SUMMARY PLAN DESCRIPTION

FOR

THE TWIN CITIES BAKERY DRIVERS HEALTH AND WELFARE FUND

CLASS 6A

JANUARY 2008

ATTENTION:

THE BENEFITS CONTAINED HEREIN DO NOT CONSTITUTE, NOR SHOULD THEY BE CONSTRUED AS CONSTITUTING, A CONTRACT TO PROVIDE FUTURE BENEFITS OR A PRESENT PROMISE FOR A FUTURE BENEFIT. THE TRUSTEES OF THE PLAN HAVE THE RIGHT UPON THIRTY (30) DAYS' WRITTEN NOTICE TO THE PARTICIPANTS, TO MODIFY, CHANGE, ALTER, REDUCE OR DISCONTINUE ANY OR ALL OF THE BENEFITS PROVIDED BY THE PLAN WITHOUT THE SHOWING OF ANY NECESSITY THEREFORE.

NOTHING IN THIS SUMMARY PLAN DESCRIPTION IS MEANT TO INTERPRET OR EXTEND OR CHANGE IN ANY WAY THE PROVISIONS EXPRESSED IN ANY INSURANCE POLICIES THAT ARE PART OF THE PLAN OF BENEFITS OFFERED BY THIS TRUST FUND.

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SUMMARY PLAN DESCRIPTION
FOR

THE TWIN CITIES BAKERY DRIVERS HEALTH AND WELFARE FUND

NORTHERN STAR – CLASS 6A

JANUARY 2008

The Twin Cities Bakery Drivers Health and Welfare Fund is maintained for the purpose of providing disability, medical and dental benefits in the event of death, sickness or accident. This booklet contains the Summary Plan Description for the weekly disability, major medical, dental coverage, and life.

Weekly disability, major medical benefits and dental benefits are **self funded by the Twin Cities Bakery Drivers Health and Welfare Fund** (any excess losses are covered by Blue Cross/Blue Shield of Minnesota). Claims are administered in accordance with an Administrative Service Agreement between Comprehensive Care Services, Inc. and Twin Cities Bakery Drivers Health and Welfare Fund. The eligibility requirements and benefits are shown in this Summary Plan Description booklet. The coverage is effective only if the employee and employee's dependent(s) are eligible for the coverage, become covered and remain covered as described in this booklet.

PART I - GENERAL INFORMATION

1.1 GENERAL PLAN INFORMATION

NAME OF PLAN: The Twin Cities Bakery Drivers
Health and Welfare Fund

TYPE OF PLAN: This is a welfare plan providing group life insurance, disability, dental, pharmacy, vision and medical benefits. All participants are given a copy of this Summary Plan Description booklet which contains a detailed description of these benefits. If this booklet becomes misplaced, a new copy may be obtained from the Contract Administrator. If there is any inconsistency between other information a participant may be provided and the information in this Summary Plan Description document, this Summary Plan Description document together with any amendments or modifications thereto is controlling.

FUND ADDRESS: Twin Cities Bakery Drivers
Health and Welfare Fund
2919 Eagandale Boulevard, Suite 120
Eagan, MN 55121

EMPLOYER IDENTIFICATION NUMBER: 41-6027254

EMPLOYER PLAN NUMBER: 501

FISCAL YEAR OF THE PLAN: The Plan Year begins on January 1 and ends December 31.

1.2 TRUSTEES OF THE TWIN CITIES BAKERY DRIVERS HEALTH AND WELFARE FUND:

Union Trustees
Daniel P. Bartholomew
Teamsters Local 289
Suite 305
3001 University Ave. SE
Minneapolis, MN 55414

Mike DeBuck
Teamsters Local 289
Suite 305
3001 University Avenue, SE
Minneapolis, MN 55414

Dave Laxen
Teamsters Local 471
Suite 407
3001 University Ave. S.E
Minneapolis, MN 55414

Paul Masica
Teamsters Local 471
Suite 407
3001 University Avenue S.E.
Minneapolis, MN 55414

Alternate Trustee
Darryl L. Palm
5100 7th Street N.E.
Columbia Heights, MN 55421

Employer Trustees
James Akervik
Pan-O-Gold Baking Co.
444 E. St. Germain St.
P.O. Box 848
St. Cloud, MN 56302

Trace Benson
Old Dutch Foods, Inc.
2375 Terminal Road
P.O. Box 64627
St. Paul, MN 55164-0627

Alternate Trustee
Curt Jenson
Pan-O-Gold Baking Co.
Human Resources & Safety Manager
P.O. Box 848
St. Cloud, MN 56302-0848

TYPE OF ADMINISTRATION OF THE PLAN: The Plan is administered by the Contract Administrator, subject to the approval of the trustees and pursuant to the Plan, the trust agreement establishing the Twin Cities Bakery Drivers Health and Welfare Fund and the rules and regulations established by the trustees.

CONTRACT ADMINISTRATOR:
Formula Corporation
Richard Jay Johnson
Contract Administrator
2919 Eagandale Boulevard, Suite 120
Eagan, MN 55121
Telephone: 651-686-7705
1-800-689-7713 (outside Twin Cities)
FAX: 651-686-0513

1.3 **PLAN SPONSOR**: The Board of Trustees of the Twin Cities Bakery Drivers Health and Welfare Fund is the Plan Sponsor.

1.4 **FUNDING FOR PLAN BENEFITS**: The benefits described in this Summary Plan Description are provided through employer contributions and if so negotiated, through employee contributions. The amount of contributions and the employees on whose behalf contributions are made are determined in accordance with their collective bargaining agreements with the Bakery, Laundry, Allied Sales Drivers and Warehousemen Union Local 289. Contributions are also paid pursuant to Participating Agreements between an Employer and the Fund on behalf of the members of Local 289.

A copy of any such collective bargaining agreement will be sent to a Participant or a beneficiary for a reasonable charge upon written request to the Contract Administrator. Also, copies of such collective bargaining agreements are available for examination by Participants and beneficiaries at:

(1) the office of the Contract Administrator;
(2) the office of each contributing employer; and
(3) at each Union office.

Upon written request to the Contract Administrator, Participants and beneficiaries will receive information as to whether a particular employer contributes to the Plan and, if the employer is a contributing employer, the employer's address. A complete list of the employers contributing to the Plan may also be obtained by participants and beneficiaries upon written request to the plan and is available for examination by participants and beneficiaries at the office of the Contract Administrator, the office of each contributing employer which has at least 50 participants in the Plan, and each Union office.

1.5 **AGENT FOR SERVICE OF LEGAL PROCESS**: The Board of Trustees is the Fund's agent for service of legal process. Accordingly, if legal disputes involving the Fund arise, any legal documents should be served upon the Board at the Fund office address or upon any of the Trustees.

1.6 **TRUSTEES RIGHTS AND POWERS**: While the Board of Trustees of the Twin Cities Bakery Drivers Health and Welfare Fund currently intends to continue the benefits provided by this Plan, the Board of Trustees reserves the right to amend or modify the Plan, in whole or in part, at any time, including retroactive amendments if necessary or appropriate to meet the requirements of the Internal Revenue Code or ERISA. The authority to make any such changes to the Plan rests with the Board of Trustees. Any such amendment or modification of the Plan shall be made by a resolution adopted by the Board of Trustees. To the full extent permitted by law, the Trustees shall have exclusive authority and discretion to interpret or construe any term or provision in the Plan, and to decide any matter relating to Plan administration, including, but not limited to, the following:

1. determining whether an individual is eligible for any benefits under the Plan;
2. determining the amount of benefits, if any, an individual is entitled to under the Plan;
3. interpreting all of the provisions of the Plan;
4. interpreting all the terms used in the Plan; and
5. determining questions of fact.

The Trustees' exercise of discretionary authority shall be binding upon any individual claiming benefits under the Plan, including but not limited to, the employee, eligible dependents, the employee's estate, and any service provider, and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious. The Board of Trustees has delegated the duty to determine eligibility for benefits and to construe the provisions of the Plan to the Contract Administrator. Benefits under this plan will be paid only if the Contract Administrator decides in his discretion that the applicant is entitled to them. As a result, no statements made by the Board of Trustees, or any of its officers, directors, employees, or agents relating to eligibility of benefits or construing Plan terms shall be binding on the Plan. Plan participants may not rely upon such statements by the Board of Trustees, its officers, directors, employees, or agents in making a claim for benefits. In addition no statements by the Board of Trustees, its officers, directors, employees, or agents will void any benefits due to a Plan participant under the terms of the Plan. Any amendment to this Plan may be effected by a written resolution adopted by the Board of Trustees. Any amendment shall be filed with the Plan Document. The Board of Trustees will communicate any adopted changes to the participants.

PART II - EMPLOYEE AND DEPENDENT(S) ELIGIBILITY

ACTIVE EMPLOYEE ELIGIBILITY:

2.1 **ELIGIBILITY:** All active, full time employees (full time means working at least 20 hours per week or 3 days per week) are eligible on the first day of the calendar month coinciding with or next following completion of a qualifying period of sixty (60) days continuous service with a participating employer (or longer, if stated in the collective bargaining agreement). If an employee is in the employ of or connected with two or more participating employers, such employee will not be eligible for multiple coverage under the group policy, but will be treated the same as if he was in the employ or connected with a single participating employer. The benefits for such employee will, under no circumstances, exceed the benefits which would apply if the employee was employed or connected with a single participating employer.

2.2 **EFFECTIVE DATE OF INDIVIDUAL COVERAGE**: The employee will become covered on the day the employee becomes eligible, provided the employee is actively at work on that day. If the employee is not actively at work (for non-health related reasons) the coverage will begin on a day that the employee returns to active work. If the employee is not actively at work on a regularly scheduled working day for health related reasons, coverage will take effect as though the employee was actively at work on that day.

2.3 **CHANGE IN CLASSIFICATION OR THE AMOUNT OF COVERAGE**: Any change in the Participant's classification or coverage will take effect on the day of the change, provided he or she is actively at work on that day. If the Participant is not actively at work, the following conditions will apply:

a. If the change involves an increase in coverage, the change will not take effect until the day he or she returns full time to his or her regular job; and

b. If the change involves a decrease in coverage, the change will take effect on the day of the change.

2.4 **TERMINATION OF INDIVIDUAL COVERAGE**: The employee's coverage will terminate upon the earliest of the following events:

a. Coverage will terminate on the last day of the calendar month following the calendar month in which the employee terminates employment (meaning the employee is removed from the Participating Employer's seniority list) except that:

(1) If the employee remains on the seniority list and is absent due to illness or injury (on or off the job), the participating employer shall continue to make the required employer's share of contributions for a period of not less than the first fourteen (14) weeks (unless stated otherwise by the collective bargaining agreement) during which the employee so absent is eligible for weekly disability benefits or is compensable under the Workers' Compensation Act. The participating employer shall advance during such period the employee's share of contributions, if any, and shall be repaid by the employee from the subsequent payment of monies due and owing the employee.

(2) If the employee whose coverage terminates in accordance with the preceding paragraphs is subsequently removed from the seniority list and is totally disabled, the employee may continue to remain eligible for the hospital and medical benefits (including Dental Benefits, if applicable, in accordance with Part XIV, Section 14.1).

(3) If the employee ceases to be employed on an active, full-time basis, it shall be the employee's responsibility to make payment to the welfare fund for all periods for less than full time employment (less than 20 hours per week or 3 days per week).

b. Coverage will terminate upon discontinuance of premium payments for the employee's coverage under the Plan.

c. Coverage will terminate upon the termination of the plan or the withdrawal from the plan by the participating employer.

2.5 **ELIGIBILITY AFTER TERMINATION OF COVERAGE**: If coverage is terminated in accordance with the terms of Item (2) of the above section 2.4, the employee will, if reemployed by the participating employer for whom he or she last worked prior to termination of employment, and within one year after the date of such termination of employment, again become eligible for coverage on the first of the month following the date the Participant is so reemployed.

If the employee leaves the employ of a participating employer and, through transfer, enter the employ of another participating employer within one (1) year from the date he or she terminates employment with the former participating employer, the employee will be eligible for coverage under the Plan on the first of the month following the date the employee enters the employ of the new participating employer; provided, that the employee makes the total contribution for coverage during the period commencing on the first of the month following the date he or she enters the employ of such employer and ending on the date the participating employer is required to make the total contribution into the Fund on the employee's behalf, pursuant to the terms of a labor contract or agreement.

If a Participant whose coverage has been terminated following entry into military service qualifying for protection under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("Uniformed Service"), returns to work for a participating employer who contributes to this Plan on behalf of the Participant, he or she shall immediately be eligible for coverage under this Plan on the first day of such reemployment.

2.6 **RETIRED EMPLOYEES' ELIGIBILITY:** When the Participant retires from work with a participating employer and the Participant's active Health and Welfare Fund Benefits are terminated in accordance with the Termination of Individual Coverage provision, he or she may apply for the Retired Employee Benefits in the Schedule, for the Participant and the Participant's eligible dependents if the following requirements are met and the Participant applies for such benefits within 60 days of the date he or she loses eligibility for active Health and Welfare Fund Benefits:

a. The Participant is at least age 60 and under age 65 and the Participant has worked for the last five years prior to retirement for a participating employer; or

b. The Participant at any age qualifies for the "Golden 84" under the Twin Cities Bakery Drivers Pension Plan or qualifies for the "30 and out" benefit under the Central States Southeast and Southwest Pension Plan.

Retirees must pay the monthly cost of their benefits to the Fund in accordance with the rules and regulations adopted by the Trustees. **THE COST FOR BENEFITS FOR RETIREES SHALL BE DETERMINED BY THE TRUSTEES AND MAY BE CHANGED AT ANY TIME UPON 30 DAYS' WRITTEN NOTICE TO THE RETIREE.**

TRUSTEES OF THE PLAN HAVE THE RIGHT, UPON THIRTY (30) DAYS' WRITTEN NOTICE TO THE RETIREES, TO MODIFY, CHANGE, ALTER, REDUCE OR DISCONTINUE ANY OR ALL OF THE RETIREE BENEFITS PROVIDED BY THE PLAN.

2.7 **DEPENDENT ELIGIBILITY**: The Participant's Eligible Dependents are the Participant's lawful spouse, each "Child" who also qualifies as a qualifying child under Code Section 152 and is either an unmarried child under 19 years of age, or a child who qualifies as an Eligible Full Time Student as defined below, or a descendant of a Participant's Child if the Participant has been ordered the custodian of the descendant by state court order.

The term "Child" means the Participant's natural child, adopted child, and a stepchild; provided that any such child must be living in the Participant's home and such child is chiefly dependent upon the Participant for support and maintenance.

The term "Eligible Full Time Student" means an unmarried child who is (a) dependent on the Participant for support and maintenance; (b) qualifies as an exemption on the Participant's income tax statement; (c) is attending an accredited high school, trade school or college; and (d) is enrolled for the lesser of 12 credits or the amount of credits required by the accredited school to constitute full-time. Such Eligible Full Time Student will continue to be eligible until the date he/she is no longer a full time student, the date he/she is no longer dependent upon the Participant for support and maintenance or the date he/she attains age 24, whichever occurs first.

Any child who would otherwise be an Eligible Full Time Student but who, by reason of sickness, injury, physical or mental disability is unable to carry a full-time course load will continue to be eligible provided:

(a) the course load carried is at least sixty percent (60%) of what the institution being attended would otherwise be considered a full-time course load;

(b) the sickness, injury, physical or mental disability is documented by a physician;

(c) the child has not attained the Limiting Age; and

(d) no other provisions relating to termination of a dependent's coverage or dependent ineligibility would otherwise apply.

When the parents of a child are covered under the plan as employees or members, the child will be covered as a dependent of both parents coordinated to not more than 100%.

In the event of divorce and remarriage, a child of the Participant will be covered if the child lives with the Participant or if the child lives with the former spouse and the divorce decree requires the Participant to continue the health coverage for their benefit.

