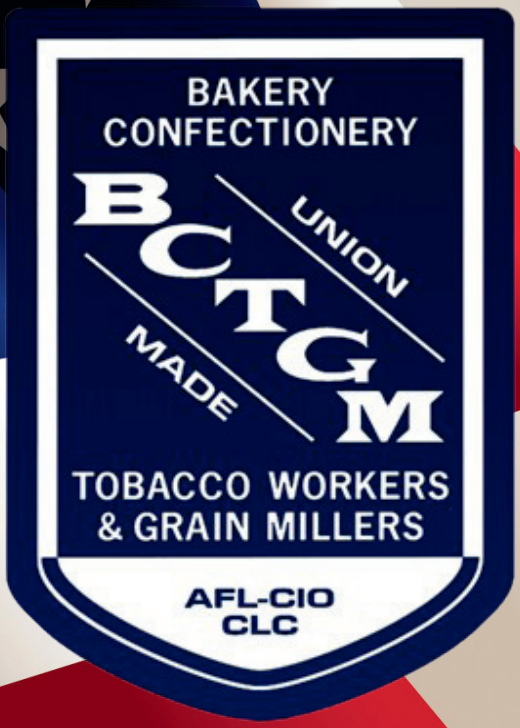
Local 68 and Employers Health and Welfare Fund



SUMMARY PLAN DESCRIPTION

October 2018

ADMINISTRATIVE MANAGER
Receives contributions
Keeps eligibility records
Provides information about the Plan

The Administrative Manager is:
Associated Administrators, LLC
www.associated-admin.com

Participant Services
(800) 638-2972

Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

Hours 8:30 a.m. to 4:30 p.m., Monday through Friday

CONTENTS

Note: Certain terms in this book are defined under the "DEFINITIONS" section on page 65. Such terms will appear in *italics* throughout this booklet.

DEAR PARTICIPANT

This *Plan* (also referred to as the "Fund") was established as a result of collective bargaining between Local 68 of the Bakery, Confectionery, Tobacco Workers and Grain Millers International Union, AFL-CIO ("*Union")* and *Participating Employers* that are signatory to collective bargaining agreements with the Union and which require the employers to pay contributions to the Plan on your behalf. The Fund is governed by a joint *Board of Trustees ("Trustees*"), *half of which* have been appointed by the *Union* and half of which of have been appointed by *Participating Employers*. All *Trustees* serve without compensation. Their authority, established under a trust agreement signed by the *Union* and *Participating Employer*s, provides the *Trustees* with the full and exclusive discretionary authority to construe and interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination by the *Trustees* is final and binding upon any person claiming benefits under the Plan. The *Trustees* may amend the rules and benefit levels or terminate the Plan at any time. If significant changes are made, you will be notified.

The Trustees *have a fiduciary duty under federal law to administer the Plan in accordance with its written terms. If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements. The terms of this Plan may not be amended by oral statements made by the* Trustees*, the* Administrative Manager *or any of its employees, OptumRx or any of its employees, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the* Administrative Manager*, in accordance with the terms of this Summary Plan Description and other Plan documents.*

The *Trustees* employ an ***Administrative Manager*** (referred to in this booklet as the "Fund Office") who receives the employer contributions, keeps eligibility records, and assists participants in getting their benefits.

The Fund has an administrative service agreement with OptumRx ("OptumRx"). OptumRx processes claims and assists participants in understanding their benefits.

We hope you always enjoy good health. However, if the need for prescription coverage arises, we believe you will share with us the satisfaction of knowing you have excellent protection.

Sincerely,

BOARD OF TRUSTEES

FACTS ABOUT THE PLAN

Plan Name
Local 68 and Employers Health and Welfare Fund

Plan Sponsor
Board of Trustees of Local 68 and Employers Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
Phone (410) 683-6500

Employer Identification Number
23-7137657

Plan Number
501

Type of Plan
This is an employee welfare benefit plan designed to provide prescription drug benefits.

Type of Administration
Contract Administration - The *Board of Trustees* has contracted with Associated Administrators, LLC to provide administrative management services. Contact your Administrative Manager at the following address:

Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

Name of Plan Administrator
Board of Trustees of Local 68 and Employers Health and Welfare Fund

Agent for Service of Legal Process
Associated Administrators, LLC or any Trustee at this address:

Local 68 and Employers Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Sources of Contribution
*Participating Employer*s make contributions to the Fund. Individuals who elect *COBRA* coverage make self-payments.

Funding Medium
All assets are held in trust by the *Board of Trustees*. Benefits are paid from the Fund.

Plan Year
January 1 - December 31

The Fund is maintained pursuant to one or more *Collective Bargaining Agreement*s which may be obtained by participants and beneficiaries upon written request to the Plan Administrator. Copies are also available for examination at the offices of the Plan Administrator, the *Union* and the *Participating Employer*s.

BOARD OF TRUSTEES

UNION TRUSTEES

Gary Oskoian, Chairman
BCTGM Local No. 68
2701 West Patapsco Avenue
Room 115
Baltimore, MD 21230-2795

Rodney Lightfoot, Sr.
BCTGM Local No. 68
2701 West Patapsco Avenue
Room 115
Baltimore, MD 21230-2795

EMPLOYER TRUSTEES

Don Mann, Secretary
Northeast Foods, Inc.
601 S. Caroline Street
Baltimore, MD 21231

Elisa Matta
Northeast Foods, Inc.
601 S. Caroline Street
Baltimore, MD 21231

PARTICIPATING EMPLOYERS

Automatic Rolls of Baltimore, MD
7111 Commercial Avenue
Baltimore, MD 21237

Crispy Bagel Company, Inc.
230 N. Franklintown Road
Baltimore, MD 21223

H&S Bakery, Inc.
603 S. Bond Street
Baltimore, MD 21231-2814

Mid-Atlantic Baking Co., LLC
3800 E. Baltimore Street
Baltimore, MD 21224-1542

Ottenberg's Bakery/Owings Mills
1413 Progress Way
Eldersburg, MD 21784

Schmidt Baking Company
7801 Fitch Lane
Baltimore, MD 21236

ELIGIBILITY RULES

Initial Eligibility
You and your eligible dependents may participate in this Plan, without cost and without medical examination, on the first day of the month in which the following qualifications are met:

1. You are employed by a *Participating Employer*;

2. You are in the bargaining unit established by the contract between your employer and BCTGM Local 68 requiring contributions to be made on your behalf; and

3. You are employed for three consecutive months in which you worked at least 96 hours per month.

Example
If an employee was hired on March 7th by Schmidt and covered under the contract with BCTGM Local 68 and worked at least 96 hours in March, April, and May, he or she would be eligible to participate on June 1st.

Enrollment Application
To enroll for benefits you must complete an enrollment application and file it with the Fund Office. You can get an enrollment application from the Fund Office, your *Union* representative, or your employer. Failure to enroll promptly will cause a delay in the start of your benefits. Only eligible dependents listed on the enrollment application are entitled to dependent coverage.

Loss of Eligibility
Once you achieve Initial Eligibility you must work a minimum of 96 hours a month to continue your eligibility, unless your employer is subject to and you are on leave under the *Family and Medical Leave Act* of 1993 ("*FMLA*"). You will cease to be eligible on the first of the month following three consecutive months in which you fail to work

at least 96 hours per month (if you are not on *FMLA* leave) even though you are still employed. Any time not worked because of disability will count toward the 96-hour requirement, if you are receiving sick pay or Workers' Compensation from your employer, up to a maximum of 26 weeks.

