PUBLISHERS'-PRESSMEN'S

WELFARE FUND

SUMMARY PLAN DESCRIPTION

FOR RETIRED EMPLOYEES

AGE 65 OR OVER

May 1, 2012

TABLE OF CONTENTS

PUBLISHERS'-PRESSMEN'S WELFARE FUND

A Summary Plan Description for Retired Employees Age 65 or Over of employers who are required to contribute to the Publishers'-Pressmen's Welfare Fund pursuant to a collective bargaining agreement with the New York Newspaper Printing Pressmen's Union No. Two.

Dear Member:

The Board of Trustees of the Publishers'-Pressmen's Welfare Fund is pleased to present you with this updated description of the health and welfare benefits for eligible retired employees and their eligible spouses. A separate Summary Plan Description describes the benefits available for active employees and retired employees less than age 65.

As you look through this booklet, you will learn how you become eligible for benefits, what your benefits are and how you claim them. Be sure to share this booklet with members of your family. We have tried to make it as easy to read as possible by presenting the information about your benefits in everyday language. For instance, the "Highlights of Your Welfare Fund Program for Retired Employees" section helps you see your benefits at a glance. (Of course, you should read further for details of those benefits.)

The Trustees may modify or eliminate any benefits and the eligibility requirements for benefits described in this booklet. The Trustees have the authority and discretion to interpret the Plan and to make final determinations regarding benefits. Neither employment nor benefits are guaranteed. Under no circumstances will any Plan benefits become vested or non-forfeitable with respect to active or retired employees or their beneficiaries or dependents.

This booklet, called the "Summary Plan Description" or "SPD", summarizes the key features of the Plan that were in effect as of May 1, 2012 (unless specified otherwise herein). Complete details of the Plan are also contained in the other official Plan documents, including the Agreement and Declaration of Trust that created the Fund, which legally govern the operation of the Plan. All official Plan documents are available for your inspection at the Fund Office during normal business hours, and all statements made in this booklet are subject to the provisions and terms of those documents. In case of a conflict or inconsistency between the official Plan documents and this booklet, the official documents will govern in all cases.

If you have any questions about your benefits, please feel free to contact the Publishers'-Pressmen's Benefits Fund office at 1501 Broadway, Suite 1724, New York, New York 10036, (212) 869-5994.

HIGHLIGHTS OF YOUR WELFARE FUND PROGRAM FOR RETIRED EMPLOYEES AGE 65 OR OVER

The Plan is supplemental to benefits that are provided by Medicare. It is your responsibility to enroll in Medicare as soon as your active employee benefits terminate. Before the Plan pays benefits, Medicare must first provide you with an explanation of benefits.

IMPORTANT: Effective January 1, 2011, the Plan no longer provides prescription drug coverage to eligible participants aged 65 and over and their eligible spouses aged 65 and over. In order to obtain coverage for your prescription drugs, you must enroll in a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

For More Information About Your Options Under Medicare Prescription Drug Coverage …

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage may also be available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

BENEFITS

Hospital Benefit (per covered person each calendar year)

The Welfare Fund pays the Medicare deductible, *i.e.* the first day in-hospital deductible, and the Medicare co-payment (you must use your lifetime reserve). Benefits are coordinated with Medicare Part A.

- **Major Medical Benefit (per covered person each calendar year)**
  - **The Welfare Fund administers this coverage**
- you pay a $300 individual deductible
- the Plan pays 80% of 20% (*i.e.* 16%) of the Medicare-approved rate

- $1 million lifetime maximum per person (which includes charges incurred under the Publishers'-Pressmen's Welfare Fund prior to qualifying for this retirees-over-65 coverage)

ELIGIBILITY FOR BENEFITS

WHO IS ELIGIBLE?

For Yourself

You are eligible for benefits under this Plan if you:

- have retired prior to age 65 and elect to continue coverage at age 65, when you normally become eligible for Medicare benefits, or
- retire at age 65 or older with five years of Credited Service, or
- retire due to a total and permanent disability and you are eligible at the time of retirement for Medicare benefits and you are (a) at least 55 years of age with fifteen years of Credited Service or (b) you have completed twenty years of Credited Service regardless of age.

VERY IMPORTANT: Retiree coverage is not available if you initially elect severance or terminate your employment with a right to a deferred (or vested) pension. In other words, to qualify for retiree health benefits under the Plan, you must have been an active employee with a right to immediate pension benefits from the Pressmen's-Publishers' Pension Fund at the time you lost your eligibility for health benefits as an active employee of a contributing employer.

For Your Spouse

Your Spouse (*i.e.,* an individual to whom you are legally married under federal law) is eligible for benefits under this Plan if:

- you are eligible for benefits under this Plan, and
- your Spouse is age 65 or over and eligible for Medicare benefits.