With respect to health coverage only, an unmarried child whose benefits would otherwise terminate solely due to reaching the Limiting Age will continue to be eligible **IF**: (a) the child cannot work due to mental retardation or physical handicap; (b) the child became so incapacitated before reaching the Limiting Age; (c) written evidence of such incapacity is sent to the Contract Administrator with respect to any such child by the later of 31 days after he/she attains the Limiting Age or 31 days after you have been notified that such child is eligible for such continued coverage; and (d) proof that he or she is so incapacitated is sent to the Contract Administrator from time to time as requested.

2.8 **DEPENDENTS NOT ELIGIBLE**: The following are not eligible for dependent coverage:

a. A child who is covered under this plan as an employee;

b. A child who has benefits due under any extension of such insurance;

c. The "guardian of a person of" said child by Court Order;

d. Grandchild(ren) of Participant (unless court orders Participant as custodian of such grandchild(ren);

e. A person placed with the Employee for purposes of foster care, and

f. an Employee's former spouse (through marriage dissolution or legal separation).

2.9 **EFFECTIVE DATE OF DEPENDENT COVERAGE**: If the Participant wants to cover eligible dependents, he or she must make a written request for dependent coverage. If the request is made before the Participant is eligible for coverage, dependent coverage will begin the same day the Participant is covered. If the request is received by the plan office within 60 days after the Participant is eligible for coverage, dependent coverage will begin the day the request is received.

Once the Participant has a dependent covered, any newly acquired eligible dependent will be covered automatically if no additional premium is required. If additional premium is required, coverage for a newly acquired dependent will not begin until a written request is received in accordance with the above paragraph and the premium is paid.

If a Participant does not have a dependent until after he or she is covered, the plan must receive the Participant's written request no later than 60 days from the date he or she acquires the dependent. Coverage for that dependent will begin the later of the date the request is received or the date the Participant acquired the dependent.

If the written request to cover a dependent is received after the 60-day limit, the Participant must furnish evidence acceptable to the plan that each dependent the Participant wishes to cover is in good health. If the evidence is acceptable, the plan will determine the date dependent coverage begins. The evidence of good health requirement does not apply to handicapped dependents.

If the Participant wants to reinstate any dependent's coverage after it has lapsed, the Participant must furnish evidence acceptable to the plan that each dependent the Participant wishes to have covered is in good health. The plan will determine the date dependent's coverage begins. The evidence of good health requirement does not apply to handicapped dependents.

2.10 **EXCEPTIONS TO EFFECTIVE DATE OF DEPENDENT COVERAGE**:

a. **Newborn Children**: A child born to any Participant will automatically be covered for 31 days after birth.

b. **Adopted Children**: A child placed with the Participant in the Participant's home for the purpose of legal adoption will automatically be covered for 31 days from the day of placement and may be covered beyond 31 days subject to the provisions of Section 2.10. Coverage will continue, provided the child is not removed from placement prior to legal adoption.

c. **Confinement Rule**: Coverage for a dependent who is confined to a hospital or is confined in any institution/facility other than a hospital due to an injury or sickness, will not take effect until such confinement ends. This Confinement Rule does not apply to an

eligible newborn child, eligible adopted child, or eligible handicapped dependent. Any change in the coverage of a dependent who is confined as provided in this rule will not take effect until such confinement ends.

2.11 **TERMINATION OF DEPENDENT COVERAGE**: A dependent's coverage will end at midnight on the earliest of:

a. the day the dependent is no longer eligible;

b. the day any dependent premium is due and unpaid;

c. the day the plan ends;

d. the day before a dependent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less); or

e. the day the Participant's coverage ends.

PART III - BENEFITS

3.1 **MEDICAL BENEFITS**:

The amount of coverage for the Participant and the Participant's dependents under this Plan will be in accordance with this Schedule. Fees for services in excess of usual and customary charges will not be allowed in determining benefits under this Plan.

3.2 **WEEKLY DISABILITY BENEFITS:**

The Weekly Benefits will be reduced by any benefits the Participant receives or is entitled to receive under a disability provision of an individual or group No Fault automobile plan.

The Weekly Benefits will be payable only for periods of disability that begin on or after the date the collective bargaining agreement provides for the payment of such benefit.

Two or more periods of disability are considered as one unless between periods of disability you have returned to active full-time work for at least two weeks, or unless the disabilities are due to causes entirely unrelated and begin after you have returned to full-time active work and have completed one day of continuous active work.

3.3 **PREFERRED PROVIDER ORGANIZATION NETWORK**: The Twin Cities Bakery Drivers Health and Welfare Fund participates in a Preferred Provider Organization (PPO) network currently sponsored by Blue Cross Blue Shield of Minnesota. PPO networks are arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for the employees and their Eligible Dependents of participating employers.

A current listing of the participating Hospitals, Physicians and other providers will be given to each Participant at the time he or she becomes covered under the Plan.

The Plan's participation in the PPO will result in significant savings of funds needed to maintain the Plan. These savings are passed on to the Participants in the form of higher plan benefits payable for services received by a Participant or Eligible Dependent from Preferred Providers.

3.4 CLASS 6A SCHEDULE OF BENEFITS

	IN NETWORK BlueCross BlueShield Blue Link Network	OUT OF NETWORK
CALENDAR YEAR DEDUCTIBLE Per Individual Per Family (Aggregate)	 $400 $1200	 $ 400 $1,200
CALENDAR YEAR OUT-OF-POCKET Per Individual Per Family	 2,500 3,500	 3,000 4,000
LIFETIME MAXIMUM	$1,000,000	$1,000,000
PREVENTATIVE SERVICES		
ROUTINE PHYSICAL (Once in a 12 month period) IMMUNIZATIONS WELL CHILD CHARE PRE/POST NATAL MATERNITY CANCER SCREENINGS	100% 100% 100% 100% 100%	60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible
MEDICAL SERVICES		
Inpatient Hospital Services Semi-private room and board, intensive care unit, ancillary service and supplies, anesthesiology, pathology and radiology fees.	80% after Deductible	60% after Deductible
Outpatient Medical Services Office calls/visit and all related expenses, including x-ray and lab tests, and injections. Scheduled diagnostic and therapeutic, pre-admission tests, Ambulatory surgery.	80% after Deductible	60% after Deductible
Emergency Care	80% after Deductible	60% after Deductible
MENTAL HEALTH BENEFIT **(Requires referral – See Parts VIII and XI)** **Inpatient Care** **Outpatient Care**	 After Deductible, 80% up to 30 days per calendar year and 90 days per lifetime maximum After Deductible, 80% up to 30 visits per calendar year and 120 visits per lifetime maximum	 After Deductible, 60% up to 30 days per calendar year and 90 days per lifetime maximum After Deductible, 60% up to 30 visits per calendar year and 120 visits per lifetime maximum

	IN NETWORK **BlueCross BlueShield Blue Link Network**	OUT OF NETWORK
CHEMICAL DEPENDENCY BENEFIT **(Requires referral –** **See Parts VIII and XI)**		
Inpatient Care	After Deductible, 80% up to 30 days per calendar year and 90 days per lifetime maximum	After Deductible, 60% up to 30 days per calendar year and 90 days per lifetime maximum
Outpatient Care	After Deductible, 80% up to 30 visits per calendar year and 120 visits per lifetime maximum	After Deductible, 60% up to 30 visits per calendar year and 120 visits per lifetime maximum
OTHER COVERED SERVICES		
Ambulance (to nearest facility)	80% after Deductible	80% after Deductible
Durable Medical Equipment, Prosthetic and Non-Durable Medical Supplies	80% after Deductible	60% after Deductible
	IN NETWORK **BlueCross BlueShield of MN AWARE Network**	**OUT OF NETWORK**
ACUPUNTURE	80% after Deductible	60% after Deductible
HOSPICE (care of terminal illness)	80% after Deductible	60% after Deductible
VISION Routine Exam (one exam per 24-month period)	100% after $20 Co-pay	60% after $20 Co-pay
WEEKLY DISABILITY BENEFIT Weekly benefit Maximum number of weeks Waiting period Accident Illness	 $250 18 0 days 8 days	NOT APPLICABLE
CHIROPRACTICE SERVICES Chiropractic Benefit No coverage for children under 10 years of age.	 100% after Deductible There is a $25 Co-pay per visit with a maximum 30 visits per year.	No coverage
LIFETIME MAXIMUM OF ALL BENEFITS Hospice Care Services	 $7,500 per person	 $7,500 per person
Individual (all providers combined)	$1,000,000	$1,000,000

PRESCRIPTION DRUGS ***(No coordination of benefits)***	**IN NETWORK** **Caremark**	**OUT OF NETWORK**
Retail: 34-Day Supply	100% after $25 Co-pay	80% after $25 Co-pay
Mail Order Prescriptions: Generic Brand Formulary Brand Non-Formulary	100% after $25 Co-pay (90-day supply)	80% after $25 Co-pay (90-day supply)

3.5 **COST CONTAINMENT PROVISIONS**: In order to provide cost effective health coverage, the Plan contains the following Cost Containment Provisions: Hospital Confinement Review, Case Management Program, Second Opinion Program, Mental and Nervous Disorders, Alcohol and Drug Abuse Outpatient Review.

3.6 **OUT-OF-NETWORK DEDUCTIBLE**:

INDIVIDUAL DEDUCTIBLE: $400 of expense incurred for covered services. The Participant or Eligible Dependent must satisfy the Deductible once each calendar year.

FAMILY DEDUCTIBLE: After $1,200 of expense has been incurred for covered services and applied toward the Deductible by all covered family members combined in a calendar year, no other covered family member must satisfy the Deductible in that calendar year.

WAIVER OF DEDUCTIBLE: The Deductible is waived for covered services in connection with routine physical and vision exams or well baby care.

COMMON ACCIDENT DEDUCTIBLE: If two or more covered persons of Participant's family are injured in the same accident, only one Deductible applies for that accident.

3.7 **MAXIMUM PAYMENT FOR ALL COVERAGE UNDER THE PLAN**: $1,000,000 for all injuries or sicknesses for each Participant or Eligible Dependent.

Benefits are payable only for expense incurred while the Participant or Participant's eligible dependents are insured under the policy.

At any time after Benefits have been paid, the Maximum may be restored; however, evidence of good health must first be approved by the Plan.

3.8 **ROOM CHARGE LIMIT**:

SEMIPRIVATE ROOM: The semiprivate room charge of the hospital where the Participant or Eligible Dependent is confined.

WARD ACCOMMODATION: The ward accommodation charge of the hospital where the Participant or Eligible Dependent is confined.

PRIVATE ROOM: The average semiprivate room charge of the hospital where the Participant or Eligible Dependent is confined.

INTENSIVE CARE UNIT/CARDIAC CARE UNIT: The intensive care unit/cardiac care unit charge of the hospital where the Participant or Eligible Dependent is confined.

3.9 **COVERED SERVICES IN AND OUT OF NETWORK**:

a. Covered Hospital Services:

(1) Hospital room and board up to the semi-private Room Charge Limit;

(2) Hospital services and supplies used when benefits are payable under (a) above.

(3) Hospital outpatient services.

(4) Preadmission tests for surgery which are given within 72 hours of admission as a resident patient, ordered by a physician, performed on Participant or Participant's dependent at the hospital, and necessary for and consistent with the reason for which surgery is to be performed.

Hospital charges for the services of a physician, private duty nurse or other practitioner are not covered under (a) above.

b. Covered Surgical Services:

(1) Physician's services for an operation, or the repair of a dislocation or fracture; but not including the services of an assisting surgeon;

(2) Administration of anesthesia by persons not employed by the hospital.

c. Other Covered Services (if not included in (a) or (b) above):

(1) Physician's services for medical care;

(2) Active services of an assisting surgeon;

(3) Services of a registered graduate nurse (RN) for private duty nursing care, or of a licensed physiotherapist; but the Plan will not pay for services provided by a person who lives with you in your home or is a part of your family;

(4) Ambulance services for:

(i) local professional ambulance service; and

(ii) transportation within the United States by professional non-air ambulance or on a regularly scheduled flight on a commercial airline when special and unique Covered Hospital Services are required which are not provided by a local hospital, transportation is medically necessary, and transportation is to the nearest hospital equipped to furnish the services.

(5) The following services and supplies:

(i) drugs and medicines requiring a physician's written prescription;

(ii) diagnostic X-ray and laboratory service;

(iii) blood or blood plasma and its administration;

(iv) radium, radioactive isotopes and X-ray therapy;

(v) the following items of durable medical equipment:

- oxygen and the rental of equipment for its administration
- casts, splints, braces, trusses and crutches
- rental (up to the purchase price) of a hospital bed for patient care
- rental (up to the purchase price) of a wheelchair when medically necessary

(vi) artificial limbs and eyes to replace natural limbs and eyes lost while the covered person is covered under this provision;

(vii) initial placement of contact lenses required because of cataract surgery;

(viii) dental services by a physician or dentist for the treatment of a Dental Injury to Sound Natural Teeth (including the initial replacement of the injured teeth and any necessary dental X-rays), provided the injury occurs while covered under this provision, and the treatment plan begins within 90 days of the injury and is completed within one year after the injury

SOUND NATURAL TEETH means teeth which are whole or properly restored, are without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.

DENTAL INJURY means an injury to sound natural teeth caused by an external force such as a blow or fall. It does not include tooth breakage while chewing.

(ix) acupuncture; and

(x) hospice care;

3.10 **EMOTIONALLY HANDICAPPED CHILD**: If an emotionally handicapped dependent child is confined as an inpatient in a residential center, the Plan will pay the expense incurred for the confinement in the same manner as the Plan would pay if the child were confined in a hospital. The Plan will not pay for any day of confinement after a child's 19th birthday.

3.11 **SCALP HAIR PROSTHESES**: If the Participant or Eligible Dependent, because of alopecia areata or loss of hair due to chemotherapy, incur expense for a scalp hair prostheses, the Plan will pay benefits in the same manner as any other illness, not to exceed $350 in a calendar year. Any deductible shown in the plan will not apply.

3.12 **AMBULATORY MEDICAL-SURGICAL CENTER**: If the Participant or Eligible Dependent, while covered under this provision, is treated in a medical-surgical center, the Plan will pay for the expense incurred as if the treatment were received in a hospital.

3.13 **DENTAL EXCLUSION**: The Plan will not pay benefits for services which are dental in nature, including (but not limited to):

a. bite adjustment by temporary bridgework;

b. long-term bite therapy (including crowns, bridgework and orthodontia); and

c. long-term orthodontics or intra-oral splinting to reposition or align the teeth;

The Plan will pay benefits for surgical removal of impacted teeth if the surgery is performed on an outpatient basis at a medical facility.

When an item of expense is covered under both the Medical benefits and Dental benefits provisions, the Plan will pay under the provision providing greater benefits. The Plan will not pay, however, for the same item of expense under both provisions.

3.14 **VENTILATOR-DEPENDENT**: If benefits are payable for the expenses incurred for services provided by a private duty nurse or personal care assistant to a ventilator-dependent person in the person's home, such services are payable up to 120 hours per calendar year when the ventilator-dependent person is confined to a hospital. Benefits are payable in the same manner as for any other covered service.

The private duty nurse or the personal care assistant shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours per calendar year to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety and personal care needs of the patient.

3.15 **CLEFT LIP AND CLEFT PALATE**: If, while covered under this provision, an eligible dependent child incurs expense for treatment of the birth defects known as Cleft Lip and Cleft Palate, the Plan will pay benefits for medical and dental treatment (including orthodontic and oral surgery treatment) in the same manner as for any sickness.

If orthodontic services are covered under both a dental plan and another plan or contract, the dental plan shall be primary and the other plan or contract shall be secondary for the orthodontic benefits in this provision.

