PUBLISHERS'-PRESSMEN'S

WELFARE FUND

SUMMARY PLAN DESCRIPTION

May 1, 2012

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INTRODUCTION

GRANDFATHERED STATUS DISCLOSURE

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (212) 869-5994. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WHAT THIS SUMMARY PLAN DESCRIPTION TELLS YOU

A. This Summary Plan Description describes the medical, prescription drug, dental, optical, and life insurance benefits for active Employees of Contributing Employers to the Publishers'-Pressmen's Welfare Fund. The key features of the Plan summarized in this Summary Plan Description were in effect as of May 1, 2012 (unless specified otherwise herein).

B. If you are an Early Retiree age 59 but less than age 65 or a Disability-Pension Retiree under age 65, you may also be eligible for the medical, prescription drug and life insurance benefits described in this Summary Plan Description. However, Early Retirees and Disability-Pension Retirees are not eligible for dental or optical benefits under the Plan.

C. If you are a retired employee age 65 or over, there is a separate Summary Plan Description that describes the benefits available to you and your eligible spouse if he or she is also age 65 or over.

D. This Summary Plan Description will help you understand the benefits provided through the Publishers'-Pressmen's Welfare Fund and how to use them well. You should review it and show it to those members of your family who are or will be covered by the Plan. It will give all of you an understanding of:

- the coverages provided;
- the procedures to follow in submitting claims; and
- your responsibilities to provide necessary information to the Plan.

Be sure to read the Exclusions and Definitions chapters. Remember not every expense you incur for health care is covered by the Plan.

E. ALL PROVISIONS OF THIS SUMMARY PLAN DESCRIPTION CONTAIN IMPORTANT INFORMATION. However, some provisions include the notation "VERY IMPORTANT INFORMATION" in their headings. This is because they explain very important obligations that you must satisfy in order to preserve your rights under the Plan, or because they explain certain very important limitations of the liability of the Plan and its Trustees, and the Employers. THE USE OF THIS NOTATION IN THE HEADINGS OF SOME PROVISIONS SHOULD NOT LEAD YOU TO ASSUME THAT OTHER PROVISIONS DO NOT CONTAIN IMPORTANT INFORMATION. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to contact the Fund Office for assistance. A Quick Reference to sources of help or information about the Plan appears on page 4 *(See Whom to Call for Help or Information).*

F. As the Plan is amended from time to time, the Welfare Fund's Plan Administrator will send you information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

G. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them. If you lose this document, please contact the Publishers'-Pressmen's Benefits Fund Office at 1501 Broadway, Suite 1724, New York 10036, (212) 869-5994, to receive another copy.

SUGGESTIONS FOR USING THIS SUMMARY PLAN DESCRIPTION

This Summary Plan Description provides a great deal of detail about your Plan. We suggest that you and your covered family members take the following steps to become familiar with what is included in this document:

A. Read through this Introduction and look at the Table of Contents that immediately precedes it. This Introduction lists the topics covered by each of the chapters, so you will understand the broad outline of this summary description of the Plan. The Table of Contents provides you with an outline of the topics covered within each chapter.

B. Review the chapters that describe the medical, prescription drug, dental, optical, and life insurance coverages in more detail. As you look through the text, you will notice that there are examples, charts and tables to help clarify the key provisions and more technical details of the coverages.

C. As you review each chapter describing coverage, you should:

   1. Refer to the Definitions chapter at the back of the document. Words that appear throughout the text with initial capital letters have specific meanings that are set forth in the Definitions chapter. You may also encounter technical terms that may or may not have initial capital letters, but that are also defined in the Definitions chapter. As you consult this Summary Plan Description, when you see words or terms with initial capital letters, be sure you understand their meanings by consulting the Definitions chapter.

   2. Refer to the Other Information chapter for information regarding your rights under the law and with respect to the Plan.

   3. Refer to the Medical Management Program chapter to find out what you must do to file an in-network medical claim and how to seek review if you are dissatisfied with an in-network medical claim decision. Refer to the Claims Information chapter to find out what you must do to file an out-of-network medical claim, or a prescription drug, dental, optical or life insurance benefit claim, and how to seek review if you are dissatisfied with a related claim decision.

   4. Refer to the chapter on Duplicate Coverage of Medical Expenses for information regarding the handling of situations where you have coverage under more than one group health care plan, Medicare and other government plans (including personal injury protection under mandatory no-fault automobile insurance coverage), workers' compensation, or where you can recover your medical expenses from a third party who wrongfully caused the injury or illness giving rise to those expenses.

5. If coverage ends for you or for a covered Spouse or Dependent Child, see the chapter on When Coverage Ends. This chapter explains when your coverage may be extended, or (with respect to your medical coverage) converted to an individual policy of medical expense insurance.

WHOM TO CALL FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed below:

FOR INFORMATION ABOUT IN-NETWORK MEDICAL BENEFITS - CONTACT EMPIRE BY TELEPHONE AT:

WHAT	WHY	WHERE
EMPIRE MEMBER SERVICES	For questions about your benefits, claims or membership	**1-800-342-9816** TDD for hearing impaired: **1-800-682-8786** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**1-800-342-9816** Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
BLUECARD® PPO PROGRAM	Get network benefits while you are away from home Locate a PPO provider outside Empire's network service area	**1-800-810-BLUE (2583)** ***www.bcbs.com*** 24 hours a day, 7 days a week
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain surgeries, therapies, diagnostic tests and medical supplies	**1-800-982-8089** 8:30 a.m. to 5:00 p.m. Monday -– Friday
HEALTHLINE[SM] NURSE ACCESS AND RECORDED TOPICS	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes	**1-877-TALK-2RN (825-5276)** 24 hours a day, 7 days a week

BEHAVIORAL HEALTHCARE MANAGEMENT	To locate a participating behavioral healthcare provider in your area Precertification of mental health and alcohol/substance abuse care	**1-800-626-3643** NON-EMERGENCY CARE 8:30 a.m. to 5:00 p.m. Monday – Friday EMERGENCY CARE 24 hours a day, 7 days a week
VISION CARE	To find a participating Davis vision care network provider in your area	**1-877-923-2847** 8:00 a.m. to 8:00 p.m. Monday – Friday 9:00 a.m. to 4:00 p.m. Saturday
FRAUD HOTLINE	Help prevent health insurance fraud	**1-800-I-C-FRAUD (423-7283)** 9:00 a.m. to 5:00 p.m. Monday – Friday

OR CONTACT EMPIRE IN WRITING AT:

Empire BlueCross BlueShield
EPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

FOR INFORMATION ABOUT -

Eligibility, Out-of-Network Medical Benefits, Prescription Drug Benefits, Dental Benefits, Optical Benefits, Life Insurance, and Claims Related to any of these benefits,

Contact the Fund Office at (212) 869-5994, or you can write to the Fund at:

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

OVERALL CONTENTS OF THIS SUMMARY PLAN DESCRIPTION

Following this Introduction, the Summary Plan Description includes chapters on the following:

- ELIGIBILITY: HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED, AND ENDS
- MEDICAL EXPENSE COVERAGE
- MEDICAL NETWORKS
- SCHEDULE OF MEDICAL BENEFITS
- MEDICAL MANAGEMENT PROGRAM
- PRESCRIPTION DRUG PROGRAM
- DENTAL BENEFITS
- OPTICAL BENEFITS
- LIFE INSURANCE BENEFITS
- EXCLUSIONS: EXPENSES NOT COVERED BY THE PLAN
- CLAIMS INFORMATION
- PRIVACY OF PROTECTED HEALTH INFORMATION
- DUPLICATE COVERAGE OF MEDICAL EXPENSES
- WHEN COVERAGE ENDS
- OTHER INFORMATION
- DEFINITIONS

ELIGIBILITY

HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED, AND ENDS

ELIGIBILITY FOR COVERAGE

A. Your Eligibility

1. Active Employees –

   (a) If you are an active Employee of a Contributing Employer whose employment is subject to a collective bargaining agreement between your employer and the New York Newspaper Printing Pressmen's Union No. Two, and

   (i) you are listed by the Joint Apprentice Committee, and

   (ii) you have accumulated at least 39 Credited Shifts (see the Definitions chapter for the definition of "Credited Shifts") during the three-month Eligibility Period (see chart on following page),

   Or

   (b) If you are an active Full-Time Salaried Employee (see the Definitions chapter for the definition of "Full-Time Salaried Employee") of a Contributing Employer for whom the Contributing Employer makes contributions to the Publishers'-Pressmen's Welfare Fund during the three-month Eligibility Period (see chart on following page),

   And, in the case of either (a) or (b) above,

   all required Employee contributions are remitted to the Publishers'-Pressmen's Welfare Fund on a timely basis*,

   you are eligible for your own medical, prescription drug, dental, optical and life insurance coverage for the corresponding Benefit Period.

