Medicare Part B–Medical*	W-1 Plan	W-102 Plan
Medical Coverage			
Deductible	$135 per year	Covered in full after the annual deductible has been met.	Not covered
Coinsurance	Medicare pays 80% of approved charges. You pay 20%.	Covered in full after the annual deductible has been met.	Covered in full.
Excess Physician Charges	Not covered.	Not covered.	Covered at 80%
Home Health Services	Covers costs of part-time services such as nursing and therapy services and certain medical supplies.	Covered in full after the annual deductible has been met.	Covered in full.
At Home Care After Injury, Illness or Surgery	No coverage for assistance with activities of daily living (e.g. eating, dressing, custodial care).	Not covered.	100% coverage within 60 days after initial medical treatment for assistance with activities of daily living up to $1,600 per year.
Preventative Care	Not covered.	Not covered.	Not covered.

SUMMARY OF BENEFIT CHOICES – Prescription Drug Coverage

(Refer to appropriate section of booklet for complete provision)

Provision or Coverage	Medicare Part D–Prescription Drug for W-1 Plan and W-102 Plan*
Prescription Drug Coverage	
Deductible	$100
Co-pays	
30-day supply	$15 – Generic Drugs $45 – Preferred Brand Drugs $65 – Non-Preferred Brand Drugs
90-day supply by mail order	$30 – Generic $90 – Preferred Brand Drugs $130 – Non-Preferred Brand Drugs
	After $3,600 out-of-pocket per year, co-pay is reduced to 5%

*Medicare dollar amounts subject to change annually.

within 90 days after you enroll in Medicare if you become eligible for Medicare before age 65.

(B) If you do not elect supplemental coverage at one of the times described in (A), or if you elect supplemental coverage and later discontinue it, you may not elect it at a later date, except as provided in Section 2.6(b)(ii).

(C) You may also elect supplemental coverage for your Spouse, if your Spouse is covered for Plan W-1 Benefits. (Supplemental coverage is not available for Dependents other than your Spouse.)

(D) The times to elect supplemental coverage for your Spouse are:

i. when you elect your own supplemental coverage; or

ii. if later than when you elect your own supplemental coverage, when your Spouse first becomes covered by Plan W-1; or,

iii. if you are younger than age 65, when your Spouse first becomes eligible for Medicare (either at age 65 or earlier due to disability).

If you do not elect supplemental coverage for your Spouse at one of these three times, or you elect supplemental coverage for your Spouse and later discontinue it, you may not elect it at a later date, except as provided in Section 2.6(b)(ii).

(c) Benefits For Participants Who Are Not Eligible for Medicare. If you or your enrolled Dependents are under age 65 (and not eligible for early Medicare), Plan W-1 pays the following benefits once you have met the annual deductible (subject to the lifetime maximum described in subsection (b) above, the cost containment provisions described in Article 5, the coordination of benefits provisions in Article 6, the subrogation and reimbursement provisions in Article 8, and the general exclusions described in Article 11):

(1) 80% of Covered Medical Expenses (or 50% of expenses incurred for Mental and Nervous Disorders while not a resident inpatient in a Hospital). Covered Medical Expenses are described in Section 3.4.

(2) Prescription drug benefits as described in Article 4.

(d) Benefits For Participants Who Are Eligible for Medicare. If you or your enrolled Dependents are age 65 or older (or eligible for early Medicare), Plan W-1 pays the following benefits once you have met the deductible (subject to the lifetime maximum described in subsection (b) above, the coordination of benefits provisions in Article 6, the subrogation and reimbursement provisions in Article 8, and the general exclusions described in Article 11):

(1) 100% of the Medicare Part A and Part B deductibles.

(2) 100% of the coinsurance for Medicare Part B benefits.

(3) 80% of Covered Medical Expenses, as described in Section 3.4, that are not covered by Medicare.

(4) Prescription drug expenses as described in Article 4.

(5) The monthly premium for Medicare Part B is not a covered benefit under Plan W-1.

Section 3.3. Plan W-102. This plan of benefits is available as an alternative to Plan W-1, only for Participants or Dependents who are eligible for Medicare.

(a) Deductible. There is no deductible for Plan W-102 benefits.

(b) Lifetime Maximum. There is a lifetime maximum on Plan W-102 benefits of $250,000.

(c) Benefits. Plan W-102 pays the following benefits (subject to the lifetime maximum described in subsection (b) above, the coordination of benefit provisions in Article 6, the subrogation and reimbursement provisions in Article 8, and the general exclusions described in Article 11):

(1) 80% of the Medicare Part A deductible.

(2) 100% of Covered Medical Expenses, as described in Section 3.4, that are not covered by Medicare.

(3) 100% of the following non-Covered Medical Expenses:

a. Physician's charges for the treatment of an Illness or Injury that are in excess of Medicare's maximum allowable charge.

b. At-home custodial care after Illness or Injury that is provided within 60 days of initial medical treatment for

such Illness or Injury, up to a maximum of $1,600 per year.

(4) Prescription drug benefits as described in Article 4.

(5) The deductible and the monthly premium for Medicare Part B are not covered benefits under Plan W-102.

Section 3.4. Covered Medical Expenses. "Covered Medical Expenses" are Covered Expenses up to the Maximum Allowable Charge only for the following services and supplies:

(a) Hospital Services. Charges made by a Hospital for (i) Room and Board; and (ii) other hospital services and supplies. Charges for Hospital Services under Plan W-102 are limited to 365 days per Injury or Illness.