Benefits for a retired employee less than age 65 and eligible dependents less than age 65 are described in a separate booklet. If you are under 65 but your Spouse is 65 or older, your Spouse's benefit is described in this booklet but your benefit is described in the separate booklet. The separate booklet is available free of charge from the Fund Office.

Is Coverage Automatic or Must I Enroll?

You must enroll for coverage and you must elect retiree coverage at the time of enrollment for yourself and your eligible Spouse. If you are declining enrollment for yourself or your eligible Spouse because of other health insurance coverage, you must inform the Welfare Fund in writing that such other coverage is the reason you are declining coverage under this Plan. In that event, you may be able to enroll yourself and your eligible Spouse in this Plan if you request enrollment within 30 days after your other coverage ends. **However, if you do not elect coverage when**

you first become eligible, or if you fail to inform the Welfare Fund in writing that you are declining initial enrollment because of other health insurance coverage at that time, you forfeit the right to participate in this Retiree Welfare Plan entirely.

If you have any questions about enrollment, please call the Fund Office at (212) 869-5994

What Should I do if My Family Status Changes?

You should notify the Fund Office within 30 days of a change in family status (e.g., if you marry, divorce, are legally separated, or if you or your eligible Spouse dies). If you have any question about a change in family status, please call the Fund Office at (212) 869-5994 as soon as possible.

Qualified Medical Child Support Orders

Federal law requires group health plans to honor Qualified Medical Child Support Orders ("QMCSOs"). In general, QMCSOs are orders issued by a state court or state administrative agency requiring that medical coverage be provided under a plan for a child or children. A QMCSO usually results from a divorce, legal separation or paternity proceeding.

A QMCSO may require the Fund to make coverage available to your child even though, for income tax or Fund purposes, the child is not your dependent due to divorce or legal separation. In order to qualify as a QMCSO, the medical child support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- specifies your name and last known address, and the child's name and last known address;
- provides a reasonable description of the type of coverage to be provided by the Fund, or the manner in which the type of coverage is to be determined;
- states the period to which it applies; and
- specifies the plan to which it applies.

The QMCSO may not require the Fund to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Plan.

Upon approval of a QMCSO, the Fund is required to pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order to the extent it is consistent with the terms of the Plan.

You and the affected child will be notified if an order is received and will be provided with a copy of the Fund's QMCSO procedures. A child covered under the Fund pursuant to a QMCSO will be treated as an eligible dependent child under the Plan.

For further details on QMSCOs and how you should proceed if you receive a medical child support order, you should contact the Plan Administrator. Further, you may obtain, without charge, a copy of the Plan's "Procedures for Determining the Qualified Status of a Medical Child Support Order" from the Plan Administrator.

CONTRIBUTIONS TO THE COST OF COVERAGE

Contributions for health care coverage under this Plan are determined annually by the Fund's actuary. The Fund Office will tell you the specific amount of your required contributions at the time you enroll and elect coverage under this Plan, and will also inform you thereafter of any changes in the amount of your required contributions.

Participants who fail to pay required contributions by the first of the month following the month for which such contributions are due will have their benefits cancelled.

BENEFITS

HOSPITAL AND MAJOR MEDICAL

Under this Plan, the supplemental hospital and major medical coverage for a retiree age 65 or older or an eligible Spouse age 65 or older is coordinated with Medicare (Part A, hospital; Part B, medical). This rule applies even if you have not enrolled for Medicare. In order to receive the most coverage, therefore, you should enroll in Medicare for yourself (and your spouse, if age 65 or older) as soon as your active employee benefits terminate. Otherwise, you will be treated as though Medicare paid your benefits even though it did not.

The Plan will cover only expenses normally covered by Medicare — and will supplement the benefits that Medicare provides, up to the applicable Medicare-approved amount.

CLAIMING BENEFITS

COORDINATION OF BENEFITS WITH MEDICARE

The Plan supplements hospital and major medical benefits provided by Medicare. Since Medicare is the primary provider of benefits, any claims must first be submitted to Medicare before Plan benefits are payable.
These are the steps for reimbursement once you are eligible for Medicare:

Step 1: Have your doctor complete the claim form and submit the claim to Medicare

Step 2: Medicare will send you an Explanation of Benefits statement

Step 3: Medicare will electronically forward the supplementary portion of the claim to the Fund Office.

The Plan will not duplicate Medicare's benefits. In order to qualify for benefits, the Fund Office must receive a claim within one year of the date the expense was incurred or the services were rendered. It remains the responsibility of each participant to ensure that claims for payment are timely received by the Fund Office.

HOSPITAL

The Plan will pay for the first day in-hospital deductible (which is not covered by Medicare). Medicare Part A will generally pay 100% of the eligible charges for the remaining days of most hospital stays (up to 60 days).