   Your coverage will become effective on the first day of the corresponding Benefit Period, but only if you have submitted a completed written enrollment form which may be obtained from the Fund Office.

* If you think you may be eligible for (or are a participant in) an Employer-sponsored pre-tax cafeteria plan, you are responsible for making sure that your Employer has submitted your contributions to the Fund on a timely basis.

Eligibility Period:	Benefit Period:
You must meet all of the requirements set forth in Section A.1. (a) or Section A.1. (b) above and remit all required Employee contributions during the three-month period below to be eligible for Benefits during the corresponding Benefit Period.	Your eligibility begins on the first day of the first month of the period listed below. Once you have attained eligibility, you will receive Benefits for two consecutive Benefit Periods, even if you fail to accumulate 39 Credited Shifts or you are no longer a Full-Time Salaried Employee during the second Eligibility Period.
September 1 - November 30	January 1 - March 31
December 1 - February 28(29)	April 1 - June 30
March 1 - May 31	July 1 - September 30
June 1 - August 31	October 1 - December 31

2. Early Retirees and Disability-Pension Retirees -

If you are (i) an Early Retiree age 59 but less than age 65 or a Disability-Pension Retiree under age 65 (see the Definitions chapter for definitions of "Early Retiree" and "Disability-Pension Retiree"); and (ii) you are currently collecting a pension from the Pressmen's-Publishers' Pension Fund; and (iii) you pay your required monthly contributions to the Publishers'-Pressmen's Welfare Fund on a timely basis, you are eligible for your own medical, prescription drug, and life insurance coverage until you reach age 65 or you become eligible for Medicare, whichever occurs first. Your coverage will become effective on the first day of the month following your retirement from active employment with a Contributing Employer, but only if you have submitted a completed written enrollment form which may be obtained from the Fund Office.

VERY IMPORTANT INFORMATION: You will <u>not</u> be eligible for coverage under the Plan if you initially elected severance or otherwise terminated your employment with a right to a deferred (or vested) pension. In other words, to qualify for 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.

B. Your Dependents' Eligibility

1. Active Employees –

Eligible Dependents of active Employees are also eligible for medical, prescription drug, dental and optical coverage on the later of the day you become eligible for your own coverage or the day you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if (i) you have submitted a completed written enrollment form and all applicable marriage certificates, birth certificates, adoption papers and/or certifications for dependent coverage, and (ii) coverage is in effect for you on that day.

2. Early Retirees and Disability-Pension Retirees –

Eligible Dependents of Early Retirees and Disability-Pension Retirees are also eligible for medical and prescription drug coverage on the later of the day you become eligible for your own coverage or the day you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if (i) you have submitted a completed written enrollment form and all applicable marriage certificates, birth certificates, adoption papers and/or certifications for dependent coverage, (ii) coverage is in effect for you on that day, and (iii) you pay all additional required monthly contributions to the Publishers'-Pressmen's Welfare Fund on a timely basis.

C. Who Your Eligible Dependents Are

Your Eligible Dependents include your lawful Spouse and your Dependent Child(ren). See the Definitions chapter of this document for definitions of "Dependent Child(ren)" and "Spouse." Anyone besides you who does not qualify as a Dependent Child or Spouse as those terms are defined by this Plan has no right to coverage or services under this Plan.

ENROLLMENT FOR AND START OF COVERAGE

A. Enrollment Is Required for Coverage

You and/or your Eligible Dependents may become covered under this Plan only upon submission of a completed written Enrollment form which may be obtained from the Fund Office (and any required certificates for dependent coverage). A person who fails to submit a completed written Enrollment form (and any required certificates for dependent coverage) has no right to any coverage or services under this Plan.

B. Initial Enrollment

1. Initial Enrollment Period and Procedure

The Fund requires that you supply certain information (and all applicable

marriage certificates, birth certificates, adoption papers and/or certifications for dependent coverage) in order to provide Benefits to you and/or your family. If you do not Enroll, you and your family may lose significant coverage.

You should notify the Fund Office within 30 days of a change in your family status. A change in family status includes the birth of a new Dependent Child or if you marry, divorce, are legally separated, or an Eligible Dependent dies or otherwise no longer qualifies as Eligible Dependent as that term is defined by this Plan. If you have any question whether a change in family status requires a new election, please call the Fund Office immediately.

2. Start of Coverage Following Initial Enrollment
    - Your coverage begins on the first day of the Benefit Period after you have attained eligibility.
    - Coverage of your Enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins.
3. Failure to Enroll During Initial Enrollment

    (VERY IMPORTANT INFORMATION)

    - **If you do not Enroll yourself during the initial Enrollment period, you will not be covered** unless you qualify for the Special Enrollment described in the following section of this subchapter; and
    - If you do not Enroll your Eligible Dependents during the initial Enrollment period, they will not be covered unless they qualify for the Special Enrollment described in the following section of this subchapter.

C. Special Enrollment

1. Newly Acquired Spouse and/or Dependent Child(ren)
    - If you are eligible and Enrolled for individual coverage and if you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption, you may Enroll your newly acquired Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption by providing the Fund with written notice of your Enrollment request.
    - If you are eligible but <u>not</u> Enrolled for individual coverage, and if you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption, you may Enroll yourself and your newly acquired Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption by providing the Fund with written notice of your Enrollment request.

- If you did not Enroll your Spouse for coverage within 31 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may Enroll your Spouse together with your newly acquired Dependent Child(ren) no later than 31 days after the date of your newly acquired Dependent Child(ren)'s birth, adoption or placement for adoption by providing the Fund with written notice of your Enrollment request.

2. Loss of Other Coverage

A Special Enrollment rule also applies if (i) you did not Enroll yourself, your Spouse and/or any Dependent Child(ren) for coverage within 31 days after the date on which you or they first became eligible for coverage because you or they were covered under any other health insurance policy or program or employer plan, including COBRA continuation coverage, individual insurance, Medicare, Medicaid, or other public program; and (ii) you, your Spouse and/or any Dependent Child(ren) cease to be covered by that other health insurance policy, plan or program; then

In that case, you may Enroll yourself and/or that Spouse and/or Dependent Child(ren) within 31 days after the termination of the coverage under the other health insurance policy or plan if that other coverage terminated because:

- of the loss of eligibility as a result of any of the following:
    - termination of employment or reduction in the number of hours of employment;
    - death, divorce or legal separation;
    - cessation of dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the other health insurance policy or plan);
    - a situation in which you or your Dependent incur a claim that would meet or exceed a lifetime limit on all benefits available under the other health insurance policy or plan;
    - a situation in which the other health insurance policy or plan no longer offers any benefits to the class of similarly situated individuals that includes you or your Dependent; or
    - of the termination of employer contributions toward that other coverage; or
- if that other coverage was COBRA continuation coverage, the coverage terminates for any reason other than either the failure of the individual to timely pay the applicable COBRA premium, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). This provision also

applies where the other health care plan is terminated and there is no other COBRA continuation coverage available to the individual, the individual no longer resides, lives, or works in a service area of the EPO program and there is no other COBRA continuation coverage available to the individual, or the 18-month or 36-month period of COBRA continuation coverage has expired. (See the chapter on When Coverage Ends – *Continuation of Coverage* (*COBRA*) for more details.)

3. Special Enrollment Rights under the Children's Health Insurance Program Reauthorization Act of 2009

   You are also entitled to an additional special enrollment right if (i) you or your Dependent Child(ren) are covered under Medicaid or a State Children's Health Insurance Program ("CHIP") and such coverage is terminated due to loss of eligibility, or (ii) you or your Dependent Child(ren) becomes eligible for a premium assistance program under Medicaid or CHIP, provided that you request enrollment under this Plan within sixty (60) days after such termination or eligibility.