(b) Physicians' Services. Charges for the services of a Physician for performing a surgical procedure and for other medical care and treatment, limited to Medicare's maximum allowable charge for Medicare-eligible Participants. For outpatient treatment for Mental and Nervous Disorders, charges for visits in excess of $40 per visit or for more than 100 visits during the calendar year shall not be considered a Covered Medical Expense.

(c) Alcoholic, Drug or Psychiatric Treatment Facility. Charges made by an Alcoholic, Drug or Psychiatric Treatment Facility, subject to the limits set forth in subsection (d) below. Physicians' charges are not covered under this provision; they are paid separately.

(d) Alcohol and Drug Abuse Services. Expenses for alcohol and drug abuse services are limited to the following expenses incurred during a period of 12 consecutive months ("benefit period") beginning on the date the initial expense is incurred and subject to a two-benefit period lifetime maximum:

(i) Inpatient Care.

(1) Detoxification in a Hospital with a 7-day maximum per benefit period.

(2) Rehabilitation treatment in an Alcoholic, Drug or Treatment Facility with a 30-day maximum per benefit period.

(ii) Outpatient Care. A maximum of sixty outpatient visits per benefit period through an Alcoholic, Drug or Treatment Facility, with a maximum of $50.00 payable per visit.

(e) Dental Work and Oral Surgery. The only dental services and oral surgery that are Covered Medical Expenses are:

(i) Charges made by a duly qualified dentist or oral surgeon for treatment of fractures and dislocations of the jaw, and for cutting procedures in the oral cavity.

(ii) The excision of partially or completely unerupted impacted teeth; the excision of a tooth root without the extraction of the entire tooth; and other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with care of the gums or the extraction or repair of teeth.

(iii) The following charges incurred as a result of an Injury:

a. Medical expenses required for the prompt repair of natural teeth or other body tissues.

b. Replacement of a bridge or denture within five years following the date of its original installation if such bridge or denture is damaged beyond repair.

(f) Nursing Care Services. Charges, on an outpatient basis, for the services of a Licensed Practical Nurse (LPN) or Registered Nurse (RN), provided the nursing care is necessary as evidenced by a written statement by the attending Physician. The care will not be considered "necessary" unless only an LPN or RN could have rendered the necessary care.

(g) Nursing or Convalescent Home. Charges made by a licensed nursing or convalescent home, provided the patient goes to the first available nursing or convalescent home from the Hospital but in no event goes more than thirty days from the date of discharge from the Hospital. Under Plan W-102, charges by a licensed nursing or convalescent home are covered only for the first 100 days.

(h) Ambulatory Surgical Facility Services. Charges made by an Ambulatory Surgical Facility. Physician's charges are not covered under this provision; they are paid separately.

(i) Emergency Transportation Services. Charges for emergency transportation within the continental limits of the United States of America and Canada, and within the geographical boundaries of Puerto Rico and the State of Hawaii, that are (i) by professional ambulance other than air ambulance to and from a Hospital, or (ii) by regularly scheduled airline or railroad or by air ambulance

from the city or town in which the covered individual incurs the Injury or Illness requiring such emergency transportation to and from the nearest Hospital qualified to provide treatment incidental to such Injury or Illness, except that only charges incurred for the first trip to and the first trip from a Hospital are payable.

(j) X-ray and Laboratory Examinations. Charges made for X-ray examinations and for laboratory tests or analyses made for diagnostic or treatment purposes.

(k) Radiation Therapy. Charges made for X-ray, radon, radium and radioactive isotope treatments.

(l) Anesthetic. Charges made for an anesthetic and its administration.

(m) Medical Supplies. Charges for the following:

(i) Bandages and surgical dressings.

(ii) Surgical supplies such as appliances to replace lost physical organs or parts or to aid in their functions when impaired, except that only the initial charge for the first such appliance shall be included.

(iii) Oxygen and rental of equipment for the administration of oxygen.

(iv) Rental of a wheelchair or hospital-type bed.

(v) Rental of an iron lung or other mechanical equipment for the treatment of respiratory paralysis.

The Fund retains the option of purchasing equipment or appliances that would otherwise be rented if the rental of such equipment or appliances would equal or exceed the purchase price of the equipment or appliance.

(n) Cosmetic Surgery. Hospital and other medical expenses incurred in connection with cosmetic surgery, but only when necessary for the prompt repair of an Injury that occurred after the date on which you became a Participant.

(o) Psychological Diagnostic Testing. Psychological testing for the diagnosis of mental disorders.

(p) Home Health Care

(i) General. An eligible Participant or Dependent shall be entitled to a Home Health Care Expense Benefit for Medical Social Services and Home Health Care Services provided at

home by a Home Health Care Agency pursuant to a Home Health Care Plan.

(ii) Amount Payable. Expenses for Home Health Care Services shall be payable in an amount not to exceed the Maximum Allowable Charge for Home Health Care Services.

(iii) Medical Social Services. Medical Social Services are services rendered under the direction of a Physician by a qualified social worker holding a master's degree from an accredited school of social work including, but not limited to:

(a) assessment of the social, psychological, and family problems related to or arising out of such covered person's illness and treatment;

(b) appropriate action and utilization of community resources to assist in resolving such problems; and

(c) participation in the development of the overall plan of treatment for such covered person.

