

PENSIONERS' HEALTH BENEFITS PLANS

W-Plans

**for Medicare-Eligible
Pensioners**

**SUMMARY PLAN DESCRIPTION
AND RULES AND REGULATIONS**



**Bakery and Confectionery
Union and Industry
International Health
Benefits Fund**

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[The eighth trustee position
is vacant at the present time.]

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The Kroger Company

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

EXECUTIVE DIRECTOR: John Beck

CONSULTANT AND ACTUARY: The Segal Company

LEGAL COUNSEL: Bredhoff & Kaiser, P.L.L.C.
Littler Mendelson, P.C.

ACCOUNTANTS: Bond Beebe, P.C.

**BAKERY AND CONFECTIONERY UNION AND
INDUSTRY INTERNATIONAL HEALTH BENEFITS
FUND**

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

Dear Pensioner:

This booklet describes the health benefits by which you and your dependents will be covered under the Health Benefit Plan for Medicare-Eligible Pensioners (the “Plan”) if you meet the eligibility requirements, enroll at the proper time, and pay the applicable premiums, as explained in Article 2.

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

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

Sincerely,

David Durkee
*Union Trustee and
Chairman of Board of Trustees*

Lou Minella
*Employer Trustee and
Secretary of Board of Trustees*

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GENERAL INFORMATION

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

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

The premium rates for Pensioners and contribution rates for Employers are determined by the Board in its sole discretion, and may be revised by the Board from time to time. Benefits are provided from the Fund's assets, which are accumulated in a separate account under the trust agreement establishing the Fund (the "Trust"). These assets are held in trust for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's assets and reserves are deposited in PNC, 2 Hopkins Plaza, Baltimore, MD 21203. Assets for the W-Plans (including the W-plans for pensioners who are not yet eligible for Medicare) are kept in a separate account and are not mixed with the assets for any of the Health Benefits Fund's other plans of benefits. All benefits for this Plan are paid from those assets. The assets in the account for W-Plans may be used only for W-Plan benefits and administrative expenses. (Similarly, the assets held in the Trust for other plans of benefits under the Health Benefits Fund may not be used to provide benefits under the W-Plans.)

Hospital, medical and prescription benefits under the W-Plans for Medicare-eligible pensioners and dependents are provided under

contracts between the Fund and two insurance companies. The insurance companies are solely responsible for providing the benefits that are promised under the insurance contracts. Hospital and medical benefits are provided through UnitedHealthcare and prescription drug benefits are provided through UniCare. In future years, if the Trustees determine that contracting with a different company to provide these benefits would be better for the pensioners, either to obtain higher quality service or to reduce the cost, the Trustees retain the discretion to change the arrangement under which the W-Plan benefits are provided.

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

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review Article 4 of this summary plan description for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund. The people who operate the Fund, called “fiduciaries” of the Fund, have a duty to do so prudently and in the interest of you and other Plan 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest Office of the Employee Benefits Security 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.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

Introduction

The Board of Trustees of the Bakery and Confectionery Union and Industry International Health Benefits Fund (“the Fund”) sponsors and administers this health care plan and several others. This Notice applies to all of these health plans. This Notice refers to the Fund’s health plans as the “Plans.”

The Plans’ Duties

1. Safeguard The Privacy Of Your Protected Health Information (“PHI”). Federal law requires that the Plans safeguard the

privacy of your “protected health information” or PHI. “PHI” includes individually identifiable information created, received or maintained by, or on behalf of, the Plans relating to your past, present or future physical or mental health condition, treatment for that condition, or payment for that treatment.

2. Notify You Of The Plans’ Privacy Policies. Federal law requires that the Plans notify you of their legal duties and privacy policies and procedures with respect to your PHI. This Notice is intended to satisfy that requirement.

3. Use And Disclose Your PHI Only As Described In This Notice. The Plans will abide by the terms of this Notice as long as it remains in effect. The Plans will use and disclose your PHI only as described in this Notice unless it requests and obtains your written authorization. If the Plans obtain your written authorization for a use or disclosure not described in this Notice, you may revoke or modify that authorization at any time by submitting the appropriate form to the Privacy Official designated on page 14 below. The Privacy Official will provide you with a copy of the form upon request.

