

**Bakery and Sales Drivers Local Union No. 33  
Industry Welfare Plan  
Summary Plan Description  
2010**

**Bakery & Sales Drivers  
Local Union No. 33 Industry Welfare Plan**

9411 Philadelphia Road - Suite S  
Baltimore, Maryland 21237  
Phone: (410) 444-2833 or (800) 922-0602  
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December 2010

Dear Retiree Participant:

The Board of Trustees of the Bakery & Sales Drivers Local Union 33 Industry Welfare Plan is pleased to issue this Summary Plan Description that describes the Plan's benefits for eligible Retirees and eligible dependents. This document has been updated through August 2010, and has been designed to be easy to read and understand. The Summary Plan Description contains important information about the benefits available to you and your eligible dependents under the Plan. These benefits include comprehensive medical, prescription drug and vision benefits.

In addition, this document sets forth the information that must be made available to Plan participants in order to comply with the Employee Retirement Income Security Act of 1974 (ERISA), including a statement of your rights and protection under the law. This information is on page 26.

We encourage you and your family to read this Summary Plan Description carefully to get the best use of the benefits this Plan offers.

If you have any questions concerning the benefits or your eligibility, please feel free to contact the Fund Office at (410) 444-2833 or (800) 922-0602.

Sincerely,

Board of Trustees

## **Board of Trustees**

<b>Union Trustees</b>	<b>Employer Trustees</b>
Philip Giles Vice President Teamsters Local 639 3100 Ames Place, NE Washington, District of Columbia 20018	Ray Ottenberg Ottenberg's Bakers, Inc. 655 Taylor Street, NE Washington, District of Columbia 20017
J. Anthony Smith Recording Secretary Teamsters Local 639 3100 Ames Place, NE Washington, District of Columbia 20018	

The Board of Trustees consists of two employer representatives and two union representatives who are designated in accordance with the Trust Agreement to have full authority and discretion to operate and administer this Plan. The Trust Agreement went into effect on September 1, 1957. The Trustees reserve the right to amend the Plan from time to time, or to terminate the Plan.

### **Fund Administrator**

Joseph Swann  
Administrator  
Benefits Administration Corporation, Inc.  
9411 Philadelphia Road – Suite S  
Baltimore, Maryland 21237

### **Fund Counsel**

O'Donoghue & O'Donoghue, LLP

### **Consultants**

The Segal Company

### **Auditor**

Calibre CPA Group, PLLC

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## **General Information about Your Plan**

The Bakery & Sales Drivers Local Union No. 33 Industry Welfare Plan offers comprehensive health care coverage for you, as a pre-Medicare retiree, and your eligible dependents. Benefits include medical care, hospitalization and surgery, and coverage for prescription drugs, for you and your eligible family members.

The Union sponsoring this Plan is the Drivers, Chauffeurs and Helpers Local No. 639, affiliated with the International Brotherhood of Teamsters.

### **Self-Funded Plan**

The Welfare Plan is “self-funded.” This means that the Plan uses the employer contributions, participant self-payments, and investment earnings to provide benefits to eligible retirees and their dependents, and to pay all expenses incurred to maintain the Plan. The Board of Trustees periodically reviews the funding status of the Plan.

### **Bakery & Sales Drivers Benefits**

The following is a list of the benefits offered by this Plan. Each of these benefits is explained in more detail in this booklet.

- Medical Benefits
- Hospitalization and Surgery
- Home Health Care
- Hospice Care
- Examinations and Immunizations
- Maternity Benefits
- Laboratory and X-Ray Benefits
- Chiropractic and Physical Therapy
- Hearing Aids
- Prescription Drugs
- Vision Benefits

## **Eligibility**

As a participant in the Bakery & Sales Drivers Local Union No. 33 Industry Welfare Plan, you and eligible family members will be covered with a package of health and welfare benefits. This section describes the eligibility requirements you must meet in order to participate in the Plan.

### **Employment Prior to Retirement**

If you were a retiree participant in this Welfare Plan as of December 1, 2006, or were eligible for coverage in this Welfare Plan as an active employee on the date specified below with continuous active coverage under the Teamsters Local 639-Employers Health Trust (hereinafter, the "Local 639 Trust"), at retirement, you can be eligible for health coverage as a retiree.

In order to be eligible to participate in the Local 33 Welfare Plan's retiree welfare program, you must satisfy the requirements specified in this Section and have had active coverage under the Local Welfare 33 Plan as of the following dates, depending on which employer you were working for at that time:

- Ottenberg's Bakery, Inc. – December 31, 2004
- Interstate Brands Corp. – February 28, 2005

At the time of your retirement, you must be covered under the Local 639 Trust as an active employee. At that time, you will be offered COBRA coverage from the Local 639 Trust. You must elect COBRA Coverage from the Local 639 Trust. You will be required to make timely monthly retiree health contributions to the Local 33 Industry Welfare Plan at the applicable rate in effect when you retire.

Currently, the monthly retiree contribution rates are:

- \$115.00 per person for you and your spouse if your retirement commenced before July 1, 2008; or
- \$150.00 per person for you and your spouse if your retirement commenced on or after July 1, 2008.

These rates are subject to change by the Welfare Plan Trustees.

If you make the required monthly premium payments on behalf of yourself, then any eligible child or children will automatically be covered without an additional premium payment. The Local 33 Industry Welfare Plan will then pay the applicable monthly COBRA premium payment to the Local 639 Trust, for the length of the COBRA coverage period (up to 18 months), provided you otherwise remain eligible for coverage under the Local 33 Industry Welfare Plan.

Once COBRA coverage is exhausted under the Local 639 Trust, if you remain eligible for Retiree Coverage, you will then receive retiree health benefits from the Local 33 Industry Welfare Plan.

### **Retirement Eligibility**

To be eligible for Retiree Coverage you must meet the following criteria, in addition to the active employment criteria described immediately above:

- You must have worked in ten different calendar years:
  - For an Employer obligated to contribute to this Fund; and/or
  - Under the terms of a Collective Bargaining Agreement between an employer and the former Local No. 33 or Local No. 246; and/or
  - Under the terms of a Collective Bargaining Agreement between an employer and Local 639 for a job classification that was formerly covered by Local No. 33;

- You must be an active participant in the Local 639 Trust at the time of retirement; and
- You must be able to demonstrate that you are receiving a Regular, Early, Service 85, or Disability Pension from the Bakery and Sales Drivers Local Union No. 33 Industry Pension Fund or a similar pension from an employer that was either signatory to a Collective Bargaining Agreement with:
  - Former Local No. 33; or
  - Former Local No. 246, which covered Bakery and Sales Drivers; or
  - Drivers, Chauffeurs and Helpers Local No. 639, which covers Bakery and Sales Drivers.
- You must be at least 55 years of age unless you are receiving a Disability Pension from the Bakery and Sales Drivers Local Union No. 33 Industry Pension Plan.

### **Coverage for Your Family**

Generally, your eligible dependents are covered under the Plan when you are covered. The following members of your family are considered to be eligible under the Plan:

- Your spouse, if you are married and not legally separated;
- Your unmarried child from birth to the end of the month in which his or her 19<sup>th</sup> birthday occurs, or if a full-time student, to the end of the month in which his or her 23<sup>rd</sup> birthday occurs; and
- Your disabled child.

### **Acquiring a New Dependent**

If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in the Welfare Plan's retiree coverage, you may add that dependent to your coverage for the balance of the eligibility coverage period. To enroll your new dependent for coverage, you must notify the Fund Office **within 31 days** of acquiring the new dependent. Adding a new dependent may cause an increase in the amount you pay for coverage.

### **When Retiree Coverage Ends**

Retiree Coverage will end:

1. when you fail to make the timely monthly required premium payments to the Welfare Fund, or
2. when you become eligible for Medicare, or
3. when you become covered coverage under another employer's health plan, either as a participant or a spouse; or
4. when you become engaged in employment or self-employment in the industry covered by this Plan.

Once Retiree Coverage ends, it will not be reinstated unless you once again qualify for active coverage and subsequently meet the requirements for Retiree Coverage.

### **When Retiree Coverage Ends for Dependents**

Dependent coverage will end on the earliest of the following dates:

1. on the date your Retiree coverage terminates, or
2. on the date your dependent(s) becomes covered under another plan, or
3. on the date your dependent becomes eligible for Medicare; or
4. on the last day of the month in which you die.