(iv) Home Health Care Services. Home Health Care Services are the following:

(a) part-time professional nursing care by or under the supervision of a licensed nurse, not to exceed eight hours a day;

(b) part-time services, primarily of a medical or therapeutic nature, by a Home Health Aide;

(c) physical, occupational, and speech therapy;

(d) medical supplies, legend drugs and medications prescribed by a Physician;

(e) laboratory services;

(f) X-ray and electrocardiogram services.

(v) Home Health Care Agency. A Home Health Care Agency is an organization which meets each of the following requirements:

(a) It is primarily engaged in and is federally certified as a home health care agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services;

(b) Its policies are established by a professional group associated with such agency or organization, including at least one Physician and at least one licensed nurse, to govern the services provided;

(c) It provides for full-time supervision of such services by a Physician or by a licensed nurse;

(d) It maintains a complete medical record on each patient; and

(e) It has an administrator.

(vi) Home Health Aide. A Home Health Aide is an individual certified for home care of the Ill or Injured.

(vii) Home Health Care Plan. A Home Health Care Plan is a program for continued care and treatment which is Medically Necessary and is prescribed by a Physician in lieu of confinement in a Hospital or nursing facility.

(viii) Limitations. No Home Health Care Expense Benefit shall be payable for any expense, fee or charge for:

(a) services provided by a person who ordinarily resides in the home of the Participant or is a member of the individual's family;

(b) treatment of any Mental or Nervous Disorder;

(c) custodial care or domestic or housekeeping services;

(d) rental or purchase of renal dialysis equipment or supplies;

(e) home food or meal delivery; and

(f) care provided in a nursing home or similar facility.

(q) Organ Transplant. Expenses incurred for approved organ transplants, so long as the following conditions are met:

(a) the particular procedure must be pre-approved by the Fund Office; contact the Fund Office for details.

(b) the patient must be admitted to a transplant center program and thoroughly screened.

(c) a consensus must be reached by the attending Physicians on the treatment.

(d) the transplant center must meet acceptable standards and criteria utilized by Medicare and must have state and fed-

eral agency approval and authorization to perform transplants.

Covered expenses for approved organ transplants include the reasonable and necessary cost of securing the organ or tissue for transplant and transporting it to the transplant center, and of emergency transportation for the patient to the transplant center. Non-emergency transportation is not covered. If securing the organ or tissue requires surgery or hospital confinement that the donor would not otherwise require, the cost of securing the organ or tissue includes the donor's surgical and hospital expenses specifically related to the transplant, up to the Maximum Allowable Charge. If the donor is eligible for other medical coverage, the Fund's coverage of the donor's expenses will be secondary, as described in Section 6.1(b).

(r) Hospice Care. Charges for Hospice Care provided by a licensed hospice facility or hospice care provider.

Section 3.5. Non-Covered Benefits. Covered Medical Expenses do not include, and no benefits will be paid for, any expenses excluded under Article 11 (General Exclusions) or any expenses incurred as a result of any of the following:

(a) Expenses not specifically included as Covered Medical Expenses.

(b) The monthly premium for Medicare Part B and, for Plan W-102 only, the deductible for Medicare Part B.

(c) Charges for the services of a dentist or X-rays of the teeth unless otherwise permitted under Section 3.4 (e).

(d) Charges incurred for eye refraction, eye glasses, hearing aids, dental prosthetic appliances, or the fitting of any thereof, except as may be required on account of Injury sustained while the individual was covered under the Fund.

(e) Reversal of sterilization.

(f) Injection treatment of varicose veins, hemorrhoids and hernias.

(g) Orthopedic shoes (except when joined to braces) or supportive devices for the feet, including, but not limited to, arch supports, heel lifts, or orthotics.

(h) Palliative or cosmetic foot care including, but not limited to, callus or corn paring; trimming or excision of toenails, except radical surgery for ingrown nails; treatment of chronic conditions of the foot such as fallen arches, weak feet, flat or pronated foot metatarsalgia, or foot strain.

(i) Disturbances of the temporomandibular joint (TMJ dysfunction).

(j) Radial keratotomy and refractive keratoplasty for vision that can be corrected to 20/80 with the aid of eyeglasses or contacts.

(k) Vision training of any kind.

(l) Rehabilitative or occupational therapy not directly associated with an Illness or Injury or required to restore a person to the activities of daily living following an Illness or Injury.

(m) Hypnotism, stress management and behavioral modification.

(n) Screening for various health risks, including, but not limited to, a screening or testing process in or around the premises of an Employer for more than one person working for that Employer.

(o) Treatment of (but not diagnostic testing to determine the existence of) learning disabilities, mental retardation, hyperkinetic syndromes, developmental delay, attention deficit disorders, autism, conduct disorders or oppositional defiant disorders.

(p) Psychological testing, except for purposes of diagnosis.

(q) Gastric by-pass or bubble, or similar procedures to treat obesity.

(r) Obesity or physical fitness: Programs for the treatment of obesity, weight reduction or physical fitness.

(s) Except as Section 3.3(c)(3)(b) provides under Plan W-102, there is no coverage for custodial care of any kind that does not require the continuous care of a person with the education, training or technical skills of an RN or LPN. Such care includes but is not limited to bathing, feeding, exercising, moving the patient, giving oral medication, acting as a companion or sitter, or other services which are provided to help a person with personal hygiene, or to perform activities of daily living. Services are custodial regardless of who recommends, orders, provides or directs the care and regardless of the location for the care.

(t) Private duty nursing while Hospital-confined.

(u) X-ray examinations without film.

(v) Physicals, routine examinations or pre-marital tests.