How The Plans Will Use And Disclose Your PHI Without Your Authorization

1. UsesAndDisclosuresForTreatment. ThePlansmayuseanddisclose your PHI for “treatment.” “Treatment” includes the provision, coordination or management of health care and related services by one or more health care providers. For example, the group health plan may assist in coordinating health care and related benefits.

2. Uses And Disclosures For Payment. The Plans will use and disclose your PHI for “payment.” “Payment” includes, but is not limited to, claims processing, claims payment, payroll deductions, eligibility determinations, and claims disputes. For example, the Plans will use your PHI to determine whether you are entitled to benefits, and, if you are, to determine your benefits.

3. Uses And Disclosures For Health Care Operations. The Plans

will use and disclose your PHI for “health care operations.” “Health care operations” include, but are not limited to, securing or placing a contract for reinsurance of risk relating to claims for health care; arranging for medical review, legal services, and auditing functions; fraud and abuse detection programs; business planning and development; investigating and resolving complaints of privacy violations; and business management and general administrative activities. For example, the Plans may disclose PHI as part of an investigation into a fraudulent claim.

4. Disclosures To The Plans’ Sponsor. The sponsor of the Plans is the Board of Trustees. The Plans will disclose your PHI to the Fund’s employees responsible for “plan administration functions.” Plan administration functions include, but are not limited to, claims processing, eligibility determinations, and appeals from denials of coverage. The Fund employees are prohibited from using or disclosing your PHI for employment-related decisions.
5. Disclosures To Business Associates. The Plans have contracted with one or more third parties (each of them is referred to as a business associate) to use and disclose your PHI to perform services for the Plans. The Plans will obtain each business associate’s written agreement to safeguard your PHI.
6. Information-Sharing Among The Plans. The Fund’s health plans will share PHI with each other, and with business associates, as permitted by state and federal law, to carry out treatment, payment or health care operations.

How The Plans Might Use Or Disclose Your PHI Without Your Authorization

Federal law generally permits the Plans to make certain uses or disclosures of PHI without your permission. Federal law also requires the Plans to list in the Notice each of these categories of uses and disclosures. The listing is below.

1. Uses Or Disclosures Required By Law. The Plans may use or disclose your PHI as required by any statute, regulation, court order or other mandate enforceable in a court of law.
2. Disclosures For Workers' Compensation Purposes. The Plans may disclose your PHI as required or permitted by state or federal workers' compensation laws.
3. Disclosures To Family Members Or Close Friends. The Plans may disclose your PHI to a family member or close friend who is involved in your care or payment for your care if (a) you are present and agree to the disclosure, or (b) you are not present or you are not capable of agreeing, and the Trustees or their authorized representative determines that it is in your best interest to disclose the information.
4. Disclosures For Judicial And Administrative Proceedings. The Plans may disclose your PHI in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. The Plans will disclose your PHI in these circumstances only if the requesting party first provides written documentation that the privacy of your PHI will be protected.
5. Disclosures For Law Enforcement Purposes. The Plans may disclose your PHI for law enforcement purposes to a law enforcement official, such as in response to a grand jury subpoena.
6. Incidental Uses And Disclosures. The Plans may use or disclose your PHI in a manner which is incidental to the uses and disclosures described in this Notice.
7. Disclosures For Public Health Activities. The Plans may disclose your PHI to a government agency responsible for preventing or controlling disease, injury, disability, or child abuse or neglect. The Plans may disclose your PHI to a person or entity regulated by the Food and Drug Administration ("FDA") if the disclosure relates to the quality or safety of an FDA-regulated product, such as a medical device.