3.16 **PREEXISTING CONDITIONS PROVISION**: If a Participant or Eligible Dependent received treatment or service for an injury or sickness in the 90 day period before that person was covered under the plan:

a. The Plan will not pay benefits of more than $500 for that injury, sickness or any related condition until the earlier of:

(1) the day after a 90 day period has passed from the time that person was covered and during which no treatment or service was received for that injury, sickness or related condition; or

(2) the day after a 365 day period has passed from the time that person was covered; and

b. The Plan will pay only for loss or expense incurred after such 90 day or 365 day period. Payment will be in accordance with the provisions of the plan.

This Section 3.17 shall not apply to any injury or illness sustained by a Participant who entered military service qualifying for protection under the Uniformed Services Employment and Reemployment Rights Act of 1994, except for any injury or illness found by the Veterans' Administration to have been incurred in or aggravated during performance of service in the Uniformed Service.

c. Credit to reduce or eliminate the 90-day period described above will be given for prior continuous Creditable Coverage.

d. When timely application for coverage is received, this limitation does not apply to a newborn infant, a child placed with you for adoption, or to a handicapped dependent. In addition, an existing pregnancy is not considered a preexisting condition.

e. The Plan will pay for the cost of Cobra coverage for any participant or dependent of a participant who is eligible for coverage under the Plan, but whose coverage is subject to the pre-existing condition requirement of this Section 3.19. The Plan will pay for the cost of Cobra coverage commencing on the date that the participant or dependent of the participant is eligible for and is actually covered by the Plan. The cost of the Cobra coverage provided by the Plan will terminate on the earlier of 12 months or the end of the month in which the pre-existing condition limitation is removed.

3.17 **ROUTINE CANCER SCREENING**: If, while covered under this provision, the Participant or Eligible Dependent incurs expense for routine screening procedures for cancer, including mammograms and pap smears, the Plan will pay in the same manner as any other covered service.

3.18 **CHILD HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES**:

a. If a dependent child, while covered under this provision, receives Child Health Supervision Services, the Plan will pay 100% of the usual and customary expense incurred; not to exceed the following:

(1) 5 child health supervision visits from birth to 12 months of age;

(2) 3 child health supervision visits from 12 months to 24 months of age; and

(3) one child health supervision visit each year from 24 months to 72 months of age.

Each visit is limited to the services of one provider.

b. If the Participant or Eligible Dependent, while covered under this provision, receives Prenatal Care Services, the Plan will pay 100% of the usual and customary expense incurred.

Benefits payable under a and b above are not subject to any deductible shown in the plan.

The Plan will not pay for any Child Health Supervision Services when the dependent is over 72 months of age.

CHILD HEALTH SUPERVISION SERVICES means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services, appropriate to the age of a child from birth to 72 months of age as defined by the American Academy of Pediatrics.

PRENATAL CARE SERVICES means the comprehensive package of medical and psychosocial support provided for the mother throughout the pregnancy. Prenatal Care Services include:

(i) risk assessment;

(ii) prenatal care services;

(iii) serial surveillance;

(iv) prenatal education; and

(v) use of specialized skills and technology when needed; as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

Such services do not include services received in connection with the actual delivery of a child.

3.19 **DIETARY TREATMENT FOR PHENYLKETONURIA (PKU)**: Special dietary treatment of phenylketonuria (PKU), when recommended by a physician, is payable as any other covered service.

3.20 **EXTENDED BENEFITS**: If the Participant or Eligible Dependent is totally disabled by injury or sickness on the date coverage ends, the Plan will pay the expense incurred for Covered Services as if coverage had not ended. Benefits will be paid until the earliest of: (a) one year from the date coverage ended; (b) the date the Participant or Eligible Dependent becomes covered under another group plan; or (c) the date the total disability ends. Benefits payable are those in effect on the date coverage ended. The Plan will pay only for the injury or sickness which existed on the date coverage ended.

3.21 **SPECIAL PROVISIONS**: Benefits which are otherwise payable under the plan will not be denied or reduced because:

a. the Participant or Eligible Dependent is eligible for or receiving public assistance (under Minnesota Statutes, Chapter 256B); or

b. the services are provided by a county agency:

(1) for care of juveniles or the mentally retarded residing outside of home;

(2) under Minnesota Statutes Sections 252.27, 260.251(a), 261.27 or 393.07(1) or (2).

If the Plan receives a notice of subrogation for services provided by a county agency in accord with Paragraph (b) above, any benefits payable will be paid to the county agency which provided the services up to the cost of the services provided.

3.22 **CHIROPRACTIC NETWORK**: The Twin Cities Bakery Drivers Health and Welfare Fund participates in the Blue Cross Blue Shield Blue Link Network. The Participant should present his or her Blue Cross Blue Shield Card at the time of services. This benefit is limited to 30 visits per year. There is no benefit for coverage outside the network. Children under age 10 are not covered.

PART IV - GENERAL EXCLUSIONS - MEDICAL

4.1 **GENERAL EXCLUSIONS**: No benefits shall be payable under This Plan for the following: (NOTE: Additional specific exclusions are included in other parts of This Plan.)

a. any treatment, service or supply unless it is shown under Covered Services;

b. contact lenses, except as provided under the Vision Benefit;

c. eye refractions or the fitting or cost of visual aids;

d. the fitting or cost of hearing aids;

e. alcohol abuse, chemical dependency or drug abuse, except as provided under Alcohol Abuse, Chemical Dependency or Drug Abuse provision;

f. mental or nervous disorders, except as provided under the Mental or Nervous Disorders provision;

g. scalp hair, except as provided under the Scalp Hair provision;

h. ambulatory medical-surgical center, except as provided under the Ambulatory Medical-Surgical provision;

i. jaw joint disorder or TMJ Dysfunction;

j. ventilator-dependent, except as provided under the Ventilator-Dependent provision;

k. cleft lip and cleft palate, except as provided under the Cleft Lip and Cleft Palate provision;

l. routine cancer screening, except as provided under the Routine Cancer Screening provision;

m. child health supervision and prenatal care services, except as provided under the Child Health Supervision and Prenatal Care Services provision;

n. dietary treatment (PKU), except as provided under the Dietary Treatment (PKU) provision; or

o. any injury or sickness for which the covered person is entitled to benefits under a workers' compensation or occupational disease law;

p. any expense which is in excess of the usual and customary charges;

q. any expense or charge for services or supplies not medically necessary or not recommended by a physician;

r. any expense incurred after coverage ends (except as specifically provided under any extended benefits provisions in the plan);

s. any loss, expense or charge which results, whether the Participant or Eligible Dependent is sane or insane from an intentionally self-inflicted injury or sickness, or suicide or attempted suicide, except for the following benefits:

   (1) Medical expenses are limited to $5,000.

   (2) No benefits will be paid for the second or subsequent suicide attempts.

   (3) In order for any benefits to be paid, the Participant or Eligible Dependent who has attempted suicide must participate in a minimum of six (6) (unless the counselor specifies a lesser number) counseling sessions relating to the attempted suicide.

t. any loss, expense or charge resulting from the Participant's or Eligible Dependent's participation in a riot or in the commission of a felony;

u. any expense or charge which the Participant or Eligible Dependent does not have to pay;

v. any expense or charge for custodial care, developmental care, or domiciliary care;

w. any loss, expense or charge which results from cosmetic or reconstructive surgery, except surgery performed:

(1) incidental to or following surgery which results from injury to or disease of the involved part; or

(2) on an eligible dependent child because of a congenital disease or anomaly which results in a medically diagnosed functional defect;

The Plan will pay benefits for that expense in the same manner as any other injury or sickness;

x. any loss, expense or charge which results from appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by us, and present significant symptomatic medical problems) or any treatment of obesity (except for surgery to treat morbid obesity);

y. any expense or charge for orthopedic shoes, orthotics or other supportive devices for the feet;

z. any expense or charge in connection with dental work, dental surgery or oral surgery (unless specifically provided), including:

(1) treatment involving any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or

(2) surgery or splinting to adjust dental occlusion;

EXCEPT that the Plan will pay for surgical removal of impacted teeth on an outpatient basis at a Medical Facility which is not covered under the Plan's Dental Benefits;

aa. any loss, expense or charge for sex transformations or any treatment related to sexual dysfunction;

ab. any expense or charge for the promotion of fertility including (but not limited to):

(1) fertility tests;

(2) reversal of surgical sterilization; and

(3) any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method.

ac. chelation therapy except for acute arsenic, gold, mercury or lead poisoning;

ad. any expense or charge for services or supplies which are:

(1) not provided in accord with generally accepted professional medical standards;

(2) for experimental treatment; or

(3) investigative, and not proven safe and effective

ae. any expense or charge which is primarily for the Participant's or Eligible Dependent's education, training or development of skills needed to cope with an injury or sickness.

af. any expense or charge for services or supplies which are provided or paid for by federal government or its agencies; The Plan will pay for:

(1) covered services provided by the Veterans Administration to a veteran for a disability which is not service-connected, and which are not otherwise paid for; or

(2) covered services provided to a retiree (or dependent of a retiree) from the armed services at a military hospital or facility;

ag. any loss, expense or charge which results from an act of declared or undeclared war or armed aggression;

ah. any loss, expense or charge:

(1) which is incurred while the Participant or Eligible Dependent is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and

(2) for which any governmental body or its agencies are liable;

ai. any expense or charge which is primarily for the Participant's or Eligible Dependent's convenience or comfort or that of his or her family, caretaker, physician or other medical provider; or

aj. any expense incurred as a result of any injury or illness under circumstances which create a legal liability with a third person or party, provided that This Plan will advance payment of benefits otherwise payable so long as the Participant and/or the dependent executes a subrogation agreement to the satisfaction of the trustees of This Plan in the form attached to the Summary Plan Description as Exhibit A.

PART V - FAMILY SERVICE BENEFIT

The Plan has entered into a contract with the Minnesota Teamsters Service Bureau to provide an Employee Assistance Program (EAP). The EAP provides participants and their families with short-term counseling and consultation services. Counselors will identify, discuss, and develop a plan of action to help participants and/or their families resolve their problems. The EAP services include:

- 1- 800 access to service
- 24 hour emergency service
- Confidential assessment, referral and/or brief counseling with professional counselors
- Substance abuse evaluations
- Financial assessment counseling
- Legal consultation services

As needed, the EAP will refer participants for appropriate health care services.

The EAP does not provide coverage for:

a. Inpatient treatment of any kind, or Outpatient treatment for any medically treated illness.

b. Prescription drugs.

c. Treatment or services for Mental Retardation or autism.

d. Services by counselors who are not part of the Minnesota Teamster Service Bureau.

e. Counseling required by law or a court, or paid for by Workers' Compensation.

f. Formal psychological evaluations and fitness-for-duty opinions.

g. Investment advice.

h. Legal representation in court, preparation of legal documents, or advice in the areas of taxes, patents or immigration.

i. Tax representation or preparation services.

Before you incur any expenses for chemical dependency and/or mental health treatment, you must contact the Plan office to obtain the location of the nearest Minnesota Teamsters Service Bureau facility to assist you with your needs. No expenses for chemical dependency and/or mental health treatment will be paid unless the treatment or services have been recommended or authorized by the Minnesota Teamsters Service Bureau.

PART VI - VISION BENEFIT

Each participant and eligible dependent is entitled to vision care benefits under this Plan. Each participant and eligible dependent is entitled to one eye exam every 24 months. The Plan utilizes the Blue Cross/Blue Shield of Minnesota Blue Link Network.

VISION	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Exam (one exam per 24-month period)	100% after $20 Co-pay	60% after $20 Co-pay

PART VII - COORDINATION OF BENEFITS (COB)

Members of a family are frequently covered by more than one group health insurance plan. As a result, there are many instances of a duplication of coverage: two plans paying benefits for the same dollar of hospital and medical expenses. For that reason, a Coordination of Benefits provisions has been adopted which will coordinate the benefits payable as described in this booklet (with the exception of Life, Accidental Death and Dismemberment and Loss of Time) with similar benefits payable under other plans. Under the Coordination of Benefits provision, if an employee (or that employee's dependent if covered under this Plan) are also insured under any other group plan, the total payment received from any one person from all such programs combined may not amount to more than 100% of the Allowable Expense.

EXCLUSION:

There is no coordination of benefits for payment of pharmacy claims.

7.1 **HOW IT WORKS**: If the claimant is covered by another Plan or Plans, the benefits under the plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s) any remaining unpaid Allowable Expenses.

a. The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

b. The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

(1) 100% of total Allowable Expense; or

(2) the amount of benefits it would have paid had it been the Primary Plan.

The Order of Benefit Determination paragraph below explains the order in which Plans must pay.

This COB provision will not apply to a claim when the Allowable Expense for a Claim Period is $50 or less; but if:

(1) additional expense is incurred during the Claim Period; and

(2) the total Allowable Expense exceeds $50;

then this COB provision will apply to the total amount of the claim. “Claim Period” means the period January 1 through December 31 of any Calendar Year, or that portion of a Calendar Year during which the Participant or Eligible Dependent are covered under this Plan.

7.2 **ORDER OF BENEFIT DETERMINATION**: When another plan does not have a COB provision, that Plan must always determine benefits first.

When another Plan does have a COB provision, the first of the following rules which applies govern:

a. If a Plan covers the claimant as an employee, member or non-dependent, then that Plan will pay its benefits first.

b. If the claimant is covered as an employee under two plans, the plan which has covered the claimant longer is primary.

c. A plan which covers the claimant as an active employee pays before a plan which covers the claimant as a laid-off employee or as a retiree. This does not apply if either plan does not have a provision regarding laid-off or retired employees.

If the claimant is a dependent child who is covered under two or more plans, the following rules apply:

a. If the dependent child’s parents are not divorced or separated, then:

(1) The Plan which covers the parent whose date of birth occurs earlier in the calendar year pays first; or

(2) If both parents’ birthdays are on the same date, the plan which has covered the parent for the longer period of time will pay benefits first.

b. If the claimant is a dependent child whose parents are divorced or separated, then the following rules apply:

(1) A Plan which covers a child as a dependent of a parent who by court decree must provide health coverage will pay first.

(2) When there is no court decree which requires a parent to provide health coverage to a dependent child, a plan is primary if:

(i) First, it is the plan of the natural parent with custody;

(ii) Then, it is the plan of the spouse of the parent with custody; or

(iii) Finally, it is the plan of the parent not having custody of the child.

If none of the above rules apply, the Plan which has covered the claimant for the longer period of time will pay its benefits first; except when:

a. one Plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee); and

b. the other Plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law);

then the Plan which covers the claimant as other than a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

If another plan pays benefits that should have been reduced because of coordination of benefits, the plan may, at its option, pay the amount by which the benefits should have been reduced to the other plan. Amounts so paid will be deemed benefits under this Plan, and will reduce the Plan's obligations to pay benefits to the extent of such payment.

7.3 **HOW COB AFFECTS BENEFIT LIMITS**: If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those plan provisions.

7.4 **RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION**: In order to receive benefits, the claimant must provide the Plan with any information which is needed to coordinate benefits. With the claimant's consent, the Plan may release to or collect from any person or organization any needed information about the claimant.

7.5 **FACILITY OF PAYMENT**: If benefits which this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts reimbursed are policy benefits and are treated like other Plan Benefits in satisfying Plan liability.

7.6 **RIGHT OF RECOVERY**: If this Plan pays more for a Covered Charge than is required by this provision, the excess payment may be recovered from:

a. the claimant;

b. any person to whom the payment was made; or

c. any company, service plan or any other organization which should have made payment.