ARTICLE 4
PRESCRIPTION DRUG BENEFITS

Section 4.1. General. Prescription drug benefits are provided to you and your enrolled Dependents.

(a) Participants Who Are Not Eligible for Medicare. If you or your enrolled Dependents are under age 65 (and not eligible for early Medicare), the Fund's prescription plan is administered by a national prescription benefits manager (PBM) to which the Fund Office provides your name and other information necessary to establish your eligibility. The PBM then provides you with a plastic identification card, a brochure explaining the benefits and a directory of participating pharmacies in your area. The identification card is valid unless you cease to be a Participant, or coverage for any of your Dependents terminates for other reasons.

(b) Participants Who Are Eligible for Medicare. If you or your enrolled Dependents are age 65 or older (or eligible for early Medicare), the Fund will enroll you and your Dependents in a Medicare Part D prescription drug plan (PDP). The Fund Office will provide your name and other information necessary to establish your eligibility to the PDP. The PDP then provides you with a plastic identification card, a brochure explaining the benefits and a directory of participating pharmacies in your area. The identification card is valid unless you enroll in another PDP or cease to be a participant, or coverage for any of your Dependents terminates for other reasons.

Section 4.2. Benefits Payable.

(a) The Fund pays for drugs that by either State or Federal laws may be purchased only by prescription, and insulin and prescriptions which must be compounded by the pharmacist. The Fund will not pay for drugs which can be legally dispensed without a prescription, even though a Physician may have prescribed them, and the Fund will not pay for drugs that are excluded under the prescription administrator's formulary or under General Exclusions in Article 11.

(b) Benefits paid are subject to a $100 annual deductible and copay listed below for each prescription and refill:

Co-pays	Retail	Mail Order
Generic	$15	$30
Preferred Brand Name	$45	$90
Non-Preferred Brand Name	$65	$130

Once your annual out-of-pocket costs reach $3,600 the coverage will be 95% of the cost of the drug and your responsibility will be the remaining 5%.

(c) Each prescription or refill not ordered through the mail-order service described below is limited to a 30-day supply. If a Physician authorizes it, a prescription may be refilled up to five times within six months from the time it was first filled.

Section 4.3. Payment Procedures For Prescriptions Filled by Pharmacies.

(a) If a prescription is filled by a participating pharmacy, you present your identification card to the pharmacist along with your prescription.

(b) In order to obtain payment if you use a non-participating pharmacy or if you did not use your identification card, you must submit the pharmacy receipt to the attention of the Prescription Desk at the Fund Office. We will then forward your receipt along with an authorization for payment to the prescription benefits manager.

Section 4.4. Mail Order Prescription Drug Service. A mail order prescription drug service is provided for your convenience for the purchase of up to a 90-day supply of maintenance prescription drugs used for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc. Your co-pay for each prescription or refill is provided in Section 4.2(b) above. The mail order service saves money for both you and the Fund, and you are encouraged to use the service for all appropriate medications. Contact the Fund Office for additional information.

ARTICLE 5
COST CONTAINMENT

The Board of Trustees has examined the problems associated with spiraling health care costs and has adopted a program of utilization review and case management, as described below, to help hold down increases in

health costs and improve the quality of care which you receive. (This program applies only to Participants not eligible for Medicare). Their success depends on you. It's your money which will be saved.

Section 5.1. Utilization Review.

The utilization review program is designed to review and monitor all health care delivered by Hospitals and to ensure that the Hospitals' services and costs are medically justified. The Fund selects from time to time a utilization review firm or firms to administer this program. The firm or firms use trained medical personnel in consultation with your Physician to review all hospitalizations—elective, urgent and emergency admissions.

This is the way the utilization review program works: **Before you are hospitalized** (except in the case of an emergency, as described below), **you must call** the Fund's utilization review administrator at the toll-free number on the reverse side of your Fund identification card (the number can also be obtained from the Fund Office). If the admission is approved, you, your Physician and the Hospital will be notified within 15 days (30 days in some circumstances) that the admission has been authorized and will be advised of the number of approved days for the hospitalization. If you are seeking pre-admission approval that constitutes an Urgent Claim, you will receive a decision on your application for utilization review within 72 hours. If the admission is questioned, your Physician will be notified directly regarding additional information which may be necessary to justify the hospitalization. **If you cannot obtain pre-admission approval because of an unexpected Illness or Injury that requires immediate medical attention, you (or someone acting on your behalf) must contact the utilization review administrator within 48 hours after admission.**

While you are in the Hospital, your progress will be monitored by medical professionals in communication with the Hospital and/or your personal doctor. Extended hospitalization (beyond the approved number of days) will be evaluated based on the medical information and services prescribed. Your discharge will be planned consistent with your health care needs.

Failure to comply with the pre-admission procedures described above will result in a penalty equal to a 20% reduction in the amount the Fund would have otherwise paid, up to a maximum of $1,000.

If you are not satisfied with the decision of the utilization review administrator, you may appeal that decision as prescribed in Article 9, below.

Section 5.2. Case Management.

The Fund's case management program enables a patient with a chronic, catastrophic or recurrent illness to receive medically necessary and appropriate health care in the most cost-effective environment. The program is administered by the Fund's utilization review firm or firms, which identify situations that warrant case management at the time hospital admission is proposed, and review each situation, taking into consideration any alternative sites of care that would be more appropriate to the patient's level of illness. The firm or firms work closely with the patient's attending Physician to assure the quality and appropriateness of medical treatment.