8. Disclosures For Health Oversight Activities. The Plans may disclose your PHI to a government agency responsible for overseeing the health care system or health-related government benefit programs.
9. Disclosures About Victims Of Abuse, Neglect, Or Domestic Violence. The Plans may disclose your PHI to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) the Plans are required or permitted by law to make the disclosure. The Plans will promptly inform you that such a disclosure has been made unless the Plans' Privacy Official determines that informing you would not be in your best interests.
10. Uses And Disclosures To Avert A Serious Threat To Health or Safety. The Plans may use or disclose your PHI to reduce a risk of serious and imminent harm to you, another person or to the public.
11. Disclosures To HHS. The Plans may disclose your PHI to the United States Department of Health and Human Services ("HHS"), the government agency responsible for overseeing the Plans' compliance with federal privacy law and regulations regulating the privacy of PHI.
12. Uses And Disclosures For Research. The Plans may use or disclose your PHI for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.
13. Disclosures In Connection With Your Death Or Organ Donation. The Plans may disclose your PHI to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.
14. Uses And Disclosures For Specialized Government Functions. The Plans may disclose your PHI to the appropriate federal officials for intelligence and national security activities authorized by law or to protect the President or other national or foreign leaders. If you are a member of the U.S. Armed Forces

or of a foreign armed forces, the Plans may use or disclose your PHI for activities deemed necessary by the appropriate military commander. If you were to become an inmate in a correctional facility, the Plans may disclose your PHI to the correctional facility in certain circumstances.

If applicable State law does not permit the disclosure described above, the Plans will comply with the stricter State law.

The Plans' Disclosures With Your Prior Authorization

The Plans are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. The Plans also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records.

Prohibition On The Plans' Use And Disclosure Of Your PHI

The Plans are prohibited from using or disclosing your PHI that is genetic information for "underwriting purposes." Underwriting purposes includes determination of eligibility for, or benefits under, any of the Plans; computation of premium or contribution amounts under any of the Plans; application of any pre-existing condition exclusion under any of the Plans; and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Your Privacy Rights As A Participant In One Or More Of The Plans

As a participant in the Plans, you may exercise the rights described below. The forms referenced below can be obtained from the Fund's Privacy Official (the "Privacy Official").

1. Right To Access Your PHI. You may ask to review your PHI

on file with the Plans, or to receive copies of it in paper or electronic form, by submitting the appropriate form to the Privacy Official. The Plans will provide access, or will deliver copies to you, within 30 days of your request. The Plans may extend the deadline by up to an additional 30 days. The Plans will provide you with a written explanation of any denial of your request for access or copies. The Plans may charge you a reasonable, cost-based fee for copies or for delivery. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

2. Right To Amend Your PHI. You may amend your PHI on file with the Plans by submitting the appropriate request form to the Privacy Official. The Plans will respond to your request within 60 days. The Plans may extend the deadline by up to an additional 30 days. If the Plans deny your request to amend, the Plans will provide a written explanation of the denial. You would then have 30 days to submit a written statement explaining your disagreement with the denial. Your statement of disagreement would be included with any future disclosure of the disputed PHI.
3. Right To An Accounting Of Disclosures Of Your PHI. You may request an accounting of the Plans' disclosures of your PHI by submitting the appropriate form to the Privacy Official. The Plans will provide the accounting within 60 days of your request. The Plans may extend the deadline by up to an additional 30 days. The accounting will exclude the following disclosures: (a) disclosures for "treatment," "payment," or "health care operations"; (b) disclosures to you or pursuant to your authorization; (c) disclosures to family members or close friends involved in your care or in payment for your care; (d) disclosures as part of a data use agreement; and (e) incidental disclosures. The Plans will provide the first accounting during any 12-month period without charge. The Plans may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

4. Right To Request Additional Restrictions On The Use Or Disclosure Of Your PHI. You may request that the Plans place restrictions on the use or disclosure of your PHI for “treatment,” “payment,” or for “health care operations” in addition to the restrictions required by federal law by submitting the appropriate request form to the Privacy Official. The Plans will notify you in writing within 30 days of your request whether the Plans will agree to the requested restriction. The Plans are not required to agree to your request.