4. Start of Coverage Following Special Enrollment

If a completed written enrollment form (and all applicable marriage certificates, birth certificates, adoption papers and/or student certifications for dependent coverage) has been submitted on a timely basis:

- Your coverage, your Spouse's coverage, and/or the coverage of any of your other Dependent Child(ren) will become effective, if you have attained eligibility, on the first day of the month following the date that the completed request for Enrollment is received.
- Coverage of a newborn or newly adopted Dependent Child who is Enrolled within 31 days after birth will become effective as of the date of the Dependent Child's birth.
- Coverage of a newly adopted Dependent Child who is Enrolled more than 31 days after birth, but within 31 days after the Dependent Child's adoption or placement for adoption, will become effective as of the date of the Dependent Child's adoption or placement for adoption, whichever occurs first.

D. Late Enrollment Procedure

If you and/or any of your Eligible Dependents are not entitled to Special Enrollment as described in this subchapter, you may Enroll yourself and/or any of your Eligible Dependents during the normal Enrollment periods.

E. Newborn Dependent Children

(Special Rule for Coverage)

Your newborn Dependent Child(ren) will be covered from the date of birth, provided:

- you submit a completed written enrollment form and birth certificate for that newborn Dependent Child within 31 days after the Dependent Child's date of birth.

F. Adopted Dependent Children

(Special Rule for Coverage)

1. Your adopted Dependent Child will be covered from the date that Dependent Child is adopted or "placed for adoption" with you, whichever is earlier. A Dependent Child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the Dependent Child whom you plan to adopt.
2. A Dependent Child who is placed for adoption with you within 31 days after the Dependent Child was born will be covered from birth if you comply with the Plan's requirements for obtaining coverage for a newborn Dependent Child.
3. However, if a Dependent Child is placed for adoption with you, and if the adoption does not become final, coverage of that Child will terminate as of the date you no longer have a legal obligation to support that Child.

G. Qualified Medical Child Support Orders (QMCSOs) (Special Rule for Enrollment)

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.

WHEN COVERAGE ENDS

A. Events Causing Coverage to End

1. If you are an active Employee, your coverage ends on the earlier of the last day of the Benefit Period during which:
   - your employment ends; or
   - you are no longer eligible to participate in the Plan because you were not credited with a minimum of 39 Credited Shifts during two consecutive Eligibility Periods (see the chart in the chapter on Eligibility); or
   - you did not timely pay all required Employee contributions.
2. If you are an Early Retiree or a Disability-Pension Retiree, your coverage ends on the earlier of the last day of the month in which:
   - you reach age 65; or
   - you become eligible for Medicare; or
   - you fail to pay your required contributions.
3. Coverage of your Covered Dependents ends on the earlier of the last day of the month in which:
   - your coverage ends; or
   - your covered Spouse or Dependent Child(ren) no longer meet the definition of Spouse or Dependent Child(ren).
4. VERY IMPORTANT INFORMATION. You, your Spouse, or any of your Dependent Children must notify the Plan no later than 60 days after the date that:
   - you and your Spouse divorce or become legally separated;
   - a Dependent Child reaches the Plan's limiting age; or

- a Dependent Child becomes eligible to enroll in other employer-provided group health coverage (other than a plan of another parent's employer); or
- a Dependent Child reaches the Plan's limiting age, and who:
    - has any physical or mental Handicap; or
    - ceases to have any physical or mental Handicap.

See the subchapter on *Information You or Your Dependents Must Furnish to the Plan* in the Other Information chapter of this Summary Plan Description for information regarding other notices you must furnish to the Plan.

B. Special Circumstances

1. Family and Medical Leave (FMLA)

- You may be entitled by law to up to a maximum of 12 weeks each year of unpaid Family or Medical Leave for specified family or medical purposes, such as the birth, adoption or placement with you for adoption of a Child, or to provide care for a Spouse, Child or parent who is seriously ill, or for your own serious illness.
- You may also be entitled to up to a maximum of 12 weeks of unpaid leave because of any qualifying exigency (as defined in Department of Labor Regulations) arising out of the fact that your Spouse, son, daughter or parent is on active military duty or has been notified of an impending call to active duty status, in support of a contingency operation. (If you believe you are entitled to leave due to a qualifying exigency, you should contact your Employer.)
- You may also be entitled to up to 26 weeks of leave during a 12-month period to take care of a service member who is your Spouse, child, parent, or next-of-kin and is undergoing medical treatment or recuperating from serious Illness or Injuries as a result of their military service.
- You generally are eligible if you work for an Employer who has 50 or more Employees at a worksite, and you worked at least 12 months for that Employer and at least 1,250 hours in the 12 months preceding the leave.
- If you are entitled to FMLA leave, you can continue your health coverage under the Plan during that leave period for yourself and your Dependents by paying the required Employee contributions during that period. Your Employer is required to continue paying its Employer contributions for that coverage during the period of leave.
- Since you will not be paid by your Employer while you are on Family or Medical Leave, you may pay your contributions as they come due on the dates you would have been paid had you not taken Family or

Medical Leave. However, please note that your contributions will be made on an after-tax basis.

- Whether or not you keep your health coverage while you are on Family or Medical Leave, if you return to work promptly at the end of the Family or Medical Leave, your health coverage will be reinstated without any additional limits or restrictions imposed on account of your Family or Medical Leave. This is also true for any of your Dependents who were covered by the Plan at the time you took Family or Medical Leave. If you do not return to covered employment after your leave ends, coverage for yourself and your Dependents will end.
- Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that Family or Medical Leave will apply to you and your Dependents in the same way they apply to all other Employees and their Dependents.
- Questions regarding your entitlement to FMLA leave should be referred to your Employer. Questions about the continuation of coverage during Family or Medical Leave should be referred to the Publishers'-Pressmen's Benefits Fund Office at 1501 Broadway, Suite 1724, New York 10036, (212) 869-5994.

2. Leave for Military Service

   - If you are covered by the Plan and enter the United States Armed Forces (including the United States Army, Navy, Marine Corps, Air Force, the Coast Guard, Reserves, the Army National Guard, the commissioned corps of the Public Health Service, the Air National Guard, and certain other categories of service), you may be entitled to continue your (and your Dependents') health coverage under the Plan during your military service for a period of up to 24 months.
   - If your military service is 30 days or less, your coverage continues at the same cost as before – as long as the ordinary Employee contributions are paid, your coverage continues. If your military service exceeds 30 days, you will need to pay the applicable COBRA premium in order to remain covered. See the chapter When Coverage Ends – *Continuation of Coverage (USERRA)* for an explanation of when and how these circumstances may apply to your coverage.
   - Questions regarding your entitlement to military leave and to the continuation of medical coverage should be referred to Publishers'-Pressmen's Benefits Fund Office at 1501 Broadway, Suite 1724, New York 10036, (212) 869-5994.

3. Reinstatement of Coverage After Leaves of Absence

   - If you were eligible for coverage and your coverage ends while you

are on an approved leave of absence for family or medical leave, your coverage will be reinstated on the day you return to active employment, if you return within 14 days after your leave of absence ends.

- If you were eligible for coverage and your coverage ends while you are on an approved leave of absence for military leave, your coverage will be reinstated on the day you return to active employment, if you return within the periods prescribed by law. See the chapter When Coverage Ends – *Continuation of Coverage (USERRA)* for more details.
- Any period of any approved leave of absence including a leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act will not be counted as a break in coverage.
- Questions regarding your entitlement to an approved leave of absence and to the continuation of medical coverage should be referred to the Publishers'-Pressmen's Benefits Fund Office at 1501 Broadway, Suite 1724, New York, NY 10036, (212) 869-5994.

C. Extension and Continuation of Medical Coverage

Under certain circumstances:

- your medical coverage may be extended for a limited period of time after it would otherwise cease; or
- you may be able to continue your medical coverage at your own expense for a limited period of time after it ends.

See the chapter When Coverage Ends for an explanation of when and how these circumstances may apply to your coverage.