Example
If you achieved Initial Eligibility and then failed to work at least 96 hours in February, March, and April, you will lose benefits on May 1st. If you achieved Initial Eligibility and then failed to work at least 96 hours in February, March, and April because you were out sick or injured, your benefits would be continued as long as you receive sick pay or collect Workers' Compensation benefits, up to a maximum of 26 weeks. If loss of eligibility occurs, you may be entitled to exercise your *COBRA* rights as described on pages 15-25.

Reinstatement of Eligibility
A participant who achieved Initial Eligibility and then lost eligibility (because of the 96 hour requirement) may be reinstated on the first of the month following the month in which the participant again works at least 96 hours, as long as this occurs within one year from the date eligibility was lost. If a participant does not satisfy the requirement within one year, he or she must again establish Initial Eligibility.

Example
If you achieved Initial Eligibility and then failed to work at least 96 hours in February, March, and April, benefits would terminate May 1st. However, if you worked 96 hours in May of the same year, benefits would be reinstated June 1st.

Termination of Benefits
Eligibility status for benefit coverage will terminate when employment terminates or job classification changes to a classification which is not covered by the Fund.

Leave of Absence

If your employer grants you a leave of absence, other than a leave of absence taken under *FMLA*, your benefits will terminate at the end of the month in which such leave of absence begins. However, you can continue your benefits under *COBRA* for up to 18 months if you pay for the benefits yourself. See pages 15-25 for more information. If you take a leave of absence under *FMLA*, you will continue to receive your benefits under the same terms as if you were working for your employer during that time.

DEPENDENT ELIGIBILITY

A participant may apply to include the following dependents in this Plan:

1. The participant's spouse.

2. Your child under age 26 until the end of the month in which the child turns age 26. A child includes:
   a. A natural born child,
   b. A legally adopted child, or child placed for adoption,
   c. A stepchild if the child resides with the participant, or
   d. A child for whom the participant is the child's legal guardian.

3. An unmarried child (as defined above), age 26 or over, who is incapable of self-support because of mental or physical incapacity that began before the child's 26th birthday, may continue to be covered for benefits as long as the disability continues. The participant must submit a *Physician*'s statement certifying the disability to the Fund Office.

Dependent coverage is **not** automatic. You must enroll each dependent with the Fund Office. Only those dependents who meet the above qualifications and who are registered will be covered for benefits. You can get an enrollment application from the Fund Office. The Fund requires proof of the dependent's status, such as a birth certificate for your child or a marriage certificate for your spouse.

Special Enrollment Rights

Loss of Other Group Health Plan Coverage

If you turned down coverage for either yourself or your spouse or dependents because you or your spouse or dependents, as the case may be, were then covered under another group health plan, and later that other coverage ends (or the employer stops contributing towards

the other coverage), you or your spouse or dependents may be eligible to enroll in this Plan, provided you do so within 30 days from the date the other coverage ends or employer contributions stop.

However, there are a limited number of circumstances in which such enrollment is permitted. If the other coverage was *COBRA* coverage (see page 65 for the definition of *COBRA*), you may request enrollment under this Plan only if the *COBRA* coverage is exhausted. For other group health plan coverage that is not *COBRA*, you may request enrollment under this Plan if the other coverage was lost as a result of loss of eligibility or because employer contributions toward the other coverage ceased. (If the other coverage was lost because of a failure to pay premiums, neither you or your spouse or dependents are eligible to enroll under this provision.)

New Dependent or Spouse

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

Dependents - Termination of Coverage

Your dependent's benefits will cease automatically on the earliest of the following dates:

1. The date you are no longer eligible for benefits;

2. If the dependent is a spouse, the date of his or her divorce or legal separation from you;

3. The end of the month in which your child turns 26 years old;

4. The date your adult disabled child is no longer disabled or becomes married;

5. The date your dependent becomes eligible as a participant;

6. The date your dependent is offered coverage either through an employer-based coverage or through the dependent's spouse's coverage.

Children of an eligible participant who will lose eligibility solely because of age may continue coverage under *COBRA* as described beginning on page 15.

GRANDFATHERED HEALTH PLAN

The Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the Fund Office, 911 Ridgebrook Road, Sparks, MD 21152, Telephone (800) 638-2972. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("*COBRA*"), you and your eligible dependents may continue your coverage temporarily at your own expense, where coverage otherwise would end due to a "*Qualifying Event*." Under the law, only "*Qualified Beneficiaries*" are entitled to elect *COBRA* Continuation Coverage. Depending on the type of *Qualifying Event*, a *Qualified Beneficiary* can include an employee, and his or her spouse and dependent(s) who were covered by the Plan when a *Qualifying Event* occurs. A child who becomes a dependent child by birth, adoption, or placement for adoption with the employee during a period of *COBRA* Continuation Coverage is also a *Qualified Beneficiary*. A person who becomes your spouse during a period of *COBRA* Continuation Coverage is not a *Qualified Beneficiary.*

What is a Qualifying Event?

To be eligible to elect *COBRA* Continuation Coverage, you or your dependent must lose coverage due to any one of the following *Qualifying Events*:

Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
Voluntary or involuntary termination of your employment (other than by reason of gross misconduct), or loss of eligibility due to a reduction of your work hours.	Employee, Dependent Spouse, Child	18 months
You or your dependent becomes disabled (as determined by the Social Security Administration) at some time before the 60th day of *COBRA* Coverage and the disability lasts until the end of the 18-month *COBRA* Coverage period.	Employee, Dependent Spouse, Child	29 months
You die.	Dependent Spouse, Child	36 months
You become legally separated or divorced from your spouse.	Dependent Spouse, Child	36 months
Your child is no longer considered a dependent under this Plan's definition (*e.g.*, he or she reaches the maximum age limit).	Dependent Child	36 months

When is COBRA Continuation Coverage Available?
The Plan will offer *COBRA* Continuation Coverage to *Qualified Beneficiaries* only after the Plan Administrator determines that your employment has been terminated, your hours have been reduced so that you are no longer eligible for coverage under the Plan, or you have died. However, you or your family should also notify the Fund Office promptly if such a *Qualifying Event* occurs in order to avoid confusion over the status of your Plan coverage in the event there is a delay or oversight in providing that notice.

You Must Give Notice of Some Qualifying Events
For all other *Qualifying Events* (your divorce or legal separation from your spouse, or your dependent child losing dependent status under the Plan), you must notify the Fund Office no later than sixty (60) days after the *Qualifying Event* occurs. The notice of occurrence of any of these events must be provided to the Fund Office in writing.

In addition to the *Qualifying Events* listed above, you are responsible for notifying the Plan Administrator within 60 days when a *Qualified Beneficiary* is determined by the Social Security Administration ("SSA") to be disabled during a *COBRA* Continuation Coverage period or within 30 days when the SSA determines that a *Qualified Beneficiary* is no longer disabled. See the section below entitled, "*COBRA* Continuation Coverage for Disabled Participants."