### **No Rescission of Coverage**

Coverage under this Plan will not be rescinded (retroactively terminated) unless an individual performs an act, practice, or omission that constitutes fraud or unless the individual makes intentional misrepresentation of material facts.

### **Certification of Coverage when Coverage Ends**

When your coverage ends, the Fund Office will mail you and/or your dependents a Certificate of Creditable Coverage that indicates the period of time that you were covered under the Bakery and Sales Drivers Local No. 33 Industry Welfare Plan.

If you become eligible for coverage under another group health plan within 62 days of the day you lose coverage under the Welfare Plan, this certificate may be necessary if your new group health plan has pre-existing condition limitations that apply to you.

The Fund Office will mail this certificate to you shortly after they learn that your coverage has ended. You may request a certificate from the Fund Office within two years from the date your coverage ended.

### **Deduction from Pension Fund**

You may pay your retiree medical premiums through a deduction from your pension check. If you wish to have the deductions made, complete, sign, and return to the Fund Office the "Authorization to Withhold Retiree Premium From Pension Check." This form authorizes the Trustees of the Pension Fund to deduct the amount of the monthly payment due to the Welfare Fund from your monthly pension benefits. This option is not available if the amount of your monthly pension benefit is less than the retiree medical premium.

You have no obligation to authorize these deductions; they are solely for your convenience. You may continue to make your own payments monthly, in advance, if you wish.

If you do authorize the deduction from your pension check, your written authorization must be on file with the Fund Office before any money can be deducted from your pension. You may end the deductions from your pension check by notifying the Fund Office in writing. All written notices ending the deduction must be received by the Fund Office no later than at least 20 days before your next pension payment is due. The Fund will not withhold more than the amount of the self-pay contribution required to maintain your eligibility for benefits.

If you qualify for retiree coverage and your pension benefit is too small or you wish to pay by personal check, payment must be received by the Fund Office by the first day of the month for which coverage is desired.

## **Continuing Your Coverage**

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows your dependents to continue health care coverage at your own expense under certain circumstances called "Qualifying Events" when your health care coverage would otherwise end. **Important: This Section is applicable only if you last received Retiree Coverage under the Local 33 Industry Welfare Plan's program of benefits; it does not apply to dependents receiving coverage under the Local 639 Health Trust.**

- You may make self-payments to continue your dependent's health care coverage under COBRA if you experience a Qualifying Event.
- Your children are eligible to continue coverage under COBRA when they no longer satisfy the Plan's definition of dependent because of age, marriage, or student status.
- Your dependent's COBRA coverage can continue for up to 36 months.

Under COBRA, your covered dependent may continue the same health coverage that the dependent had before a COBRA Qualifying Event, including hospitalization, surgery, prescription drug, and vision for a limited period of time.

### Notifying the Fund Office

You or a family member must notify the Fund Office in writing, no later than **60 days** after one of the following events occurs:

- Your divorce;
- Your legal separation;
- Your child is no longer considered a “dependent child” by the Plan’s definition (see page 6); or
- Your death.

Send your written notification to:

Benefits Administration Corporation, Inc.  
9411 Philadelphia Road - Suite S  
Baltimore, Maryland 21237

The Fund Office will then send you information about COBRA coverage.

You or your family member should notify the Fund Office promptly and in writing if a Qualifying Event occurs in order to avoid confusion over the status of your health care.

### COBRA Qualifying Events

Qualifying Event	Who May Purchase COBRA Continuation Coverage	For How Long
Retired employee dies	Spouse and/or dependent children	36 months
Retired employee is divorced or legally separated	Spouse and/or dependent children	36 months
Child is no longer considered a dependent child	Dependent child	36 months

### How to Elect COBRA

When you notify the Fund Office of a Qualifying Event, the Fund Office will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms you will need to elect COBRA Continuation Coverage.

By law, you and/or your covered dependents will only have 60 days from the date you receive notice from the Fund Office to apply for COBRA Continuation Coverage.

COBRA Continuation Coverage may be elected for some members of your family and not others. However, in order to elect COBRA, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her.

### Your Coverage Under COBRA

COBRA Coverage consists of medical benefits and prescription drug benefits, plus vision benefits. The Board of Trustees reserves the right to modify the benefits provided under the Plan.

### Cost of COBRA

Individuals who continue coverage under COBRA pay at rates determined by the Board of Trustees in compliance with applicable law. These rates may change from time to time. Payments are due monthly. The Fund Office will notify you of the cost of coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount charges. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days after your COBRA election to pay the first amounts due. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to make these monthly payments. If you do not pay the amount due by the end of the applicable grace period, your COBRA coverage will terminate.

### **Duration of COBRA Coverage**

Your COBRA coverage can continue for up to 36 months, depending on the COBRA Qualifying Event. Your period of COBRA coverage begins on the date of the loss of coverage.

### **When COBRA Coverage May Be Cut Short**

Once COBRA coverage has been elected, it may be cut if any of the following events occur:

- The first day of the time period for which your dependent fails to pay the COBRA premiums within the required time period;
- The date on which the Plan is terminated;
- The date, after the date of the COBRA election, on which your eligible dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have;
- The date, after the date of the COBRA election on which your eligible dependent first becomes entitled to Medicare (usually age 65); and
- If you fail to follow the Plan's policies and procedures. (For example, if you submit false claims to the Plan).

### **When COBRA Coverage Ends**

Your Dependent's COBRA coverage ends on the earliest date that:

- Any of the events listed under "When COBRA Coverage May Be Cut Short" above occur; or
- The COBRA period (36 months) ends.

### **Confirmation of Coverage to Health Care Providers**

Under certain circumstances, federal rules require the Plan to inform your health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances:

1. If a health care provider requests confirmation of coverage during the COBRA election period, and you, your spouse or your dependent child(ren) have not yet elected COBRA Continuation Coverage, the Fund Office will give a complete response to the health care provider about you and your dependents' COBRA Continuation Coverage rights during the election period.
2. If, after you have elected COBRA Continuation Coverage, a health care provider requests confirmation of coverage for a period for which the Fund Office has not yet received payment, the Fund Office will give a complete response to the health care provider about you and your dependents' COBRA rights during that period.

## **Life Events**

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when you experience certain “Life Events” and what you must do to make sure you get the most from your coverage.

- You should notify the Fund Office as soon as possible if you experience a Life Event that may affect your coverage.
- You and/or your dependents may qualify to continue coverage through COBRA in the event of a loss of eligibility, divorce, legal separation, or your termination or reduction of your work hours.

The following Life Events may affect your coverage:

- Moving to a new address
- Getting married, divorced or legally separated
- Having a baby or adopting a child
- Becoming disabled
- Retiring and/or becoming eligible for Medicare
- Death

### **If You Move**

If you have a change of address, notify the Fund Office of your new address **in writing** as soon as possible to make sure your records are up to date and to avoid a delay in payment of claims.

### **If You Get Married**

If you legally marry, your spouse is eligible to receive dependent benefits under this Plan.

### **What You Need To Do**

To ensure your spouse is covered when you marry, you should provide the Fund Office with the following information:

- A copy of your marriage certificate;
- Your spouse’s date of birth; and
- Verification that your spouse is not covered by another group insurance plan.

You must notify the Fund Office within 30 days of the date of your marriage. Once you provide the required information, coverage for your new spouse will begin on the later of:

- The date you become eligible for benefits under this Plan; or
- The date you notify the Fund Office of your spouse’s dependent status.

If your spouse is covered under another group health plan, you must report this other coverage to the Fund Office.

### **If You Acquire a Child through Marriage**

Notify the Fund Office within 30 days if you are planning to cover a stepchild under this Plan.

### **What You Need To Do:**

You will need to provide the following information to the Fund Office:

- The date of your marriage;
- A copy of your marriage certificate; and
- A copy of your child’s other medical insurance information, if he or she is covered under another group insurance plan;
- A copy of a Qualified Medical Child Support Order (QMCSO) or documentation that proves that you (as the Plan Participant) are responsible for at least 50% of the child’s support; and

- The child's birth certificate.