7.7 **DEFINITIONS**: For purposes of this section "Plan" means any of the following coverages, including Plan coverage and any coverage which is declared to be "excess" to all other coverages, which provide benefit payments or services to a covered person for hospital, medical, or surgical care:

a. group, blanket or franchise coverage (except student accident coverage);

b. other prepayment coverage on a group basis, including HMO's (Health Maintenance Organizations);

c. coverage under a labor management trusteed plan, a union welfare plan, an employer organization plan or an employee benefit plan;

d. coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;

e. group or individual or automobile "no fault" coverage; or

f. other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, "Plan" also means that amount of indemnity benefits which exceeds $100 per day.

"Claimant" means the Participant or Eligible Dependent for whom the claim is made.

"Claim Period" means part or all of a Calendar Year during which the claimant is covered under the Plan.

"Allowable Expense" means any Necessary, Reasonable and Customary item of expense for services, supplies or treatment covered, in whole or in part by one of the plans under which the individual is insured. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of this service during a Claim Period will also be considered an Allowable Expense.

PART VIII - COST CONTAINMENT PROVISIONS

NOTE: PART XI ONLY APPLIES TO BENEFITS PAYABLE UNDER THE OUT-OF-NETWORK PROVISION. THE COST CONTAINMENT PROVISIONS DO NOT APPLY TO BENEFITS UNDER THE IN NETWORK PREFERRED PROVIDER ORGANIZATION (PPO) PROVISION.

8.1 **EXPERIMENTAL**: Benefits are not provided for services and supplies that are investigational, experimental or are mainly for research purposes. A drug, device, medical treatment or procedure is experimental, investigational or mainly for research purposes:

a. If the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

b. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

c. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is 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

d. If 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 necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable Evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or 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 used by the treatment facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

8.2 **HOSPITAL CONFINEMENT REVIEW**: Review of any hospital confinements due to any sickness, injury, or mental or nervous disorder, and review of any confinement in a hospital or treatment center for alcohol and drug abuse (when covered by the Plan) is required. The Participant's physician's and the Participant's responsibilities under the review provisions vary depending on whether the situation is a non-emergency admission, childbirth or a Medical Emergency.

Please READ these sections CAREFULLY.

IT IS THE PARTICIPANT'S RESPONSIBILITY TO INITIATE THIS HOSPITAL REVIEW REQUIREMENT. THE LACK OF SUCH REVIEW WILL RESULT IN A REDUCTION OF THE PARTICIPANT'S BENEFITS AS DESCRIBED BELOW.

These provisions do not apply when Medicare has primary responsibility for the covered person's claim.

8.3 **EFFECT ON BENEFITS**:

a. Expense incurred for hospital confinements which are certified by the Care Review Unit (or by the Participant's or eligible dependent's primary plan, if any, as determined in accordance with the COB provision) as medically necessary will be considered in accord with plan provisions.

b. For expense incurred for hospital confinements for which review does not first occur (subject to the Emergency Admission or Childbirth provision below), benefits will be reduced by the lesser of $500, or 25% of the amount otherwise payable under the plan (for all unreviewed days combined and while in the same hospital); however, no benefits will be payable unless the services are medically necessary and all other plan requirements are satisfied.

When benefits are reduced, the reduction for unreviewed confinements will be used to satisfy any stop loss limit shown in the plan.

c. For expense incurred for hospital confinements for which review does occur but for which inpatient care is not certified by the Care Review Unit as medically necessary:

(1) benefits for hospital room and board will not be payable; and

(2) expenses for other covered hospital services will be considered in accordance with plan provisions.

In accordance with plan provisions, benefits will not be payable for hospital, surgical, medical or other services which: (a) are not medically necessary; or (b) are not covered by the plan.

8.4 **REVIEW REQUIREMENT FOR HOSPITAL CONFINEMENT**:

a. Non-emergency Admission. If the Participant or Eligible Dependent is advised by a physician to enter a hospital as a resident patient for a reason other than childbirth or a medical Emergency, then the Participant or the physician must notify the Care Review Unit by phone at least seven (7) days prior to the scheduled hospital admission.

Within one business day after the Care Review Unit: (a) receives the required notice; and (b) obtains the Admission Information from the attending physician by phone, the Participant, the physician and the hospital will be sent written notice of any period of confinement which is certified as medically necessary.

b. Emergency Admission or Childbirth. If the Participant or Eligible Dependent enters a hospital as a resident patient for childbirth or because of a Medical Emergency, the Participant or the attending physician must notify the Care Review Unit by phone by the second business day following admission.

Within one business day after the Care Review Unit (a) receives the required notice; and (b) obtains the Admission Information, the hospital will be sent written notice to confirm any additional days of confinement which are certified as medically necessary.

NOTE: Failure to obtain preauthorization within 48 hours of a weekday admission, or within 72 hours of an admission on a weekend or legal holiday, for a medical emergency (other than for a nervous or mental disorder or alcohol and drug abuse) shall not render Participant or Eligible Dependent ineligible to receive benefits unless actual prejudice is suffered by the Plan, and then only to the extent of the prejudice.

c. Continued Confinement. Before the approved period of confinement ends, the Care Review Unit will phone the attending physician to determine whether the Participant or Eligible Dependent requires further hospital confinement. Within one business day, the Participant, the physician and the hospital will be sent written notice to confirm any additional days of confinement which are certified as medically necessary.

The Plan may not retroactively deny benefits otherwise payable if the Plan fails to provide prior to concurrent review or authorization for the expenses when required to do so under this provision. If prior or concurrent review or authorization was provided, the Plan may not deny on the basis of medical necessity payment for the authorized service or time period, except in cases where fraud or substantive misrepresentation has occurred.

8.5 **CASE MANAGEMENT PROGRAM**: Case Management Program means a written alternate treatment plan endorsed by the Participant's physician and accepted by the Plan to provide medically necessary and appropriate care in a cost-effective setting. It is the covered person's final decision to participate in the program. There is no penalty for not participating in the program or for leaving during its course. In either case, any further benefits will be paid in accordance with the other provisions, limits and exceptions of the plan.

EFFECT ON BENEFITS: If, while covered under this provision, Participant or Eligible Dependent incurs expenses as a result of an injury or sickness listed below, or as a result of any sickness or injury of comparable severity for which an alternate more cost-effective treatment plan may be

developed by the Plan, these expenses are eligible for consideration under our Case Management Program. This program is provided automatically as part of this plan; and may include as Covered Services some services or supplies otherwise limited, excluded, or not specifically shown under the Benefits description of the plan, but shown in the alternate treatment plan. Benefits payable for services covered under the Case Management Program will be at least equal to benefits otherwise payable by the plan for the same services; and are subject to the Maximum provided in the Plan.

8.6 **ELIGIBLE FOR THE CASE MANAGEMENT PROGRAM**:

Amputations
Acquired Immune Deficiency Syndrome
Burns
Chemotherapy
Chronic Infections
Chronic Liver Disease
Chronic pulmonary diseases and conditions
Coagulation defects
Coma
Conditions related to diabetes mellitus
Demyelinating diseases of the central nervous system
Diseases related to intracranial hemorrhage or occlusion
Disorders of the immune system
Inflammatory diseases of the central nervous system
Intestinal disorders
Multiple fractures, with or without other system involvement
Myoneural disorders
Organ transplants
Paralytic disorders
Radical surgeries
Renal diseases
Spinal cord injuries
Tumors, malignant or unspecified

8.7 **SECOND OPINION PROGRAM**: **IT IS THE PARTICIPANT'S RESPONSIBILITY TO INITIATE THIS SECOND OPINION PROGRAM REVIEW REQUIREMENT. THE LACK OF SUCH A REVIEW WILL RESULT IN A REDUCTION OF THE PARTICIPANT'S BENEFITS AS DESCRIBED BELOW. THE SECOND OPINION PROGRAM APPLIES TO SURGICAL AND OTHER PROCEDURES PERFORMED IN OR OUT OF THE HOSPITAL.**

EFFECT ON BENEFITS: If the Participant or Eligible Dependent is advised by a physician to have a procedure which is listed below performed, the Plan will pay the expense incurred for a second opinion on the need for the covered procedure (including any X-ray and laboratory services) as described below.

a. The Plan will pay 100% of the expense incurred for a second opinion on the need for the covered procedure; provided:

(1) the second opinion is for a procedure listed below; and

(2) the Care Review Unit requires the second opinion.

The deductible will not apply.

b. The Plan will pay benefits in the same manner as any other Covered Service for expense incurred for a second opinion on the need for the covered procedure; if:

(1) the second opinion is for a surgical procedure not shown on the list below; or

(2) the second opinion is for a covered procedure listed below, but the Care Review Unit waived the second opinion requirement because the covered procedure is medically necessary.

c. If the second opinion does not confirm the need for the proposed procedure, the Plan will pay benefits for a third opinion in the same manner as for a second opinion in accordance with Part 1 or Part 2 above.

d. Benefits will be payable only if the second or third opinion is given by a physician who:

(1) specializes in a field related to the proposed procedure;

(2) is independent of the first physician to advise the procedure;

(3) makes a personal exam of the covered person and sends the Care Review Unit a written report; but

(4) does not perform the procedure for the participant or eligible dependent.

e. EXCLUSION: The Plan will not pay for any expense paid under any other provision of the plan or anything excluded under the General Exclusions and Limitations.

8.8 **SECOND OPINION PROGRAM REQUIREMENTS**: If a Participant or Eligible Dependent is advised by a physician to undergo a procedure listed below, the Care Review Unit must be notified by phone. For the toll-free telephone number, contact the Plan Administrator. The Care Review Unit will review the proposed procedure to determine if a second opinion must be obtained by the covered person or if a second opinion may be waived.

The Care Review Unit may also be notified by phone to review the need for a second opinion for surgical procedures not shown on the procedures list below. However, in this situation it is **not** required that the Care Review Unit be notified.

8.9 **BENEFITS LIMITATION ON PROCEDURES FOR WHICH A SECOND OPINION IS MANDATORY**:

A second opinion is mandatory when any procedure listed below is to be performed and the second opinion is not waived by the Care Review Unit because the covered procedure does not appear to be medically necessary.

If the second opinion does not confirm the need for the proposed procedure, a third opinion is also required.

a. If the Participant or Eligible Dependent incurs expense for a procedure listed below without first obtaining a second or third opinion (as described herein), then benefits for all covered hospital, medical and surgical services received as a result of that procedure will be reduced by the lesser of $500 or 25% of the amount otherwise payable under the plan. However, no benefits will be payable unless the services are medically necessary and all other plan requirements are satisfied.

When benefits are reduced, the expense will be used to satisfy any stop loss limit provided in the Plan.

b. If the Participant or Eligible Dependent incurs expense for a procedure listed below:

(1) after obtaining both a second and third opinion which do not confirm the need for the proposed procedure; or

(2) which is not covered by the plan;

then, benefits for all hospital, medical and surgical services received as a result of that procedure will not be payable.

Note: This limitation will not apply if:

(1) no physician, satisfying the Conditions shown above performs medical services within a 50 mile radius of the Participant's or Eligible Dependent's residence;

(2) the Participant or Eligible Dependent undergoes a procedure listed below:

(i) after first obtaining a second or third opinion which was required by the Care Review Unit (or by the Participant's or Eligible Dependent's primary plan, if any, as determined in accordance with the COB provision) and which confirms the need for the proposed procedure; or

(ii) as the result of a medical emergency; or

(3) Medicare has primary responsibility for the Participant's or Eligible Dependent's claims.

8.10 **PROCEDURES WHICH REQUIRE A SECOND OPINION:**

Arthroscopy of the knee
Back surgery
Breast surgery
Bunionectomy
Carotid endarterectomy
Carpal tunnel release
Cataract removal and/or lens insertion
Cataract surgery
Cesarean section (elective and/or repeat)
Cholecystectomy
Coronary artery bypass surgery
Heart catheterization
Hip replacement
Hysterectomy
Ligation and/or stripping of varicose veins in legs
Magnetic resonance imaging (MRI)
Meniscectomy
Pacemaker
Prostatectomy
Rhinoplasty
Septoplasty
Tonsillectomy and/or adenoidectomy
Tympanotomy

Tympanotomy with resection/removal of ventilating tubes

8.11 **MENTAL AND NERVOUS DISORDERS, ALCOHOL AND DRUG ABUSE OUTPATIENT REVIEW PROVISION**: Outpatient review is required for outpatient treatment of a specific mental or nervous disorder or alcohol or drug abuse.

NOTE: It is the Participant's responsibility to initiate this outpatient review requirement. The lack of such a review will result in a reduction of your benefits as described below.

EFFECT ON BENEFITS:

a. Expense incurred for outpatient treatment which is certified by the Care Review Unit (or by the Participant's or Eligible Dependent's primary plan, if any, as determined in accordance with the COB provision) as medically necessary will be considered in accordance with plan provisions.

b. For expense incurred for outpatient treatment for which review does not first occur, benefits will be reduced by 25% of the amount otherwise payable under the plan for each unreviewed outpatient treatment (except this does not apply to the first 10 hours or 6 visits of a calendar year of outpatient treatment of a mental or nervous disorder). However, no benefits will be payable unless the services are medically necessary and all other plan requirements are satisfied.

When benefits are reduced, the reduction for each unreviewed outpatient treatment will be used to satisfy any stop loss limit shown in the plan.

c. For expense incurred for outpatient treatment for which review does occur but which is not certified as medically necessary, benefits for such treatment will not be payable.

In accordance with plan provisions, benefits will not be payable when treatments are not medically necessary or covered by the plan.

8.12 **OUTPATIENT REVIEW REQUIREMENTS**:

a. If the Participant or Eligible Dependent is advised by a physician or voluntarily elects to receive outpatient treatment for a mental or nervous disorder or drug or alcohol abuse program, the Participant's or Eligible Dependent's physician must notify the Care Review Unit by phone at least 24 hours prior to the seventh outpatient treatment for a mental or nervous disorder, or the seventh outpatient treatment for alcohol or drug abuse.

Within one business day after the Care Review Unit receives the required notice and obtains the Treatment Information, the facility will be sent written notice of any treatment which is certified as medically necessary.

TREATMENT INFORMATION means the following information, which the attending physician must provide to the Care Review Unit before treatment is certified:

(1) the diagnosis and reason for the treatment;

(2) any proposed treatment;

(3) the expected number and frequency of proposed outpatient treatment; and

(4) any related information regarding the patient's history, condition and proposed outpatient treatment.

OUTPATIENT TREATMENT means group therapy, individual therapy, partial hospitalization or any other covered service provided in a covered mental health facility, alcohol or drug dependency facility, or physician's office on an outpatient basis.

b. Continued Treatment. The Care Review Unit will contact the attending physician prior to the expiration of the certification period to determine if further outpatient treatment can be certified as medically necessary. Within one business day, written notice will be sent to confirm any additional outpatient treatment which is certified as medically necessary.

The Plan may not retroactively deny benefits otherwise payable if the Plan fails to provide prior to concurrent review or authorization for the expenses when required to do so under this provision. If prior or concurrent review or authorization was provided, the Plan may not deny on the basis of medical necessity payment for the authorized service or time period, except in cases where fraud or substantive misrepresentation has occurred.

PART IX - MEDICARE COORDINATION OF BENEFITS

9.1 **WHEN THIS PROVISION IS APPLICABLE**: This Medicare Coordination of Benefits provision applies when the Participant or Eligible Dependent:

a. has health coverage under the Plan; and

b. is eligible for hospital coverage under Medicare Part A (whether or not the Participant or Eligible Dependent has applied or is enrolled for Medicare Benefits).

It applies before any other COB provision of the plan.

EFFECT ON BENEFITS

a. If, under the following rules, the Plan has primary responsibility for the Participant's or Eligible Dependent's claims, then the Plan pays benefits first.

b. If, under the following rules, the Plan has secondary responsibility for the Participant's or Eligible Dependent's claims:

(1) first Medicare Benefits are determined or paid; and

(2) then plan benefits are paid.

For services payable under both plans, however, the combined Medicare Benefits and plan benefits will not exceed 100% of the expense incurred.