If you have any questions about how to provide a written notice of a *Qualifying Event* or other events, please contact the Fund Office. **Failure to provide written notice within the timeframe described above may prevent you and/or your dependents from obtaining or extending the COBRA Continuation Coverage.**

How is COBRA Continuation Coverage Provided?
Within 14 days after the Fund Office receives notice that a *Qualifying Event* has occurred, the Fund Office will then provide you and/or your Dependents with notice of the date on which your coverage under the Plan will end, and the information and election form that you will need in order to elect *COBRA* Continuation Coverage. Under the law, you and/or your dependents will then have only 60 days from the later of the date you ordinarily would have lost coverage because of one of the *Qualifying Events* described above, or the date you and/or your dependents received the notice, to apply for *COBRA* Continuation Coverage.

IF YOU AND/OR ANY OF YOUR DEPENDENTS DO NOT CHOOSE *COBRA* CONTINUATION COVERAGE WITHIN **SIXTY (60) DAYS** AFTER THE *QUALIFYING EVENT* (OR, IF LATER, WITHIN **60 DAYS** AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL LOSE THE RIGHT TO ELECT *COBRA* CONTINUATION COVERAGE.

Each *Qualified Beneficiary* has an independent (separate) right to elect *COBRA* Continuation Coverage. *COBRA* Continuation Coverage may be elected for some members of the family and not others. In addition, one or more dependents may elect *COBRA* even if the employee does not elect it. However, in order to elect *COBRA* Continuation Coverage, the members of the family must have been covered by the Plan on the date of the *Qualifying Event* or became an eligible dependent by marriage, birth, adoption, or placement for adoption during the period of *COBRA* Continuation Coverage. An employee may elect *COBRA* Continuation Coverage on behalf of his or her spouse. An employee may elect or reject *COBRA* Continuation Coverage on behalf of a dependent child living with him or her.

In considering whether to elect *COBRA* Continuation Coverage, you should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in coverage, and election of *COBRA* Continuation Coverage may help you

not have such a gap. Second, you will lose the guaranteed right to purchase individual insurance policies that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Plan coverage ends because of the *Qualifying Event* listed above. You will also have the same special enrollment right at the end of *COBRA* coverage if you get *COBRA* coverage for the maximum time available to you.

Payment for COBRA Coverage

You are responsible for the entire cost of *COBRA* Continuation Coverage and can pay for the coverage on a monthly basis. When you and/or your dependents become entitled to this coverage, the Fund Office will notify you of the *COBRA* premium amounts that you must pay. Individuals who continue full coverage under *COBRA* pay 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "*COBRA* Continuation Coverage for Disabled Participants.")

If you elect *COBRA* Continuation Coverage, you do not have to send any payment with the Election Form. However, the first *COBRA* payment must be sent to the Fund Office not later than 45 days after the date you elect the *COBRA* Continuation Coverage. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for *COBRA* in full within this timeframe, you will lose all *COBRA* Continuation Coverage rights under the Plan.

Payments for subsequent months are due on the first day of the month for which coverage is provided. **Please note that you will not be billed; it is your responsibility to remit payments to the Fund Office. Late payments can result in the termination of *COBRA* Continuation Coverage.**

Grace Period for Payments

Although payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your *COBRA* Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make your payment before the end of the grace period for that coverage period, you will lose all rights to *COBRA* Continuation Coverage under the Plan.

Maximum Coverage Period

The maximum time period for *COBRA* Continuation Coverage depends upon the Qualifying Event that causes the termination of coverage. Please refer to the "What is a Qualifying Event?" section above to determine how long your coverage will last. In no event will a *COBRA* Continuation Coverage period be longer than a total of 36 months.

COBRA Continuation Coverage for Disabled Participants

If during an 18-month *COBRA* Continuation Coverage period the Social Security Administration ("SSA") determines that you (or a member of your family who is eligible for *COBRA* Continuation Coverage) were disabled at some time before the 60th day of *COBRA* Continuation Coverage, the disabled person, and any Qualified Beneficiary who elected coverage may receive up to 11 additional months of *COBRA* Continuation Coverage for a total maximum of 29 months. **You must notify the Fund Office of the determination of the disability within 60 days of the date of that determination and before the end of the 18-month period of *COBRA* Continuation Coverage**. The notice of disability must be in writing to the Fund Office. If the 18-month period of *COBRA* Continuation Coverage is extended because of an SSA-determined disability, the *COBRA* premiums for any period of coverage covering the disabled person (whether single or family coverage) may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This extended period of *COBRA* Continuation Coverage will end on the earlier of:

- The last day of the month, 30 days after the SSA has determined that you and/or your Dependent(s) are no longer disabled;
- The end of the 29 months *COBRA* Continuation Coverage; or
- The date the disabled person becomes entitled to Medicare.

You must notify the Fund Office within 30 days of a final SSA determination that you are no longer disabled.

Multiple Qualifying Events While Covered under COBRA

If, during an 18-month period of *COBRA* coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, or if a covered dependent child ceases to be an eligible dependent under the Plan, the maximum *COBRA* continuation period for the affected spouse and child is extended to 36 months from the date of your termination of employment or reduction in hours.

Example: Assume you lose your job (the first COBRA-Qualifying Event), and you enroll yourself and your Dependents for COBRA Continuation Coverage. Three months after your COBRA Continuation Coverage begins, your child attains age 26 and ceases to qualify as an eligible Dependent. Your child then can continue COBRA Continuation Coverage for an additional 33 months, for a total of 36 months of COBRA Continuation Coverage.

In no case are you (the Employee) entitled to *COBRA* Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional *COBRA* Continuation Coverage on account of disability). As a result, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second *Qualifying Event* and *COBRA* Continuation Coverage may not be extended beyond 18 months from the loss of

coverage due to the initial Qualifying Event. You must notify the Plan Administrator within 60 days of a second *Qualifying Event.*

Termination/Reduction in Hours That Follows Medicare Entitlement
If you become entitled to Medicare and are still actively employed, and you later have a termination of employment or reduction in hours, your dependents who are *Qualified Beneficiaries* would be entitled to *COBRA* Continuation Coverage for a period of: (a) 18 months (29 months if the 11-month Social Security Disability extension applies) from your termination of employment or reduction in hours; or (b) 36 months from the date you became entitled to Medicare, whichever is longer.

Special Enrollment Rights
If while you are enrolled for *COBRA* Continuation Coverage you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Dependent for coverage for the balance of the period of *COBRA* Continuation Coverage by doing so within **30 days** after the marriage, birth, adoption, or placement for adoption. Written notice is to be provided to the Fund Office.

You may add a new spouse or child to your *COBRA* Continuation Coverage. However, the only newly added family members who have the rights of a *Qualified Beneficiary*, such as the right to extend a *COBRA* Continuation Coverage period in certain circumstances, are children born to, adopted, or placed for adoption with the Employee.

If while you are enrolled for *COBRA* Continuation Coverage, your dependent(s) lose coverage under another group health plan, you may enroll that Dependent for coverage for the balance of the period of *COBRA* Continuation Coverage by doing so within 30 days after the termination of the other coverage. Written notice is to be provided to the Fund Office.