### **If You Divorce or Legally Separate**

If you divorce or legally separate from your spouse, notify the Fund Office as soon as possible. Your spouse's coverage under this Plan will end on the last day of the month in which the legal separation or the divorce becomes final.

### **What You Need To Do**

If you get legally separated or divorced, you must provide the Fund Office with the following information:

- A copy of your divorce decree or separation agreement; and
- If you have children and you do not have custody, a copy of any QMCSO, if applicable.

### **If your spouse wants to continue coverage, he or she must:**

- Contact the Fund Office; and
- Enroll for COBRA Continuation Coverage.

Your former spouse may continue coverage under COBRA for up to 36 months. You or your spouse must notify the Fund within 60 days of the day that the divorce becomes final.

### **Qualified Medical Child Support Orders (QMCSOs)**

A Qualified Medical Child Support Order (QMCSO) is a court order, judgment, or decree that recognizes that an alternative recipient may be entitled to benefits under this Plan in the event of a divorce or other family law action. Orders must be submitted to the Fund Office to determine whether the order is a QMCSO under federal law. As required under the Employee Retirement Income Security Act (ERISA), this Plan will recognize a QMCSO that:

- Provides for health coverage to the child(ren) under state domestic relations law (including a community property law); and
- Relates to benefits under this Plan.

You and/or your and beneficiary(ies) can obtain, without charge, a copy of the Plan's QMCSO procedure from the Plan Administrator.

### **If You Have a Baby**

If you have a baby, you must contact the Fund Office within 30 days in order to cover your child under this Plan. Coverage for your baby will begin on the later of:

- The date you become eligible for benefits under this Plan; or
- The date you notify the Fund Office of your baby's dependent status.

### **What You Need To Do**

If you have a baby, you should provide the Fund Office with the following information:

- The baby's birth date;
- A copy of the baby's birth certificate; and
- A copy of your baby's other medical insurance information if he or she is covered under another group insurance plan, such as through your spouse's plan.

### **If You Adopt A Child**

If you adopt a child, contact the Fund Office. Your child will be covered on the later of:

- The date you become eligible for benefits under this Plan; or

- The date you notify the Fund Office of your child's dependent status.

### **What You Need To Do**

If you need to add a child to your coverage, you should provide the Fund Office with the following information:

- Your child's birth date;
- A legal adoption certificate;
- The effective date of adoption or placement for adoption; and
- A copy of your child's other medical insurance information if he or she is covered under another group insurance program.

### **If Your Child's Eligibility for Benefits Changes**

If your child's eligibility status changes, you must notify the Fund Office as soon as possible. Generally, your child will continue to be eligible until the first of these dates occur:

- The date he or she turns 19,
- The date he or she turns 23 if a full-time student;
- The date he or she marries;
- The date he or she becomes covered under another group health plan; or
- The date your coverage ends.

**Coverage for your dependent(s) will terminate when your retiree coverage terminates (including termination as a result of your death).**

### **If You Become Eligible for Medicare**

When you become eligible for Medicare, your coverage and your dependent(s) coverage under this Plan will terminate.

Medicare makes available two plans of health insurance to those age 65 and over. Part A of Medicare covers hospital expenses, and Part B covers other medical expenses.

Part A is automatically provided to eligible individuals who are receiving Social Security Benefits. All other eligible individuals may enroll by signing the necessary forms available at any Social Security office.

Part B is also provided by Social Security and is available to all eligible individuals who wish to enroll. Benefits under Part B are not automatic. Therefore, you must obtain and complete the necessary forms, available at any Social Security office, in order to be covered under this section of Medicare.

Please keep in mind that you and/or your spouse must contact a Social Security office prior to the date on which you wish to enroll in Medicare. Neither the Trustees nor the Administrator can enroll you under Medicare, and the Trustees suggest that, if you have remained in active employment beyond your 65th birthday, you contact Social Security at least 90 days prior to the date on which you plan to retire to make the necessary arrangements for participation under Part B. If you fail to enroll on a timely basis, you will be subject to a penalty premium on your monthly Part B premium.

## **How Your Medical Plan Works**

The Bakery and Sales Drivers Local Union No. 33 Industry Welfare Plan covers a portion of your medical expenses, including doctor's office visits, hospitalization and surgery, and Wellness benefits for adults and

children. While you have the option of visiting any doctor you like, if you use a doctor in the Plan's Preferred Provider Organization (PPO) network, you will save money for yourself and for the Fund.

**Fast Facts:**

- The Plan offers a Preferred Provider Organization (PPO) through One-Net so that you can obtain convenient, cost effective and quality health care.
- Office visits to doctors within the PPO network are just \$20 and are not subject to the annual deductible.
- If your out-of-pocket expenses (excluding deductibles) exceed \$2,400 in a calendar year for any covered individual, the Plan will pay 100% of eligible expenses for the remainder of the year, up to an annual maximum of \$150,000.

**How Your Medical Expenses Are Paid**

Covered medical expenses are subject to a deductible and coinsurance. In-network services are provided at discounted fees. Payments of Out-of-Network services are based on the Allowable Charges; you are responsible for expenses in excess of the Allowable Charges.

**What is Allowable Charge?**

**An Allowable Charge** is a charge, up to a maximum reimbursable charge, that is allowable under the Plan for a service or supply that is medically necessary for the diagnosis, treatment, mitigation, or cure of an illness or injury to a structure or function of the body. No amount in excess of the Allowable Charge for a service or supply will be payable under the Plan.

**Medical Expense** benefits protect you financially in the event of a catastrophic illness. This means that the Plan will generally pay 80% of covered expenses (up to the Allowable charge) after you meet your annual deductible. You are responsible for the amount the Plan does not pay (your coinsurance). If you use an out-of-network provider, you are responsible for paying any amount the provider charges that is over the Allowable charge. Medical Expenses are subject to the maximum annual and lifetime amount the Plan will pay—\$150,000 annually and \$1,000,000 lifetime.

**Your Major Medical Benefits At-A-Glance**

Major Medical Expenses	In-Network	Out-of-Network
The maximum annual/lifetime benefit the Plan will pay	\$150,000/\$1,000,000	
Coinsurance	80%	80%
Your Coinsurance (payments in excess of allowable charges are not applied to the out-of-pocket maximum)	Up to \$2,400—20% Over \$2,400—0%	
Office Visit Well Child, Well Woman and Physical Exam	\$20 co-pay	80%, subject to deductible
<b>Your Annual Deductible (where applicable)</b>		
Individual	\$250	\$250
Family	\$750	\$750
<b>Special hospital deductible per day (out-of-network)</b>		\$90
<b>Deductible if you do not have hospital confinement or surgery precertified*</b>	\$300	\$300

\*This deductible is per confinement or surgery, whichever applicable.

**The Preferred Provider Organization (PPO)**

You and your family have the option of obtaining medical treatment through a network of preferred doctors, hospitals, and other health care professionals. The providers who make up the network, called One-Net, must meet strict qualification standards to join and must be re-qualified regularly. One-Net is committed to providing quality, cost-effective care to you and your family.

By seeking your medical treatment from a One-Net provider, you save money for yourself as well as for the Plan because One-Net will discount the fees charged by Preferred Providers who will accept this discount as full payment. There is no waiting for reimbursements, and in the event you must be hospitalized and/or have surgery, your One-Net provider will usually assist in facilitating any required precertification. **However, please remember that ultimately it is your obligation to make sure any applicable precertification requirements are met.**

### **Need to Find a One-Net PPO Provider?**

Log on to [www.onenetppo.com](http://www.onenetppo.com) and look for the link to “Find a Doctor,” or contact the One-Net PPO directly at 1-800-342-3289 for a directory of physicians and hospitals that participate in the network. If you are currently under treatment by a doctor who is not a member of the network, tell him or her about the network and ask if they would be interested in becoming a One-Net Preferred Provider. For information, your physician should call 1-800-342-6141.

### **Office Visits**

When you see your In-Network physician, your cost is only \$20 for the office visit and is not subject to the annual deductible. The balance is paid by the Fund. If you are referred to a specialist, you pay a \$20 charge for the office visit.

### **Identification Cards**

You will receive an Identification Card when you become eligible for benefits under the Plan. Use the card to access the One-Net networks and to verify your coverage. Be sure to keep it in a safe place. Report a lost or stolen card to the Fund Office.