MAJOR MEDICAL

As a general rule, Medicare Part B will pay 80% of the reasonable charges (as determined by Medicare) of these benefits, after you have paid the annual Medicare Part B deductible.

After you meet the Plan's medical deductible, the Plan will pay 80% of 20% (i.e. 16%) of the Medicare-approved charges. In addition, your payment of the annual Medicare Part B deductible will be applied toward the Plan's medical deductible of $300 per year.

For example: Jim is an eligible retiree who is over age 65. He has a $600 medical bill that he submits to Medicare. Assuming that Jim has already met the Medicare Part B deductible and the Plan's $300 deductible, his benefits would be paid as follows:

Assume Medicare approves $600 as the reasonable charge

Part B pays 80%	x	$600	=	$480
plus				
Plan pays 80% of 20% [i.e. 16%]	x	$600	=	$ 96
Total payment	=	96%	=	$576

Medicare has regulations that apply to the maximum amount that a doctor may charge. The Plan coordinates with Medicare by paying 16% of the amount Medicare approves. A doctor can charge more than this amount, up to limits set by law, in which case you are responsible for what the doctor charges above the usual, customary and reasonable amounts. For further information, check with your local Social Security office.

TIME LIMIT FOR FILING CLAIMS

All claims for benefits must be received by the Fund Office within one (1) year from the date the expense was incurred or the services were rendered. The Plan is not responsible for payment of any claims not actually received by the Fund Office. It remains the responsibility of each participant to ensure that claims for payment are timely received by the Fund Office. No Plan benefits will be paid for any claim not received by the Fund Office within one (1) year from the date the expense was incurred or the services were rendered.

NOTICE OF CLAIMS DECISIONS

Within a reasonable period of time, but not later than 30 calendar days after receipt of a claim, the Fund Office will notify you in writing of the Fund's determination with respect to your claim. If the Plan Administrator determines that an extension of the 30-day period is necessary due to matters beyond the Fund's control, the 30-day period will be extended for an additional 15 days, and you will be notified (within the initial 30-day period) of the circumstances necessitating the extension and the date by which the Fund expects to make a decision on the claim. If the extension is necessary due to your failure to provide sufficient information for the Fund to make a determination with respect to the claim, the Plan Administrator will notify you (within the initial 30-day period) what additional information is needed to complete the claim. You will have at least 45 days to provide the additional information. The 15-day period within which the Fund will issue its decision will be tolled from the date on which notice of the extension is sent to you until the earlier of: (i) the date you respond to the request for additional information or (ii) the end of the period within which you were required to provide the additional information.

NOTICE OF AN ADVERSE BENEFIT DETERMINATION

If your claim is denied, in whole or in part, or any other Adverse Benefit Determination has been made, you will be sent a written notice that will include, at a minimum, the following information, provided in a manner that is calculated to be understood by you:

- The specific reason(s) for the denial or other Adverse Benefit Determination;
- Reference to the specific Plan provision(s) on which the decision was based;
- When applicable, a description of any additional information or material necessary for the proper processing of the claim, and the reason(s) it is needed;
- A copy of the Plan's review procedures and time limits applicable to such review procedures, including a statement about your right to bring suit pursuant to Section 502(a) of ERISA.

REVIEW PROCEDURE IF YOUR CLAIM IS DENIED

1. If your claim is denied in whole or in part, or any other Adverse Benefit Determination is made, you have a right to request a review of that decision. In order to do so, you (or your authorized representative) must submit your written request for review **within 180 days after you receive notice of denial**. The address to which you must send your written request for review is:

   Publishers'-Pressmen's Benefits Fund
   1501 Broadway, Suite 1724
   New York, NY 10036

2. You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or if constitutes a statement of Plan policy regarding the denied treatment or service.
3. In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your Claim.
4. Your claim will be reviewed by a person other than the person who initially denied your claim. This second reviewer will not be a person subordinate to the person who initially denied your claim. The reviewer will not give deference to the initial adverse benefit determination. The review will take into account all comments, documents, records and other information, including such additional documents and comments that may be submitted by you.
5. A decision on review will be made within 60 days after receipt of your request for review. However, in special circumstances, an extension of time up to an additional 60 days may be necessary to reach a decision. You will be notified of the extension in writing within 60 days after receipt of your request for review if an extension of time will be necessary, and the extension notice will indicate the special circumstances requiring the extension as well as the date by the Fund expects to the determination on review to be made.

6. You will be notified of the determination in writing within 5 days after the determination is made. If an Adverse Benefit Determination is made on review, the notice will include the specific reason(s) for the determination, with references to the specific Plan provisions on which it is based.