In order to be eligible for this special enrollment right, the dependent must have been eligible for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined,

the dependent must have been covered under another group health plan or had other health insurance coverage. The loss of coverage must be due to loss of eligibility under another plan, including, but not limited to, termination of employment, termination of employer contributions or exhaustion of *COBRA* Continuation Coverage under another plan. Loss of eligibility does not include a loss of coverage due to failure of the individual or participant to pay premiums on a timely basis or termination of employment for cause. **Adding a dependent may cause an increase in the amount you must pay for *COBRA* Continuation Coverage.**

Notice of Unavailability of COBRA Coverage

In the event the Fund is notified of a *Qualifying Event*, but the Fund Office determines that an individual is not entitled to the requested *COBRA* Continuation Coverage, the individual will be sent an explanation indicating why the *COBRA* Continuation Coverage is not available. This notice of the unavailability of the *COBRA* Continuation Coverage will be sent according to the same timeframe as a *COBRA* election notice.

Early Termination of COBRA Coverage

COBRA Continuation Coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- All required payments are not made on time;
- The person receiving the coverage becomes covered by another group health plan that does not contain any legally applicable exclusion or limitation with respect to preexisting conditions that the covered person may have;
- If under the *COBRA* disability extension, you or your Dependent(s) are no longer disabled;
- You or your eligible dependent become eligible for Medicare;
- The Plan is terminated; or
- The Employer that employed you prior to the *Qualifying Event* has stopped contributing to this Fund, but is making group health plan coverage available through another health plan.

You should contact your former employer to determine whether it will assume your *COBRA* Continuation Coverage.

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or dependent not receiving Continuation Coverage (such as fraud).

Once your *COBRA* coverage terminates, it cannot be reinstated. You and your eligible dependents can only become covered under the Plan again if you return to covered employment and meet the eligibility requirements.

Notice of Early Termination of COBRA Coverage

The Fund Office will notify a *Qualified Beneficiary* if *COBRA* Continuation Coverage terminates earlier than the end of the maximum period of coverage applicable to the *Qualifying Event* that entitled the individual to *COBRA* Continuation Coverage. This written notice will explain the reason *COBRA* terminated earlier than the maximum period and the date *COBRA* Continuation Coverage terminated. The notice will be provided as soon as practicable after the Fund Office determines that *COBRA* Continuation Coverage will terminate early.

Confirmation of COBRA Coverage to Providers

Under certain circumstances, federal rules require the Fund to inform your health care providers as to whether you have elected and/or paid for *COBRA* Continuation Coverage. This rule only applies in certain situations where the provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, *COBRA* Continuation Coverage, or you have elected *COBRA* Continuation Coverage but have not yet paid for it. In these circumstances, the providers will be given the status of the election and/or payment, and will be given notice that no claims will be paid until the amounts due have been received. They also will be informed that *COBRA* Continuation Coverage will terminate effective as of the date of any unpaid amount if payment is not received by the end of the grace period.

If You Have Questions

Questions concerning the Plan or your *COBRA* Continuation Coverage rights should be addressed to the Fund Office. For more information about your rights under *ERISA*, including *COBRA*, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Other Rights

This notice describes your rights under *COBRA.* It is not intended to describe all of the rights available under *ERISA*, the Health Insurance Portability and Accountability Act (HIPAA), the Trade Act of 2002, and other laws.

Contact for Additional Information

If you have questions or wish to request additional information about *COBRA* coverage or the health plan, please contact the Fund Office as follows:

COBRA Department
Local 68 and Employers Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

YOUR RESPONSIBILITIES TO THE PLAN

- Notify the Fund Office of any change in your address so that you can be sent all the required information, notices of change, etc.

- Notify the Fund Office of any change in the status of your dependents, such as:
  - Marriage,
  - New child to be covered,
  - Divorce or legal separation, or
  - Children who cease to be eligible because they are age 26 or older.

Present your Plan identification card to the participating pharmacy.

Report a lost or stolen prescription I.D. card as soon as possible by calling the Fund Office at (800) 638-2972.

PRESCRIPTION DRUG BENEFIT

Your prescription drug plan is processed through OptumRx. Each covered individual is entitled to Prescription Drug Benefits as described below.

What Prescriptions Are Covered?
The Fund will cover *medically necessary* prescription drugs, including those that require compounding, and insulin. Prescriptions must be written by an individual who is legally licensed to prescribe drugs.

Where Do I Fill My Prescription?
You must fill your prescription at a participating pharmacy (unless it is a maintenance drug – see pages 29-30 regarding the Mail Order Program).

To locate the most current list of participating pharmacies, log on to www.optumrx.com. You will be able to find information about refilling prescriptions, managing your account, get medication pricing and receive medication information. You may speak with a Customer Service Advocate toll free by call (800) 797-9791 at any time of the day or night.

Generic Drugs
Generic drugs are mandatory. Generic drugs are drugs that go by their chemical names and are required to meet the same government standards as brand name drugs. Brand name drugs are much more expensive than generic drugs. **You must request generic drugs, if available.**

If you purchase a brand name drug when a generic equivalent is available, **the Plan only covers the cost of the generic drug, and the covered individual must pay the difference in cost between the generic and the brand name drug. If there is no generic equivalent, the Plan will cover the cost of the brand name drug.** Always request that your doctor prescribe generic drugs.

Co-Payment

There are three different *co-payment*s you pay to the pharmacy for non-maintenance drugs, per prescription, depending on the type of drug you purchase.

For Non-Maintenance Drugs, Your Co-Payment Will Be:

- $10 per prescription for Generic Drugs
- $25 per prescription for Brand Name Drugs on the Preferred Formulary List **
- $45 per prescription for Brand Name Drugs NOT on the Preferred Formulary List **

** *The Formulary List is a list of Preferred and Non-Preferred drugs as provided by OptumRx. A copy of the Formulary List can be obtained by calling the Fund Office at (800) 638-2972.*

Once you pay the *co-payment*, the Plan generally pays the balance of the cost of the prescription, provided:

1. The prescription is filled by a participating pharmacy;
2. You present your prescription drug identification card with the prescription to the pharmacist; and
3. Refills are authorized by your physician (or other individual legally licensed to prescribe drugs).

The participating pharmacist will fill the prescription to a maximum of a 34-day supply (unless you use the mail-order program). If the cost of ingredients exceeds a certain amount, the pharmacist will call OptumRx for approval.

MAIL ORDER PROGRAM

Participants and dependents must use the OptumRx Mail Order Program for all maintenance drugs in order for them to be covered. OptumRx Mail Order telephone number is (800) 562-6223. The Mail Order Program not only helps control costs, but it will allow you the convenience of having your medications delivered right to your home.

Maintenance drugs are drugs which you take for 90 days or more, or on a permanent basis for an ongoing condition to treat high blood pressure, thyroid, or many other illnesses.

The first time you fill a prescription for a maintenance drug at a retail pharmacy, OptumRx will send you a letter reminding you to transfer it to mail order. After you receive your second refill of that same prescription at a retail pharmacy, you will no longer be able to fill it at a retail pharmacy and will have to fill it through OptumRx' mail service. **Prescriptions that are required to be filled through mail order but instead are filled at a retail pharmacy will not be eligible for reimbursement.**

Your medicine will be mailed directly to your home with no shipping charges. The appropriate co-pay is either billed on your credit or debit card or, if you filled the prescription via the mail, you may send in your *co-payment* along with the original prescription.

Co-Payments
There are three different *co-payment*s you pay to the pharmacy for maintenance drugs through Mail Order, per prescription, depending on the type of drug you purchase.

For Maintenance Drugs through Mail Order, Your Co-Payment Will Be:

- $20 per prescription for Generic Maintenance Drugs,
- $50 per prescription for Brand Name Drugs on the Preferred Drug Formulary List, and
- $90 for Brand Name Drugs NOT on the Preferred Drug Formulary List.