### **Your Share of the Cost**

To help cover health care expenses, you are responsible for sharing some of the cost for services. You are responsible for:

- The annual deductible;
- Your coinsurance, or co-payments; and
- Charges (if any) above the allowable charges (if you use an Out-of-Network provider).

### **Annual Deductible**

Before you become eligible for Medical Expense coverage, you must meet an annual deductible. For an individual, the deductible is the first \$250 of covered expenses incurred each calendar year. The deductible for a family is a total of \$750, which may be paid by any combination of two or more family members. Note that the deductible does not apply to certain covered expenses.

If two or more covered members of your family are injured in the same accident, the medical expenses that result from the accident will be combined and only one deductible will be charged against all such expenses, regardless of the number of family members injured.

Effective June 1, 2010, the \$250 annual deductible is waived for services rendered for the care and treatment for participants diagnosed with any of the following conditions:

- Back and neck pain with surgery
- Cancer
- Chronic Obstructive Pulmonary Disease
- Chronic Renal Failure
- Congestive Heart Failure
- Coronary Artery Disease

- Diabetes with complications
- HIV/AIDS/other immune disease treatment
- Joint Replacement
- Organ Transplant

### **Your Coinsurance**

After you pay the annual deductible, the Plan pays 80% of covered expenses and you are responsible for the remaining 20%.

### **Charges Above the Allowable Charge Amount**

If you visit an Out-of-Network provider that charges in excess of the Allowable Charge amount, you are responsible for paying the excess over the Allowable Charge amount.

Covered Expense means a charge, up to the maximum Allowable Charge, that is allowable under the Plan for a service or supply that is Medically Necessary for the diagnosis, treatment, mitigation, or cure of an illness or injury to a structure of function of the body. No amount in excess of the actual charge for a service or supply shall be considered a Covered Expense.

### **Maximum Out-of-Pocket Expense**

After you pay the annual deductible, the maximum amount of covered expenses you must pay in a calendar year is \$2,400 (that is, 20% of \$12,000). The Fund pays 100% of all your covered expenses over and above that amount for the remainder of that year, up to the annual maximum of \$150,000. Please recall that charges above Allowable Charge are your responsibility regardless of whether you have reached the out-of-pocket maximum.

For example: Michael incurs a Medical Expense. The Allowable Charge is \$400 and is equal to the PPO provider charge. The chart below shows Michael's out-of-pocket costs when he uses a provider in the One-Net PPO network or an out-for-network provider. For the purposes of this example, let's assume Michael has met his annual deductible but has not met his maximum out-of-pocket expense.

	<b>One-Net PPO Provider</b>	<b>Out-of-Network Provider</b>
Michael's provider's charge for this service	\$400	\$500
The Plan pays 80% of the Allowable Charge of \$400	\$320	\$320
Michael pays his coinsurance	\$60	\$60
Michael pays the amount that is more than the Allowable Charge	\$0	\$100
Michael's total out-of-pocket cost	\$60	\$160 (only \$60 is applied to the out of pocket maximum for the year)

### **Out-of-Network Care**

Benefits for medical treatment obtained outside of the One-Net Network will be paid at 80% of the Allowable Charge, subject to the annual deductible. You will be responsible for the other 20%, as well as any charges your out-of-network provider may charge above the Allowable Charge.

### **Hospitalization and Surgery**

- Covered hospital expenses are paid as a Medical Expense.
- If you are admitted to an out-of-network hospital, you must pay an additional \$90 per day deductible.
- If you do not have your surgery pre-certified, you must pay an additional \$300 special deductible.

## Hospital Expenses

▪ In-Network Hospitals	The Plan will pay 80% coinsurance, after a deductible of \$250.
▪ Out-of-Network Hospitals	The Plan will pay 80% coinsurance, after a deductible of \$250, plus \$90 per day deductible while hospitalized.

### What are Medical Expense benefits?

Medical Expense benefits means you must first pay the annual deductible, then the Plan will pay 80% of the lesser of the billed amount, or the Allowable Charge allowance, or if applicable, the One-Net discounted charge. You must pay the other 20%. If you utilize an Out-of-Network physician, you may also be responsible for charges in excess of the Allowable Charges.

### Period of Confinement

One confinement may include more than one hospital stay unless:

- The stays are due to entirely unrelated causes; or
- You have recovered completely from the illness or injury causing the first confinement before the later confinement begins, or
- If you are an employee, you have returned to active work for at least one full working day before the later confinement begins.

### What is a Hospital?

A hospital is an institution that provides medical, diagnostic, therapeutic, and surgical facilities for the care and treatment of sick and injured persons, and that provides such facilities under the supervision of a staff of duly qualified physicians, with continuous round-the-clock nursing service by or under the supervision of registered graduate nurses.

The term includes hospitals accredited by the Health Care Organizations and hospitals, psychiatric hospitals, and tuberculosis hospitals as defined under Medicare and that are eligible to participate in and receive benefits under Medicare.

### In-Hospital Physician Visits

The Plan covers charges for physician visits during your hospital confinement. If you have surgery, only those physician visits that occur on the days before the date of your operation will be covered under this provision.

### Emergency Room

The Plan includes coverage for sudden and severe onset of an illness or injury. However, coverage for emergency room services will not be provided for non-emergency situations. For example, visits for headaches, colds, flu, childhood diseases, and nausea are not considered to be emergency care under this Plan. Treatment for these conditions will be covered at a physician's office or other qualified non-hospital facility.

### Out-of-Network Hospital Visits

If you do not use a PPO hospital when you are hospitalized, you will be charged a \$90 per day deductible.

Covered Expenses are the reasonable charges for necessary medical care and services that are ordered by a physician. These include:

- Charges made by a hospital, except that the daily room and board coverage is limited to the hospital's regular rate for a semi-private room (provided that, if the hospital does not have such accommodations, no more than 80% of the hospital's minimum daily rate for private room and board is covered);

- Charges for diagnosis, treatment, and surgery by a physician;
- Charges made by a registered graduate nurse for private duty nursing services; and
- Charges for local ambulance service, equipment, medication, appliances, x-ray services, laboratory tests, anesthesia (and the administration thereof), the use of radium and radioactive isotopes, oxygen, iron lung, physiotherapy, and similar services, supplies and treatment.

### **Precertification Requirements**

The Plan requires precertification of all hospitalization and surgical procedures performed in a freestanding facility, whether inpatient or outpatient. A special deductible of \$300 will apply to surgeries that are not precertified. To receive precertification, call One-Net at 1-800-962-0643.

In addition, precertification is required on all physical therapy, chiropractic services, durable medical equipment expenditures, home health care services and for MRI services.

### **Surgical Expenses**

Surgeon fees are covered under the Plan. The Plan will pay 80% of the Allowable Charge. You must pay the other 20%. If you do not use a PPO provider, you must first meet your annual deductible before the Plan will pay benefits. You will also be responsible for the charges, if any, that are more than the Allowable Charge.

Please note:

- All elective surgery must be approved in advance by One-Net and emergency treatment must be reported within twenty-four hours. Call One-Net at 1-800-962-0643.
- The operation must be recommended and performed by a physician or surgeon.
- The operation must be performed in accordance with the findings of One-Net's pre-admission certification review in a hospital (in an in-patient or an outpatient basis) or in an ambulatory-surgery center.
- Where multiple procedures are performed through the same incision, the total payments for all such procedures may not exceed the amount specified in the Plan's Schedule of Surgical Procedures for the operation with the highest amount payable.
- Where multiple procedures are performed through the anus (except for treatment of cancer) at any one time, the total payments for all such procedures may not exceed one and one-half times the maximum payment specified in the Plan's Schedule of Surgical Procedures for the operation with the largest amount payable.

### **Organ Transplants**

The Plan covers organ transplants. First, you must satisfy your deductible, then the Plan will pay 80% of the remaining Allowable Charge. You must pay the other 20% up to the annual maximum, plus any charges above the Allowable Charge. Services related to an organ transplant are covered, provided:

- The transplantation is not considered experimental or investigational as determined by a Fund-designated medical/surgical consultant; and
- The patient is admitted to a transplant center program at an established transplant facility, in which case the following payment rules apply:
  - The Plan pays expenses incurred by a Retiree or dependent while eligible for benefits under the Plan if the expenses are related to the transplantation of an organ; patient and donor screening; organ procurement; transportation of the organ; follow-up care in the home or hospital; and immunosuppressant drugs;

- The Plan pays live donor expenses as provided above. However, if the live donor has other group insurance coverage for such expenses, the Plan pays such expenses only as a secondary payor; and
- In no event will the Plan cover expenses for transportation of surgeons or family members or expenses related to any transplant that is not performed at an established transplant facility.