9.2 **RULES FOR DETERMINING ORDER OF BENEFITS**:

a. **For Participant.** The Plan has primary responsibility for the Participants' claims, if all of the following apply:

(1) the Participant is age 65 or older;

(2) the Participant is eligible for Medicare Part A solely because of age; and

(3) the Participant is actively employed by an ADEA Employer which pays all or part of the plan premium.

The Plan has secondary responsibility for claims when the Participant is eligible for Medicare Part A because of age, if you are not actively employed by an ADEA Employer which pays all or part of the plan premium.

b. **For Participant's Dependent Spouse.** The Plan has primary responsibility for Participant's dependent spouse's claims, if all of the following apply:

(1) Participant's spouse is age 65 or older;

(2) Participant's spouse is eligible for Medicare Part A solely because of age; and

(3) Participant is actively employed by an ADEA Employer which pays all or part of the plan premium.

The Plan has secondary responsibility for Participant's dependent spouse's claims when he or she is eligible for Medicare Part A because of age, if Participant is not actively employed by an ADEA employer which pays all or part of the plan premium.

c. **For a Disabled Person.** The Plan has primary responsibility for the claims of a Participant or Eligible Dependent:

(1) who is eligible for primary Medicare Benefits because he or she is disabled and has received Social Security disability benefits for 24 months in a row; and

(2) whose employer normally employed 100 or more employees on a typical business day during the previous calendar year.

The Plan has secondary responsibility for the claims of a Participant or Eligible Dependent:

(1) who is eligible for primary Medicare Benefits because he or she is disabled and has received Social Security disability benefits for 24 months in a row; and

(2) whose employer normally employed less than 100 employees on a typical business day during the previous calendar year;

even if he or she is also eligible for Medicare Part A because of age.

d. **For a Participant or Eligible Dependent with End-Stage Renal Disease.** The Plan has secondary responsibility for the claims of a Participant or Eligible Dependent:

(1) who is eligible for primary Medicare Benefits because of end-stage renal disease;

(2) even if he or she is also eligible for Medicare Part A because of age.

The Plan has primary responsibility for the claims of a Participant or Eligible Dependent who is eligible for secondary Medicare Benefits solely because of end-stage renal disease.

9.3 **DEFINITIONS**:

Medicare Benefits means benefits for services and supplies which the Participant or Eligible Dependent receives or is entitled to receive under Medicare Part A or B.

Age 65 (as used in this provision) means the age attained at 12:01 a.m. on the first day of the month in which the Participant or Eligible Dependent's 65th birthday occurs.

ADEA Employer means an employer which:

a. is subject to the U.S. Age Discrimination in Employment Act (ADEA); and

b. has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

Important Information About Medicare

Medicare may affect plan benefits; therefore, Participants or dependents may want to contact the local Social Security office for information about Medicare. This should be done before a Participant's spouse's 65th birthday. Most workers age 65 and over do not have to pay for Medicare Part A (basic hospital coverage). Medicare Part B (supplementary medical coverage) may be purchased for a low monthly premium. Any Social Security office can provide more information.

PART X - PAYMENT OF CLAIMS

10.1 **HOW TO FILE CLAIMS UNDER THE IN-NETWORK PPO PROVISION**:

When the Participant or Eligible Dependent presents his or her Health Plan ID card at the time of service, all paperwork will be handled for him or her. The Participant will be required, however, to complete a Family Status Card as required from time to time by the Trustees.

10.2 **HOW TO FILE OTHER CLAIMS**:

Any individual, beneficiary or his or her authorized representative may file a claim for a plan benefit. Such a claim must be in writing on a benefit claim form supplied by the Plan Administrator and filed at the location indicated on the claim form. Benefit claim forms may be obtained by writing or calling the Plan Administrator. The Plan Administrator shall certify whether the Individual has coverage and notify the Individual accordingly. A covered Individual shall be sent appropriate benefit claim forms.

10.3 **PROOF OF LOSS REQUIREMENTS: (OUT OF NETWORK)**:

a. First, request a claim form from the Health and Welfare Fund Office or Claim Administrator.

This request should be made:

(1) within 20 days after a loss occurs; or

(2) as soon as reasonably possible.

When the Plan receives the request, the Plan will send a claim form for filing proof of loss. If the Plan does not send it within 15 days, the Participant can meet the proof of loss requirement by providing the Plan with a written statement of what happened. The Plan must receive a written statement within the time shown in 3 below.

b. Next, complete and sign the claim form. If a physician must complete part of the claim form, have the physician complete and sign that part.

c. Finally, return the claim form (with any bills) to the Health and Welfare Fund Office. The claim form is due:

(1) within 90 days after the loss occurs; or

(2) as soon as reasonably possible, but not later than one year after (a) above.

10.4 **PROOF OF LOSS REQUIREMENTS OUT OF NETWORK (FOR DENTAL BENEFITS)**:

a. Complete the upper part of the claim form (Part I) and sign where shown.

b. Take the form to the dentist on the first visit. The dentist will perform the initial exam. This exam may include necessary X-rays. The dentist will list on the form all procedures needed to complete treatment, including the fee.

c. Before the treatment is begun, unless of an emergency nature or the cost of the treatment is less than $300, the dentist must send the form to the Welfare Fund Office. The Plan will verify eligibility and determine what benefit payments will be made under the plan.

d. After the form is returned, the dentist will contact the Participant to arrange appointments for treatment.

e. Finally, return the claim form (with any bills) to the Welfare Fund Office. The claim form is due:

(1) within 90 days after the loss occurs; or

(2) as soon as reasonably possible, but not later than one year after (a) above.

10.5 **WHEN CLAIMS ARE PAID**: All policy benefits will be paid as soon as the Plan receives acceptable proof of loss.

10.6 **APPEAL PROCEDURE**: An employee who believes he has been denied benefits provided for under the Plan shall be entitled to a full and fair review of his claim under the following appeal procedures.

a. ***Claim Denial***. Upon denial of an employee's application for benefits, the employee shall be furnished a written statement of the specific reason or reasons for denial, including reference to the specific Plan provisions on which the denial is based, a description of any additional material or information necessary for the employee to establish his or her right to benefits and an explanation of why such material or information is necessary. This written notice shall also contain an explanation of the appeal procedure which the employee can follow to have his or her claim for benefits reviewed. The written notice shall be furnished in accordance with the time frames described in paragraph d. below.

(1) An employee who has been denied benefits, or his duly authorized representative, shall have the following rights in appealing the initial decision.

(i) The right to submit additional proof of entitlement to benefits.

(ii) The right to examine any document in possession of the Plan related to the application.

(iii) The right, within 180 days of receipt of the notice of the denial of benefit, to appeal the decision to the Board of Trustees by submitting a written statement setting forth which of the reasons for denial of the application with which he disagrees, along with any supporting documents or additional comments related to his appeal. The written statement is to be submitted to the Board of Trustees at the Fund Office address.

(iv) In the normal case, the Trustees shall make their determination on the basis of the supporting file documents and the employee's written statement as submitted. However, the Trustees may, in their discretion, require the employee to submit additional written information, to appear before the Trustees for oral examination or both. In the event the employee is required to appear before the Trustees, the hearing shall be held at the next regular meeting of the Trustees or at such other time as may be determined by the Board of Trustees, with reasonable notice of the date and place of the hearing given to the employee.

(2) An individual shall not begin a legal proceeding in law or in equity to enforce his/her rights until exhaustion of the claims procedures provided by this Plan. All actions must be brought within 1 year from the expiration of the time within which proof of loss is required by the Plan.

b. **Four Types of Claims: Definitions and Rules**

Under the plans rules there are different processing deadlines for four types of group health plan claims:

(1) ***Urgent Claims*** An urgent claim is a claim for medical care or treatment that, if normal pre-service standards are applied, would seriously jeopardize the life or health of the participant or the ability of the participant to regain maximum function or, in the opinion of a physician with knowledge of the participant's medical condition, subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. (An example of this type of claim would be a request for prior approval of a diagnostic test for appendicitis.) A health care professional with knowledge of participant's medical condition may act as the participant's authorized representative in claims involving urgent care.

(2) ***Pre-Service Claims*** Any claim for a benefit under the plan for which the plan requires approval before medical care is obtained is a pre-service claim. (An example of this type of claim would be a request for prior approval of a treatment plan for physical therapy after a broken leg.) Even if a benefit requires preauthorization, the benefit cannot be denied for lack of approval under circumstances that would make obtaining such prior approval impossible, or where application of the prior approval process could seriously jeopardize the life or health of the participant (e.g., if the participant is unconscious and unable to seek preapproval).

(3) ***Post-Service Claims*** A post-service claim is any claim for benefits under a group health plan that is not a pre-service claim. (An example of this type of claim would be a claim for reimbursement for diagnostic tests already performed).

(4) ***Concurrent Claims*** A concurrent claim is a claim that is reconsidered after an initial approval was made and results in a reduced or terminated benefit. (An example of this type of claim would be an inpatient hospital stay originally

certified for 5 days that is reviewed at 3 days to determine if the full 5 days is appropriate.) The plan must notify a participant of such a reconsideration of a benefit as soon as possible, but in any event early enough to allow the participant to have an appeal decided before the benefit is reduced or terminated. In addition, for approved urgent care treatment, any request by a participant to extend that treatment must be acted upon by the plan within 24 hours after receipt of the claim (but only if the claim is received at least 2 hours prior to the expiration of the approved treatment).

c. **Deadlines for Initial Determinations, Appeals and Communications**

The following are the deadlines for initial determinations, appeals and communications requirements for urgent, pre-service, post-service and concurrent claims:

(1) Urgent Claims.

(i) For an initial claim determination, the participant must be notified of the decision as soon as possible, but not later than 72 hours from receipt of the claim. The response from the fund can be oral with a written confirmation provided no later than 3 days after the oral response.

(ii) If additional information is needed, the fund must notify the participant of the need for additional information within 24 hours of receipt of the claim. The participant has up to 48 hours to respond to the request for the needed information. The deadline for responding to the claim is suspended for 48 hours or until the information is received.

(iii) The only extension of time is the 48 hour period after the earlier of the receipt of the information from the participant or the end of the period given to the participant to provide the specified information.

(iv) Participant has 180 days following receipt of a notification of adverse benefit determination to appeal.

(v) The plan has to respond to the participant's appeal within 72 hours from the receipt of the appeal. There is only one level of appeal.

(vi) The decision regarding the participant's appeal cannot be made at the Trustee's quarterly meeting unless the meeting falls within the time frames described above.

(2) Pre-service Claims.

(i) For an initial claim determination, the participant must be notified of the decision as soon as possible, but not later than 15 calendar days from receipt of the claim.

(ii) Additional information needed must be requested within 15 days from receipt of the claim. The participant has at least 45 days to respond. The fund then has 15 days to respond from the end the earlier of the 45-day period or the time in which the information is provided.

(iii) There can be one 15 calendar day extension of time, if the plan administrator determines it is necessary due to matters beyond the

control of the plan and informs the participant of the extensions within the normal deadline for processing the claim.

(iv) The participant has 180 days following receipt of notification of the adverse benefit determination to appeal. The plan has 15 days to respond to the participant's appeal. If the appeal is denied, the participant has the right to appeal the denial to the Board of Trustees. Such appeal to the Board of Trustees must be made within 60 days following receipt of the notification of the denial of the appeal. The Trustees must respond to the participants request for review of the denial within 15 days from the receipt of the appeal to the Board of Trustees by the participant.

(v) The decision regarding the participant's appeal cannot be made at the Trustee's quarterly meeting unless the meeting falls within the time frames described above.

(3) Post-service Claims.

(i) For an initial claim determination, the participant must be notified of the decision as soon as possible, but not later than 30 calendar days from receipt of the claim.

(ii) If additional information is needed, it must be requested within 30 days from receipt of the claim. The participant has at least 45 days to respond to the request for additional information. The plan then has 15 days to respond from the end of the earlier of the 45 day period or the time in which the information is provided. One 15 calendar day extension of time is allowable, if the Plan Administrator determines it is necessary due to matters beyond the control of the plan and informs the participant of the extension within 30 calendar days from receipt of the claim.

(iii) The participant has 180 days following receipt of notification of the adverse benefit determination to appeal. The plan has 30 days to respond to the participant's appeal. If the appeal is denied, the participant has the right to appeal the denial to the Board of Trustees. Such appeal to the Board of Trustees must be made within 60 days following receipt of the notification of the denial of the appeal. The Trustees must respond to the participants request for review of the denial within 30 days from the receipt of the appeal to the Board of Trustees by the participant.

(iv) If the appeal is received within 30 days of the next scheduled quarterly meeting of the trustees, the appeal can be reviewed at the following quarterly meeting. The participant will be notified within 5 calendar days following the conclusion of the meeting at which the appeal is heard as to the decision on the appeal.

(4) Concurrent Claims.

(i) The participant must be given an opportunity to appeal the concurrent review decision sufficiently in advance to allow an appeal and determination on the appeal before termination of the benefit. The plan must respond to the participant's appeal prior to the termination of the benefit. The appeal of the initial decision to terminate the benefit shall be

made to the Plan Administrator. If the Plan Administrator determines that the appeal is to be denied, then the participant may appeal that decision to the full Board of Trustees. There can be no termination of the benefit until the Board of Trustees has reviewed the appeal and has denied the appeal.

d. **Administration of Claim Procedures**

(1) Medical Judgments.

(i) If a claim was denied due to a medical judgment (including denials for experimental, investigational or not medically necessary or appropriate exclusions) the claims processor for the Fund will consult with a health care professional who has appropriate training and experience in the filed of medicine involved in the medical judgment. The health care professional who will be consulted must not have been consulted in connection with the adverse benefit determination initially made that is the subject of the appeal, nor will the health care professional be that person's subordinate. In the course of the review of the adverse benefit determination, the medical or vocational experts whose advice was originally relied upon will be identified.

(ii) In all cases, unless otherwise determined by the plan administrator, physicians employed by or retained by Blue Cross/Blue Shield will be utilized in the initial benefit determination, as well as the appeal of any adverse benefit determination. The physicians will be utilized in this process shall be trained and experienced in the field of medicine involved in the particular claim.

(2) Providing Documents Related to the Appeal.

(i) A full and fair review means that participants must have the opportunity to submit written comments, documents, records and other information for consideration by the decision maker, without regarding to whether such information was submitted or considered in the initial benefit determination. The participant must be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to their claims for benefits.

(ii) A document, record or other information is "relevant" to the claim if it was:

- Relied upon in making the benefit determination,
- Submitted, considered or generated in the course of making the benefit determination, without regarding to whether it was relied upon in making the benefit determination.

10.7 **MANNER OF CLAIMS PAYMENT**: This Plan reserves the right to pay eligible claims in any one or more (including a combination thereof) of the following methods:

a. directly to the service provider without regard to whether or not there has been an assignment of benefits, provided that the service provider confirms in writing that it has not been paid for that part of the outstanding claim to be paid to it;

b. as reimbursement to any Participant provided that the claim has been paid by the participant; and/or

c. to any third party (including a dependent of a Participant or other plan beneficiary) who establishes to the satisfaction of the Plan in writing that such third party has paid part or all of the claim to be reimbursed. Such reimbursement shall not exceed the amount paid by such third party.

10.8 **OVERPAYMENT OF CLAIMS**: Any overpayment of claims shall be returned to the Plan by the person or entity (whether it be a covered person, dependent of a covered person, plan beneficiary, service provider or a third party) to whom the overpayment was made. Any overpayment not refunded to the Plan (regardless of whether or not the participant has been notified in writing of such overpayment) shall be deducted from future benefits due the Participant or beneficiary upon whose behalf such overpayment was made. Overpayments made on behalf of a dependent of a Participant may be deducted from the Participant's future benefits, and overpayments made on behalf of a participant can be deducted from benefits due the dependent of that Participant. In cases where the dependent and Participant are separated or divorced, such rules shall not apply. In the event of separation or divorce, overpayments may only be deducted from future benefits due the individual (including such children as may be in the custody of such individual) who received the overpayment.