Using the Mail Order Program
There are two ways you can order or refill your maintenance drugs:
1. By phone: Call OptumRx Mail Order at (800) 562-6223, or
2. By website: Log on to www.optumrx.com and register as a member. Once registered, you can use this website to manage your prescription drug benefits, order refills, sign up for text message reminders, track your orders, view the status of claims, and more.

Diabetic Supplies
Diabetic supplies, such as insulin syringes, needles, devices, pump supplies, blood glucose test strips, urine tests, lancets, lancet devices, and swabs are covered under the Plan, but **must be purchased through the Mail Order Program in order to be covered** (see pages 29-30 for details on the Mail Order Program). You will be charged the preferred brand *co-payment* of $50.00 per product. If the total cost of the drug is less than the *co-payment*, you will pay the total cost of the drug. There are no generic diabetic supplies. Blood glucose monitor and kits, and blood glucose calibration solutions are not covered under this Plan.

Contraceptives
Oral and injectable contraceptives are covered at the same *co-payment* as for any other drug.

PRESCRIPTION IDENTIFICATION CARD

1. Upon becoming eligible, participants will receive an identification card. Show the card to the pharmacist when you go to pick up your prescription.

2. Take your doctor's prescription to a participating pharmacy.

3. Pay the pharmacist the appropriate *co-payment* per prescription. There are no claim forms to complete.

Rules Governing Use of Card
1. No purchase may be made without presentation of card.

2. The card is NOT TRANSFERABLE and may not be used by anyone other than the person to whom it has been issued.

3. The card is invalid and void if you are no longer working for a *Participating Employer*.

4. If you use your card after eligibility is terminated, you must reimburse the Fund for amounts paid.

5. The Fund reserves the right to suspend your benefit or to place you on the direct reimbursement program of claim payment when abuse of the benefit is suspected.

Lost Card
If you lose your card, you can get another by contacting the Fund Office at (800) 638-2972.

QUANTITY LIMITS/PRIOR AUTHORIZATION

There are dispensing limits and prior authorization requirements on specific medications. The Fund's prescription drug manager, OptumRx, developed these guidelines based on the Food and Drug Administration's (FDA's) and manufacturers' recommended dosages. They were established to help ensure the safe and effective use of medications.

If a prescription is written for a quantity in excess of the established limits, a prior authorization request must be submitted and approved before the quantity of medication requested can be dispersed.

Below are examples of prescription drugs and supplies requiring prior authorization:

1. Weight loss medications are covered with the same *co-payment* as any other prescription, but must be pre-authorized by OptumRx.

2. Needles required for the insulin medications such as **Byetta and Symlin.**

3. **Dexedrine, Adderall, and Desoxyn** are covered for individuals who are under age 22. Prior-authorization by OptumRx of these medications is required of those 22 years and older.

Have your medical provider or pharmacist call OptumRx for prior authorization at (800) 711-4555.

LIMITATIONS AND SPECIFIC DRUG COVERAGES

The Plan limits the quantities per prescription for certain drugs. **Prescriptions for more than the allowed quantity will not be covered**.

Viagra and all erectile dysfunction medications are covered with a limit of six (6) tablets per month.

For all medications that are prescribed in order to cure (rather than simply to treat) Hepatitis C (currently available examples of which include Harvoni, Sovaldi, and Olysio), the Plan will pay no more than $5,000.00 per prescription.

EXCLUSIONS

The Plan will **not** pay for the following:

- over-the-counter drugs,
- injectable drugs (except insulin and contraceptives),
- appliances or devices (such as glucose monitors, peak flow meters and spacers for inhalers),
- immunological agents,
- smoking cessation medication or products,
- drugs for which a person is compensated under a Workers' Compensation law,
- prescription drugs for uses not approved by the U.S. Food & Drug Administration (FDA), or
- vitamins or nutritional supplements.

If you receive care in a Veterans, Marine, or other federal hospital or elsewhere at government (federal, state, or municipal) expense, generally no benefits are provided under this Plan. However, if a charge is made, you will be eligible for benefits for prescription drugs to the extent provided under the Plan.

STEP THERAPY PROGRAM

OptumRx, the company chosen to manage your prescription drug plan, developed the Step Therapy program based on the FDA's approved drug labeling, clinical guidelines, and research studies. With Step Therapy, you can maintain your health with affordable prescription drugs that are covered by your plan.

What is Step Therapy?
Step Therapy is a program especially for people who take prescription drugs regularly – that is, for an ongoing condition like arthritis, asthma or high blood pressure. It provides the safe, effective treatment you need while keeping your costs as low as possible.

The program moves you along a well-planned path, with your doctor approving your medications.

- ***Generic drugs are usually in the first step.*** Tested and approved by the FDA, the generics provided by your plan are effective for treating many medical conditions. This first step lets you begin or continue treatment with prescription drugs that have the lowest *co-payment*.
- ***Brand-name drugs are usually in the second step.*** If your path requires more medications, then the program moves you along to this next step. Brand-name drugs have a higher *co-payment*.

How does Step Therapy work?
- When you submit a prescription that is not for a first-step (generic) drug, you or your pharmacist should contact your doctor. Only your doctor can approve and change your prescription to a first-step drug. You can call OptumRx to get some examples of safe, effective first-step drugs to discuss with your doctor.

- If you have already tried the first-step drugs provided by your program or your doctor decides you need a different drug for medical reasons, then your doctor can call OptumRx to request a

"prior authorization." An OptumRx representative will check your Plan's guidelines to see if a second-step drug can be covered. If it can, you could pay a higher *co-payment* than for a first-step drug. If it cannot be covered, you may need to pay the full price for the drug.

CLAIMS FILING AND REVIEW PROCEDURE

Payment of a Claim

Normally you do not need to file a claim for prescription drug benefits. The pharmacy will submit the claim to OptumRx and OptumRx will either pay or deny the claim. However, it is possible that the pharmacy may ask you to pay for the prescription. In this case, you need to submit a claim for reimbursement to OptumRx. You may obtain a claim form by contacting the Fund Office.

Claims Review – Types of Claims

1. Pre-Service Claim. A pre-service claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or part, on the Fund's approval of the benefit before you receive the medical care. For example, a prescription requiring prior authorization, as described elsewhere in the Summary Plan Description, would be a pre-service claim. If your pre-service claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within five days of the date you filed the claim. The Fund will notify you of its decision on your pre-service claim (whether approved or denied) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claim is received by the Fund. The Fund may extend the period for a decision for up to 15 additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial 15-day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly re-file the claim, the Fund will decide the claim based on the information it has available, and your claim may be denied.

2. Post-Service Claim. A *post-service claim* is any claim under the Plan that is not a pre-service claim. Typically, a *post-service claim* is a request for payment by the Fund after you have received the prescription.

If the Fund denies your *post-service claim*, in whole or in part, the Fund will send you a notice of the claim denial within a reasonable period of time, but not later than 30 days after the claim is received by the Fund. The Fund may extend the period for a decision for up to 15 additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial 30-day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If your *post-service claim* is incomplete, the Fund will deny the claim within the 30-day period mentioned above. You may resubmit the claim, with the necessary additional information, at any time within 180 days from the date of service.