### **Post-Mastectomy Benefits**

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage is subject to the Plan's annual deductibles and coinsurance provisions. If you have questions, please contact the Fund Office.

### **Home Health Care**

The Plan covers home health care expenses if you would have required hospitalization or care in an extended care facility had home health care benefits not been available.

Fast Facts:

- You and your family members are eligible for up to 40 visits from a home health care provider during a calendar year.
- All home health care services must be precertified by One-Net. Call 1-800-962-0643 to precertify home health care.

When you are referred to a home health care program, your attending physician must develop a plan of treatment with a home health care provider that defines the health care services that you are to receive.

The home health care provider must be licensed and must be a Medicare-certified home health care agency. The Plan will pay 100% of the Allowable Charge of covered services. Visits by a home health care provider are covered in full. Services are covered at 100% of the Allowable Charge.

### **Covered Services**

The Plan covers up to 40 visits by members of the home health care team during a calendar year. Any single visit of up to four hours by a member of the team will be considered one home health care visit. Home health care includes the following services and supplies if medically necessary and required under the treatment plan:

- Visits by your attending physician (limited to one visit per week);
- Registered nurse services;
- Licensed practical nurse services;
- Physical, respiratory, and occupational therapists' services;
- Speech pathologist and/or audiologist services;
- Home health aide services (that is, non-skilled personal care to the patient under the supervision of a skilled team member);
- Drugs and medicines prescribed by the physician and provided and billed by the home health care agency;
- Medical and surgical supplies;

- Professional ambulance services to or from a hospital (up to \$50 each trip, balance is covered as a major medical expense);
- Hemodialysis services and equipment; and
- Rental of durable medical equipment such as hospital beds, respirators, oxygen tents, crutches, and wheel chairs.

### **What's Not Covered**

Coverage of home health care expenses is subject to the General Exclusions stated on page 22. In addition, the following services are not covered under this provision:

- Diversional or recreational therapy;
- Home health care visits for treatment of nervous or mental conditions;
- Food or housing;
- Homemaker services (such as cleaning, laundry, errands, etc.);
- Nutritional services;
- Hearing aids, eyeglasses, contact lenses, and eye refractions;
- Services provided to a participant whose place of residence is an institution which provides treatment to injured or disabled persons; or
- Any other services or supplies not specifically covered.

### **Hospice Care**

Hospice Care Benefit will be available under the Fund for terminally ill participants and qualified dependents. The Fund will pay a lifetime maximum of 30 days of inpatient or home based Hospice Care, up to a lifetime maximum benefit of \$5,000.00.

### **Other Medical Expenses That Are Covered**

- You pay just a \$20 copayment when you use a One-Net PPO provider for well-child, well-woman, or physical exams.
- Diagnostic tests or x-rays are payable at 80% of the Allowable Charge after you've met your annual deductible. You are responsible for the other 20% of costs, plus any charges over the Allowable Charge if you use an Out-of-Network provider.

### **Wellness Benefits**

For children age 3 and under, well-child office visits are \$20 when you visit a One-Net PPO provider. All diagnostic, immunization, and inoculation services related to the well visit will be covered as Major Medical Expenses, subject to the annual deductible, and paid at 80% of the Allowable Charge.

If you do not use an In-Network provider, the office visit will be subject to the Out-of-Network benefits. For children ages 4 and older and for adults, well-child visits and routine adult annual physical exams will be covered, subject to the annual maximum payment of \$300 per person. If you use an In-Network provider, the office visit will be covered with the \$20 copayment. All diagnostic, immunization, and inoculation services related to the well-visit or physical exam will be covered and will be subject to the \$250 annual deductible and payment at 80% of the Allowable Charge, up to the \$300 per person annual maximum benefit.

### **Allergy Shots**

Allergy shots and the costs of administering them will be covered under the Plan's Major Medical Provisions, subject to the annual deductible, with payment at 80% of the Allowable Charge.

### **Well-Woman Exams**

If you visit an In-Network PPO provider, your well-woman office visit is covered with your \$20 copayment, however, any diagnostic testing will be paid, subject to the deductible and then payable at 80% of the Allowable Charges. If you do not use a Network provider, you may be subject to paying charges in excess of Allowable Charge, in addition to the deductible and coinsurance.

### **Maternity Benefits**

The Plan provides coverage for the following obstetrical procedures for participants and dependent spouses only, and not to dependent children:

### **Newborns' and Mothers' Health Protection Act of 1996**

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### **Laboratory and X-Ray Expenses**

You are eligible for laboratory and x-ray coverage, paid as a Medical Expense. If you use a provider in the PPO, no deductible applies. These expenses are subject to the General Exclusions on page 22. In addition, expenses for therapeutic or dental x-rays, eye refractions, or examinations made in connection with dental work or treatment are not covered under this benefit.

### **Chiropractic Treatment**

The Plan pays 80% of Allowable Charges. You pay the other 20% and any amount that your provider charges above the UCR amount. If you use a PPO provider, no annual deductible applies to chiropractic treatment. Chiropractic coverage is limited to 24 visits per year.

### **Hearing Aid Expenses**

The Plan covers 80% of the expenses you incur for a hearing aid device, up to \$250. The maximum amount applies whether one or two hearing aids are prescribed and include the charge for an examination by an audiologist. You may visit any audiologist. This benefit is available once every five years. If you have questions, contact the Fund Office.

Hearing Aids are not subject to the annual deductible if you use a PPO provider. To find a participating provider, visit [www.onenetppo.com](http://www.onenetppo.com).

## **Prescription Drug Expenses**

The Plan provides convenient coverage that makes prescription drugs extremely affordable to you and your family.

This benefit is provided through an arrangement with Express Scripts Inc., and is available to eligible retired Plan participants and their eligible dependents. Express Scripts contracts with local pharmacies to enable you to purchase prescription drugs at a reduced cost. Simply present your Express Scripts card at the participating pharmacy when you order your medication.

- The Prescription Drug Program is a Mandatory Generic Program, which means when a generic drug is available, it will be dispensed unless your physician indicates "no substitution" or "dispense as

written” on your prescription. If your physician determines you should not take the generic, you will be responsible for any additional cost for taking the brand name medication.

- The prescription program is a three-tiered formulary co-payment arrangement. The co-pays for medication from a retail pharmacy will be \$5 for generics, \$15 for preferred brand name medication on the formulary listing, and \$30 for brand name medication NOT contained on the formulary listing. Please make sure you review the formulary listing with your physician.
- The co-payments for mail order prescriptions, which allow you to obtain a 3-month supply, will be \$10 for generics, \$30 for preferred brand name medication and \$60 for brand name medication not on the formulary listing.
- The annual maximum prescription benefit shall be \$10,000 per covered individual.

### **Need to find a Participating Pharmacy?**

Most pharmacies participate in the Express Scripts network. You may log on to [www.express-scripts.com](http://www.express-scripts.com) or you may contact the Express Scripts customer service department at 1-800-962-3784 to find out if your pharmacy participates in the network.

### **Non-Participating Pharmacies**

If you incur an expense for prescription drugs obtained from a non-participating pharmacy (for example, if you become ill while traveling), you may submit a claim to Express Scripts for reimbursement. Contact the Fund Office for a claim form. Express Scripts will reimburse you for the amount the Plan would have paid less your applicable copayment.

### **Mail Order Service**

If you are receiving medication for chronic conditions (such as high blood pressure, diabetes, or asthma), you can arrange to have up to a three-month supply of this medication mailed to you. By using the optional mail-order service, you may pay the equivalent of two monthly copayments for a three-month supply rather than three copayments over the same period of time.

To participate in the mail order program, simply obtain a mailing envelope and forms from the Fund Office. Send the completed forms with your prescription to Express Scripts at:

Express Scripts, Inc.  
3684 Marshall Lane  
Bensalem, PA 19020-5997

Your medication will be delivered to your home.