ARTICLE 6
COORDINATION OF BENEFITS

Section 6.1. General. Coordination of Benefits rules apply to persons who are covered by the Plan and another group benefit plan, governmental program or individual insurance policy ("additional plan") or who are eligible to receive benefits through an additional plan. Casualty insurance—including, without limitation, no-fault automobile insurance, personal injury protection, and uninsured or underinsured motorist coverage—is an additional plan to the extent that it includes coverage for expenses that are Covered Expenses under the Plan (without regard to any provision that purports to deny benefits solely because the covered person also has coverage under this Plan). When services provided are coverable under both this Plan and another plan, a determination will be made as to which plan is "primary" and which is "secondary."

(a) If the Plan is primary, it will pay for the amounts that are payable by the Plan regardless of the provisions of the secondary plan.

(b) If the Plan is secondary, it will pay only the maximum amounts payable by the Plan minus the amounts payable by the primary plan for services covered under the Plan, regardless of whether the primary plan actually meets its obligation to pay for covered services. However, if the primary plan establishes to the satisfaction of the Board that it is unable to pay the claim in question, then the Plan may in the sole discretion of the Board pay a portion or all of the claim that would ordinarily be a covered expense of the primary plan.

Section 6.2. Determining the Primary Plan. The primary plan will be determined by applying the following rules in the order that they appear below:

Other Plan Pays Primary. If the other plan pays primary coverage, this Plan will pay secondary.

Casualty Insurance. Casualty insurance—including, without limitation, no-fault automobile insurance, personal injury protection, and uninsured or underinsured motorist coverage—always pays primary.

Active/Inactive. For individuals who also have coverage through their own or their Spouse's active employment, the plan covering the individual as an employee (or Spouse of an employee) is primary and the Plan is secondary. (If the individual is also eligible for Medicare, Medicare will generally be secondary and the Plan will pay third, regardless of whether the individual actually receives Medicare benefits.)

If both plans do not have the Active/Inactive rule, and thus cannot agree on the order of benefits, this rule is ignored.

Longer/Shorter Coverage. If the above rules do not determine the order of benefits, the plan that has covered the person longer is primary for that person, and the plan that has covered him or her for the shorter time is secondary for that person. The Longer/Shorter Coverage Rule does not apply to an individual insurance policy that is specifically designed and priced solely to cover gaps in other medical coverage.

Medicare Eligible. For non-working Pensioners and non-working Dependents who are age 65 or over or covered by early Medicare, Medicare is primary and the Plan is secondary. For eligible persons covered by Medicare because of end stage renal disease, Medicare is secondary for the first 30 months of Medicare coverage; after that time Medicare will pay first. For individuals who are eligible to receive Medicare benefits under Medicare Parts A, B, and/or C, the Plan will pay as if Medicare is primary even if the individual elects not to receive benefits through the Medicare program or does not comply with the necessary requirements to receive Medicare benefits.

Service Benefits. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered a Covered Medical Expense. A secondary plan that provides benefits in the form of services may recover the reasonable

cash value of providing the services from the primary plan to the extent that benefits for the services are covered by the primary plan and have not already been paid. Nothing in this provision shall be interpreted to require the Fund to reimburse a covered person in cash for the value of service provided by a plan which provides benefits in the form of service.

In the case of Dependents who are covered by both parents' plans, the primary plan will be determined as follows:

Birthday Rule. The plan of the parent whose birthday falls earlier in the calendar year pays claims for the child first. If both parents have the same birthday, the plan of the person who has been covered longer pays first. A person's year of birth is not relevant.

Longer/Shorter Coverage Rule. If the other plan has not adopted the Birthday Rule, both plans must use the Longer/Shorter Coverage Rule. The Longer/Shorter Coverage Rule provides that the plan covering the family the longest is primary for children.

Separated or Divorced Parents. Regardless of the Birthday Rule or the Longer/Shorter Coverage rule, if the parents are separated or divorced, the plan that covers the child as a Dependent of the parent with financial responsibility for the child's health care under a court decree is primary. If there is no such court decree, the plan of the parent with custody is primary; the plan of the spouse of the parent with custody (stepparent) is secondary; and the plan of the parent without custody pays third.

ARTICLE 7
COBRA CONTINUATION COVERAGE

Section 7.1. General. Your Dependents are entitled to a temporary extension of health coverage (called "COBRA continuation coverage") at group rates, but at their expense, in certain circumstances where their coverage under the Fund would otherwise end. The following events will entitle your Dependents ("eligible individuals") to elect COBRA continuation coverage:

(a) Your spouse has the right to choose COBRA continuation coverage for himself or herself if he or she would otherwise lose coverage under the Fund because of divorce.

(b) Each of your non-spouse Dependents has the right to choose COBRA continuation coverage if he or she would otherwise

lose coverage under the Fund because of your death or divorce, or because he or she ceases to qualify as a Dependent.

Section 7.2. Required Notices to the Fund. You or Your Dependents have the responsibility to inform the Fund of a divorce or a child losing Dependent status. When the Fund is notified that one of these events has happened, the Fund will in turn notify your Dependents of the right to choose COBRA continuation coverage.

Section 7.3. Choosing COBRA Continuation Coverage. Eligible individuals have 60 days to inform the Fund that they want COBRA continuation coverage, starting from the date they would otherwise lose coverage because of one of the events described above. If an eligible individual does not choose COBRA continuation coverage within that 60-day period, his or her coverage under the Fund will end. If an eligible individual chooses COBRA continuation coverage and pays the required premium, the Fund will give that individual the same coverage that, as of the time coverage is being provided, it provides to similarly situated individuals. A Participant who has entered active duty in the United States Armed Forces will not be required to pay COBRA premiums for the first 30 days of that active duty.