Denial of a Claim

With respect to any claim relating to prescription benefits, if the Fund denies the claim, in whole or in part, the Fund will send you a written notice of the denial. The notice will provide 1) the specific reason or reasons for denial; 2) reference to specific Plan provisions on which the denial is based; 3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; 4) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures; 5) a statement of your right to bring a civil court action under Section 502(a) of *ERISA* following a denial of your appeal; 6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or

other similar criterion will be provided free of charge upon request; and 7) if the denial is based on a determination of medical necessity or *experimental* treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

Review of a Denied Claim

You have the right to appeal a denial of your benefit claim to the Fund's *Board of Trustees.* Your appeal must be in writing and must be sent to the *Board of Trustees* at the following address:

Board of Trustees
Local 68 and Employers Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

If your claim is denied, you (or your authorized representative) may, within 180 days from receipt of the denial, request a review by writing to the *Board of Trustees*. You will have the right 1) to submit written comments, documents, records, and other information relating to your claim for benefits; and 2) upon request, to have reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits. In making a decision on review, the *Board of Trustees* or a committee of the *Board of Trustees* will review and consider all comments, documents, records, and all other information submitted by you or your authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing your claim, the *Board of Trustees* will not automatically presume that the Fund's initial decision was correct, but will independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is *experimental*, investigational, or not *medically necessary* or appropriate), the *Board of Trustees* will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and

will identify the medical or vocational experts who provided advice to the Fund on the initial claim.

In the case of an appeal of a pre-service claim, the *Board of Trustees* will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Fund's receipt of your appeal. The Fund may also request that you voluntarily extend the period of time for the *Board of Trustees* to make a decision on your appeal.

In the case of an appeal of a *post-service claim*, the *Board of Trustees* or a committee of the *Board of Trustees* will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the Fund within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the *Trustees*, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The *Trustees* will send you a written notice of their decision (whether approved or denied) within five days of the decision.

If the *Board of Trustees* has denied your appeal, the notice will provide 1) the specific reason or reasons for the denial; 2) references to specific Plan provisions on which the denial is based; 3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and 4) a statement of your right to bring a civil court action under Section 502(a) of *ERISA.* **If you choose to bring an action under Section 502(a) of ERISA, you must do so within one year of the date on which you received the appeal denial.** The notice will also state that 1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and 2)

if the denial of your appeal was based on a medical necessity or *experimental* treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

The *Board of Trustees* has the exclusive power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and to make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the *Board of Trustees* is final and binding.

For certain benefits, before filing an appeal with the *Board of Trustees* as described above, you may wish to contact OptumRx at (800) 562-6223 with any questions or concerns that you have regarding the claim denial. If you choose to do so, please refer to the relevant section of this booklet, or contact the provider directly, for important information regarding the appropriate procedures, including any time limits.

Whether or not you choose to address your concerns to the provider, you have the right to appeal a benefit denial to the *Board of Trustees* as described above. However, if you choose to address your concerns to the provider, you must do so before you appeal to the *Board of Trustees* and, if you are not satisfied with the results through the provider and wish to file an appeal to the *Board of Trustees*, you must do so within 180 days from the day you received the claim denial from the Fund Office or other Fund provider. If you do not choose to address your concerns to the provider and wish to appeal directly to the *Board of Trustees*, you must do so within 180 days from the day you received the claim denial from the Fund Office. Please remember that if you are not able to resolve your concerns by contacting OptumRx, you must appeal to the *Board of Trustees* before filing a lawsuit against the Fund.

SUBROGATION: WHEN SOMEONE ELSE IS RESPONSIBLE FOR YOUR INJURY OR ILLNESS

This provision explains what happens if a third party is potentially responsible for causing an illness or injury to you or your covered dependents, or for paying monies, damages or benefits related to that illness or injury, and you have filed a qualified claim with the Fund related to that illness or injury. This provision will normally apply if you or your covered dependents are involved in a motor accident and then you sue to recover from the driver of the other vehicle.

For purposes of this provision: (1) "you" or "yours" refers to the ill or injured person, whether it is you or your covered dependent; (2) "third party" refers to any individual or entity other than you who is liable for expenses relating to the illness or injury suffered by you, including insured or uninsured motorists programs, workers' compensation programs, or any other insurance programs or benefits plans; (3) "recovery" (or any variation of that word) refers to any monies, damages or benefits that you receive from a third party through lawsuit, workers' compensation award, judgment, settlement or any other payment that relate to the illness or injury that you have suffered.

If you become ill or are injured and a third party is potentially liable to you for the illness or injury, or a third party may be responsible for paying damages or benefits related to the illness or injury, you must promptly notify the Fund of any potential recovery from any third party and/or of the filing of any claim or legal action against any third party that is related to an illness or injury that is or may be the subject of qualified claims for benefits under the Plan. Also, if the Fund requests it, you must promptly provide the Fund with any information and documents that may be related to such third party recovery, claim or legal action.

If you become ill or injured, and a third party is potentially responsible for such illness or injury and/or for the payment of benefits or

damages related to such illness or injury, the Fund may advance the payment of benefits to cover your qualified claims under the Plan. However, if you recover money from a responsible third party, you are required to repay the Fund for the benefits it advanced, up to the amount of the recovery from the third party.

This repayment obligation also applies if the Fund has inadvertently paid your qualified claims when a third party is actually responsible for your illness or injury and/or for the payment of benefits or damages related to such illness or injury. Repayment is required even if your only monetary recovery is through your or your covered dependent's own insurance company. Regardless of the exact circumstances, the Fund always is fully subrogated to any and all rights of recovery and causes of action that you may have against a responsible third party. For purposes of these subrogation provisions, the Fund specifically rejects the double-recovery rule, and the common-fund and make-whole doctrines.

These reimbursement and subrogation rules are in place to assist you—by paying qualified claims while you proceed against the responsible third party. They also prevent a situation where you are compensated twice for the same injury or illness—once by the Fund when it pays your prescription claims and a second time by the third party when it pays your damages for your loss. The bottom line is that the rules help to insure that assets are available for all of the Fund's participants.

If you become ill or are injured and a third party is potentially liable to you for the illness or injury or a third party may be responsible for paying damages or benefits related to the illness or injury, the Fund may advance payment of benefits on your behalf, but only under the following conditions:

- You and your attorney, if you have one, must sign and return the Fund's Subrogation Agreement. Benefits will not be paid on your or your dependent's behalf unless the Fund Office receives a copy of the Agreement signed by you and your

attorney. Alternatively, if you or your attorney fails or refuses to sign and return the Subrogation Agreement and the Fund still pays your or your dependent's benefits, your acceptance of those benefits will constitute an agreement by which you acknowledge and consent to the Fund's right to reimbursement and subrogation. By that agreement, you will agree to hold any monies or damages that are recovered from a third party in a constructive trust, or equitable lien by agreement, in favor of the Fund.

- If you recover money from a third party related to an illness or injury for which the Fund has paid benefits, you must repay the Fund for the benefits it paid out on your behalf, up to the amount of the recovery. (Example: the Fund pays out $5,000 in prescription claims on your behalf. Later, you recover $25,000 from the third party responsible for your injury or illness. You must reimburse the Fund for the $5,000 of prescription claims paid on your behalf.) In addition, if your third party recovery is less than the full amount of damages or expenses that you claim, the Fund's share of the recovery will not be reduced and will remain the full amount of the benefits the Fund has paid on your behalf, unless the Fund agrees in writing to a reduced amount.