### **What's Not Covered**

Your prescription drug coverage includes insulin and those drugs and medicines which may be obtained by prescription and that either bears the legend Caution, Federal Law Prohibits Dispensing Without a Prescription or requires compounding by a pharmacist. The Plan does not cover expenses for drugs or medicines prescribed in amounts that exceed quantity limitations imposed by federal, state, or local laws on prescriptions for narcotics or controlled substances. Also, it does not cover:

- Blood or blood plasma;
- Medication that is to be taken or administered, in whole or in part, while you are in a hospital, rest home, sanitarium, extended-care facility, convalescent hospital, nursing home or similar institution;
- Any drug labeled Caution—Limited by Federal Law to Investigational Use, or any experimental drug even though you are charged for it;
- Any drug or medicine which you are entitled to receive under any workers' compensation law, occupational disease law, or similar legislation;
- Prescription contraceptives for female dependent children of a participant, unless medically necessary; and

- Prescriptions for weight loss.

Refer below for a detailed list of your Plan's exclusions.

If you have a question about whether or not a new drug is covered by the Plan, contact the Fund Office at 1-800-922-0602.

## **Vision Benefits**

Each covered individual is eligible for a \$50 reimbursement of eligible vision benefits, and this reimbursement will be renewable every two calendar years.

Eligible vision benefits are as follows:

- A complete vision care examination by a licensed optometrist or ophthalmologist; and
- The prescription of corrective lenses, if needed; and
- Your choice of a selection of frame styles; or
- Contact lenses, when medically necessary, in lieu of eyeglass frames and lenses.

## **General Exclusions**

Coverage under this Plan does not include any expense, charge, or fee incurred in connection with the following:

- Any bodily injury or sickness resulting from or arising out of any employment or occupation for compensation or profit;
- Any bodily injury or sickness for which benefits are payable under any workers' compensation law, occupational disease law or similar legislation;
- To the extent permitted by law, any bodily injury or sickness for which care, treatment or supplies are obtained from any federal, state or local government agency or program or from a hospital or institution owned thereby;
- Any bodily injury or sickness for which medical care, treatment and supplies are available without cost or for which payment would not be required were this Plan not in effect;
- Any bodily injury or sickness caused by or arising from an act of war, whether declared or not, or a conflict involving armed forces;
- Any medical care, treatment or supply not prescribed by or under the direction of a physician;
- Medical services or supplies determined by the Board of Trustees as not reasonably necessary for the care or treatment of a bodily injury or sickness;
- Treatment of infertility or for services to reverse voluntary, surgically-induced infertility;
- Any treatment that is not pursuant to generally-accepted medical practice;
- Prescription contraceptives for female dependent children of a participant, unless medically necessary;
- Prescriptions for weight loss;
- Maintenance for covered Durable Medical Equipment, such as replacement batteries for battery-powered wheelchair;

- Hospital dentist's charges while hospitalized for a dental procedure;
- Cosmetic, plastic or reconstructive surgery for developmental malformations, or as a result of earlier cosmetic, plastic or reconstructive surgery, unless the surgery is necessary due to accidental bodily injury (see, however, the section of this Plan on Post-Mastectomy Benefits regarding reconstructive surgery and certain related expenses following a mastectomy);
- Suicide, attempted suicide, or any intentionally self-inflicted injury attempted or committed if not the result of a mental incapacity; any bodily injury or illness resulting from or occurring during the attempt to commit or the commission by a covered participant of a misdemeanor or felony;
- Provision, replacement, or repair of any prosthetic device unless this Plan specifically states otherwise;
- Learning deficiencies, behavioral problems, or special education;
- Orthopedic shoes or supportive devices for the feet, such as arch supports, heel lifts, orthotics, etc;
- Disturbances of the temporomandibular joint (TMJ dysfunction);
- Callus or corn paring; toenail trimming or excision; treatment of chronic conditions of the foot (such as weak or fallen arches, flat feet, or prorated foot metatarsalgia); or foot strain;
- Humidifiers, air conditioners, exercise equipment or whirlpools;
- Charges incurred prior to or after termination of the individual's coverage, except as may be provided under the extended coverage or continuation of benefits provisions of this Plan;
- Private duty nursing care, home health care, medical care or treatment, performance of surgical procedures, dental care or physical therapy when those services are rendered by a nurse, home health aide, physician, dentist or physiotherapist who ordinarily resides in the individual's home or who is a member of the individual's immediate family;
- Gastric by-pass or bubble to treat obesity; obesity, weight reduction, or physical fitness programs;
- Laetrile, enzymes, vitamins, minerals or dietary supplements;
- Radial keratotomy (a form of eye surgery undertaken to correct or to improve nearsightedness);
- Supplies or equipment for personal hygiene, comfort or convenience such as telephone, television or similar items not required for medical care;
- Failure to appear for a scheduled appointment or office visit or failure to complete or furnish medical documents or claim forms;
- Custodial care, rest cures, or confinement in a nursing or convalescent home;
- Experimental or educational services or supplies;
- Participation in a riot;
- Speech or occupational therapy (except rehabilitation treatment following stroke or injury), myofunctional therapy, or pulmonary rehabilitation;
- Hypnotism, biofeedback, stress management, or goal-oriented behavioral modification therapy;
- Travel or lodging, whether or not recommended by physician;
- Pregnancy, childbirth, or miscarriage of a dependent other than the spouse;
- Work-related physical examinations;
- Acupuncture;
- Therapeutic devices or appliances;
- Services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes, except for treatment of tumors or cysts or except as required because of accidental injury to natural teeth which occurs while you are covered under the Plan;
- Cosmetic surgery, except as required because of accidental injury occurring while you are covered under the Plan;
- Eye refractions; or
- Transportation, except local ambulance service.

## **Coordination of Benefits**

### **Cases Involving a Third Party/Subrogation**

In the event you are injured or become ill due to the negligence or wrongful act of a third party, the Plan is only obligated to cover your expenses resulting from that illness or injury to the extent they exceed any amounts recovered from your other insurance coverage for this purpose (e.g. auto insurance), or from the third party (whether or not the amounts recovered are designated to cover medical expenses). In such circumstances, you must agree to repay the Plan if you are successful in your claim against the third party. The Plan will ask you to sign a subrogation agreement as a condition of receiving benefits. However, the Plan's subrogation rights are established by the terms of the Plan and not the subrogation agreement. Still, failure to sign the subrogation agreement will result in the denial of the claim(s). You also must, at all times, cooperate with the Plan in enforcing your right to recover amounts from the third party in order to be eligible to have the Plan advance money on your behalf.

In the event that you accept benefits from the Plan and amounts are recovered from claims arising from the accident, the amounts recovered are assets of the Plan by virtue of the Plan's subrogation interest. Such Plan assets may not be distributed without a release from the Plan of its subrogation interest.

If monies are recovered and the Plan is not reimbursed, the Plan may take all action necessary to recover benefits paid including an offset of future benefits due to the employee or eligible dependents. Such offsets may be deducted from amounts due to third parties that have provided medical services even if the Plan may have provided a certification of coverage to such a provider.

### **CHAMPUS**

If you are covered by both this Plan and CHAMPUS, this Plan is the primary plan and CHAMPUS is the secondary plan.