D. Certification of Coverage When Coverage Ends

When your medical coverage ends, you and/or your Covered Dependents are entitled by law to, and will be provided with, a certificate of coverage that indicates the period of time you and/or your Covered Dependents were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your Covered Dependent(s) has ended. In addition, such a certificate will be provided upon request by the Plan Administrator within two years after the date coverage ended. See the chapter When Coverage Ends for an explanation of when and how those certificates of coverage will be provided.

MEDICAL EXPENSE COVERAGE

ELIGIBLE MEDICAL EXPENSES

A. Eligible Medical Expenses Explained

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called Eligible Medical Expenses, and they are limited to those that are:

1. determined by the Plan Administrator or its designee to be "Medically Necessary" and "Usual and Customary" as those terms are defined in the Definitions chapter of this Summary Plan Description; and
2. not services or supplies that are excluded from coverage as provided in the Exclusions chapter (including those listed under the heading "What's Not Covered" in other chapters) of this Summary Plan Description; and
3. not in excess of any of the Plan's Limited Maximum or Annual Maximum Plan Benefits, or in excess of any other limitations of the Plan.

B. Non-Eligible Medical Expenses Explained

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. This means you are responsible for paying the full cost of all expenses: (1) that are not determined to be Medically Necessary; (2) that are determined to be in excess of the Usual and Customary charges; (3) that are not covered by the Plan; or (4) that are determined to be in excess of any applicable Limited Maximum and/or Annual Maximum Plan Benefits.

C. Network Healthcare Provider Services

If you receive health care services or supplies from a healthcare Provider that is a member of the Plan's Empire Exclusive Provider Organization ("EPO"), you will be responsible for paying less money out of your pocket. The healthcare Providers who are members of the Empire EPO network have agreed to accept the amounts the Plan pays for covered services, plus any additional amounts you must pay, as described in the Medical Networks chapter and Schedule of Medical Benefits chapter of this Summary Plan Description.

D. Eligible Medical Expenses Not Payable by the Plan

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually, you will have to satisfy some Deductibles, pay some Coinsurance, or make some Copayments toward the costs you incur that are Eligible Medical Expenses. In addition, there as certain Limited Maximum Plan Benefits and Annual Maximum Plan Benefits applicable to each Plan Participant with

respect to certain Eligible Medical Expenses. These features are described in the following subchapters and are shown in the Schedule of Medical Benefits chapter.

DEDUCTIBLES

A. Individual and Family Deductibles

Each year, you (and not the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible. At such time, the Plan begins to pay Benefits. There are different types of Deductibles.

1. Medical Benefits Deductibles – Individual and Family:
    a. The Individual Deductible is the maximum amount one Covered Individual has to pay before Plan medical Benefits begin. The Plan's Individual Deductible is $300.
    b. The Family Deductible is the maximum amount that a family of two or more is responsible for paying before Plan medical Benefits begin. The Family Deductible is $750.
2. Prescription Drug Benefits Deductible – The maximum amount each Covered Individual has to pay each Calendar Year before Plan prescription drug Benefits begin is $50.

B. Expenses Not Subject to Deductibles

Certain Eligible Medical Expenses are not subject to Deductibles. These expenses may be covered 100% by the Plan, or they may be subject to Copayments (see page 20). See the Medical Networks, Schedule of Medical Benefits, and the Medical Management Program chapters of this Summary Plan Description to determine when Eligible Medical Expenses are not subject to Deductibles.

COINSURANCE

A. Coinsurance Explained

Once you have met your annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and not the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. Unless the Schedule of Medical Benefits chapter indicates otherwise, the Plan pays 80% of the Eligible Medical Expenses after the Deductible is satisfied, and you are responsible for the remaining 20%.

B. Coinsurance When You Use the Network Healthcare Providers

If you use the services of a healthcare Provider that is a member of the Plan's Empire EPO network, you will be responsible for paying less money out of your pocket.

C. Coinsurance When You Don't Comply with the Medical Management Program

If you fail to follow the Medical Management Program, you may be required to pay a greater percentage of your Eligible Medical Expenses. This feature is described in more detail in the Medical Management Program chapter of this document.

COPAYMENT

Copayment (or "Copay") is a set dollar amount you (and not the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan pays the balance. When Copayments apply, there are no Deductibles or Coinsurance, unless the Plan specifically provides otherwise. The Plan's Copayments are indicated in the Schedule of Medical Benefits chapter.

OUT-OF-POCKET EXPENSES

You are always responsible for paying for certain expenses for medical services and supplies. Under the Plan, each year, you will be responsible for paying the following expenses out of your own pocket:

1. Your Individual or Family Deductible.
2. Any applicable Copayment.
3. All expenses for medical services or supplies that are not covered by the Plan.
4. All charges in excess of the Usual and Customary Charge determined by the Plan.
5. All charges in excess of the Plan's Limited Maximum and/or Annual Maximum Benefits, or in excess of any other limitation of the Plan.
6. Any additional other amounts you have to pay because you failed to comply with the Medical Management Program set forth in the Medical Management Program chapter of this document.

MAXIMUM PLAN BENEFITS

Annual Maximum Plan Benefits

Plan Benefits for certain medical expenses are subject to Annual Maximums per Covered Individual or family during each Calendar Year. Once the Plan has paid the Annual Maximum Plan Benefits for such services or supplies on behalf of any Covered Individual or family, it will not pay any additional Plan Benefits for those services or supplies for the balance of the Calendar Year. The services or supplies that are subject to Annual Maximum Plan Benefits are identified in the Schedule of Medical Benefits chapter.

Important Notice Regarding Annual Dollar Limits: In accordance with applicable law, none of the annual dollar limits (except to the extent they exceed $750,000 for 2011) set forth in this Plan shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act of 2010. The law defines "essential health benefits" to include, at a minimum, items and services covered within certain categories, including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services. Due to limited guidance at this time, a determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Board of Trustees of the guidance available as of the date on which the determination is made. If you have any questions about whether a benefit is an "essential health benefit," contact the Fund Office.

MEDICAL NETWORKS

Plan Participants may obtain health care services from In-Network or Out-of-Network healthcare Providers. Your out-of-pocket expenses will be smaller if you choose In-Network Providers, and larger if you choose Out-of-Network Providers.

A. In-Network Services

In-Network services are healthcare services provide by a doctor, hospital or healthcare facility that has been selected by Empire or another Blue Cross and/or Blue Shield plan to provide care to Plan Participants who are members of Empire's Exclusive Provider Organization (EPO). When a Plan Participant uses the services of an In-Network healthcare Provider, the Plan Participant is responsible for paying only the applicable Copayment for any Medically Necessary services or supplies. The In-Network healthcare Provider generally deals with the Plan directly for any additional amount due.

To receive In-Network benefits, you must use a participating health care provider in the Empire network in New York State or across the country from providers participating in the BlueCard PPO network through local Blue Cross and Blue Shield plans. When you use In-Network services, you get these advantages:

- CHOICE – You can choose any participating provider from the largest network of doctors and hospitals in New York State or across the country from providers participating in the BlueCard PPO® network through local Blue Cross and Blue Shield plans.
- FREEDOM – You do not need a referral to see a specialist, so you direct your care.
- LOW COST – Benefits are paid after a small co-payment for office visits and many other services.

- BROAD COVERAGE – Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home healthcare.
- CONVENIENCE – Usually, there are no claim forms to file.

Where to Find In-Network Providers -

1. EPO In-Network Services in New York State

   Empire's network gives you access to providers within its operating area of 28 eastern New York State counties. See "Operating Area" in the Definitions chapter for a listing of counties.

   To locate a provider in Empire's operating area, visit *www.empireblue.com*. You can search for providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the provider's office. Or, ask the Plan Administrator to see Empire's Provider Directory. You can also request that a directory be mailed to you free of charge by calling Member Services at 1-800-342-9816.