DELAYED BENEFITS

The Plan will not pay interest on any delayed or late benefit payments, regardless of the reason or cause of the delay or late payment.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits with respect to any claim unless and until you have first requested a review and a final decision has been reached on review, or until 90 days have elapsed since you filed a request for review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. In addition, under no circumstances may any lawsuit be started more than two years after the time any claim must first be submitted.

WHEN DOES YOUR COVERAGE END?

Subject to the Plan's continued existence and the right of the Trustees to amend the Plan (See page 20 for more), your coverage under this Plan will continue until your date of death as long as you continue to timely pay your required contributions. If your contributions stop, your coverage will end as of the last day of the month for which contributions are paid.

Coverage for your Spouse ends on the earliest of the following events:

- your coverage ends. However, an eligible Spouse of a deceased retiree who is covered immediately prior to the death of the retiree will continue to be covered, as long as he or she timely pays the required contributions, or
- your Spouse is no longer eligible.

In certain cases, however, you or your Spouse may be eligible to elect continuation coverage. See the next section for details.

CONTINUATION OF COVERAGE

Under certain circumstances, you or your surviving Spouse can continue coverage after eligibility ends, but you (or your surviving Spouse) will have to pay for the cost of this coverage.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan in the event that you or your family members lose your coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you and your dependents need to do to protect the right to receive it.

The right to elect COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family who are covered under the Plan when you or they would otherwise lose group health coverage. This notice gives only a summary of your continuation coverage rights under the Plan. For additional information about your rights and obligations under the Plan (besides what is provided in this booklet), you can contact the Fund Office at the address and telephone number listed in this booklet.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of your health coverage under the Plan when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage is offered to each person who is a "qualified beneficiary." You or your spouse could become qualified beneficiaries if coverage

under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Note that, for purposes of COBRA and the section below, you can qualify as a "covered employee" if you elect retiree coverage under the Plan, provided that you are otherwise eligible for retiree benefits at the time you retire.

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the Plan because a proceeding in bankruptcy is filed with respect to your former employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan.

In addition to the above employee qualifying event, if you are the spouse of a covered employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because you become divorced or legally separated from your spouse.

Note that if you are the spouse of a covered employee and the covered employee dies while eligible for benefits, COBRA continuation coverage does not apply since an eligible Spouse who is covered immediately prior to the death of the covered employee will continue to be covered, as long as he or she timely pays the required contributions.

Notice of COBRA Qualifying Event

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is commencement of a proceeding in bankruptcy with respect to the former employer, the former employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (i.e., divorce or legal separation of the employee and spouse), you (or your spouse) must notify the Plan Administrator within 60 days after the date of the qualifying event. You must provide this notice in writing and send it to the Plan Administrator at the Publishers'-Pressmen's Benefit Funds Office at 1501 Broadway, Suite 1724, New York, NY 10036. Your written notice must include: (i) the name of the employee, (ii) the name(s) of the qualified beneficiary(ies) who will lose coverage due to the event, (iii) the type of qualifying event, and (iv) the date on which the event occurred. You can contact the Fund Office to obtain the appropriate form to provide this required notice.
You or your spouse (or any representative acting on behalf of either) can provide notice on behalf of yourself as well as other family members affected by the qualifying event.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified

beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of your health coverage under the Plan when coverage is lost due to certain qualifying events. When the qualifying event is divorce or legal separation, COBRA continuation coverage for the spouse can last for up to a total of 36 months. When the qualifying event is the former employer's filing of a bankruptcy petition under Title 11 of the United States Code, COBRA continuation coverage for the retiree and spouse can last up to the date of death of the retiree or the surviving spouse; if this occurs, you should contact the Plan Administrator concerning your rights.

Early Termination of Continuation Coverage

The law provides that continuation coverage may be cut short prior to the end of the maximum coverage period for any of the following reasons:

(1) The premium for continuation coverage is not timely paid (within the applicable grace period); or

(2) The group health coverage provided to you is terminated (and the Plan is not required by COBRA to provide you with other group health coverage that it maintains, if any);

(3) The individual first becomes, after electing COBRA coverage, covered under another group health plan (as an employee or otherwise) that does not contain any preexisting condition exclusion or limitation applicable to the individual.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Electing COBRA Coverage

Qualified beneficiaries have 60 days from the later of (i) the date of the loss of coverage because of the qualifying event, or (ii) the date they are furnished with a COBRA Election Notice, to elect COBRA continuation coverage. To elect continuation coverage, you must complete the Election Form (which will be mailed to you by the Fund Office once it has received notification of a qualifying event). Election Forms must be post-marked within that 60-day period and must be received by the Fund Office.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's Spouse may elect continuation coverage even if the employee does not. The employee or the employee's Spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

For each qualified beneficiary who timely elects and pays for COBRA continuation coverage, coverage will begin on the date that coverage under the Plan would otherwise have been lost due to the qualifying event. If you timely elect (and pay for) COBRA continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their spouses). If you do not timely elect (and pay for) COBRA continuation coverage, your health coverage under the Plan will end.