5. Right To Request Communications By Alternative Means Or To An Alternative Location. The Plans will honor your reasonable request to receive PHI by alternative means, or at an alternative location, if you submit the appropriate request form to the Privacy Official.

6. Right To Receive Notice Of A Breach Of Your Unsecured PHI: If the Plans discover a breach of your unsecured PHI, the Plans will notify you of the breach and provide the information required by law.

7. Right To A Paper Copy Of This Notice. You may request at any time that the Privacy Official provide you with a paper copy of this Notice.

A Note About Personal Representatives

All of the rights described above may be exercised by your personal representative after the personal representative has provided proof of his or her authority to act on your behalf. Proof of authority may be established by (a) a power of attorney for health care purposes, or a general power of attorney, notarized by a notary public; (b) a court order appointing the person to act as your conservator or guardian; or (c) any other document which the Privacy Official, in his or her sole and absolute discretion, deems appropriate.

Your Right To File A Complaint

If you believe that your privacy rights have been violated because any of the Plans has used or disclosed your PHI in a manner inconsistent

with this Notice, because any of the Plans has not honored your rights as described in this Notice, or for any other reason, you may file a complaint in one, or both, of the following ways:

1. Internal Complaint: Within 180 days of the date you learned of the conduct, you can submit a complaint using the appropriate complaint form to the Privacy Official, c/o Bakery and Confectionery Union and Industry International Health Benefits Fund, 10401 Connecticut Ave., Kensington, MD 20895, or call 301-468-3731 and ask for the HIPAA Privacy Officer. You can obtain a complaint form from the Privacy Official.
2. Complaint To HHS: Within 180 days of the date you learned of the conduct, you may submit a complaint by mail to the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C. 20201.

The Plans' Anti-Retaliation Policy

The Plans will not retaliate against you for submitting an internal complaint, a complaint to HHS, or for exercising your other rights as described in this Notice or under applicable law.

Whom To Contact For More Information About The Plans' Privacy Policies And Procedures

If you have any questions about this Notice, or about how to exercise any of the rights described in this Notice, you should contact the Plans' Privacy Official by mail c/o Bakery and Confectionery Union and Industry International Health Benefits Fund, 10401 Connecticut Ave., Kensington, MD 20895, or call 301-468-3731 and ask for the HIPAA Privacy Officer.

Revisions To The Privacy Policy And To The Notice

The Plans have the right to change this Notice or the Plans' privacy policies and procedures at any time. If the change to the Plans' privacy policies and procedures would have a material impact on your rights, the Plans will notify you of the change by mailing (either electronically or by

U.S. Postal Service) a revised Notice to you, in accordance with applicable regulations, which reflects the change. Any change to the Plans' privacy policies and procedures, or to the Notice, will apply to your PHI created or received before the revision.

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

Employer Identification Number: 53-0227042

Plan Number: 501

Plan Year: January 1 - December 31

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

ARTICLE I DEFINITIONS

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

Section 1.1. Board. The persons from time to time who are acting collectively as the Board of Trustees of the Fund appointed to control and manage the operation and overall administration of the Fund.

Section 1.2. Covered Employment. Employment by an Employer under an agreement that requires the Employer to contribute to the Fund for benefits under the Plan, or by the Fund or the Pension Fund.

Section 1.3. Dependent. A Dependent includes: (a) a Participant's spouse, (b) each of the Participant's unmarried children or stepchildren (or persons for whom the Participant has been appointed legal guardian) from birth until his or her 19th birthday (or 23rd birthday if living at home and registered as a full-time student of an accredited educational institution); (c) each of the Participant's unmarried children or stepchildren who resides in the United States or Canada who is wholly dependent upon the Participant for support and who is incapable of self-support because of mental or physical incapacity that existed prior to reaching 19 years of age and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months; and (d) any Alternate Recipient as identified in and as required by any Qualified Medical Child Support Order, but only to the extent required by such Qualified Medical Child Support Order. A Dependent who is a student in an accredited educational institution will continue to be eligible as a Dependent for up to one year during a leave of absence or other change in enrollment that would otherwise result in loss of Dependent status, if the Fund Office receives written certification from the Dependent's treating physician that the leave of absence or other change in enrollment status is medically necessary because of a serious illness or injury. The extension of eligibility described in the immediately preceding sentence will begin on the first day of the medically necessary leave of absence or other change in enrollment status, and will end upon the earlier of (a) the Dependent's resumption of full-time student status; (b) the passage of