2. EPO Benefits Out-Of-Area

   When you live or travel outside of Empire's operating area, Empire's EPO provides benefits through the following programs:

- **BlueCard® PPO Program.** Nationwide, Blue Cross and Blue Shield plans have established Preferred Provider Organization (PPO) networks of physicians, hospitals and other healthcare providers. As a Participant in the EPO Network, you have access to these networks through the BlueCard PPO Program. By presenting your Empire I.D. card to a provider participating in the BlueCard PPO Program, you receive the same benefits as you would receive from an Empire network provider. The suitcase logo on your I.D. card indicates that you are a member of the BlueCard PPO Program. Call 1-800-810-BLUE (2583) or visit *www.bcbs.com* to locate participating providers.
- **BlueCard® Worldwide.** The BlueCard Worldwide program provides coverage through an international network of hospitals, doctors and other healthcare providers. This program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance.

Here's an example of how In-Network works.

	IN-NETWORK
PROVIDER'S CHARGE	$500
ALLOWED AMOUNT	$400
PLAN PAYS PROVIDER	$375 (non-specialist) $365 (specialist)
CO-PAYMENT (for office visits and certain covered services)	$25 per visit (non-specialist) $35 per visit (specialist)
CO-PAYMENT (for hospital inpatient admissions)	$0
CO-PAYMENT (for emergency room)	$35 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	$0
LIFETIME MAXIMUM	Unlimited

B. Out-of-Network Services

Effective April 1, 2011, the $1 million per Covered Individual lifetime limit for Out-of-Network medical expenses is eliminated. However, keep in mind that Out-of-Network healthcare Providers have no agreements with the Plan or with Empire or another BlueCross and/or BlueShield plan, and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan Participant for an Allowed Amount (Usual and Customary Charge) for any Medically Necessary services or supplies, subject to the Plan's Deductibles, Coinsurance, Copayments, Limitations and Exclusions. Plan Participants must submit proof of claim before any such reimbursement will be made, and Out-of-Network healthcare Providers may bill the Plan Participant for any balance that may be due in addition to the amount payable by the Plan.

SCHEDULE OF MEDICAL BENEFITS

A chart summarizing the Plan's medical Benefits appears below, with explanations and limitations of those Benefits on the following pages. Each of the Plan's medical Benefits is summarized in the first column of the chart. Specific differences in the Benefits and the Out-of-Pocket expenses payable by you when the Benefits are provided In-Network (when you use Network Providers) and Out-of-Network (when you use Out-of-Network Providers) are shown in the last two columns. To determine if Benefits are payable for any health care services or supplies you receive, even if they seem to be included in the chart below, **you should also check to see if those services are listed separately in the Coverage section or if they are described in the Exclusions chapter of this Summary Plan Description.**

BENEFITS SUMMARY

When you see the phrase "Precertification Necessary", you'll know that you or your doctor will need to precertify these services with Empire's Medical Management Program. In most cases, it is your responsibility to call. In some cases the provider or supplier of services needs to call. See the Medical Management Program chapter for details.

Whether medical services are provided In-Network or Out-of-Network, call Empire's Medical Management Program at 1-800-982-8089. This will ensure that you receive maximum benefits.

MEDICAL BENEFIT	In-Network (You Pay)	Out-of-Network[1] (You Pay)
Deductible	N/A	$300 / $750
Coinsurance	N/A	20% (except as otherwise noted)
Lifetime Maximum	Unlimited	Unlimited

[1] In addition to paying the Deductible and Coinsurance, you are responsible for paying all amounts charged by the Out-of-Network Provider in excess of the Allowed Amount. This excess amount is also referred to as "balance billing".

HOME, OFFICE/OUTPATIENT CARE	In-Network (You Pay)	Out-of-Network[1] (You Pay)
HOME/OFFICE VISITS Non-Specialist = Family Practice, General Medicine, Pediatrician, Internists, OB/GYN's, GYN's, OB's, Geriatrics, Certified Nurse Midwife, Nurse Practitioner	$25 co-payment per visit	Deductible and Coinsurance
SPECIALIST VISITS	$35 co-payment per visit	Deductible and Coinsurance
CHIROPRACTIC CARE	$35 co-payment per visit	Deductible and Coinsurance
SECOND OR THIRD SURGICAL OPINION* **Precertification necessary**	$35 co-payment per visit	Covered In-Network only
DIABETES EDUCATION AND MANAGEMENT	$35 co-payment	Deductible and Coinsurance
ALLERGY CARE • Office Visit • Testing • Treatment	$25 co-payment per visit $0 $0	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
DIAGNOSTIC PROCEDURES • X-rays and other imaging • Radium and Radionuclide therapy • MRIs/MRAs** **Precertification necessary** • Nuclear cardiology services ** • PET/CAT scans** • Laboratory tests	$0 $0 $0 $0 $0 $0	Deductible and Coinsurance Deductible and Coinsurance Covered In-Network only Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
SURGERY **Precertification necessary**	$0	Deductible and Coinsurance
PRE-SURGICAL TESTING	$0	Deductible and Coinsurance
ANESTHESIA	$0	Deductible and Coinsurance
CHEMOTHERAPY, RADIATION	$0	Deductible and Coinsurance
KIDNEY DIALYSIS	$0	Deductible and Coinsurance
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	$35 co-payment per visit	Deductible and Coinsurance
CARDIAC REHABILITATION **Precertification necessary**	$35 co-payment	Covered In-Network only

[1] In addition to paying the Deductible and Coinsurance, you are responsible for paying all amounts charged by the Out-of-Network Provider in excess of the Allowed Amount. This excess amount is also referred to as "balance billing".

* The co-payment is waived if the surgical opinion is arranged through Empire's Medical Management Program.

** It is the provider's responsibility to call Empire for precertification of all In-Network, MRI/ MRA service.

PREVENTIVE CARE	In-Network (You Pay)	Out-of-Network[1] (You Pay)
ANNUAL PHYSICAL EXAM • One per Calendar Year	$25 co-payment per visit	Deductible and Coinsurance
DIAGNOSTIC SCREENING TESTS • Cholesterol: 1 every 2 years • Diabetes (if pregnant or considering pregnancy) • Colorectal cancer - Fecal occult blood test if age 40 or over: 1 per year - Sigmoidoscopy if age 40 or over: 1 every 2 years • Routine Prostate Specific Antigen (PSA) in asymptomatic males - Over age 50-: 1 every year - Between ages 40-49 if risk factors exist: 1 per year - If prior history of prostate cancer, PSA at any age • Diagnostic PSA: 1 per year	 $0 $0 $0 $0 $0	 Deductible and Coinsurance Deductible and Coinsurance Covered In-Network only Covered In-Network only Covered In-Network only
WELL-WOMAN CARE • Office visits • Pap smears • Bone Density testing and treatment • Mammogram (based on age and medical history) - Ages 35 through 39 – 1 baseline - Age 40 and older – 1 per year	 $25 co-payment per visit $0 $0 $0	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
WELL-CHILD CARE **(covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics)** • In-hospital visits - Newborn: 2 in-hospital exams at birth • Office visits and associated lab services provided within 5 days of office visit - From birth up to age 1: 7 visits - Ages 1 through 4: 6 visits - Ages 5 through 11: 7 visits - Ages 12 up to 19th birthday: 8 visits • Immunizations	 $0 $0 $0	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance

[1] In addition to paying the Deductible and Coinsurance, you are responsible for paying all amounts charged by the Out-of-Network Provider in excess of the Allowed Amount. This excess amount is also referred to as "balance billing".

EMERGENCY CARE	In-Network (You Pay)	Out-of-Network[1] (You Pay)
EMERGENCY ROOM (Facility Charge) **Precertification necessary**	$35 co-payment per visit (waived if admitted to the same hospital within 24 hours)	Covered In-Network only
PHYSICIAN'S OFFICE	$25 co-payment per visit	Deductible and Coinsurance
AIR AMBULANCE **Precertification necessary** • Transportation to nearest acute care hospital for emergency inpatient admissions	$0	Covered In-Network only
AMBULANCE • Local professional ground ambulance to nearest hospital	$0 up to Allowed Amount	Deductible and Coinsurance

MATERNITY CARE AND INFERTILITY TREATMENT	In-Network (You Pay)	Out-of-Network[1] (You Pay)
PRENATAL AND POSTNATAL CARE **(In doctor's office) Precertification necessary**	$0	Covered In-Network only
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	$0	Deductible and Coinsurance
ROUTINE NEWBORN NURSERY CARE **(In hospital)**	$0	Deductible and Coinsurance
OBSTETRICAL CARE (In hospital)	$0, **Precertification necessary**	Deductible and Coinsurance
INFERTILITY TREATMENT	$0	Deductible and Coinsurance
OBSTETRICAL CARE **(In birthing center) Precertification necessary**	$0	Covered In-Network only

[1] In addition to paying the Deductible and Coinsurance, you are responsible for paying all amounts charged by the Out-of-Network Provider in excess of the Allowed Amount. This excess amount is also referred to as "balance billing".