Section 7.4. Duration of COBRA Continuation Coverage. Eligible individuals generally may maintain COBRA continuation coverage for up to 3 years. However, COBRA continuation coverage may be cut short for any of the following reasons: your former Employer no longer provides group health coverage to any of its employees or ceases to contribute to the Plan; the eligible individual does not pay the premium for COBRA continuation coverage on time; the eligible individual becomes covered, following the individual's election of COBRA under this Fund, under any other group health plan that does not limit coverage for the individual's pre-existing conditions; or the eligible individual becomes, following the individual's election of COBRA under this Fund, entitled to benefits under and enrolled in Medicare.

ARTICLE 8
SUBROGATION AND REIMBURSEMENT

Section 8.1. When Subrogation and Reimbursement Apply.

(a) If the Fund makes payment for any Covered Expenses, and the Participant or Dependent receives payment in whole or in part

from any other source on account of or in connection with the Injury or Illness for which the Covered Expenses were incurred, the Fund is entitled to reimbursement of the monies that it has paid.

(b) If legal action is instituted against any such other source, the Fund is entitled to intervene and participate in said action. If a Participant (or the Participant's Dependent or the estate of either of them) refuses or is unable to institute such legal action, the Fund is entitled to do so in the name of the Participant, Dependent, or estate.

(c) Where a covered individual is injured through an act or omission of another person (for example, a car accident) or where another person is otherwise potentially responsible for the Injury or Illness of a covered individual, benefits under the Fund will be provided only if the covered individual agrees in writing:

(i). To reimburse the Fund (to the extent of benefits provided) immediately upon receipt from any other source of any payment in whole or in part on account of or in connection with such Injury or Illness;

(ii). To authorize any insurance company that is obligated to make any payment described in subsection (c)(i) to make payment directly to the Fund to the extent of benefits provided;

(iii). To provide the Fund with a lien against any monies recovered as described in subsection (c)(i); and

(iv). To authorize the Fund to intervene in any suit or other proceeding to recover losses on account of or in connection with such Injury or Illness, and/or to institute such legal action in the name of the covered individual as described in subsection (b).

(d) In all claims where subrogation is applicable, the covered individual is requested to submit such claims to the other source for payment before filing with the Fund.

Section 8.2. Terms of Subrogation and Reimbursement. The Fund's rights of subrogation and/or reimbursement shall have first priority and shall not be reduced for any reason, including for attorney's fees and without regard to whether the Participant or Dependent is "made whole" for his or their loss, unless the Trustees or their designee determine, in the exercise of their or his sole discretion, to reduce the Fund's recovery in appro-

priate circumstances. Those circumstances may include, with respect to attorney's fees, a condition that the attorney representing the Participant or Dependent has agreed in advance to honor the rights of the Fund with respect to subrogation and reimbursement contained in this Article.

Section 8.3. Definitions. For purposes of this Article, the following terms are defined as follows:

(a) "Any other source" includes, without limitation, other benefit plans, insurance policies, workers' compensation plans or insurers, tortfeasors, or any other party that may be responsible to pay for damages or losses in connection with an Injury or Illness.

(b) "Insurance policies" includes, without limitation, policies of casualty insurance, no-fault automobile insurance, and uninsured and underinsured motorist coverage, regardless of who owns the policy or is named as the insured.

(c) "Payment in whole or in part" includes, without limitation, voluntary payments and payments made as the result of litigation, judgment, settlement, or compromise, without regard to whether the payment fully reimburses or "makes whole" the Participant or Dependent for his or her losses, and without regard to whether the payments are characterized as reimbursement for medical care or other Covered Expenses.

ARTICLE 9
CLAIMS PROCEDURES

Section 9.1. General Requirements. All claims for benefits must comply with the following rules:

(a) All claims must be filed on the Fund's claim forms. Please contact the Fund Office for claim forms.

(b) All claim forms must be fully completed, signed and dated and must include your Social Security number. If any essential information is missing, the claim will be returned to you for completion, causing a delay in payment.

(c) The Board may, in its sole discretion, have the person who is eligible for benefits examined when and as often as may reasonably be required during the pendency of a claim.

Section 9.2. Time Limits for Making Claims. All claims must be received by the Fund Office within the following time limits:

(a) two years from the date on which the expenses were incurred, or

(b) for patients who are covered by Medicare, one year after the date of the notice of Medicare's payment or denial of benefits for the same expenses. This alternative time limit will be applied only when it will give you more time than the normal two years to submit your claim to the Fund Office, for example, if Medicare has taken a long time processing your claim.

For purposes of these time limits, an expense is incurred as of: a) in the case of a service, the date the service is rendered, or b) in the case of a supply, the date the supply is purchased.

A claim that is submitted after these time limits will not be paid.

Section 9.3. Specific Procedures.

(a) Patient and member information (Sections 1 through 12) of the Fund's claim form must be completed. Incomplete claim information will be returned to you and no payment will be made until the Fund receives complete information.

(b) The provider must complete the section of the claim form concerning the exact dates of treatment. If the provider has not completed this section of the claim form, you must submit along with the claim form an itemized bill from the provider showing the diagnosis, the date of each treatment, whether each treatment was given in the home, office, or the hospital, the procedure code and the amount charged for each treatment.