one year; or (c) the occurrence of any event that would have terminated the student's eligibility as a Dependent for a reason other than not being enrolled as a full-time student. Any Dependent (as defined in this section) who does not meet the age or support requirements applicable under Internal Revenue Code Section 106 for nontaxable health coverage, may be covered by the Fund only upon the timely payment of amounts set from time to time by the Fund Office as the amount that the Fund is required to withhold in taxes for the health coverage. A Dependent will be eligible for benefits only if he or she was enrolled as specified in Section 2.2(c) and if his or her eligibility for benefits has not been terminated as specified in Section 2.5. A Dependent who is not yet eligible for Medicare will receive benefits under Plan W-1, which is described in a separate booklet. You can obtain a copy of that booklet by making a request to the Fund Office at the address on page 13.

Section 1.4. Employer. Any of the following that becomes a party to the standard collective bargaining clause prescribed by the Trustees:

- (a) A signatory to a collective bargaining agreement with a Local Union that requires contributions to the Fund on behalf of all employees who work in the bargaining unit that is covered by that collective bargaining agreement.
- (b) A Local Union that has signed a written agreement with the Fund agreeing to make contributions to the Fund on behalf of all of its full-time salaried employees, or that has executed a collective bargaining agreement with a labor organization providing for contributions to the Fund on behalf of all employees who work in the bargaining unit that is covered by that collective bargaining agreement.
- (c) The Union.
- (d) The Fund.
- (e) The Pension Fund.
- (f) A Federal Credit Union that is affiliated with or sponsored by a Local Union, where a written agreement is in effect between such credit union and the Fund providing for contributions to be made to the Fund on behalf of its employees.

Section 1.5. Fund. The Bakery and Confectionery Union and Industry International Health Benefits Fund.

Section 1.6. Local Union. Any local union affiliated with the Union.

Section 1.7. Participant. A Pensioner who has met the requirements set forth in Sections 2.1 and 2.2 to receive benefits from the Plan, and whose eligibility for benefits has not terminated as specified in Section 2.5. When this Summary Plan Description uses the term “You,” it means Participants or (as used in Article 2) employees who may become Participants.

Section 1.8. Pension Fund. The Bakery & Confectionery Union and Industry International Pension Fund.

Section 1.9. Pensioner. An individual who is receiving benefits from the Pension Fund or another pension plan sponsored by an Employer.

Section 1.10. Plan. This Pensioner’s Health Benefits Plan, which is maintained under the Fund and which also includes Plan W-1 benefits for pensioners who are not yet eligible for Medicare.

Section 1.11. Spouse. The person to whom a Participant is lawfully married.

Section 1.12. Union. The Bakery, Confectionery, Tobacco Workers and Grain Millers International Union.

ARTICLE 2

ELIGIBILITY AND ENROLLMENT

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

- (a) You must be a Pensioner – that is, you must be receiving pension benefits from the Pension Fund or from another pension plan sponsored by an Employer.
- (b) You must generally become eligible to become a Pensioner no later than four months after leaving continuous Covered Employment (as defined below). However, if you have 15 or more years of pension credit under the Pension Fund (or an equivalent amount of pension credit under another pension plan to which

your former Employer contributes, as determined by the Board), you must become eligible to become a Pensioner no later than three years (or five years, if you ceased Covered Employment as a result of a permanent reduction in workforce) after leaving continuous Covered Employment (as defined below).