IN HOPSPITAL SERVICES* Precertification Necessary	In-Network (You Pay)	Out-of-Network[1] (You Pay)
SEMIPRIVATE ROOM AND BOARD	$0	Covered In-Network only
ANESTHESIA AND OXYGEN	$0	Covered In-Network only
CHEMOTHERAPY AND RADIATION THERAPY	$0	Covered In-Network only
CARDIAC REHABILITATION	$35 co-payment per outpatient visit	Covered In-Network only
DIAGNOSTIC X-RAYS AND LAB TESTS	$0	Covered In-Network only
DRUGS AND DRESSINGS	$0	Covered In-Network only
GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0	Covered In-Network only
INTENSIVE CARE	$0	Covered In-Network only
KIDNEY DIALYSIS	$0	Covered In-Network only
PRESURGICAL TESTING	$0	Covered In-Network only
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0	Deductible and Coinsurance
SURGERY **(Inpatient and outpatient)****	$0	Deductible and Coinsurance

DURABLE MEDICAL EQUIPMENT AND SUPPLIES	In-Network (You Pay)	Out-of-Network[1] (You Pay)
DURABLE MEDICAL EQUIPMENT **(i.e., hospital-type bed, wheelchair, sleep apnea monitor)**	$0, **Precertification necessary**	Deductible and Coinsurance
ORTHOTICS	$0, **Precertification necessary**	Deductible and Coinsurance
PROSTHETICS **(i.e., artificial arms, legs, eyes, ears) Precertification necessary**	$0	Covered In-Network only

[1] In addition to paying the Deductible and Coinsurance, you are responsible for paying all amounts charged by the Out-of-Network Provider in excess of the Allowed Amount. This excess amount is also referred to as "balance billing".

* Does not include inpatient or outpatient behavioral healthcare or physical therapy/rehabilitation. See the Coverage section for a description of these benefits. Outpatient hospital surgery and inpatient admissions need to be precertified.

** For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the highest Allowed Amount. For a second procedure done through a separate incision, Empire will pay the Allowed Amount for the procedure with the highest allowance and up to 50% of the Allowed Amount for the other procedure.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES	In-Network (You Pay)	Out-of-Network[1] (You Pay)
MEDICAL SUPPLIES **(i.e., catheters, oxygen, syringes)**	$0	$0 up to Allowed Amount
NUTRITIONAL SUPPLEMENTS*** **(enteral formulas and modified solid food products)**	$0	Covered In-Network only

SKILLED NURSING AND HOSPICE	In-Network (You Pay)	Out-of-Network[1] (You Pay)
SKILLED NURSING FACILITY **Precertification necessary**		
• Up to 60 days per Calendar Year	$0	Covered In-Network only
HOSPICE **Precertification necessary**		
• Up to 210 days per lifetime	$0	Covered In-Network only

HOME HEALTH CARE	In-Network (You Pay)	Out-of-Network[1] (You Pay)
HOME HEALTH CARE **Precertification necessary**		
• Up to 200 visits per Calendar Year (a visit equals 4 hours of care)	$0	Covered In-Network only
• Home infusion therapy	$0	Covered In-Network only

PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	In-Network (You Pay)	Out-of-Network[1] (You Pay)
PHYSICAL THERAPY AND REHABILITATION **Precertification necessary**		
• Up to 30 days of inpatient service per Calendar Year	$0	Covered In-Network only
• Up to 30 visits combined in home, office or outpatient facility per Calendar Year	$35 co-payment per visit	Covered In-Network only
OCCUPATIONAL, SPEECH, VISION THERAPY**** **Precertification necessary**		
• Up to 30 visits per person combined in home, office or outpatient facility per Calendar Year	$35 co-payment per visit	Covered In-Network only

[1] In addition to paying the Deductible and Coinsurance, you are responsible for paying all amounts charged by the Out-of-Network Provider in excess of the Allowed Amount. This excess amount is also referred to as "balance billing".

*** $2,500 limit for modified solid food products in any continuous 12-month period.

**** Vision therapy does not require precertification.

MENTAL HEALTH CARE	In-Network (You Pay)	Out-of-Network[1] (You Pay)
OUTPATIENT **Precertification necessary** • Up to 20 visits per Calendar Year	$25 co-payment per visit	Covered In-Network only
INPATIENT **Precertification necessary** • Up to 30 days per Calendar Year • Up to 30 visits from mental health care professionals per Calendar Year	$0 $0	Covered In-Network only Covered In-Network only

ALCOHOL OR SUBSTANCE ABUSE TREATMENT	In-Network (You Pay)	Out-of-Network[1] (You Pay)
OUTPATIENT **Precertification necessary** • Up to 60 visits per Calendar Year, including up to 20 visits for family counseling	$0	Covered In-Network only
INPATIENT **Precertification necessary** • Up to 7 days detoxification per Calendar Year • Up to 30 days rehabilitation per Calendar Year	$0 $0	Covered In-Network only Covered In-Network only

EMPIRE VISION CARE	In-Network (You Pay)	Out-of-Network[1] (You Pay)
EYE EXAM • One eye exam every 24 months	$5 co-payment per visit	Covered In-Network only

[1] In addition to paying the Deductible and Coinsurance, you are responsible for paying all amounts charged by the Out-of-Network Provider in excess of the Allowed Amount. This excess amount is also referred to as "balance billing".

COVERAGE

BE SURE YOU KNOW WHAT'S COVERED BY THE PLAN. That way, you and your doctor are better able to make decisions about your healthcare. Empire will work with you and your doctor so that you can take advantage of your healthcare options and are aware of limits the Plan applies to certain types of care.

VERY IMPORTANT – PLEASE REMEMBER TO PRECERTIFY hospital, ambulatory surgery (for Medically Necessary cosmetic/reconstructive surgery, outpatient transplants, ophthalmologic or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures, and certain types of equipment and supplies to ensure maximum benefits. Precertification gives you and your doctor an opportunity to learn what the plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.

Whether medical services are provided In-Network or Out-of-Network, call Empire's Medical Management Program at 1-800-982-8089. This will ensure that you receive maximum benefits.

Doctor's Services

By staying In-Network, you pay only a co-payment and there are no claim forms to fill out for X-rays, blood tests or other diagnostic procedures—as long as they are requested by the doctor and done in the doctor's office or a network facility. For In-Network allergy office visits, you pay only a small co-payment. In-Network allergy testing is covered in full. Ongoing In-Network allergy treatments are covered in full.

Tips For Visiting Your Doctor

- When you make your appointment, confirm that the doctor is an Empire network provider and that he/she is accepting new patients.
- Arrange ahead of time to have pertinent medical records and test results sent to the doctor.
- If the doctor sends you to an outside lab or radiologist for tests or X-rays, visit *www.empireblue.com* or call Empire's Member Services to confirm that the supplier is in Empire's network. This will ensure that you receive maximum benefits.

Ask about a second opinion any time that you are unsure about surgery or a cancer diagnosis. Second and third opinions for surgery are paid in full when arranged through Empire's Medical Management Program. The specialist who provides the second or third opinion cannot perform the surgery. To confirm a cancer diagnosis

or course of treatment, second or third opinions are paid at the In-Network level, even if you use an out-of-network specialist, as long as your participating (i.e., In-Network) doctor provides a written referral to a non-participating (i.e., Out-of-Network) specialist.