- This repayment obligation applies to any recovery from a third party, regardless of how the recovery is structured, and regardless of whether the payment is characterized as compensation for medical expenses, pain and suffering, or something else.

- The Fund has a specific and first right of reimbursement out of the proceeds of any recovery to you. This means that your obligation to repay the Fund has priority over other obligations you may have, including any obligation to pay attorneys' fees out of the recovery. You may not reduce the amount you owe the Fund to account for the payment of attorney's fees or other obligations.

- Once Fund benefits are paid, the Fund has an equitable lien on the proceeds of any recovery from a third party received by you or on your behalf. Therefore, you consent and agree that an equitable lien by agreement in favor of the Fund exists with regard to any recovery from a third party. In addition, you grant the Fund an irrevocable vested future interest in the proceeds of any recovery from a third party that is predicated on an illness or injury for which Fund benefits were paid to you. You also agree that once you receive a recovery, you are responsible for holding and safeguarding the Fund's funds in a constructive trust until those funds are surrendered to the Fund. You will act as the trustee and fiduciary of the Fund's funds, and you may be liable for your failure to safeguard those funds.

- In accordance with the lien described in the paragraph above, you agree to cooperate with the Fund to effect the Fund's reimbursement or subrogation rights, including but not limited to reimbursing the Fund for its costs and expenses. You also agree not to do anything that may impair, prejudice or discharge your right to recover from a third party and/or the Fund's right to reimbursement or subrogation, including but not limited to settling any claim or lawsuit without the written consent of the Fund.

- You will not assign to any other party, including your attorney, any rights or causes of action that you may have against a third party related to the illness or injury for which the Fund may pay, is paying or has paid benefits without the written consent of the Fund. As such, the Fund's reimbursement will not be reduced by attorney fees and expenses.

- The Fund's right to reimbursement and subrogation will not be affected, reduced or eliminated by the make-whole doctrine, the comparative fault doctrine, the regulatory diligence doctrine, the collateral source rule, the attorney

fund doctrine, the common fund doctrine, or any other defenses or doctrines that may affect the Fund's recovery.

- If you recover money through a third party recovery, but fail or refuse to repay the Fund, future Plan benefits will not be paid on your and your dependent's behalf until such time as the Fund offsets the full amount due to be reimbursed under these rules.

- You agree that the Fund may bring an action or claim against a third party in your place to recover the paid Fund benefits. If the Fund recovers from a third party an amount that is greater than the amount of benefits the Fund has paid and the expenses incurred in making the recovery (including the Fund's attorneys' fees), the Fund will pay the excess amount to you.

YOUR RIGHTS UNDER ERISA

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:

- Examine all Plan documents, insurance contracts, collective bargaining agreements, and documents filed by the Plan with the U.S. Department of Labor, such as annual financial reports. Participants may examine these documents without charge at the Plan Administrator's office.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate your Plan, called fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and their covered dependents.

If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the *Trustees* review and reconsider your claim.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day (or such other amount as may be prescribed by law) until you receive them, 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 state or federal court.

If you have any questions about your Plan, please contact the Plan Administrator. If you have any questions about your rights under ERISA, you may contact the Employee Benefits Security Administration, U.S. Department of Labor, Frances Perkins Building, 200 Constitution Ave., NW, Washington, DC 20210, (866) 444-3272.

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 *("FMLA")* requires *participating employer*s with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for his/her own *sickness* or to care for a seriously ill child, spouse, or parent.

In compliance with the provisions of the *FMLA*, your *participating employer* is required to maintain pre-existing coverage under the Plan during your period of leave under the *FMLA* just as if you were actively employed. Your coverage under the *FMLA* will cease once the Fund Office is notified or otherwise determines that you have terminated employment, exhausted your 12 week *FMLA* leave entitlement, or do not intend to return from leave. Your coverage will also cease if your *participating employer* fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of *FMLA* leave, you may elect to continue your coverage under the *COBRA* continuation rules, as described in the previous section. The qualifying event entitling you to *COBRA* continuation coverage is the last day of your *FMLA* leave.

If you fail to return to covered employment following your leave, the Fund may recover the value of benefits it paid to maintain your health coverage during the period of *FMLA* leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the *FMLA*. If you fail to return from *FMLA* for impermissible reasons, the Fund may offset payment of outstanding medical claims *incurred* prior to the period of *FMLA* leave against the value of benefits paid on your behalf during the period of *FMLA* leave.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If a court or state administrative agency has issued an order with respect to health care coverage for your Dependent child(ren), the Fund or its designee will determine if the court or state administrative order is a Qualified Medical Child Support Order (QMSCO), as defined by federal law. The Fund will notify the parents of each child and advise them of the Fund procedures that must be followed to provide coverage to the Dependent Child(ren). However, no coverage will be provided for any Dependent Child pursuant to a QMSCO unless all of the Fund's requirements for coverage of that Dependent child have been satisfied. If you have any questions about QMSCOs, or if you would like a copy of the Fund's QMSCO procedures free of charge, please contact the Fund Office.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a QMSCO, you may file suit in Federal court. However, if you have a denied claim or disagree with the Plan's decision regarding an order, you must appeal these decisions within the plan's time limits discussed on pages 36-40 before you can bring suit.

CONTINUATION OF COVERAGE UNDER USERRA

As required by the Uniformed Services Employment and Re-Employment Rights Act of 1994 ("*USERRA*"), the Fund provides you with the right to elect continuous health coverage for you and your eligible dependent(s) for up to 24 months, beginning on the date your absence begins from employment due to military service, including Reserve and National Guard Duty, as described below. Contact the Fund Office for more information if this may apply to you.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible dependent(s) under the provisions of *USERRA*. The period of coverage for you and your eligible dependent ends on the earlier of:

1. the end of the 24-month period beginning on the date on which your absence begins; or

2. the day after the date on which you are required but fail to apply under *USERRA* for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

After 31 days, you must pay the cost of the coverage unless your *participating employer* elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in accordance with the provisions of the *USERRA* by the same method that the Fund uses to determine the cost of *COBRA* continuation coverage.

You must notify your *participating employer* or the Fund Office that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must contact the Fund Office and elect continuation coverage for

yourself or your eligible dependent(s) under the provisions of *USERRA* within 60 days after your military service begins. Payment of the *USERRA* premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of election of your *USERRA* coverage.

Ongoing payments must be made by the last day of the month for which coverage is to be provided. **You will not be billed; it is your responsibility to remit payments to the Fund Office. Late payments can result in termination of coverage.** You are responsible for the payment of required premiums.

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under *USERRA*.

NOTICE OF PRIVACY PRACTICES

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

THE PLAN'S COMMITMENT TO PRIVACY

The Plan is committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Plan's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refers to participants and dependents who are eligible for benefits under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

The Plan collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you

complete, through conversations you may have with the Plan's administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Notice. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, Social Security number, employment information, and medical and health claims information.

SUMMARY OF THE PLAN'S PRIVACY PRACTICES

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Plan discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan may also disclose your health information to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Plan will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;

- File a complaint with the Fund Office or the Secretary of the Department of Health and Human Services if you believe that your that privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Practices
The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information
If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or if you wish to obtain additional information about the Plan's privacy practices, please contact:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

DETAILED NOTICE OF THE PLAN'S PRIVACY POLICIES

THE PLAN'S USES AND DISCLOSURES

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and the processing of your health claims.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** While the Plan does not anticipate making disclosures "for treatment," if necessary, the Plan may make such disclosures without your authorization. For example, the Plan

may disclose your health information to a health care provider, such as a hospital or *Physician*, to assist the provider in treating you.