Paying for COBRA Coverage

The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and will also notify you of any changes in the monthly COBRA premium amount.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (The date your Election Form is post-marked will be used as the date of your election, if you decide to mail your payment.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund Office or refer to the Election Form you receive for this information.

Monthly payments for continuation coverage

After you make your initial premium payment, monthly premium payments are due on the first day of each month, and there will be a grace period of 30 days each month to make these payments. If a monthly payment is not made by the end of the applicable grace period, your (and your spouse's) COBRA coverage will terminate retroactive to the last date for which you timely paid for coverage. Premium payments must be post-marked within the applicable grace period and must be received by the Fund Office. The Plan will not send periodic notices of payments due.

Your first payment and all monthly payments for continuation coverage should be sent to:

Publishers'-Pressmen's Benefits Fund
1501 Broadway, Suite 1724
New York, New York 10036
Attention: Plan Administrator

If You Have Questions

If you have questions about your rights to COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

CERTIFICATE OF CREDITABLE COVERAGE

When your or your Spouse's coverage under the Plan ends, you and/or your Spouse are entitled by law to receive, and will be provided with, a "Certificate of Creditable Coverage", pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Certificates of Creditable Coverage indicate the period of time you and/or your Spouse were covered under the Plan (including, if applicable, COBRA continuation coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your Spouse become eligible for coverage under another group health plan, or if you buy for yourself and/or your Spouse a health insurance policy, within 63 days after your coverage under the Plan ends (including COBRA continuation coverage). The Certificate is necessary because it shows that you and/or your Spouse had prior health coverage that may reduce an exclusion for pre-existing conditions that may apply to you and/or your Spouse under the other group health plan or health insurance policy.

The Certificate of Creditable Coverage will be sent to you (and/or your Spouse) by the Plan Administrator by first class mail:

- automatically, when your (or your Spouse's) coverage under the Plan ends and you (or your Spouse) are entitled to elect COBRA continuation coverage,
- automatically, when your (or your Spouse's) coverage under the Plan ends, even if you (or your Spouse) are not entitled to elect COBRA continuation coverage, and
- automatically, when COBRA continuation coverage ends.

In addition, a Certificate of Creditable Coverage will be provided to you and/or your Spouse upon receipt of a written request for such a certificate if that request is received by the Plan Administrator within 24 months after the later of the date your coverage under this Plan ended or the date COBRA continuation coverage ended, if the request is addressed to:

Publishers'-Pressmen's Benefits Fund
1501 Broadway, Suite 1724
New York, NY 10036
ATT: Plan Administrator

Be sure to include your (or your Spouse's) current address in your request.

Certificates should be retained as proof of prior coverage for your new health plan. For further information, contact the Fund Office.

REIMBURSEMENT AGREEMENT (SUBROGATION)

Benefits payable by the Plan for the treatment of an illness or injury shall be limited in the following ways when the illness or injury is the result of an act or omission of another (including a legal entity) and when the participant or dependent pursues or has the right to pursue a recovery for such act or omission.

The Plan shall pay benefits for covered expenses related to such illness and injury only to the extent not paid by the third party and only after the participant or dependent (and his or her attorneys, if applicable) has entered into a written subrogation and reimbursement agreement with the Plan.

By accepting benefits related to such illness or injury, you agree:

- that the Plan has established a lien on any recovery received by you (or your dependent, legal representative or agent);
- to notify any third party responsible for your illness or injury of the Plan's right to reimbursement for any claims related to your illness or injury;
- to hold any reimbursement or recovery received by you (or your dependent, legal representative or agent) in trust on behalf of the Plan to cover all benefits paid by the Plan with respect to such illness or injury and to reimburse the Plan promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss;
- that the Plan has the right of first reimbursement against any award, recovery or other proceeds of any claim against the other person (whether or not the participant or dependent is made whole) and that the Plan's claim has first priority over all other claims and rights;
- to reimburse the Plan in full up to the total amount of all benefits paid by the Plan in connection with the illness or injury from any award, recovery or other proceeds payable by or received from a third party, regardless of whether the award, recovery or other proceeds is characterized or otherwise specifically identified as being on account of or as reimbursement of medical expenses. All awards, recoveries or other proceeds payable by or received from a third party, whether by demand, lawsuit, settlement, insurance or otherwise, must be turned over to the Plan as reimbursement up to the full amount of the benefits paid.
- that the Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise;

- that, in the event that you elect not to pursue your claim(s) against a third party, the Plan shall be equitably subrogated to your right of recovery and may pursue your claims;
- to assign, upon the Plan's request, any right or cause of action to the Plan;
- not to take or omit to take any action to prejudice the Plan's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Plan in obtaining reimbursement;
- to cooperate in doing what is necessary to assist the Plan in recovering the benefits paid or in pursuing any award or recovery;
- to forward any recovery or proceeds to the Plan within ten days of disbursement by the third party or to notify the Fund as to why you are unable to do so; and
- to the entry judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on behalf of you or your dependent with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Plan's attorneys' fees and costs.