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations:

- Consultation requested by the attending physician for advice on an illness or injury
- Diabetes supplies prescribed by an authorized provider:
  - Blood glucose monitors, including monitors for the legally blind
  - Testing strips
  - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
  - Oral agents for controlling blood sugar
  - Other equipment and supplies required by the New York State Health Department
  - Data management systems
- Diabetes self-management education and diet information, including:
  - Education by a physician, certified nurse practitioner or member of their staff:
    - ➢ At the time of diagnosis
    - ➢ When the patient's condition changes significantly
    - ➢ When medically necessary
  - Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
  - Home visits for education when Medically Necessary
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
- Diagnosis and treatment for orthognathic surgery that is not dental in nature
- Medically Necessary hearing examinations
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician.
- Chiropractic care

What's Not Covered

The following medical services are not covered:

- Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain
- Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes
- Orthotics for treatment of routine foot care
- Routine hearing exams
- Hearing aids and the examination for their fitting
- Services such as laboratory, X-ray and imaging, and pharmacy services as required by law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship
- Services given by an unlicensed provider or performed outside the scope of the provider's license.

Healthy Living Programs

PREVENTIVE CARE

Preventive care is an important and valuable part of your healthcare. Regular physical check-ups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. That's why Empire provides many preventive care services for free or only a small co-payment when you use In-Network providers.

Tips For Using Preventive Care

- Visit your doctor once a year for a check-up. Take the screening tests appropriate for your gender and age to help identify illness or the risk of serious illness.
- Women with no prior or family history of breast cancer, get a baseline mammogram between ages 35-39, and for ages 40 and over an annual mammogram. Women who have a family history of breast cancer will be covered for a routine mammogram at any age and as often as their physician recommends one.
- Keep your children healthy by getting routine check-ups and preventive care, including certain immunizations.

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations:

- Well-woman care visits to a gynecologist/obstetrician
- Bone Density Testing and Treatment. Standards for determining appropriate coverage include the criteria of the federal Medicare program and the criteria of the National Institutes of Health for the Detection of Osteoporosis. Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy X-ray absorptiometry.
- Coverage shall be available for individuals meeting the criteria of those programs, including one or more of the following:
    - Previously diagnosed with or having a family history of osteoporosis
    - Symptoms or conditions indicative of the presence or significant risk of osteoporosis
    - Prescribed drug regimen posing a significant risk of osteoporosis
    - Lifestyle factors to such a degree posing a significant risk of osteoporosis
    - Age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.
- Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. Covered services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics (AAP) and will be determined by your child's age.
- Well-child care immunizations as listed:
    - DPT (diphtheria, pertussis and tetanus)
    - Polio
    - MMR (measles, mumps and rubella)
    - Varicella (chicken pox)
    - Hepatitis B
    - Hemophilus
    - Tetanus-diphtheria
    - Pneumococcal
    - Meningococcal Tetramune
    - Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives

What's Not Covered

These preventive care services are not covered:

- Screening tests done at your place of work at no cost to you
- Free screening services offered by a government health department
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests

Emergency Care

IF YOU NEED EMERGENCY CARE

Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy
- Cause serious problems with your body functions, organs or parts
- Cause serious disfigurement
- In the case of behavioral health, place others or oneself in serious jeopardy

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call HealthLine at 1-877-TALK2RN (825-5276) for advice, 24 hours a day, seven days a week.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's network or the PPO network of another Blue Cross and/or Blue Shield plan.

You pay only a co-payment for a visit to an emergency room. This co-payment is waived if you are admitted to the hospital within 24 hours. If you make an emergency visit to your doctor's office, you pay the same as you would for a regular (i.e., non-emergency) office visit.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. A participating provider must provide all follow-up care in order to receive maximum benefits.

You will need to show your Empire BlueCross BlueShield I.D. card when you arrive at the emergency room.

If you are admitted to the hospital, you or someone on your behalf must call Empire's Medical Management Program before services are rendered or within 48

hours after you are admitted to or treated at the hospital, or as soon as reasonably possible. If you do not obtain authorization from Empire's Medical Management Program within the required time, a penalty of 50% of benefits will apply.

Tips For Getting Emergency Care

- If time permits, speak to your physician to direct you to the best place for treatment.
- If you have an emergency while outside Empire's service area anywhere in the United States, follow the same steps described above. If the hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard PPO program, your claim will be processed by the local plan. Be sure to show your Empire I.D. card at the emergency room, and if you are admitted, notify Empire's Medical Management Program within 48 hours of admission. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim.
- If you have an emergency outside of the United States and visit a hospital which participates in the BlueCard Worldwide program, simply show your Empire I.D. card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

  What's Not Covered

  These emergency services are not covered:

  - Use of the Emergency Room:
    - To treat routine ailments
    - Because you have no regular physician
    - Because it is late at night (and the need for treatment is not sudden and serious)
  - Ambulette

Air Ambulance

Air ambulance is provided to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances, and the use of land transportation would pose an immediate threat to your health.
- Services are covered to transport you from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the Medically Necessary services needed for your treatment as determined by Empire, and use of land ambulance would pose an immediate threat to your health.

If Empire determines that the condition for coverage for air ambulance services have not been met but your condition did require transportation by land ambulance to the nearest acute care hospital, the Plan will only pay up to the amount that would be paid for land ambulance to that hospital.

Benefits must be authorized by Empire's Medical Management Program before services are rendered, or within forty eight (48) hours after a Covered Individual is admitted to or treated at the hospital, or as soon as reasonably possible. Failure to obtain authorization from Empire's Medical Management Program within the required time will result in a penalty of 50% of benefits otherwise available.

Remember to call Empire's Medical Management Program at 1-800-982-8089 for prior authorization or within 48 hours after services to receive benefits for air ambulance and to avoid the 50% penalty.

Land Ambulance

Coverage is provided for land ambulance transportation to the nearest acute care hospital, in connection with emergency room care or emergency inpatient admission, provided by an ambulance service, when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- placing the member's health afflicted with a condition in serious jeopardy, or for behavioral condition, place the health of a member or others in serious jeopardy; or
- serious impairment to a person's bodily functions,
- serious dysfunction of any bodily organ or part of a person; or
- serious disfigurement to the member.

Benefits are not available for transfers between healthcare facilities.

Maternity Care and Infertility Treatment

MATERNITY CARE/NEWBORN CHILDREN

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

IF YOU ARE HAVING A BABY

There are no out-of-pocket expenses after the initial office visit co-payment for maternity and newborn care when you use In-Network providers. That means you do not need to continue to pay a co-payment when you visit the obstetrician. Furthermore, routine tests related to pregnancy, obstetrical care in the hospital or birthing center, as well as routine newborn nursery care are all covered 100% In-Network.

Whether services are provided In-Network or Out-of-Network, call Empire's Medical Management Program at 1-800-982-8089 within the first three months of a pregnancy. This will ensure that you receive maximum benefits.

Your baby is automatically covered under the plan for the first 30 days if you have family coverage. However, you will need to add the baby's name as a covered dependent. If you do not have family coverage, call the Fund Office within 30 days to add your newborn as a dependent.

MATERNITY CARE PROGRAM

In the Maternity Care Program, specially trained obstetrical nurses working with you and your doctor, help you and your baby obtain appropriate medical care throughout your pregnancy, delivery and after your baby's birth.

While most pregnancies end successfully with a healthy mother and baby, Maternity Care is also there to identify high-risk pregnancies. If necessary, Empire will suggest a network specialist to you who is trained to deal with complicated pregnancies. Empire can also provide home health care referrals and health education counseling.

Please let Empire know as soon as you know that you're pregnant, so that you will get the appropriate help. A complimentary book on prenatal care is waiting for you when you enroll in Empire Maternity Care. **Call 1-800-845-4742 and listen for the prompt that says "precertify.**" You will be transferred to Empire's Maternity Care Program.

REMEMBER	**Obstetrical care in the hospital or an In-Network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section.**

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations:

- One home care visit fully covered by Empire if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit

from the hospital or a home health care agency within this timeframe (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.

- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician.
- Parent education, and assistance and training in breast or bottle feeding, if available
- Circumcision of newborn males
- Special care for the baby if the baby stays in the hospital longer than the mother. Call Empire's Medical Management Program to precertify the hospital stay.
- Semi-private room

What's Not Covered

These maternity care services are not covered:

- Days in hospital that are not Medically Necessary (beyond the 48-hour/96-hour limits)
- Services that are not Medically Necessary
- Private room
- Out-of-Network birthing center facilities
- Private duty nursing

REMEMBER	**Use a network obstetrician/gynecologist to receive the lowest cost maternity care.**

INFERTILITY TREATMENT

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations.