### **Motor Vehicle No-Fault Coverage Required by Law**

If you are covered by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

## Plan Facts

<b>Name of Plan</b>	Bakery and Sales Drivers Local Union No. 33 Industry Welfare Plan
<b>Type of Plan</b>	Employee Health and Welfare Benefit Plan that provides medical care, pharmaceutical care, vision care, and hearing care benefits to eligible retirees and their qualified dependents
<b>Name of Plan Sponsor</b>	Board of Trustees Bakery and Sales Drivers Local Union No. 33 Industry Welfare Plan
<b>Fund Office Address</b>	Benefits Administration Corporation, Inc. 9411 Philadelphia Road - Suite S Baltimore, Maryland 21237
<b>Agent for Service of Legal Process</b>	Service of legal process may be made upon any Fund Trustee.
<b>Union Trustees</b>	Philip Giles Vice President Teamsters Local 639 3100 Ames Place, NE Washington, DC 20018  J. Anthony Smith Recording Secretary Teamsters Local 639 3100 Ames Place, NE Washington, DC 20018
<b>Employer Trustees</b>	Ray Ottenberg Ottenberg's Bakers, Inc. 655 Taylor Street, NE Washington, DC 20017
<b>Type of Administration of the Plan</b>	Collectively bargained, jointly-trusted labor management trust
<b>Plan Number</b>	501
<b>IRS Employee Identification Number</b>	53-0259988
<b>Plan Fiscal Year</b>	September 1 to August 31
<b>Sources of Financing</b>	Payments made to the trust by some individual employers under the provisions of the collective bargaining agreements, retiree contributions, and any income earned from investment of employer and employee contributions.  Participants and beneficiaries may receive from the Fund Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.  All monies are used exclusively for providing benefits to eligible early Retirees and their dependents, and the paying of all expenses incurred with respect to the operation of the Plan. The Trustees shall review annually the funding status of the Plan.
<b>Organizations Through Which Plan Benefits are Provided</b>	<b>Medical Care</b> One-Net PPO PO Box 934 Frederick, MD. 21705 <b>Prescription Drugs</b> Express Scripts 1 Express Way St Louis MO 63121 Rx Group Number: XHQ

## **Your ERISA Rights**

As a participant in Bakery and Sales Drivers Local No. 33 Industry Welfare 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 shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan 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 plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- 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, as described in this Summary Plan Description. You or your dependents may have to pay for such coverage.
- Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have "creditable coverage" from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under a plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date of your coverage. This paragraph's provisions concerning preexisting condition limitations are not applicable to participants and beneficiaries under age 19. The preexisting condition paragraphs provisions shall not apply to any participant or eligible dependent on or after September 1, 2014.

### **Continuity of Plan and Trustees' Authority**

Although the Plan is intended to be ongoing until the last eligible retiree loses eligibility, the Board of Trustees may amend or terminate the Plan, in whole or in part, as it deems necessary. Neither this Plan nor any benefit provided thereby for retired or disabled participants or their dependents is guaranteed.

The Board of Trustees has full and exclusive authority and discretion to determine all questions of coverage, eligibility for and entitlement to benefits, methods of providing or arranging for benefits, and other related matters. The Trustees' decisions on all matters are final and binding on all parties dealing with the Plan.

### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

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

## Schedule of Benefits

	In-Network	Out-of-Network
<b>Maximum Lifetime Benefit the Plan Will Pay</b>	\$1,000,000	
<b>Maximum Annual Maximum the Plan Will Pay</b>	\$150,000	
<b>Your Coinsurance</b>	80% for first \$12,000 of covered expenses; 100% after that	80% for first \$12,000 of covered expenses; 100% after that
<b>Your Annual Deductible</b>		
▪ Individual	\$250	\$250
▪ Family	\$750	\$750
Office Visits/Specialist Visit	\$20 copayment per visit	80%, subject to the deductible
<b>Out-of-Pocket Annual Maximum</b>	\$2,400	\$2,400 (charges in excess of Allowable Charges are not applied to the Out-of-Pocket Maximum)
<b>Special Deductible for hospitals that are not in the network</b>		\$90 per day
<b>Special Deductible for surgeries that you do not have precertified</b>	\$300 per surgery	\$300 per surgery
<b>Child Wellness Exams</b>	\$20 copayment per visit.	80%, subject to the deductible
<b>Physical Examinations</b>	\$20 copayment per visit.	80%, subject to the deductible
<b>Well-Woman Exams</b>	\$20 copayment per visit.	80%, subject to the deductible
<b>Hearing Aid Expenses</b>	Up to \$250 once every five years.	Up to \$250 once every five years.

<b>Prescription Drug Benefits</b>	
	<b>Your Copayment</b>
<b>Participating Retail Pharmacy</b>	
▪ Generic	\$5.00
▪ Brand Name – Preferred	\$15.00
▪ Brand Name - Non-Preferred	\$30.00
<b>Participating Mail Order</b>	
▪ Generic	\$10.00
▪ Brand Name – Preferred	\$30.00
▪ Brand Name – Non-Preferred	\$60.00
<b>Annual Maximum Prescription Benefit per Individual</b>	\$10,000.00

### Procedures Not Listed

The Board of Trustees will determine a payment consistent with the amounts provided in this schedule for procedures of a similar nature unless payment is expressly excepted in the schedule or by other terms of the Plan.

## **Appendix A: Filing Your Claims**

### **CLAIMS**

- (a) A “Claim” is a request for a benefit made by a claimant in accordance with the Fund’s reasonable procedures.
- (b) Casual inquiries about benefit or the circumstances under which benefits might be paid according to the terms of the Plan are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, in the event a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a Claim.
- (c) The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. Similarly, interactions between Eligible Individuals and Preferred Providers do not constitute Claims in cases where the Preferred Providers exercise no discretion on behalf of the Plan. If a Physician, Hospital, or pharmacy, that does not exercise discretion, declines to render services or refuses to fill a prescription unless the Eligible Individual pays the entire cost, the Eligible Individual should submit a Post-Service Claim for the services or prescription to the Fund as described under Claim Procedures, below.
- (d) A request for prior approval of a benefit that does not require prior approval by the Plan is not considered a Claim. However, requests for prior approval of a benefit where the Plan does require prior approval (e.g., there are monetary penalties for not obtaining prior approval) are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim procedures, below.

### **ADVERSE BENEFIT DETERMINATIONS**

- (a) An “Adverse Benefit Determination” is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:
  - 1. A payment of less than 100% of a Claim for benefits (including coinsurance or copayment amounts of less than 100% and amounts applied to the deductible).
  - 2. A denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision.
  - 3. A failure to cover an item or service because the Fund considers it to be Experimental, investigational, not Medically Necessary, or not medically appropriate.
  - 4. A restriction on reimbursement for particular services because they are classified as related to a mental or nervous disorder, rather than a physical condition.
  - 5. A decision that denies a benefit based on a determination that a claimant will not be eligible to participate in the Plan.
- (b) Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the Eligible Individual pays the entire cost, will not be considered an Adverse Benefit Determination (but only to the extent that there is no discretion exercised by the pharmacy in denying the prescription). Similarly, in the event a Preferred Provider declines to render services

to an Eligible Individual unless the Eligible Individual pays the entire cost, and the provider exercises no discretion on behalf of the Plan, such a decision will not be considered an Adverse Benefit Determination.

#### **PRE-SERVICE CLAIM PROCEDURES**

- (a) A Pre-Service Claim is a Claim for a benefit for which the Plan requires approval before medical care is obtained. The Plan requires that all Hospital admissions be pre-certified, thus, pre-certification of a Hospital admission is treated as a Pre-Service Claim. Pre-Service Claims for the pre-certification of Hospital admissions must be submitted by calling One-Net at 1-800-962-0643.
- (b) Under some circumstances, the Plan may require prior approval of certain prescription drugs before the prescription drugs are obtained from the pharmacy. In such cases, a Pre-Service Claims for the prior authorization of the prescription drug must be submitted by calling Express Scripts at (800-417-8164).
- (c) For properly filed Pre-Service Claims, the claimant will be notified of a decision within 15 days from receipt of the Claim unless additional time will be needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan, the Board of Trustees or Fund Office and provided the claimant will be notified prior to the expiration of the required 15-day period, of the circumstances requiring the extension of time and the date by which a decision will be expected to be rendered.
- (d) In the event an extension is needed because the Plan Administrator needs additional information from the claimant, the claimant will be notified, before the end of the initial 15-day period, of the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information. In the event the information is not provided within that time, the Claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline will be suspended from the date of the extension notice until either 45 days or the date the claimant responds to the request (whichever will be earlier). The Plan Administrator will then have 15 days to make a decision on the Claim and notify the claimant of the determination.
- (e) In the event a claimant improperly files a Pre-Service Claim, the Fund Office or the Plan Administrator will notify the claimant, as soon as possible but not later than five days after receipt of the Claim, of the proper procedures to be followed in filing a Claim. The claimant will only receive notice of an improperly filed Pre-Service Claim if the claim includes the patient's name, specific medical condition or symptom and specific treatment, service, or product for which approval is requested.