(c) If you are eligible for Medicare, submit the Medicare Explanation of Benefits sheet with the claim form.

Section 9.4. Review Procedures.

(a) For All Claims. If you receive a notice that your claim for benefits has been denied, you may request the Board's Appeals Committee to review the denied claim within 180 days of the receipt of the Notice of Denial. You or your authorized representative may request a review, and, upon request, you will be provided reasonable access to and copies of documents, records or other information relevant to your claim, without regard to whether such documents, records and information were considered or relied upon in making the adverse benefit determination that is the subject of the appeal. You may submit issues and comments in writing in support of your appeal. Requests for review must be made in writing and should be sent to the Fund

Office. The Appeals Committee will consider the appeal de novo, without any deference to the initial benefit denial. The Appeals Committee will not include any person who participated in the initial benefit denial or who is the subordinate of a person who participated in the initial benefit denial.

(b) Claims Involving a Medical Judgment.. If an adverse decision on the application is based in whole or in part on any internal rule, guideline, or similar criterion, the Fund Office's notice of the adverse decision will either set forth the internal rule, guideline, or similar criterion, or will state that such was relied upon and will be provided free of charge to you upon request. Upon your request, the Plan will identify any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. In reviewing any benefit denial that was based in whole or in part on any medical judgment, the Appeals Committee will:

(1). consult 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 benefit determination nor is the subordinate of any person who was consulted in connection with that determination; and

(2). upon notifying you of an adverse determination on review, include in the written notice either an explanation of the clinical basis for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(c) Pre-Service Claims. If you submit a request for pre-authorization of a hospital stay pursuant to Section 5.1 you will receive a decision on that request within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 additional days, if additional time is needed for processing the claim due to matters beyond the control of the Plan, and provided that the Plan notifies you within the first 15 days of the circumstances requiring additional time and the date by which the Plan expects to render a decision. If additional time is needed because you

have failed to submit information that is necessary to process the claim, the Plan will notify you of the information that is required and allow you at least 45 days to submit the specified information. If authorization is denied, you may appeal the Plan's decision within 180 days after you are notified that the expense is not authorized. You or your representative should submit your appeal in writing to the Fund Office. You will receive a decision on the request for review within a reasonable period of time appropriate to the medical circumstances, but no more than 30 days after the Fund Office receives your appeal.

(d) Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

(1). If the Plan decides to reduce or terminate such course of treatment before the end of such period of time or number of treatments, you will receive notice of that decision at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that decision before the benefit is reduced or terminated.

(2). If you request that the Plan approves an extension of such course of treatment or increase in the number of treatments, your request will be decided as soon as possible, taking into account the medical exigencies.

If you receive notice that the Plan has decided to reduce or terminate the course of treatment or has denied your request to extend the course of treatment, you may appeal the Plan's decision within 180 days after you receive that notice. You or your representative should submit your appeal in writing to the Fund Office. You will receive a decision on the request for review within review within a reasonable period of time appropriate to the medical circumstances, but no more than 30 days after the Fund Office receives your appeal.

(e) Urgent Claims. If your request involves an Urgent Claim, you or your representative should contact your utilization review administrator at the toll-free number reflected on your Health Benefits Fund identification card to submit your request for approval of the course of treatment. Be sure to notify the utilization review administrator that your request involves an Urgent Claim. You will receive notice of the Plan's decision on your claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the

claim by the Plan, unless you failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In case of such a failure, you will receive notice as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be allowed a reasonable amount of time, taking into consideration the circumstances, but not less than 48 hours, to provide the specified information. You will receive notice of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded to the claimant to provide the specified information. If that determination denies the benefits you have requested, you may appeal the Plan's determination (but no later than 180 days after you receive notice of the denial). If you submit your appeal from the Plan's determination as an Urgent Claim, you will receive a decision on your request for review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives your request for review.

(f) Post-Service Claims. If you or your medical provider submits a claim for services after the service has been rendered, and that claim is denied, in whole or in part, you or your authorized representative may submit your request for review in writing to the Fund Office within 180 days after receiving the notice of denial.

(g) Decisions on Review of All Claims Other Than Pre-Service Claims, Concurrent Care Decisions and Urgent Claims. The Appeals Committee will make a decision on your appeal of a denial of your claim at its next regularly scheduled meeting or, if the request is received fewer than 30 days before that meeting, at the following regularly scheduled meeting. In special circumstances, the decision may be made at the third regularly scheduled meeting following receipt of your request, but in this event you will be notified of the delay and will be given an estimated date by which a decision is expected. The decision of the Appeals Committee will be in writing and will include the reasons for the decision and specific references to plan provisions on which the decision is based. In all cases, the decision on review will be final and binding on all parties, subject to your rights under ERISA. If for any reason the Fund fails to follow any of the claims procedures outlined above, you may pursue any rights you have for judicial review of your claim. If

you do not appeal a denied claim within 180 days after receiving the Notice of Denial, as described in Section 9.4(a), the Fund's decision on your claim will be final and not subject to any further review.

Section 9.5. Applicable Regulations. The claims procedures in Article 9 will be construed and applied in all cases to conform to the applicable regulations of the United States Department of Labor.

ARTICLE 10
ACTIONS OF THE BOARD

Section 10.1. Contribution Rates. The Board shall set the rates at which Participants and Employers contribute to the Fund for coverage under the Plan, and may change such rates from time to time in its discretion, as provided by Section 10.2.