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

- (c) If you are a Pensioner of a business unit or group purchased or otherwise acquired by an Employer, you will be eligible to be a Participant if all of the following conditions are satisfied:
- (1) You are currently receiving retiree health benefits under another plan;
 - (2) When you were working for the unit or group acquired by the Employer, you worked in a job classification, or performed work, similar to the job classification or work of employees for whom the Employer makes contributions to this Plan; and
 - (3) The Employer enrolls you in this Plan within 91 days of the acquisition by paying the appropriate monthly premium established by the Trustees.

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

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

- (a) Age 65 and Older. If you are age 65 or older when you become a Pensioner, you may enroll in the Plan at either of the following times: (i) when you receive your first pension check, or (ii) during the 90 days following the expiration of your coverage under the Fund or another employer health benefits plan (including coverage as a dependent, or COBRA continuation coverage). If

you do not enroll in the Plan at one of these times, you will not be eligible to enroll at any other date.

- (b) Under Age 65. If you are under age 65 when you become a Pensioner you may enroll in the Plan at any of the following four times: (i) when you receive your first pension check; (ii) during the 90 days following the expiration of your coverage under the Fund or other employer health benefits plan (including coverage as a dependent or COBRA continuation coverage); (iii) during the 90 days following the date on which you enroll in Medicare Part A and B prior to age 65 or (iv) if your pension began after December 31, 1988, when you reach age 65. If you do not enroll in the Plan at one of these four times, you will not be eligible to enroll at any other date.
- (c) Dependents. You must generally enroll Dependents at the same time that you enroll yourself, with the following exceptions:
- (1) If you have a Dependent who is eligible for coverage under the Fund as an active employee or dependent of an active employee, that Dependent is not eligible for coverage under the Plan. You may enroll your Dependent in the Plan at any time during the 90 days following the date on which the Dependent's coverage under the Fund as an active employee or a dependent of an active employee (including any extension of coverage that your Dependent elects under COBRA) ceases.
 - (2) If you have a Dependent who is covered under another plan of group health insurance sponsored by an employer, you may enroll that Dependent in the Plan at any time during the 90 days following the date on which that Dependent's coverage under the other group health insurance (including any extension of coverage that your Dependent elects under COBRA) ceases.
 - (3) If you become a Pensioner and enroll in the Plan before you reach age 65, you may defer enrolling your Dependents until you reach age 65.
 - (4) If an employee becomes a Pensioner before age 65, elects to defer enrollment, and dies before reaching age 65, the Pensioner's surviving spouse may enroll himself or herself (and any Dependents that were the employee's Dependents when the employee died) in the Plan upon reaching age 65

or, if he or she is already age 65, within 90 days following the Pensioner's death.

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

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

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

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

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

- (1) You will cease to be a Participant, and benefits under the Plan to you and your Dependents will cease, on the first day

of the first month for which you fail to pay (or have deducted from your pension check) your full monthly premium in a timely manner.

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

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

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

provided in Section 2.2(b).

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

Section 2.6. Re-Enrollment.

- (a) Except as noted below, if your enrollment in the W-Plans ceases for any reason, you will not be permitted to re-enroll at a later date.
- (b) On or after December 3, 1998, (i) if you had previously ceased enrollment in the W-Plans due to enrollment in a Medicare HMO, and the HMO subsequently ceases doing business in the geographic area in which you reside, you may re-enroll in the W-Plans if you elect to do so within 90 days of your loss of coverage under the HMO; (ii) if you become a Participant before age 65 and after December 31, 1988 and you stop paying premiums before age 65, you will have an opportunity to re-enroll at age 65.

Section 2.7. Qualified Medical Child Support Orders. The Fund pays benefits to alternate recipients as identified in and required by a Qualified Medical Child Support Order (QMCSO). If you need information regarding the qualification of a QMCSO, or the Fund's Rules and Procedures governing QMCSOs, contact the Fund Office, and copies of

these documents will be provided to you without charge.