10.9 **EXAMINATION AND AUTOPSY**: The Plan, at its own expense, will have the right and opportunity to examine the person of any individual whose injury or sickness is a basis of a claim when and as often as it may reasonably require during the pendency of a claim and to have an autopsy performed in case of death where it is not forbidden by law. The Plan will pay for any such autopsy performed at its request.

10.10 **CHANGES IN PLAN BENEFITS**: Plan benefits may be changed (including reducing or terminating benefits or increasing required contributions) at any time.

A change in plan benefits does not require the consent of any covered person or beneficiary and must be in writing. A change may affect any class of covered persons, including retirees.

10.11 **RIGHT OF RECOVERY-SUBROGATION PROVISION**: "Subrogation" is the substitution of one person in the place of another with reference to a legal right or claim. The right of subrogation arises when this Plan pays benefits on behalf of a Participant or Dependent as a result of injuries or sickness for which another party is responsible.

If a Participant or Dependent has a medical injury, illness or condition ("condition") that another person, person's insurer or other plan ("third party") may be liable for (whether or not the third party caused such condition), a claim for reimbursement of your medical expenses may exist against that third party. In this case, this Plan has a legal right to pursue (i.e., will be "subrogated" to) claims for medical expenses that requires the Participant or Dependent to:

- Do whatever is needed to secure the Plan's recovery rights, including signing all necessary forms (if any) and papers, including a Subrogation Agreement attached to this SPD as Exhibit "A". (This Plan is entitled to subrogation regardless of whether such documents are executed);

- Inform the Plan Administrator of potential or actual claims that you or your Dependents have or may have against any third party and before you or your Dependents agree to any settlement or compromise; and

- Identify to the Plan Administrator any and all third parties against whom you or your Dependents may have a claim and the date of accident or condition.

The Plan may exercise its right of subrogation to recover all of the benefits it has paid to a Participant or Dependent, whether or not the Participant or Dependent has recovered all damages.

Reimbursement

If the Plan does not recover the benefits it has paid through its right of subrogation, the Participant or Dependent or their agents must reimburse the Plan for the benefits the Plan has not recovered out of any amounts received from a third party, whether or not the Participant or Dependent have recovered all of their damages. The Plan's rights of subrogation and reimbursement are independent of each other, and the Plan is not required to exercise its right of subrogation in order to exercise its right of reimbursement.

Subrogation and Reimbursement Rules

This Plan is subrogated to each Participant or Dependent's right of recovery, to the extent of any payment or intended payment of benefits, against any person or entity, or under any liability, casualty program, insurance or self-insurance program, which is or becomes obligated to pay losses, damages or benefits to or on behalf of the Participant or a Dependent. For purposes of this clause, the term "benefits" includes amounts paid to or on behalf of such Participant or Dependent or to the providers of hospital, medical or other health benefits and includes amounts paid for loss of wages, and the employer's and employee's share of social security taxes on such wages. The Fund has also retained a subrogation right to seek reimbursement of amounts paid for the benefit of a Participant or Participant's Dependent(s), which are subsequently recovered by someone acting on the Participant's or Dependent's behalf from an insurer or other source. Each Participant and Dependent is required, after a loss occurs, to do nothing to prejudice the rights of this Plan with respect to these subrogation rights and to do everything necessary to secure such subrogation rights to this Plan.

Any amount recovered by this Plan or by the Participant or Dependent shall be apportioned as follows:

a. This Plan shall first be reimbursed to the extent of any payments made by this Plan to or on behalf of the Participant or Dependent together with legal expenses, if any, incurred by this Plan in obtaining payments pursuant to this provision.

b. If any balance then remains from such recovery, it shall be applied to reimburse the insured individual and any other Plan providing benefits to the Participant and/or Dependent as their interests may appear.

This Plan shall not be liable for any expenses in connection with such recovery of monies unless this Plan shall have agreed in writing to bear a portion of all of the expenses. However, if there is no recovery in any proceeding instituted and conducted solely by this Plan, this Plan shall bear the expenses for such proceeding.

The Participant and/or Dependent shall be required to sign a Subrogation Agreement to the satisfaction of the Trustees in the form attached to this Summary Plan Description as Exhibit A. This form may be revised by the Trustees from time to time. The purpose of this Agreement is to specifically acknowledge in writing to this Plan the subrogation rights as required by the Trustees of the Plan from time to time. The failure of the Participant and/or Dependent to sign such an Agreement containing complete information shall be grounds for this Plan refusing to pay any benefits on behalf of the Participant and/or Dependent.

No part of this provision shall be deemed waived should benefits be paid prior to obtaining the signature of the Participant and/or that of Dependent on the subrogation forms.

To the extent that the Participant, Dependent or attorney or other legal representative for the Participant or Dependent receives any monies from any third party intended to compensate the Participant or Dependent for the illness or injury for which benefits were paid under this Plan, such person shall hold that portion of the proceeds representing the amounts paid out by this Plan in trust for the benefit of this Plan, and such proceeds shall be deemed to be Plan Assets to be paid over to the Plan.

If, at the time the Participant or Dependent signs the Subrogation Agreement, the Participant or Dependent has retained an attorney, or other legal representative, such attorney or other legal representative shall also be required to sign the Subrogation Agreement. If the Participant or Dependent does not have an attorney at the time the Subrogation Agreement is signed, but later retains an attorney or other legal representative, such attorney or other legal representative shall be required to sign the Subrogation Agreement at that time. The Participant or Dependent agrees to inform the attorney or other legal representative at the time such individual is engaged by the Participant or Dependent of the obligation to sign the Subrogation Agreement.

If any terms of this provision are found to be ambiguous, the Trustees shall have discretionary authority to interpret such terms.

10.12 **ERISA RIGHTS**: As a participant in the Twin Cities Bakery Drivers Health and Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits.

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months. Until October 1, 2004, you will always be subject to the preexisting condition provisions of this plan regardless of your prior creditable coverage.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-877-444-3272. The website is www.dol.gov/ebsa..

The nearest Area Office of the Labor-Management Services Administration, Department of Labor is:

Employee Benefit Security Administration
U.S. Department of Labor
Kansas City Regional Office
2300 Main Street, Suite 1100
Kansas City, MO 64108
Phone**:** 816/285-1800

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the plan or insurance policies. The Trustees reserve the right to amend, modify, or discontinue all or part of this plan whenever, in their judgment, conditions so warrant.

10.13 **NOTICE REGARDING CHILDBIRTH**: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any

case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you have any difficulty understanding any part of this booklet, contact Jay Johnson, Contract Administrator, Richard L. ("Jay") Johnson Twin Cities Bakery Drivers Health and Welfare Fund, 2919 Eagandale Boulevard, Suite 120, Eagan, MN 55121. His phone number is 651-686-0108 or 651-686-0656. His office hours are from 8:30 a.m. to 4:30 p.m., Monday through Friday.

PART XI - CONTINUATION OF COVERAGE

11.1 **CONTINUATION OF COVERAGE**:

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires your employer to offer employees and, in some cases, their families, the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provisions of this law.

If you are covered by a group health plan sponsored by your employer, you and your covered dependent(s) have the right to elect continuation of coverage at your cost if you lose your group health coverage because of termination of your employment or because you become ineligible to participate under the terms of the group health plan due to a reduction in your hours of employment.

If you are the spouse of an employee covered by a group health plan offered by your spouse's employer and you are covered under the plan, you have the right to continue coverage for yourself if you lose group health coverage for any of the following five reasons ("Qualifying Events"):

a. The death of your spouse;

b. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

c. Divorce or legal separation from your spouse;

d. Your spouse becomes entitled to (actually covered under) Medicare; or

e. If your spouse is a retiree, your spouse's former employer files for Chapter 11 reorganization.

In the case of a dependent child of an employee covered by a group health plan (if the dependent child is covered under the plan), he or she has the right to continue coverage if coverage is lost for any of the six following reasons ("Qualifying Events"):

a. The death of the parent through whom the dependent child was covered;

b. The termination of the parent's employment (for reasons other than gross misconduct) or reduction of the parent's hours of employment so that the parent is no longer eligible to participate in the group health plan;

c. The parent's divorce or legal separation;

d. The parent through whom the dependent child was covered becomes entitled to (actually covered under) Medicare;

e. The dependent child ceases to be a "dependent child" under the group health plan (e.g., child is ineligible due to age); or

f. In the case of a dependent child whose parent is a retiree, the parent's former employer files for Chapter 11 reorganization.

Under this law, the employee or a family member has the responsibility to inform the Plan Administrator at the Plan office, of a divorce, legal separation, or a child losing dependent status within **60 days** of a Qualifying Event listed above. If a written notice of the Qualifying Event is not provided within the 60 day period, the family member is ineligible for continuation coverage.

Each person entitled to elect continuation coverage shall be notified by the Plan Administrator. **If you do not elect continuation coverage, your coverage under the group health plan shall end.** If you elect continuation coverage, your employer is required to give you coverage which, as of the time coverage is provided, is identical to the coverage provided under the Plan to "similarly situated employees or family members".

The law requires a continuation period of at least 18 months for persons losing coverage as a result of termination of employment or a reduction in hours. If you have been determined to be disabled (under the Social Security Act provisions defining disabilities) at the time of the termination of employment or reduction in hours, you may extend coverage an additional 11 months for a total of 29 months. You are required to provide the Plan Administrator with notice of the Social Security determination within 60 days of receiving it and before the end of the normal 18-month continuation period. The law also requires that you notify the Plan Administrator within 30 days of any final determination that you are no longer disabled. If during the 18-month continuation period a second Qualifying Event takes place, coverage may be extended up to 36 months measured from the date of the original Qualifying Event. Persons who lose coverage for reasons other than termination of employment or reduction of hours may be able to continue the group health coverage for up to 36 months.

The law provides that continuation coverage may be cut short for any of the four following reasons:

a. The employer no longer provides health coverage to <u>any</u> of its employees;

b. Premiums for continuation coverage are not paid in a timely fashion;

c. The person who elected continuation coverage becomes covered under another health plan. However, if the new health plan contains a pre-existing condition exclusion or limitation affecting a person under continuation coverage, coverage is not cut short for that person (contact the Plan Administrator at the fund office if you have any questions); or

d. The person who elected continuation coverage becomes entitled to Medicare.

You do not have to show that you are insurable to elect continuation coverage. However, under the law, you may be required to pay all or part of the premium for the continuation coverage. The first payment shall be due within 45 days from the date of the initial election to continue coverage. Thereafter, there is a grace period of at least 30 days to pay the premium.

11.2 **<u>RETIREE COVERAGE AND CONTINUATION OF COVERAGE</u>**: If due to retirement, a Participant becomes eligible to continue coverage under COBRA (see section 14.1) and also

meets the eligibility requirements for retiree coverage (see sections 2.6 and 2.7), the Participant and his or her spouse may elect:

a. continued coverage only under COBRA for eighteen months; or

b. retiree coverage only; or

c. no coverage.

Required premiums may vary depending on the coverage selected. Information on the required premiums under each option may be obtained from the Contract Administrator.

11.3 **YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE**: Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a preexisting condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a preexisting condition exclusion. Contact your State insurance department for further information.

You have the right to receive a certificate of prior health coverage. Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate from the Plan, provide the following information on a separate sheet of paper:

****

REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Name of Participant: _____
Date: _____
Address: _____
Telephone Number: _____
Name and relationship of any dependents for whom certificates are requested (and their address if different from above): _____

_____

****

This information should then be returned to:

Twin Cities Bakery Drivers Health & Welfare Fund
2919 Eagandale Boulevard, Suite 120
Eagan, MN 55121

For additional information, contact Richard L. “Jay” Johnson at 651/686-0108.

The certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

PART XII - PLAN TERMINATION

The Union and any Contributing Employer have the right to agree to terminate the Employer's participation in the Plan through a collective bargaining agreement. The Trustees also have the right to terminate the entire Plan. Should that occur, all the Plan assets must be used under the terms of the Plan's Trust Agreement for the benefit of Plan Participants and for the payment of the Fund's administrative expenses. No Plan assets may revert to any Contributing Employer or to the union upon termination.

PART XIII - QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO'S)

The following are the administrative procedures utilized by the Fund for Qualified Medical Child Support Orders (QMCSO's):

13.1 **PRIMARY PROCEDURES**:

a. Notify the Participant and Alternate Recipient, in writing, immediately that the Order has been received and will be reviewed to determine whether it is or is not a "Qualified" Order. A copy of these procedures will be sent to the Participant and the Alternate Recipient.

b. Advise the Alternate Recipient that he or she has the right to designate a representative for receipt of copies of notices that are to be sent to the Alternate Recipient with respect to the QMCSO.

c. Determine if coverage has been provided to another Alternate Recipient in accordance with a prior QMCSO.

13.2 **DETERMINATION OF THE STATUS OF AN ORDER**:

a. Review the Order with legal counsel to determine qualification using the following checklist:

(1) Has the Order been issued by a proper court jurisdiction and properly executed?

(2) Are names and last known addresses of the Participant and Alternate Recipient(s) included?

(3) Is the Fund specifically and correctly named?

(4) Does the Order describe the type of coverage to be provided by the Fund to each Alternate Recipient?

(5) Is the type of coverage to be provided and the manner in which the type of coverage is to be provided consistent with current Plan provisions?

(6) Does the Order describe the period to which the Order applies?

(7) Does the Order conflict with a prior QMCSO?

(8) Does the Order require payment of premiums and provide for termination of coverage on non-payment of premiums

13.3 **IF THE ORDER IS DETERMINED NOT TO BE A QUALIFIED ORDER**:

a. Send notice to Participant and Alternate Recipient advising the Order is not qualified.

(1) Advise of amendments needed to make the Order qualified.

(2) Upon receipt of amended Order begin procedures again.

13.4 **IF IT CANNOT BE DETERMINED IF THE ORDER IS QUALIFIED**:

a. If the Administrator and legal counsel cannot make a clear determination as to the qualification of the Order, take the Order to the Board of Trustees for a determination.

13.5 **IF THE ORDER IS DETERMINED TO BE QUALIFIED**:

a. Send notice to Participant and Alternate Recipient advising them the Order is qualified.

(1) State benefits payable under the Order.

(2) Include description of manner in which the Order will be administered.

(3) Send Alternate Recipient a Summary Plan Description, summary annual report and any applicable COBRA notices.

(4) Advise Participant and Alternate Recipient to keep Fund office informed of address changes and termination of employment of Participant.

Report the terms of the QMCSO to the Board of Trustees.

b. Treat the Alternate Recipient as a participant for ERISA reporting and disclosure requirements.

13.6 **RECORD KEEPING**:

a. Establish file for each of the following:

(1) Unqualified MCSO

(2) Qualified MCSO

b. Retain permanently original QMCSO with related correspondence and material.

13.7 **DEFINITIONS**:

a. The term “Medical Child Support Order” means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction.

b. The term “Alternate Recipient” means any child of a participant who is recognized under a Medical Child Support Order as having a right to receive benefits from the Twin Cities Bakery Drivers Health and Welfare Fund.

c. The term “Child” includes adopted children or children who have been placed for adoption who have not yet attained age 19 as of the date of such adoption or placement for adoption.

PART XIV - FMLA AND MILITARY SERVICE

14.1 **COVERAGE DURING ABSENCE FROM WORK DUE TO LEAVE FOR MILITARY SERVICE**: If a Covered Eligible Participant is absent from work due to leave for military service and was covered under this Plan prior to the leave, coverage for the Eligible Participant may be continued for a period that is the lesser of eighteen (18) months or a period that ends the day the Eligible Participant fails to apply for or return to a position of employment. Coverage continued during the military service leave will be counted toward the maximum COBRA continuation period. The eighteen (18) month period is measured from the date the Eligible Participant leaves work for military service.