Section 10.2. Board Discretion. The Board (and any committee of the Board) shall have the exclusive authority, in its sole and absolute discretion, to: (i) take all actions necessary to administer the Plan; (ii) apply and interpret the rules set forth in this booklet; (iii) take all actions and make all decisions concerning the eligibility for, and the amount of, benefits payable under the Plan; and (iv) resolve and/or clarify any ambiguities, inconsistencies and omissions that may arise under this booklet.

Section 10.3. Modification or Termination of the Fund. The Board intends for the Plan and the Fund to be in effect permanently. However, the Board reserves the right to amend, modify, or discontinue all or part of the Plan and/or the Fund whenever, in its judgment, conditions so warrant. In the event of Plan termination, any remaining assets will be used first to provide benefits to Participants and Dependents until all assets are exhausted. If there are any surplus assets, those assets will be used to provide health benefits to Plan Participants and beneficiaries, in a manner determined by the Fund's Trustees in their sole and absolute discretion, consistent with the provisions of the Fund's Trust Agreement and applicable law.

ARTICLE 11
GENERAL EXCLUSIONS

In addition to the exclusions from Covered Medical Expenses set forth in Section 3.4, no benefits are payable in the following circumstances:

- **Aircraft-Related Injuries:** Benefits are not payable for losses resulting from an injury sustained while operating or riding in or on an aircraft, or falling or in any other manner descending therefrom, while the aircraft is in flight or motion, except as a fare-paying passenger of a commercial airline flying on a regularly scheduled route between established airports.
- **Charge Required:** Benefits are not payable for claims that you would not be legally required to pay in the absence of the Fund.
- **Charges Incurred Outside of the U.S.:** Benefits are not payable for any charges incurred outside the United States of America, except in the event of an emergency that occurs while on vacation and within the first 90 days of the covered individual's absence from the United States.
- **Charges Incurred While not a Participant**: Benefits are not payable for expenses incurred before you became a Participant or, except as otherwise specifically provided in this booklet, after you ceased to be a Participant. An expense is incurred as of: a) in the case of a service, the date the service is rendered, or b) in the case of a supply, the date the supply is purchased.
- **Cosmetic Treatment**: Cosmetic or beautifying treatment or surgery, except as otherwise provided in Section 3.4 (n).
- **Employment-Based Injuries:** Benefits are not payable for any losses resulting from any Injury or Illness sustained while doing any act or things pertaining to any occupation or employment for remuneration or profit: (1) for which you (or any of your Dependents) are entitled to benefits in accordance with the provisions of any workers' compensation or similar law or (2) for which you (or any of your Dependents) apply for workers' compensation coverage and thereafter receive money or any other benefit pursuant to a settlement (formal or informal, with or without admission of coverage) of such claim.

- **Expenses Payable By Medicare**: Benefits are not payable for any charges that are either payable by Medicare or could have been obtained by appropriate application or enrollment or through use of approved service providers under Medicare Parts A, B, C, or D.
- **Experimental or Obsolete Treatments:** Charges for services or supplies determined by the Board to be educational, investigative, experimental or obsolete based on consideration of competent medical evidence, including the opinion of the Funds' medical advisor(s). Services or supplies are considered experimental if their use is restricted to facilities authorized by an agency of the federal government under approved protocols (also known as clinical trials). New services or supplies that are not governed by federal agencies are considered experimental until the effectiveness of using the services or supplies has been verified by several independent investigators and has been reported in major medical journals.
- **Failure to Follow Claims Procedures**: Benefits are not payable in the event that the claims procedures set forth in Article 9 are not followed within the time limits stated.
- **Form Completion:** Benefits are not payable for charges for completing a claim form.
- **Hygiene, Beautification, Comfort or Convenience:** Construction, services, supplies, appliances, or equipment for personal hygiene, beautification, comfort or convenience, including, but not limited to, admission kits, cosmetics, wigs, air conditioners, humidifiers, health club fees, exercise equipment, whirlpools, tanning beds, water beds or other items not essential for the treatment of an Illness or Injury.
- **Infertility Treatment:** Surrogate parenting, in vitro fertilization, and all other treatments of infertility.
- **Non-approved Expenses:** Benefits are not payable for any expenses that are incurred in connection with a hospitalization or treatment that has been determined by the Fund's Utilization Review organization or medical consultant to be inappropriate.
- **Non-covered Expenses:** Benefits are not payable if they do not constitute Covered Expenses.
- **Non-Medically Necessary Expenses**: Benefits are not payable for any expenses that are not Medically Necessary.

- **Participation in Crime, Violence or War:** Benefits are not payable for any expenses resulting from participation in the commission of a crime or an act of violence, or war or an act of war.
- **Pregnancy:** Charges incurred on account of pregnancy, childbirth, miscarriage or abortion.
- **Preventative Care:** Benefits are not payable for preventative care.
- **Recoverable Expenses:** Except as provided in Article 8 (Subrogation), benefits are not payable for charges incurred that are recoverable under a no-fault automobile insurance policy, liability insurance, or similar source, whether or not you make a claim to recover these charges.
- **Self-Inflicted Injuries:** Benefits are not payable for losses arising out of intentionally self-induced or self-inflicted Illness or Injury.
- **Sexual Dysfunction:** Treatment of sexual dysfunction or transsexual surgery except certain prescription drug therapy for male impotence (Viagra), limited to ten (10) pills per month, and only for male participants over the age of 18.

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