ARTICLE 3 BENEFITS

Section 3.1. Hospital and Medical Benefits that are provided under this Plan to Medicare-eligible Pensioners and Dependents are described in detail in UnitedHealthcare's benefit summaries. The summaries of benefits that UnitedHealthcare offers in your geographic area will be provided to you annually. In certain limited areas, UnitedHealthcare is not able to offer the benefits described in Sections 3.1(a) and (b); if you live in one of those areas, you will be offered a Medicare Supplement program sponsored by UnitedHealthcare.

- (a) The coverage available to you depends on whether your last Employer is still making contributions to the W-Plan. If your last Employer is still making contributions, you will be offered a choice between Plan W-300 and Plan W-301. If your last Employer has stopped making contributions to the W-Plan, but you are eligible to continue coverage as an "orphan" under Section 2.5(b), you will be offered a choice between Plan W-200 and Plan W-201.
- (b) In order to meet the needs of pensioners who have different financial circumstances, the Plan offers different levels of coverage at different costs. Plans W-200 and W-300 are "low option" plans. They provide a lower level of benefits for a lower monthly premium. If you choose W-200 or W-300, you will have higher copayments for certain services, and the amount that the insurer will pay for other services may be limited. Plans W-201 and W-301 are "high option" plans. If you choose one of those plans, you will pay a higher monthly premium but a greater portion of your medical costs will be covered.
- (c) The UnitedHealthcare detailed description of the benefits of the plan that you choose becomes a part of this Summary Plan Description. Be sure to retain a copy of the detailed summary of benefits that UnitedHealthcare provides you, and keep it with your copy of this booklet.
- (d) No matter which plan of benefits you choose, you must enroll in Medicare – both Parts A and B – to be eligible for the benefits.

Section 3.2. Prescription Drug Benefits are provided to you and your enrolled Dependents who are age 65 or older (or eligible for early Medicare) through a Medicare Part D prescription drug plan (PDP) administered by UniCare. You will receive from UniCare an Evidence of Coverage booklet that tells you how to get your Medicare prescription drug coverage through this plan. The booklet explains your rights and responsibilities, what is covered, and what you pay as a participant in the plan. Be sure to retain a copy of that information and keep it with this booklet.

ARTICLE 4

COBRA CONTINUATION COVERAGE

Section 4.1. General. Your Dependents are entitled to a temporary extension of health coverage (called “COBRA continuation coverage”) at group rates, but at their expense, in certain circumstances where their coverage under the Fund would otherwise end. The following events will entitle your Dependents (“eligible individuals”) to elect COBRA continuation coverage:

- (a) Your spouse has the right to choose COBRA continuation coverage for himself or herself if he or she would otherwise lose coverage under the Fund because of divorce.
- (b) Each of your non-spouse Dependents has the right to choose COBRA continuation coverage if he or she would otherwise lose coverage under the Fund because of your death or divorce, or because he or she ceases to qualify as a Dependent.

Section 4.2. Required Notices to the Fund. You or Your Dependents have the responsibility to inform the Fund of a divorce or a child losing Dependent status. When the Fund is notified that one of these events has happened, the Fund will in turn notify your Dependents of the right to choose COBRA continuation coverage.

Section 4.3. Choosing COBRA Continuation Coverage. Eligible individuals have 60 days to inform the Fund that they want COBRA continuation coverage, starting from the date they would otherwise lose coverage because of one of the events described above. If an eligible individual does not choose COBRA continuation coverage within that 60-

day period, his or her coverage under the Fund will end. If an eligible individual chooses COBRA continuation coverage and pays the required premium, the Fund will give that individual the same coverage that, as of the time coverage is being provided, it provides to similarly situated individuals. A Participant who has entered active duty in the United States Armed Forces will not be required to pay COBRA premiums for the first 30 days of that active duty.

Section 4.4. Duration of COBRA Continuation Coverage. Eligible individuals generally may maintain COBRA continuation coverage for up to 3 years. However, COBRA continuation coverage may be cut short for any of the following reasons: your former Employer no longer provides group health coverage to any of its employees or ceases to contribute to the Plan; the eligible individual does not pay the premium for COBRA continuation coverage on time; the eligible individual becomes covered, following the individual's election of COBRA under this Fund, under any other group health plan that does not limit coverage for the individual's pre-existing conditions; or the eligible individual becomes, following the individual's election of COBRA under this Fund, entitled to benefits under and enrolled in Medicare.