#### **URGENT CLAIM PROCEDURES**

- (a) An "Urgent Claim" is a Claim for medical care or treatment that, provided normal Pre-Service standards were applied, would seriously jeopardize the life or health of the Eligible Individual or the ability of the Eligible Individual to regain maximum function or, in the opinion of a Physician with knowledge of the Eligible Individual's medical condition, subject the Eligible Individual to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.
- (b) Urgent Claims must be submitted by calling the Fund Office at (410) 444-2833 or (800) 922-0602.
- (c) The Plan Administrator will determine whether a Claim is considered an Urgent Claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, in the event a Physician with knowledge of the patient's medical

condition determines that the Claim should be considered an Urgent Claim, and notifies the Fund Office of such, it will be treated as an Urgent Claim.

- (d) The Plan Administrator will respond to the claimant with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim by the Fund Office. The determination will also be confirmed in writing.
- (e) In the event an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Plan Administrator will notify the claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The claimant must provide the specified information within 48 hours. In the event the information is not provided to the Fund Office within that time, the Claim will be denied.
- (f) Notice of the decision will be provided no later than 48 hours after the Fund Office receives the specified information or the end of the 48-hour period given for the claimant to provide this information, whichever is earlier.
- (g) In the event a claimant improperly files an Urgent Claim, the Plan Administrator will notify the claimant, as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a Claim. Unless the claim is re-filed properly, it will not constitute a Claim.

#### **CONCURRENT CLAIM PROCEDURES**

- (a) A “Concurrent Claim” is a Claim that is reconsidered after an initial approval, which results in a reduction, termination, or extension of a benefit.
- (b) A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made by the Plan Administrator as soon as possible. In any event, the Eligible Individual will be given enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.
- (c) Any request by a claimant to extend an approved Urgent Claim will be acted upon by the Plan Administrator within 24 hours of receipt of the Claim provided the Claim has been received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to extend approved treatment does not involve an Urgent Claim will be decided according to the guidelines for Pre-Service or Post-Service Claims, as applicable.

#### **POST-SERVICE CLAIM PROCEDURES**

- (a) A “Post-Service Claim” is a Claim for benefits that is not a Pre-Service, Concurrent, or Urgent Claim.
- (b) A Post-Service Claim must be submitted to the Fund in writing, using the appropriate claim form, within 90 days after expenses are incurred. A claim form may be obtained by contacting the Fund Office. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim, provided it was not reasonably possible to file the Claim within such time. However, in that event, the Claim must be submitted as soon as reasonably possible from the date the charges were incurred. In no event will benefits be allowed in the event the claim is made beyond one year from the date the expenses were incurred.

- (c) In order to be considered a Claim, the claim form must be completed in full and an itemized bill containing the following information must be submitted:
1. Patient's name;
  2. Date of service;
  3. Type of service or CPT-4 code (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
  4. Diagnosis or ICD-9 code (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U. S. Department of Health and Human Services);
  5. Billed charge;
  6. Number of units (for anesthesia and certain other claims);
  7. Provider's federal taxpayer identification number (TIN); and
  8. Provider's billing name and address.

- (d) Post-Service Claims will be considered to have been filed when the Fund Office receives them. Claims should be submitted to the Fund Office at the following address:

Benefits Administration Corporation, Inc.  
9411 Philadelphia Road -Suite S  
Baltimore, Maryland 21237

- (e) Ordinarily, claimants will be notified of decisions on Post-Service Claims within 30 days from the Plan's receipt of the Claim. This period may be extended one time by the Plan for up to 15 days in the event an extension is necessary due to matters beyond the control of the Plan. In the event an extension is necessary, the claimant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Fund expects to render a decision.
- (f) In the event an extension is required because the Fund needs additional information from the claimant, the Fund will issue a Request for Additional Information that specifies the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information. In the event the information is not provided within that time, the Claim will be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline will be suspended from the date of the request for additional information until either 45 days or until the date the claimant responds to the request (whichever is earlier). The Fund will then have 15 days to make a decision on the Claim and notify the claimant of the determination.
- (g) In the event the Plan determines that additional information is required from the claimant, the Plan may issue a combined Request for Additional Information and Notice of Adverse Benefit Determination. The Notice of Adverse Benefit Determination would only be applicable in the event the claimant fails to provide any information within 45 days. In this event, the Plan would not issue a separate Notice of Adverse Benefit Determination if the claimant failed to submit any

information within 45 days. The combined notice will clearly state that the Claim will be denied if the claimant fails to submit any information in response to the Fund's request and will satisfy the content requirements of both the Request for Additional Information and the Notice of Adverse Benefit Determination. When the combined notice is used, the timeframe for appealing the Adverse Benefit Determination will begin at the end of the 45-day period prescribed in the combined notice for submitting the requested information.

#### **APPEALING AN ADVERSE BENEFIT DETERMINATION**

- (a) In the event a Claim is denied in whole or in part, or if the claimant disagrees with the decision made on a Claim, the claimant may appeal the decision.
- (b) The appeal of a Post-Service Claim must be submitted in writing to the Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:
  - 1. The patient's name and address;
  - 2. The claimant's name and address, if different;
  - 3. A statement that this is an appeal of a decision by the Board of Trustees;
  - 4. The date of the Adverse Benefit Determination; and
  - 5. The basis of the appeal; i.e., the reason why the Claim should not be denied.

#### **PRE-SERVICE OR URGENT CLAIM APPEALS**

Appeals of Adverse Benefit Determinations regarding Pre-Service or Urgent Claims may be made orally within 180 days after receipt of the Notice of Adverse Benefit Determination by calling the Fund Office at (410) 444-2833 or toll-free at (800) 922-0602, and providing the following information:

- (a) The patient's name and address;
- (b) The claimant's name and address, if different;
- (c) A statement that this is an appeal of a decision by the Board of Trustees;
- (d) The date of the Adverse Benefit Determination; and
- (e) The basis of the appeal, i.e., the reason why the Claim should not be denied.

#### **APPEAL DETERMINATION NOTICES – TIME FRAMES**

- (a) **Pre-Service Claims.** Notice of the appeal determination for Pre-Service Claims will be sent within 30 days of receipt of the appeal by Fund Office.
- (b) **Urgent Claims.** Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by Fund Office.
- (c) **Concurrent Claims.** Notice of the appeal determination for a Concurrent Claim that involves a termination or reduction of previously approved care will be sent by the Fund Office before the care is terminated or reduced. Notice of the appeal determination for a Concurrent Claim that involves an extension of care will be sent by the Fund Office based on the timeframes for an Urgent, Pre-Service, or Post-Service Claim, whichever category applies to the appeal.

- (d) **Post-Service Claims.** Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for appeal. However, in the event the request is received within 30 days of the next regularly scheduled meeting, it will be considered at the second regularly scheduled meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. The claimant will be advised in writing in advance if this extension will be necessary. Once a decision on the appeal has been reached, notice of the appeal determination will be sent as soon as possible, but no later than five days after the decision has been reached.

### **Decision Upon Appeal**

Unless special circumstances require an extension of time, a decision will be made by the Board of Trustees on your appeal at their next quarterly meeting following receipt of your appeal, or in cases where the appeal is received within 30 days of the date of that meeting, by the date of their second regularly scheduled quarterly meeting after receipt of the appeal. You will be notified promptly, in writing, of the decision of the Board of Trustees on your appeal.

### **Right of Recovery**

If you file a false claim or receive payment from the Plan through error or misrepresentation, you must make immediate repayment to the Plan. Failure to do so within 30 days of the date of the error or misrepresentation will result in the following penalties:

- Interest at the rate of 10% per year will be added to the amount due; and
- Future benefit claims filed by you and your dependents will be offset until the amount payable exceeds the amount that is due to be reimbursed to the Plan. The Plan may offset benefits payable to you, your dependents, or a third party medical provider rendering benefits to you even if coverage has been pre-certified by the Plan.

The Fund Office also may notify the proper legal authorities if it appears that you or your dependents have submitted falsified information to the Plan.

### **Right to an Authorized Representative in Filing a Claim**

If you wish, you may appoint an authorized representative to act on your behalf for the purposes of filing a claim and seeking a review of a denied claim. You may also represent yourself. If you wish to use an authorized representative (this person may be a lawyer, but need not be), however, you must notify the Fund Office in writing of the name, address and phone number of the authorized representative.