2. **For Payment.** The Plan may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information with its third party administrator, Associated Administrators, LLC ("Associated"), so that it may process your claims. The Plan may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered under the Plan. Associated also may disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, Associated may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.

3. **For Health Care Operations**. The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Plan, may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan.

Uses and Disclosures to Business Associates

The Plan shares health information about you with its "business associates," which are third parties that assist the Plan in its operations. The Plan discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Plan shares your health information with Associated so that it may process your claims. The Plan may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are

a non-English speaking participant who has questions about a claim, the Plan may disclose your health information to a translator.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected. Similarly, Associated contracts with the subcontractors it uses to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Board of Trustees

The Plan may disclose your health information to the *Board of Trustees*, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Plan. The Plan also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Plan, may make without your authorization.

1. **Required by Law**. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:
   - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
   - To report information related to victims of abuse, neglect, or domestic violence.
   - To assist law enforcement officials in their law enforcement duties.

2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, *injury* or disability, and to meet the reporting and

tracking requirements of governmental agencies, such as the Food and Drug Administration.

3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

4. **Active Members of the Military and Veterans**. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

6. **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.

7. **Others Involved in Your Care**. Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Plan). Also, upon request, Associated may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. **Personal Representatives**. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

9. **Treatment and Health-Related Benefits Information**. The Plan and its business associates, including Associated, may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.

10. **Research**. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

11. **Organ, Eye and Tissue Donation**. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

12. **Deceased Individuals**. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes
The Plan and its business associates, including Associated, do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization
Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose

your health information in writing. If you do so, the Plan will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

Right to Inspect and Copy Health Information
You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Plan will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, then the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying

claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a two year period, state that in your written request, and that request will be accommodated. If you request a copy of your underlying health record or a portion of your health record, the Plan will charge you a fee of $.25 per page for the cost of copying and mailing the response to your request.

In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for the Plan, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan, including disclosures by Associated, to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. The first accounting that you request during any twelve-month period will be free. For additional accountings in a single twelve-month period, you will be charged for the cost of providing the accounting, but Associated will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that Associated discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is <u>not</u> required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Plan and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a stand-alone paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy of this Notice at Associated's website, www.associated-admin.com.

CHANGES IN THE PLAN'S PRIVACY POLICIES

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it

maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be posted for review near the front lobby of Associated's office in Sparks, Maryland. Any revised notice will also be available at Associated's website, www.associated-admin.com.

EFFECTIVE DATE

This Notice will remain in effect unless and until the Plan publishes a revised Notice.

GENETIC INFORMATION NONDISCRIMINATION ACT

The Genetic Information Nondiscrimination Act of 2008 (GINA), prohibits a group health plan from discriminating on the basis of genetic information, which includes an individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Genetic information cannot be used as a basis to determine eligibility for insurance coverage, or to adjust premium or contribution amounts for the group. However, a group health plan may increase the premium for an employer based on the manifestation of a disease of an individual who is enrolled in the plan, provided it does not further increase the premium based upon other family members covered under the plan. GINA also prohibits a health plan from requesting or requiring an individual or an individual's family member to undergo a genetic test with the exception that a plan may request (but not require) a Participant or Beneficiary to undergo a genetic test for the purpose of research if certain requirements are met. A group health plan is further prohibited from requesting, requiring or purchasing genetic information prior to an individual's enrollment in the plan, or for underwriting purposes. This restriction does not prohibit a group health plan from the incidental collection of genetic information such as obtaining and using the results of a genetic test in making a determination regarding payment.

DEFINITIONS

ADMINISTRATIVE MANAGER. The company responsible for receiving *participating employer* contributions, keeping eligibility records, paying claims, and providing information to you about the Fund. The company is Associated Administrators, LLC, referred to as "the Fund Office" throughout this booklet.

COBRA. Consolidated Omnibus Budget Reconciliation Act of 1985. Provides for continuation of benefits under certain circumstances for participants and their eligible dependent(s) when benefits are lost. Refer to pages 15-25.

COLLECTIVE BARGAINING AGREEMENT. The agreement or agreements between a *participating employer* and Bakery, Confectionery, Tobacco Workers and Grain Millers International Union Local 68 .

CO-PAYMENT. The out-of-pocket amount a participant or dependent is responsible for paying when receiving benefits.

EFFECTIVE/ELIGIBILITY DATE. According to the Eligibility Rules, the date on which coverage for a participant or dependent begins.

ERISA. The Employee Retirement Income Security Act of 1974, and regulations thereunder, as amended from time to time.

EXPERIMENTAL. A drug, device, medical treatment, or procedure is considered *experimental* or investigative unless:

1. The approval of the U.S. Food and Drug Administration and approval for marketing the drug or device has been given at the time the drug or device is furnished;
2. The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other such body

serving a similar function, if federal law requires such review or approval;

3. Reliable evidence shows that the drug, device, medical treatment, or procedure is not the subject of on-going Phase I or Phase II clinical trials, or the research, *experimental* study, or investigational arm of ongoing Phase III clinical trials, or is not otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

FMLA. The Family Medical Leave Act of 1993, and any regulations thereunder, as amended from time to time.

INJURY. Bodily *injury* caused by an accident and resulting, directly and independently of all other causes, in loss which is covered by the Plan. All injuries sustained in connection with one accident will be considered one *injury*.

PARTICIPATING EMPLOYER. An employer who is a party to a *Collective Bargaining Agreement* or other similar arrangement with the Bakery, Confectionery, Tobacco Workers and Grain Millers International Union Local 68, which requires contributions to the Fund.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO). A medical child support order which creates or recognizes the existence of an alternate payee's right to receive benefits from the Plan and which complies with the requirements for a *QMCSO* under *ERISA*.

TRUSTEES. Members of the Board of Trustees of the Local 68 and Employers Health and Welfare Fund.

UNION. The Bakery, Confectionery, Tobacco Workers and Grain Millers International Union Local 68 or any successor by combination, consolidation, or merger, or any other local *union* affiliated with the Bakery, Confectionery, Tobacco Workers and Grain Millers Local 68 that: 1) has a Collective Bargaining or other Agreement with an employer requiring contributions to the Trust establishing the Local 68 and Employers Health and Welfare Fund ("Trust"); 2) has agreed in writing to participate in the Trust or has signed the Trust Agreement; and 3) is accepted for participation in the Plan by the *Trustees*.

USERRA. The Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"), which provides for the continuation of benefits for participants and their eligible dependent(s) who are absent from work due to military service. See page 50.

TELEPHONE NUMBERS AND ADDRESSES

Participant Services ..... (800) 638-2972

Fund Office
Sparks, MD ..... (410) 683-6500
(800) 638-2972

OptumRx Pharmacy Help Desk ..... (800) 797-9791

OptumRx Mail Order ..... (800) 562-6223

Prior Authorizations
from OptumRx ..... (800) 711-4555

FUND OFFICE
Local 68 and Employers
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

WEBSITES

Associated Administrators, LLC (the Fund Office):
www.associated-admin.com

OptumRx: www.optumrx.com