No benefits will be payable for charges and expenses which are excluded from coverage under any other provision of the Plan.

The Plan may permit you to turn over less than the full amount of benefits paid and recovered, as it determines in its sole discretion. Any reduction of the Plan's claim is subject to prior written approval by the Plan.

FRAUD AND RECOVERY RULE

The Trustees have the right to ask you to furnish information reasonably required to determine your or your dependent's right to Plan benefits. When inaccurate information and/or proof is provided, this ultimately can result in the improper use of Plan assets, which adversely affects the ability of the Plan to provide the highest possible level of benefits.

Therefore, if you or a dependent fail to submit the requested information or proof, make a false statement, or furnish fraudulent or incorrect information or proof, your or your dependent's benefits under the Plan (and participation in the Plan – even if you or your dependent would otherwise meet the eligibility requirements) may be denied, suspended or discontinued at any time and for any length of time (including permanently).

The Trustees have the right to recover any benefit payments that were made due to error (including, for example, clerical error) or fraud or for any other reason (including, for example, your failure to notify the Fund Office regarding a change in family status), and the Plan reserves the right to recover such payments through whatever means necessary including, without limitation, deduction of such amounts from future claims and/or legal action.

REMEDIES AVAILABLE TO THE PLAN

The Plan shall have the right to recover from you, your dependent (and/or any other person, entity or trust in possession of such funds sought by the Plan) all (a) benefits paid by the Plan on your or your dependent's behalf for injuries or disabilities that you or your dependents have suffered for which you or they recover money in a "third party" claim or lawsuit or settlement thereof, and (b) all benefits paid by the Plan to which you or your dependent were not, for any reason whatsoever, entitled. The Plan may seek such recovery through subrogation and/or any other equitable or legal relief available under state or federal law.

The Plan may also enforce its right to reimbursement by:

- filing a lawsuit against you and/or your dependent;
- recouping the amount owed from your or your dependent's future Plan benefits (regardless of whether benefits have been assigned by you or your dependent to the doctor, hospital or other provider); and/or
- or any other remedy available to the Plan.

We strongly recommend that, if you or your dependent are injured as a result of the negligence or wrongful act of a third party, you contact your attorney for advice and counsel. However, this Plan shall not pay for, or reduce its claim for reimbursement by, any of the fees or expenses your attorney might charge.

PRIVACY OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") gives you certain rights with respect to your health information, and it also imposes certain obligations on the Fund as a group health plan. The following describes the ways your health information is protected under HIPAA when that health information is disclosed to, or used or disclosed by, the Board of Trustees (the "Board"), in its capacity as the sponsor of the Fund. These rules do not apply to any disability, death or other non-health Benefits provided under the Fund.

A complete description of your rights under HIPAA is available in the Fund's Notice of Privacy Practices which the Fund was required to distribute to you. The statement that follows is not intended and cannot be considered to be the Fund's Notice of Privacy Practices.

Your "protected health information" is information about you, including demographic information that –

- is created or received by the Fund, or by your health care provider or a health care clearinghouse (and is not related to your non-health Benefits under the Fund, e.g., disability);
- relates to your past, present, or future physical or mental condition;
- relates to the provision of health care to you;

- relates to the past, present, or future payment for the provision of health care to you; and
- identifies you in some manner.

Since the Fund is required to keep your protected health information confidential, before the Fund can disclose any of your health information to the Board as the sponsor of the Fund, the Board must agree to keep your protected health information confidential. In addition, the Board must agree to handle your protected health information in a way that enables the Fund to comply with HIPAA. Toward that end, the Board agrees to the following rules in connection with your protected health information that is received from, or on behalf of the Fund:

- The Board understands that the Fund will only disclose your protected health information to the Board for the Board's use in Fund administrative functions and such disclosures explained in the Notice of Privacy Practices distributed to you by the Fund. In all cases, the Board will receive only the minimum necessary amount of protected health information necessary for the Board to perform Fund administrative functions. Such Fund administrative functions may include assisting participants in filing claims for Benefits under the Fund, or filing an appeal of a denied claim. The Board may also receive protected health information as necessary for the Board to perform its fiduciary and administrative duties as required by ERISA.
- The Board will not use or disclose your protected health information for any reason other than for the Fund's administrative functions, as otherwise expressly permitted in this SPD, as required by law, or if the Board has your written authorization.
- The Board will not use or disclose protected health information for employment-related actions or decisions or in connection with any pension or other employee benefit plan sponsored by the Board, unless it receives your express written authorization.
- If the Board discloses to any of its agents or subcontractors any of your protected health information that it receives from the Fund, the Board will require the agent or subcontractor to agree to the same restrictions that govern the Board's use or disclosure of your protected health information under this SPD.
- The Board will promptly report to the Fund's Privacy Officer if it becomes aware of any use or disclosure of your protected health information that is inconsistent with the uses and disclosures allowed under this SPD.
- The Board will allow you or the Fund to inspect and copy your protected health information that is in its custody and control to the extent required of the Fund under HIPAA. (You should review the Notice of Privacy Practices to learn more about your rights to receive copies of your health information maintained by the Fund.)

- The Board will make your protected health information available to you, or to the Fund, in order to allow you or the Fund to amend the information, to the extent required under HIPAA, and the Board will incorporate any such amendments that the Fund has accepted in accordance with HIPAA. (You should review the Notice of Privacy Practices to learn more about your rights to request an amendment to your protected health information maintained by the Fund.)
- The Board will keep a written record of certain types of disclosures that it makes, if any, of your protected health information for reasons other than for your medical treatment, payment for that medical treatment, or health care operations, or with your written permission. This written disclosure record will include those types of disclosures made during at least the previous six years, except only disclosures made after April 14, 2003 must be listed. The Board will make this disclosure record available to the Fund so that the Fund can provide you, upon request, with a copy of that list of disclosures. (You should review the Notice of Privacy Practices to learn more about your rights to request a log of certain types of disclosures of your protected health information made by the Fund.)
- The Board will make available its internal practices, books and records relating to its use and disclosure of protected health information that it receives in its capacity as the sponsor of the Fund to the Secretary of the U.S. Department of Health and Human Services to determine the Fund's compliance with HIPAA.
- The Board will, if feasible, return or destroy all protected health information received from the Fund in whatever form or medium (including in any electronic medium under the Board's custody or control) when protected health information is no longer needed for the Fund administration functions for which the disclosure was made, and the Board will retain no copies. This includes all copies of any data or compilations derived from, and allowing identification of you or your beneficiary who is the subject of, the protected health information. If it is not feasible to return or destroy all of the protected health information, the Board will limit the use or disclosure of any protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
- Only certain employees or classes of employees or other workforce members under the control of the Board may be given access to protected health information received from the Fund on behalf of the Board. These employees or workforce members may only use your protected health information for the purposes set forth in this SPD. The specific list of names of those employees are held and recorded in the Fund Office. Additionally, the individual Trustees will be permitted to have access to

and use your protected health information, but only to perform the Fund's administrative functions that the Board provides for the Fund as described in this SPD.

- If any of these employees, workforce members or individual Trustees use or disclose your protected health information in violation of HIPAA and the rules set forth in this SPD, those employees and workforce members or Trustees will be subject to disciplinary action and sanctions, up to and including the possibility of termination of employment or affiliation with the Board. If the Board becomes aware of any such violations, it will promptly report the violation to the Fund's Privacy Officer and will cooperate with the Fund to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects on you.

There are also some special rules under HIPAA related to "electronic health information." Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

Further, with respect to the implementation of security measures (as defined in 45 *Code of Federal Regulations* § 164.304) for electronic protected health information, the Board will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Fund;
- Ensure that the adequate separation required to exist between the Fund and the Board is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;
- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect that information;
- Report to the Fund if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information system; and

- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic protected health information by the issuance of additional regulations or other guidance pursuant to HIPAA.

INTERPRETING THE PLAN

The Board of Trustees, and any person or persons it designates (such as the Plan Administrator), has the exclusive right, power, and authority, in its sole discretion, to administer, apply and interpret the Plan, including this booklet and any other Plan documents, and to decide all factual and legal matters arising in connection with the operation or administration of the Plan. Without limiting the generality of the foregoing, the Board of Trustees, and its designates, have the sole and absolute discretionary authority to:

- Take all actions and make all decisions (including factual decisions) related to eligibility for, and the amount of, benefits under the Plan;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan;
- Decide questions, including legal and factual questions, related to eligibility and the calculation and payment of benefits, and any other issues arising under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet or other Plan documents;
- Process, and approve or deny, benefit claims; and
- Determine the standard of proof required in any case.

Please note that this list is for illustration purposes only and is not meant to be exhaustive of the types of determinations and interpretations under the control of the Board of Trustees or its designates.