ARTICLE 5

CLAIMS PROCEDURES

Section 5.1. Review of UnitedHealthcare or UniCare Benefits Determinations. If you disagree with any determination made by UnitedHealthcare or UniCare as to benefits for yourself or a Dependent covered by the Plan, you must follow the procedures that are described in the UnitedHealthcare booklet (for medical, hospital, or surgical benefits) or the procedures that are described in the UniCare booklet (for prescription drug benefits) in order to obtain review of that determination.

Section 5.2. Review of Eligibility Determinations. If you disagree with any determination made by the Fund Office on a question of eligibility for benefits under the Plan, this Section 5.2 describes the exclusive procedure for obtaining a review of that determination.

- (a) The time limit for requesting the Board's Appeals Committee to

review the eligibility determination is 180 days after you receive the notice of that determination.

- (b) You or your authorized representative must submit a written request for review to the address on page 13.
- (c) Upon request, you will be provided reasonable access to and copies of documents, records or other information relevant to the eligibility issue, without regard to whether such documents, records and information were considered or relied upon in making the adverse determination that is the subject of the appeal.
- (d) You may submit issues and comments in writing in support of your appeal.
- (e) The Appeals Committee will consider the appeal *de novo*, without any deference to the initial determination. The Appeals Committee will not include any person who participated in the initial determination or who is the subordinate of a person who participated in the initial determination.
- (f) The Appeals Committee will make a decision on your appeal at its next regularly scheduled meeting or, if the request is received fewer than 30 days before that meeting, at the following regularly scheduled meeting. In special circumstances, the decision may be made at the third regularly scheduled meeting following receipt of your request, but in this event you will be notified of the delay and will be given an estimated date by which a decision is expected. The decision of the Appeals Committee will be in writing and will include the reasons for the decision and specific references to plan provisions on which the decision is based. In all cases, the decision on review will be final and binding on all parties, subject to your rights under ERISA. If for any reason the Fund fails to follow any of the claims procedures outlined above, you may pursue any rights you have for judicial review of your claim.
- (g) If you do not appeal an eligibility determination within 180 days after receiving the notice of that determination, as described in Section 5.2(a), the Fund's eligibility decision will be final and not subject to any further review.

Section 5.3. Applicable Regulations. The claims procedures in Article 5 will be construed and applied in all cases to conform to the applicable regulations of the United States Department of Labor.

ARTICLE 6

ACTIONS OF THE BOARD

Section 6.1. Contribution Rates. The Board shall set the rates at which Participants and Employers contribute to the Fund for coverage under the Plan, and may change such rates from time to time in its discretion, as provided by Section 6.2.

Section 6.2. Board Discretion. The Board (and any committee of the Board) shall have the exclusive authority, in its sole and absolute discretion, to: (i) take all actions necessary to administer the Plan; (ii) apply and interpret the rules set forth in this booklet; (iii) take all actions and make all decisions concerning the eligibility for, and the amount of, benefits payable under the Plan; and (iv) resolve and/or clarify any ambiguities, inconsistencies and omissions that may arise under this booklet.

Section 6.3. Modification or Termination of the Fund. The Board intends for the Plan and the Fund to be in effect permanently. However, the Board reserves the right to amend, modify, or discontinue all or part of the Plan and/or the Fund whenever, in its judgment, conditions so warrant. In the event of Plan termination, any remaining assets will be used first to provide benefits under the Fund's plan of benefits to Fund Participants until all assets are exhausted. If there are any surplus assets, those assets will be used to provide health benefits to Plan Participants and beneficiaries, in a manner determined by the Fund's Trustees in their sole and absolute discretion, consistent with the provisions of the Fund's Trust Agreement and applicable law.

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