If an Eligible Participant is on military leave for less than thirty-one (31) days, the Eligible Participant may not be required to pay more than an Eligible Participant in Active Service. However, Eligible Participants on military leave for more than thirty-one (31) days will be required to pay 102% of the full actual cost to an Eligible Participant in Active Service. Contact the Plan Administrator for details regarding the cost of continuation.

Whether or not an Eligible Participant on military leave takes continued coverage, no exclusion or waiting period may be imposed upon the individual's return from service, as required by the Uniform Services Employment and Re-Employment Rights Act of 1994.

Effective February 1, 2003, the Plan will provide medical coverage at no cost to dependents of Participants who are military personnel who may be called up for military duty. This action is subject to:

- The coverage not to exceed 12 months.
- The coverage not to exceed 2% of covered members. If the number of covered members approaches 35 or 40, the Trustees have the right to limit or discontinue this coverage.

14.2 **COVERAGE DURING ABSENCE FROM WORK DUE TO LEAVE OF ABSENCE**: If a Covered Eligible Participant is absent from work due to Leave of Absence, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided the Covered Eligible Participant elects to continue under that provision. The Eligible Participant will continue to make contributions in full for the Eligible Participant's coverage for the period of time that coverage may be kept in effect, based upon personnel practices in effect at the time.

If the Leave of Absence qualifies under the Federal Family and Medical Leave Act (FMLA) and the Covered Eligible Participant is entitled to leave under the FMLA, the Covered Eligible Participant's coverage may be continued under the Family and Medical Leave Act provision of this Plan. Refer to that section for more information.

14.3 **FAMILY AND MEDICAL LEAVE ACT (FMLA) - (APPLICABLE TO COVERED ELIGIBLE PARTICIPANTS OF CONTRIBUTING EMPLOYERS SUBJECT TO FMLA)**: Not all Employers are covered by FMLA, and the benefits of this law do not extend to employees of such Employers. If you are uncertain as to whether FMLA applies to you, ask your Employer or the Plan Administrator.

If a Covered Eligible Participant ceases Active Service due to an Employer-approved family medical leave of absence in accordance with the requirements of the Federal Family and Medical Leave Act of 1993 (or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during leave), coverage will be continued under the same terms and conditions which would have been provided had the Covered Eligible Participant continued Active Service, provided the Eligible Participant continues

to pay the contributions if required. Contributions will remain at the same Employer/Eligible Participant percentage level as on the date immediately prior to the leave (unless contributions change for other Eligible Participants in the same classifications).

If the Covered Eligible Participant fails to make the required contribution for coverage to continue during the FMLA leave within thirty (30) days after the date the contribution was due, the Covered Eligible Participant's coverage may terminate effective on the date the contribution was due. In order to terminate coverage, the Plan Administrator must notify the Covered Eligible Participant in writing at least fifteen (15) days prior to the expiration of the thirty (30) day grace period that coverage will cease unless the contribution is paid.

If the Covered Eligible Participant does not return to Active Service after the approved Family Medical Leave or if the Covered Eligible Participant has given the Employer notice of intent not to return to Active Service during the leave, or if the Covered Eligible Participant has exhausted the twelve (12) week FMLA leave entitlement period, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided the Covered Eligible Participant elects to continue under the COBRA provision. It will be your Employer's responsibility to notify the Plan Administrator of a FMLA leave. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

a. The Covered Eligible Participant was covered under this Plan on the day before the FMLA leave;

b. The Covered Eligible Participant does not return to active Service after an approved FMLA leave; and

c. Without COBRA, the Covered Eligible Participant would lose coverage under this Plan.

However, these conditions do not entitle a Covered Eligible Participant to COBRA if the Trustees eliminate, on or before the last day of the Covered Eligible Participant's FMLA leave, coverage under this Plan for the class of Eligible Participants (while continuing to provide benefits to that class of Eligible Participants) to which the Covered Eligible Participant would have belonged if the Covered Eligible Participant had not taken FMLA leave.

PART XV - DEFINITIONS

Wherever used in this Plan:

15.1 **ACUPUNCTURE TREATMENT** means the piercing of specific peripheral nerves with needles to relieve the discomfort of painful disorders or for therapeutic purposes.

15.2 **ADMISSION INFORMATION** means the following information which the attending physician must provide to the Care Review Unit before a period of confinement is approved: the diagnosis or reason for the confinement, any proposed treatment or surgical procedure, and the expected days of confinement.

15.3 **CALENDAR YEAR** means January 1 through December 31 of the same year.

15.4 **CARE REVIEW UNIT** means any qualified party or entity appointed by the plan to conduct the review programs set forth in Part VI of this booklet. For the Care Review Unit's toll-free phone number, contact the Plan Administrator.

15.5 **CERTIFICATE OF CREDITABLE COVERAGE** means when a participant terminates employment with a contributing employer and loses eligibility under this Plan, the Plan will provide that participant with a Certificate of Creditable Coverage. When an individual or beneficiary either

loses coverage under this plan or becomes entitled to elect COBRA continuation coverage, and then the COBRA continuation coverage ceases, the Plan will issue such participant or beneficiary a Certificate of Creditable Coverage.

15.6 **COSMETIC OR RECONSTRUCTIVE SURGERY** means any surgical procedure performed primarily:

a. to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or

b. to prevent or treat a mental or nervous disorder through a change in bodily form.

15.7 **CUSTODIAL CARE** means services or treatment which, regardless of where it is provided:

a. could be rendered safely by a person without medical skills; and

b. is designed mainly to help the patient with daily living activities, including (but not limited to):

(1) personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising, dressing, enema and using the toilet;

(2) homemaking such as preparing meals or special diets;

(3) moving the patient;

(4) acting as companion or sitter;

(5) supervising medication which can usually be self-administered;

(6) oral hygiene; and

(7) ordinary skin and nail care.

An independent medical review as conducted by the plan shall determine what services are custodial care. When a confinement or visit is found to be mainly for custodial care, some services (such as prescription drugs, X-rays and lab tests) may still be covered. All bills should be routinely submitted for consideration.

15.8 **DENTIST** means a licensed dentist who performs a service which is payable under the plan.

15.9 **DEPENDENT** means the Participant's lawful spouse, each unmarried child under 19 years of age, and each child who qualifies as an Eligible Full Time Student as defined earlier in this Summary Plan Description. See Section 2.8 of this Summary Plan Description for further information on Dependent eligibility, termination of coverage, excluded from coverage.

15.10 **DEVELOPMENTAL CARE** means services or supplies which, regardless of where or by whom they are provided;

a. are provided to a Participant or Eligible Dependent who has not previously reached the level of intellectual, speech, motor or physical development normally expected for his or her age;

b. are primarily provided to assist in the development of those skills referred to in item (a) above; and

c. are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or sickness).

A qualified party or entity selected by the plan will determine what services or supplies are Developmental Care. When a confinement, visit or other service or supply is found to be primarily for Developmental Care, some services or supplies (such as prescription drugs, X-rays and lab tests) may still be covered if medically necessary and otherwise covered by the policy. All bills should be routinely submitted for consideration.

15.11 **DOMICILIARY CARE** means services or supplies which, regardless of where or by whom they are provided:

a. primarily provide a protective environment and assistance with basic personal needs for the covered person;

b. are primarily provided because the covered person's own home arrangements are not appropriate or adequate; and

c. are not part of an active treatment plan intended to or reasonably expected to improve the covered person's condition or functional ability.

The plan, through use of a qualified party or entity, will determine what services are Domiciliary Care.

When a confinement, visit or other service or supply is found to be primarily for domiciliary care, some services or supplies (such as prescription drugs, X-rays and lab testes) may still be covered if they are medically necessary and otherwise covered by the policy. All bills should be routinely submitted for consideration.

15.12 **ELECTIVE ABORTION** means any abortion other than one where the mother's life would be endangered if the fetus were carried to term.

15.13 **EMOTIONAL DISTURBANCE** means an organic disorder of the brain or clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that (1) is listed in the clinical manual of International Classification of Diseases (ICD-9-CM), current addition, code rage 290.0 to 302.99 or 306.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II or III; and (2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school and recreation. Emotional disturbance is a generic term and is intended to reflect all categories of disorder described in DSM-MD, current edition as "Usually first evident in childhood or adolescents."

15.14 **EMOTIONALLY HANDICAPPED CHILD** means a child who has an emotional disturbance and who meets one of the following criteria: (1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or (2) a child has one of the following as determined by a mental health professional: (a) psychosis or clinical depression; or (b) risk of harming self or others as a result of an emotional disturbance; or (c) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or (d) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

15.15 **EXPENSE** means the expense incurred for a covered service or supply. A physician must order or prescribe the service or supply. Expense is considered incurred on the date the service or supply is received. Expense **does not include** any charge for a service or supply which is not medically necessary or which is in excess of the usual and customary charge for a service or supply.

15.16 **HOSPITAL** means any of the following facilities which are licensed by the proper authority in the area in which they are located:

a. A place when it is licensed as a general hospital by the proper authority of the area in which it is located;

b. A place which is operated for the care and treatment of resident inpatients, has a registered graduate nurse (RN) always on duty, has a laboratory and X-ray facility, and has a place where major surgical operations are performed; or

c. A facility which is accredited by the Joint Commission on the Accreditation of Health Care Facilities, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.

When treatment is needed for a mental disease or disorder, **hospital** can also mean a place which meets these requirements:

a. Has rooms for resident inpatients;

b. Is equipped to treat mental diseases or disorders;

c. Has a resident psychiatrist on duty or on call at all times;

d. As a regular practice, charges the patient for the expense of confinement; and

e. Is licensed by the proper authority of the area in which it is located.

A hospital does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged.

15.17 **HOSPITAL CONFINEMENT** means a medically necessary hospital stay of 18 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board, and notwithstanding the hospital's classification of the stay.

Any hospital confinement satisfying this definition will be subject to all plan provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the plan provisions for outpatient services.

15.18 **HRA** means "Health Reimbursement Arrangement."

15.19 **INJURY** means an accidental bodily injury which requires treatment by a physician. It must result in loss independently of sickness and other causes.

15.20 **MEDICAL EMERGENCY** means a severe condition, as determined by the plan, which:

a. results in symptoms which occur suddenly and unexpectedly; and

b. requires immediate physician's care to prevent death or serious impairment of the covered person's health; or

c. poses a serious threat to himself herself or to others.

15.21 **MEDICAL FACILITY** means a facility that is licensed to regulate on an acute care basis. Staffed by physicians. Providing inpatient and outpatient care 24 hours a day. **NOTE:** For purposes of part IX, Section 9.1 z, the medical facility does not need to be open 24 hours a day.

15.22 **MEDICAL CENTER** means either: (1) a free standing ambulatory surgical center; or (2) a facility offering ambulatory medical service 24 hours a day, seven days a week, which is not part of a hospital and has been approved by the Minnesota Commissioner of Health.

15.23 **MEDICALLY NECESSARY SERVICE OR SUPPLY** means one which is ordered by a physician and which a qualified party or entity selected by the plan determines is:

a. provided for the diagnosis or direct treatment of an injury or sickness;

b. appropriate and consistent with the symptoms and findings or diagnosis and treatment of the covered person's injury or sickness;

c. provided in accord with generally accepted medical practice on a national basis; and

d. the most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care.)

The fact that the Participant's physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary and covered by the plan.

15.24 **MENTAL AND NERVOUS DISORDERS/ALCOHOL AND DRUG ABUSE** means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder. Not included in this definition are conditions or diseases specifically excluded from coverage.

The plan may include special benefits for any one or more of the conditions included in this definition. If it does, only those special benefits relating to those conditions are available for that condition.

15.25 **MORBID OBESITY** means a condition in which an adult has been 100 pounds over normal weight (normal weight is as defined by the plan) for at least five years despite documented unsuccessful attempts to reduce under a physician-monitored diet and exercise program.

15.26 **OUT-OF-POCKET EXPENSE** means expense which a Participant or Eligible Dependent incurs for covered services during the calendar year and must pay out-of-pocket to satisfy the Deductible or as coinsurance (the percentage the participant or eligible dependent must pay in accord with the Percentage Payable provision).

15.27 **PARTICIPANT** means any person who has met the eligibility requirements as provided in paragraph 2.1 and whose coverage has become effective as provided in paragraph 2.2 and whose coverage has not been terminated under any provision of this plan.

15.28 **PHYSICIAN** means any of the following licensed practitioners who performs a service payable under the plan:

a. a doctor of medicine (MD), osteopathy (DO), surgical chiropody, podiatry, or chiropractic;

b. a licensed clinical psychologist; or

c. where state law requires, any other licensed practitioner who:

(1) is acting within the scope of that license; and

(2) performs a service which is payable under the plan when performed by an MD.

A physician does not include a person who lives with the Participant or is part of the Participant's family (the Participant; the Participant's spouse; or a child, brother, sister or parent of the Participant or Participant's spouse).

15.29 **REFERRED PROVIDER ORGANIZATION (PPO)** means arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for the employees and their Eligible Dependents of participating employers.

15.30 **SICKNESS** means a disease, disorder or condition, which requires treatment by a physician. It includes childbirth or pregnancy. It **does not include** elective abortion; but it **does include complications which are the result of an elective abortion**.

15.31 **TOTAL DISABILITY** with respect to Health Coverage means

a. with respect to the Participant,

(1) that within the first two years of such a disability, due solely to injury or illness, the Participant is unable to engage in his or her regular occupation or employment; and

(2) that after the first two years of such disability, the Participant is unable to engage in any paid employment or work for which the Participant may, by his or her education and training, including rehabilitative training, be or become reasonably qualified.

b. with respect to an eligible dependent, that such eligible dependent due solely to injury or illness, is prevented from engaging in substantially all of the normal activities of a person of like age and like sex who is in good health.

15.32 **USUAL AND CUSTOMARY CHARGE** means a charge for a service or supply which is no higher than the 90th percentile of the plan's prevailing health care charges data. This data reflects a current statistical sampling of charges for services and supplies made in the same or comparable area.

In the event of multiple surgery or multiple surgeons in attendance during one operation, or for services or supplies for which data is unavailable, usual and customary will be determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned.

PART XVI - VOLUNTARY TERMINATION OF HEALTH AND WELFARE COVERAGE BY INDIVIDUAL PARTICIPANTS

Individual participants of the Twin Cities Bakery Drivers Health and Welfare Fund may terminate all benefit coverages with the Fund under the following terms and conditions:

16.1 The provision for election to terminate coverage in the Fund must be provided by Written Agreement between the union of which the participant is a member and the participant's employer. The written agreement shall contain the following language:

The Union and Employer which are parties to this agreement, hereby agree that the **Rules and Regulations of the Twin Cities Bakery Drivers Health and Welfare Fund for Voluntary Termination of Health and Welfare Coverage by Individual Participants** are incorporated by reference. The parties, including the members of the union agree to be bound by such rules and regulations, and any amendments thereto.

The "Written Agreement" referred to is the collective bargaining agreement between the employer and the union or an amendment or modification to the collective bargaining agreement between the union and the employer.

16.2 Voluntary termination of coverage means the Effective Date, all coverages of the participant and dependents of the participant in the Fund will terminate. These coverages include but are not limited to:

a. Medical Benefits
b. Dental Benefits
c. Vision Benefits
d. Disability Insurance Benefits

Except that participants may continue to be provided life insurance and disability insurance coverage by paying to the Plan the cost of such coverage. The obligation as to who will pay for such coverage shall be covered by the collective bargaining agreement.