Any and all determinations and interpretations made by the Board of Trustees or its designees are final and binding on all participants, beneficiaries and any other individuals claiming benefits under the Plan. The Board of Trustees may delegate any other such duties or powers as it deems necessary to carry out the administration of the Plan.

AMENDING, MODIFYING OR TERMINATING THE PLAN

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason. If the Plan is amended, modified or terminated, in whole or in part, the ability of participants and dependents (both present and future) to participate in the Plan and/or to receive benefits thereunder, as well as the type and amount of benefits provided under the Plan, may be modified or terminated.

Without limiting any other Plan provisions for the discontinuance of coverage, your coverage under the Plan shall terminate when the Board of Trustees terminates the Plan, or when you are no longer eligible to receive benefits under the Plan, whichever occurs first.

Neither you, your beneficiaries, or any other person have or will have a vested or non-forfeitable right to receive, directly or indirectly, any benefits under the Plan.

OTHER IMPORTANT FACTS ABOUT THE PLAN

Name of Plan	Publishers'– Pressmen's Welfare Fund
Name and Address of Plan Sponsor	Board of Trustees of the Publishers'– Pressmen's Welfare Fund 1501 Broadway, Suite 1724 New York, NY 10036
Employer Identification Number (EIN)	13-6116945
Plan Number	501
Type of Plan	Welfare benefit plan for retirees 65 and over providing Medicare Parts A & B supplemental benefits. All benefits provided by the Plan are self-insured.
Type of Administration	The Board of Trustees has overall responsibility for administering the benefits under the Plan. The Trustees have contracted with C&R Consulting, Inc. to serve as the Fund's third party administrator.
Plan Administrator	C&R Consulting, Inc. serves as the Fund's third party administrator. C&R Consulting can be contacted as follows: Robert A. Costello – President C&R Consulting, Inc. c/o Publishers'-Pressmen's Benefits Fund 1501 Broadway, Suite 1724 New York, NY 10036 Telephone number (212) 869-5994

Agent for Service of Legal Process	For disputes arising under the Plan, service of legal process may be made on the Board of Trustees or the Plan Administrator at the following address: Publishers'-Pressmen's Benefits Fund 1501 Broadway, Suite 1724 New York, NY 10036
Plan Trustees **Union Trustees**	 **Employer Trustees**
John M. Heffernan, President New York Newspaper Printing Pressmen's Union Number Two 1501 Broadway, Suite 1712 New York, NY 10036	Andrew Gutterman The New York Times 620 8th Avenue, 18th Floor New York, NY 10018
Joseph Connor New York Newspaper Printing Pressmen's Union Number Two 1501 Broadway, Suite 1712 New York, NY 10036	Jeffrey Zomper The Daily News 4 New York Plaza, 7th Floor New York, NY 10004
Michael Tortora New York Newspaper Printing Pressmen's Union Number Two 1501 Broadway, Suite 1712 New York, NY 10036	
Plan Year	April 1 to March 31 (Plan's fiscal year)
Source of Funding	The Plan is funded by contributing employers and employees in accordance with their Collective Bargaining Agreements and participation agreements.

Collective Bargaining Agreements:

The Plan is maintained under the terms of collective bargaining agreements between contributing employers and the New York Newspaper Printing Pressmen's Union No. 2. A copy of any of the agreements may be obtained by Plan participants upon written request to the Plan Administrator, or they are available for examination by Plan participants at the Fund Office.

YOUR RIGHTS UNDER ERISA

A. As a participant in the Publishers'-Pressmen's 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:

(1) examine, without charge, at the Fund Office, all documents governing the Plan, including summary plan descriptions, 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.

(2) 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 an updated summary plan description. The Plan Administrator may assess a reasonable charge for the copies.

(3) 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.

(4) continue health 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.

(5) reduction or elimination of exclusionary periods of coverage for pre-existing 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

C. 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 Plan Administrator.

D. 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. (However, see the "Claiming Benefits" section of this Summary Plan Description, which provides claim review procedures that must be followed before you may file a suit.) 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 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.

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

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

DISCLAIMER

The rules and regulations of the Plan are set forth in the official Plan documents. Accordingly, this summary is supplied solely for the purpose of helping you to understand the Plan, not to replace or amend it. The operation of the Plan and the benefits to which you (or your beneficiaries) may be entitled will be governed solely by the terms of the official Plan documents and the interpretations of the Board of Trustees. To the extent that any of the information contained in this booklet is inconsistent with the official Plan documents, the provisions set forth in the Plan documents will govern in all cases. No individuals (other than members of the Board of Trustees) have any authority to interpret the Plan (or other applicable documents) or to make any promises to you about it.

NOTES

NOTES