16.3 Voluntary termination of coverage by the participant cannot be made unless the participant has a spouse and the participant's spouse has health and welfare coverage which provides medical benefits to the participant, the spouse of the participant and any dependents of the participant. The spouse and the participant must sign a Voluntary Termination Form under oath in the form attached hereto and incorporated herein by reference as Exhibit B. The Fund does have the right to confirm that medical coverage by the spouse is in existence, and that it also covers the participant and the dependents of the participant.

16.4 The effective date of the voluntary termination of coverage, once signed, shall be the first day of the month following the month in which the Voluntary Termination Form has been delivered to or received in the office of the contract administrator of the Fund.

PART XVII - WOMEN'S HEALTH CARE AND CANCER RIGHTS ACT OF 1998

The Women's Health Care and Cancer Rights Act of 1998 requires that this Plan provide medical and surgical benefits for mastectomies to pay for the following benefits, as requested by the patient in consultation with her physician:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

EXHIBIT "A"

SUBROGATION/REIMBURSEMENT AGREEMENT

This Agreement, entered into this _____ day of _____, 200___, _____by and between_____(Name of Participant)_____, residing at _____ (Address)_____,(hereinafter referred to as "Participant"), who is eligible to receive benefits under Twin Cities Bakery Drivers Health & Welfare Plan, and the Trustees of the Twin Cities Bakery Drivers Health & Welfare Fund (hereinafter "Fund")

RECITALS

A. Participants are entitled to receive benefits from the Fund for medical expenses incurred which have not been reimbursed by other sources, provided that such expenses come within the coverage limitations set forth in the Plan of Benefits and the Summary Plan Description (hereinafter the "Plan") of the Fund.

B. Unless approved by the Trustees, Participants are not entitled to receive benefits from the Fund for medical expenses for which a third party is liable, even if such expenses have not and may never be paid by the third party.

C. The Fund has retained a subrogation right and/or the right to seek reimbursement of amounts paid to participants which the Participant, or its legal representative, subsequently recovers from an insurer, defendant or other source. Specifically, the Fund will pay benefits pursuant to the Plan of Benefits, but is entitled to receive from the Participant or Participant's legal representative, reimbursement of benefits previously paid to the extent the Participant is reimbursed under any liability, casualty insurance or self-insurance program or from any other source. In addition, the Participant is required by the Fund to sign such subrogation forms as the Fund may require to ensure that the Fund will receive reimbursement pursuant to its subrogation policy. All terms and conditions of the Summary Plan Description and Agreement and Declaration of Trust for the Fund are hereby incorporated and made part of this Agreement, including but not limited to those provisions setting forth the Fund's priority in subrogation.

D. For purposes of this Agreement, the term "Participant" means the individual who is entitled to benefits under the terms of the Plan. This term includes the Eligible Employee (on whose behalf contributions are made to the Fund), and any dependent or dependents of the Eligible Employee who are entitled to benefits under the plan of benefits provided by this Fund. When the Participant is someone other than the Eligible Employee, the name of the Eligible Employee shall be set forth at the end of this Agreement. If the Participant is a dependent of an Eligible Employee who is a minor, then the Eligible Employee shall be required to sign this Agreement on behalf of such minor.

E. The Participant, under the terms of the Plan, is not entitled to reimbursement by the Fund of expenses incurred as a result of an illness or injury which is work-related or for which coverage may be obtained through Workers' Compensation laws of the State of Minnesota or any other state.

F. The Participant has filed a claim for reimbursement of expenses incurred with the Plan Administrator of this Fund and, in addition, may be entitled to recover such expenses from another source or sources.

NOW, THEREFORE, the parties hereto agree as follows:

1. The Fund agrees to reimburse Participant according to the Plan of Benefits currently in effect, for medical expenses, disability benefits and benefits for time away from work, even though Participant may recover such expenses from another source.

2. Participant agrees to reimburse the Fund for all payments the Fund has made to or on behalf of Participant for medical benefits, disability benefits and/or the employers' and employees' share of social security taxes if Participant has recovered any judgment, payment or settlement from any source whatsoever with respect to the injury or illness which resulted in a claim for benefits being paid by the Fund to Participant or Participant's dependent (collectively the "Participant"). Such reimbursement by the Participant or dependent shall not exceed the amount that the Participant has received. The Fund shall be reimbursed to the extent of any payments made by the Fund to or on behalf of a Participant. If any balance remains from such recovery, it shall be applied to reimburse the Participant.

3. Participant agrees to reimburse the Fund for such benefits paid by the Fund regardless of whether or not the recovery made by the Participant is for the purpose of compensating Participant for medical expenses, lost wages, personal injury and without regard to whether the recovery is specifically designated as a recovery for certain damages or expenses. Unless otherwise agreed to by a majority of the Trustees, there shall be no reduction in the amount of reimbursement paid by the Participant to the Fund for attorneys' fees incurred or paid by the Participant in connection with said claim.

4. Should the Participant choose not to pursue any valid claims against any third party that may have caused the illness or injury for which benefits had been paid by this Fund, the Fund shall be subrogated to all rights of the Participant and the Fund may, but is not required to pursue, on behalf of the Participant, any such claims. If the Fund chooses to pursue its subrogation rights, the Participant shall not be liable for any fees or expenses that may be incurred by the Fund in pursuing such claims.

5. Participant shall notify the Fund whenever the Participant or Dependent has commenced litigation, or any administrative proceeding or otherwise made a claim in connection with the illness or injury which is the subject of this Agreement, giving the Fund the names of the parties to the proceeding, and the venue for such proceeding. This is a continuing obligation and the Participant shall notify the Fund at the time this Agreement is signed of any such proceedings, and Participant shall have a continuing obligation to notify the Fund at any time that such proceedings are commenced or claims are made.

6. The Participant agrees that Participant shall notify the Fund of any attorney that the Participant has engaged to represent the Participant (or Participant's beneficiary or Dependent) in any such proceeding. Further, the Participant shall notify the Fund of the discharge of such attorney and the further employment of any successor attorney. In addition, if the Participant (or Participant's beneficiary or, dependent) has an attorney at the time that this document is signed, the attorney shall sign this Agreement evidencing the attorney's agreement to honor the terms of this Agreement on behalf of the Participant. Should the Participant not have an attorney at the time this Agreement is signed, but subsequently retains an attorney, such attorney at that time shall be required to sign this Agreement. The Participant agrees to notify the attorney at the time the attorney is retained by the Participant of this specific requirement.

7. If the Participant or the attorney or other legal representative for the Participant receives any monies from any third party intended to compensate the Participant for the illness or injury for which benefits were paid by this Plan on behalf of the Participant, the Participant or the Participant's attorney or legal representative shall hold that portion of the proceeds representing the amounts paid out by this Plan in Trust for the benefit of this Plan, and shall treat such proceeds as Plan assets to be paid over to the Plan.

Dated this _____ day of _____, 200 _.

_____
Participant

_____
Eligible Employee

IF THE DEPENDENT IS A MINOR, THE Participant SHALL ALSO SIGN ON BEHALF OF THE MINOR DEPENDENT:

_____
Participant on Behalf of Minor Dependent

STATE OF MINNESOTA)
) ss.
COUNTY OF _____)

Subscribed and sworn to before me by _____,and_____this _____ day of _____, 200____.

_____
Notary Public

YOU ARE NOT REQUIRED TO HAVE AN ATTORNEY, BUT IF YOU DO, THE ATTORNEY MUST SIGN BELOW, ACKNOWLEDGING LEGAL REPRESENTATION AND COMPLIANCE WITH THE TERMS OF THIS REQUEST.

Date:_____ By_____
Attorney for Participant

Address_____
_____
_____

TWIN CITIES BAKERY DRIVERS HEALTH
AND WELFARE FUND

Date:_____ By_____

Its_____

EXHIBIT "B"

Twin Cities Bakery Drivers

HEALTH AND WELFARE & PENSION FUNDS

2919 Eagandale Boulevard, Suite 120
Eagan, MN 55121

VOLUNTARY TERMINATION OF PARTICIPATION IN TWIN CITIES BAKERY DRIVERS HEALTH AND WELFARE FUND

The undersigned participant, pursuant to the Rules and Regulations of the Twin Cities Bakery Drivers Health and Welfare Fund (the "Fund") for Voluntary Termination of Health and Welfare Coverage by Individual Participants, hereby voluntarily elects to terminate his/her coverage in the Fund subject to the following conditions:

(1) The participant shall not be liable for any employee contribution co-pays required by the collective bargaining agreement;

(2) The participant, the participant's spouse and any dependents of the participant are no longer entitled to the following coverages from the Fund:

- Medical Benefits
- Dental Benefits
- Vision Benefits
- Disability Insurance Benefits*

*Note: Disability Benefits may be continued at the option of the participant by paying the monthly cost therefore to the Fund.
The undersigned participant elects ____**to continue** Disability Benefits.
The undersigned participant elects ____**not to continue** Disability Benefits

(3) The participant agrees that he/she is in compliance with all the Rules and Regulations of the Fund regarding such voluntary termination as attached hereto and incorporated herein by reference.

(4) The participant hereby certifies that he/she and his/her dependents are currently provided medical coverage as described below by reason of his/her spouse's employment with _____.

(5) The voluntary termination will be effective the first day of the month following the month in which the Fund receives this form.

Dated:_____

_____
Participant

Print Name:_____

Social Security No.:_____

(**over**)

SPOUSAL CONSENT

I, the undersigned individual, under oath, certify that I am the spouse of the above-named participant, I understand my spouse is voluntarily terminating all benefit coverages under the Twin Cities Bakery Drivers Health and Welfare Fund, my employer provides health and welfare coverage which will provide health and welfare benefits to my spouse and my spouse's dependents, and I am in agreement with my spouse's voluntary termination of coverage.

Dated:_____ _____
Participant

Print Name:_____

Social Security No.:_____

STATE OF MINNESOTA)
)ss
COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____day of _____,_____by_____ (Participant) and_____(Participant's Spouse).

_____
Notary Public

The Twin Cities Bakery Drivers Health and Welfare Fund hereby acknowledges receipt of this Voluntary Termination Form on _____(date).

TWIN CITIES BAKERY DRIVERS HEALTH AND WELFARE FUND

By: _____

Its: _____

TWIN CITIES BAKERY DRIVERS HEALTH AND WELFARE FUND

DENTAL BENEFITS

JANUARY 1, 2008

PART XVIII - DENTAL COVERAGE

For You and Your Dependents

BENEFIT SUMMARY

DENTAL SERVICES	IN NETWORK Formula Dental Network	OUT OF NETWORK
DENTAL BENEFIT	$25.00 Co-pay per visit	Single: $25.00 Co-pay per visit
Diagnostic and Preventive Care	100%	100%
Basis Restorative	80%	80%
Major Restorative	50%	50%
Maximum calendar year benefit	$1,200.00	$1,000.00

18.1 **DENTAL BENEFITS**: If the Participant or Eligible Dependent, while covered under this provision, incurs expense for Covered Services, The Plan will pay a percentage of that expense after the Deductible is satisfied. The Plan will pay up to the Maximum for each Participant or Eligible Dependent. The **Percentage Payable, Deductible** and **Maximum** for the Class of Services are shown below.

Participants are also covered under the Formula Dental Network. The dentists in this network may discount their fees. Participants are not required to use these dentists. However, the participant's costs will be less by using this network. A current listing of the network dentists is available to each Participant.

18.2 **BENEFITS PROVIDED**:

a. Calendar year maximum benefit per individual: $1,200 In-Network

$1,000 Out-of-Network

b. Co-pay (per individual per visit) $25

c. Covered benefits/percentages

(1) Diagnostic and Preventative 100%
(limit 2 visits per year)

- Biannual Exams
- X-rays
- Cleanings

(2) Basic Restorative 80%

- Oral Surgery
- Restoration Work

(3) Major Restorative 50%

- o Crowns
- o Bridges
- o Inlays

(4) Prosthodontics..... 50%

d. The maximum fee allowed by the Plan is different for network and out-of-network dentists. If you see an out-of network dentist, your out-of-pocket expenses may increase.

e. List of covered dental procedures

(1) Preventative

i. Routine oral examinations once every six (6) months.

ii. Prophylaxis/Periodontal maintenance once every six (6) months.

iii. Dental x-rays:

- PA x-rays
- Bitewing x-rays once every six (6) months
- Panoramic or Full Mouth Series once every three (3) years

iv. Topical Fluoride application for children under 15 years of age, once every 12 months.

v. Sealants for children under 16 years of age, applied to permanent first and second molars, once every four (4) years.

vi. Space maintainers for children under 15 years of age.

2. Basic Restorative

i. Emergency palliative treatment.

ii. Recementing of crowns, inlays and bridgework, spacemaintainers.

iii. Amalgams, silicate or acrylic filings including pin retention.

iv. Local anesthesia and analgesia (nitrous oxide).

v. General anesthesia when administered with oral surgery.

vi. Endodontic therapy, retreatment, apicoectomy/periadicular surgery, or other treatment of the dental pulp.

vii. Periodontal non-surgical procedures-provisional splinting, periodontal scaling and root planing, full mouth debridement, and time-released therapeutic agent.

viii. Peridontal surgical procedures-gingivectomy, gingival flap or currettage, osseous surgery, bone replacement graft, guided tissue regeneration, soft tissue graft, and wedge procedures. LIMITATION: once every four (4) years

ix. Oral surgery including simple extractions and other surgical procedures. EXCEPTION: Third Molar Extractions (simple and impacted) and accompanying procedures done the same day will be paid under Medical Benefits Provision.

3. Major Restorative

i. Inlays and Onlays.

ii. Crowns including post and core buildup and crown lengthening.

LIMITATION: Benefit for the replacement of a crown will be provided only after a five (5) year period measured from the date on which the procedure was first benefited.

iii. Selective implants.

4. Prosthodontics

i. Repairs and Adjustments to Prosthetic appliances.

LIMITATION: No adjustments, relining or rebasing will be benefited if performed during the first six (6) months following denture placement. Tissue conditioning, relining, or rebasing will be allowed no more than once in a two (2) year period.

ii. Initial placement of bridges, standard partial dentures and full dentures for the replacement of teeth extracted while covered under the Plan. Benefits are limited to the commonly performed method of tooth replacement.

iii. Alveoloplasty and vestibuloplasty when required to prepare dentures.

iv. Coverage is NOT provided for the replacement of congenitally missing teeth.

v. Coverage is NOT provided for the replacement of misplaced, lost, or stolen appliances.

vi. The “Prosthesis Replacement Rule” requires the replacement or additions to existing dentures or bridgework will be covered only if the following applies:

(a) The replacement or addition of teeth is required to replace one or more permanent teeth extracted while the individual is insured under this Plan or

(b) The existing denture of bridgework cannot be made serviceable and was installed at least five (5) years prior to its placement.

18.3 **DENTAL EXCLUSION**:

No benefits shall be payable under this Plan for the following: (Note: Additional specific exclusions are included in other parts of this Plan.)

Charges for any treatment, material or supplies furnished by anyone other than a legally qualified dentist or licensed dental hygienist under the direction of a legally qualified dentist.

Charges which would be covered under WORKER'S COMPENSATION or similar legislation or for conditions resulting while at any occupation for wages or profit.

Charges for dentistry for cosmetic purposes.

Charges for treatment of temporomandibular joint disorder (TMJ) including diagnosis, consultation, appliance, or restoration.

Charges for veneers-chairside or laboratory created.

Charges for oral hygiene instruction, dietary or plaque control problems, or other educational programs.

Charges for take home items (i.e., home fluoride, Rododent or tooth brushes)

Charges for hospital calls or expenses.

Charges incurred prior to the effective date of coverage or after the termination date of coverage.

Charges for specialization techniques and characterization of prostodontics.

Charges to correct congenital conditions including but not limited to orthognastic surgery.

Charges incurred for dental services that are the result of accidental injury (should be submitted to Medical benefits for payment).