What's Covered

Medical and surgical procedures, such as

- Artificial insemination
- Intrauterine insemination and
- Dilation and curettage (D&C), including any required inpatient or outpatient hospital care, that would correct malformation, disease or dysfunction resulting in infertility; and services in relation to diagnostic tests and procedures necessary to determine infertility, or
- In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered are:

- hysterosalpingogram
- hysteroscopy
- endometrial biopsy
- laparoscopy
- sono-hysterorgram
- post-coital tests
- testis biopsy
- semen analysis
- blood tests
- ultrasound and
- other Medically Necessary diagnostic tests and procedures, unless excluded by law.

Services must be Medically Necessary and must be received from eligible providers as determined by Empire in accordance with applicable regulations of the New York State Insurance Department. In general, an eligible provider is defined as a healthcare Provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

What's Not Covered

The Plan does not cover any services related to or in connection with:

- In-vitro fertilization
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Reversal of elective sterilizations, including vasectomies and tubal ligations
- Sex-change procedures
- Cloning
- Medical or surgical services or procedures that are experimental
- Services to diagnose or treat infertility if the Plan Administrator or its designee (e.g., Empire), in its sole judgment, that the service was not Medically Necessary.

Hospital Services

IF YOU VISIT THE HOSPITAL

The Empire EPO covers most of the cost of your Medically Necessary care when you stay at a network hospital for surgery or treatment of illness or injury. No benefits are available under the Plan when you use an Out-of-Network hospital.

You are also covered for same-day (outpatient or ambulatory) hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same-day or hospital outpatient surgical facility
- Require the use of both surgical operating and postoperative recovery rooms,
- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or Medically Necessary, and
- Would justify an inpatient hospital admission in the absence of a same-day surgery program.

Remember to call Empire's Medical Management Program at 1-800-982-8089 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or emergency surgical procedure, call Empire's Medical Management Program within 48 hours or as soon as reasonably possible. Otherwise your benefits may be reduced by 50% up to $5,000 for each hospital admission or surgery that is not precertified. Benefit reductions will also apply to all care related to the admission, including physician services.

The medical necessity and length of any hospital stay are subject to Empire's Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not Medically Necessary, no benefits will be paid. See the Medical Management Program chapter for additional information.

If surgery is performed in a network hospital, you will receive In-Network benefits for the anesthesiologist, whether or not the anesthesiologist is in the network.

When you use a network hospital, you will not need to file a claim in most cases.

Tips For Getting Hospital Care

- If your doctor prescribes pre-surgical testing (unlimited visits), have your tests done within seven days prior to surgery at the hospital where surgery will be performed. For pre-surgical testing to be covered, you need to have a reservation for both a hospital bed and an operating room.
- If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Inpatient And Outpatient Hospital Care

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations for both inpatient and outpatient (same-day) care:

- Diagnostic X-rays and lab tests, and other diagnostic tests such as EKG's, EEG's or endoscopies

- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration)
- Anesthesiologist, including one consultation before surgery and services during and after surgery
- Blood and blood derivatives for emergency care, same-day surgery, or Medically Necessary conditions, such as treatment for hemophilia
- MRIs/MRAs, when pre-approved by Empire's Medical Management Program (your provider must call to precertify these services)

Inpatient Hospital Care

What's Covered

The following are additional covered services for inpatient care:

- Semi-private room and board when:
    - The patient is under the care of a physician, and
    - A hospital stay is Medically Necessary
    - Coverage is for unlimited days, subject to Empire's Medical Management Program review, unless otherwise specified
- Operating and recovery rooms
- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital
- Care related to surgery
- Breast cancer surgery (lumpectomy, mastectomy), including:
    - Reconstruction following surgery
    - Surgery on the other breast to produce a symmetrical appearance
    - Prostheses
    - Treatment of physical complications at any stage of a mastectomy, including lymphedemas

  The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery.
- Use of cardiographic equipment
- Drugs, dressings and other Medically Necessary supplies
- Social, psychological and pastoral services
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery
- Reconstructive surgery for a functional defect which is present from birth
- Physical, occupational, speech and vision therapy including facilities, services, supplies and equipment

- Facilities, services, supplies and equipment related to Medically Necessary medical care

Outpatient Hospital Care

What's Covered

The following are additional covered services for same-day care:

- Same-day and hospital outpatient surgical facilities
- Surgeons
- Surgical assistant if:
    - None is available in the hospital or facility where the surgery is performed, and
    - The surgical assistant is not a hospital employee
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor's office or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
    - At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered)
    - In a hospital-based or free-standing facility. See "Hospital/Facility" in the Definitions chapter.

Inpatient Hospital Care

What's Not Covered

These inpatient services are not covered:

- Private duty nursing
- Private room. If you use a private room, you must to pay the difference between the cost for the private room and the hospital's average charge for a semiprivate room.
- Diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
- Services performed in the following:
    - Nursing or convalescent homes

- Institutions primarily for rest or for the aged
- Rehabilitation facilities (except for physical therapy)
- Spas
- Sanitariums
- Infirmaries at schools, colleges or camps

- Any part of a hospital stay that is primarily custodial
- Elective cosmetic surgery or any related complications
- Hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility. See "Hospital/Facility" in the Definitions chapter.

Outpatient Hospital Care

What's Not Covered

These outpatient services are not covered:

- Same-day surgery not precertified as Medically Necessary by Empire's Medical Management Program
- Routine medical care including but not limited to:
  - Inoculation or vaccination
  - Drug administration or injection, excluding chemotherapy
- Collection or storage of your own blood, blood products, semen or bone marrow

Durable Medical Equipment and Supplies

IF YOU NEED EQUIPMENT OR MEDICAL SUPPLIES

The Empire EPO covers the cost of Medically Necessary prosthetics, orthotics and durable medical equipment and medical supplies from network suppliers only. Benefits and plan maximums are shown in the Benefits Summary chart.

The network supplier must precertify the rental or purchase by calling Empire's Medical Management Program at 1-800-982-8089. When using a supplier outside Empire's operating area through the BlueCard PPO Program, you are responsible for precertifying services. An Empire network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Empire Member Services at 1-800-342-9816.

Tip For Obtaining Special Medical Supplies
For prosthetics, orthotics and durable medical equipment, be sure the network vendor knows the number to call for Medical Management Precertification.

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations:

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a doctor and approved by Empire's Medical Management Program, including:
    - Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses
    - Prescription lenses, if organic lens is lacking
    - Supportive devices essential to the use of an artificial limb
    - Corrective braces
    - Wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors
- Rental (or purchase when more economical) of Medically Necessary durable medical equipment
- Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician
- Reasonable cost of repairs and maintenance for covered medical equipment
- Disposable medical supplies such as syringes
- Enteral formulas with a written order from a physician or other licensed health care provider. The order must state that:
    - The formula is Medically Necessary and effective, and
    - Without the formula, the patient would become malnourished, suffer from serious physical disorders or die.
- Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed healthcare provider must provide a written order.

What's Not Covered

Expenses for the following equipment are not covered:

- Air conditioners or purifiers
- Humidifiers or dehumidifiers
- Exercise equipment
- Swimming pools
- False teeth
- Hearing aids

Skilled Nursing and Hospice Care

IF YOU NEED SKILLED NURSING OR HOSPICE CARE

You receive coverage through Empire's EPO for inpatient care in a skilled nursing facility or hospice. Benefits are available under the Plan for In-Network facilities only.

In order to receive maximum benefits, please call 1-800-982-8089 to precertify skilled nursing and hospice care with Empire's Medical Management Program.

Skilled Nursing Care

What's Covered

You are covered for inpatient care in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services. The number of covered days is listed in the Benefits Summary chart. Prior hospitalization is not required in order to be eligible for benefits. Services are covered if:

- The doctor provides:
    - A referral and written treatment plan,
    - A projected length of stay,
    - An explanation of the services the patient needs, and
    - The intended benefits of care,

and

- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other healthcare professional.

What's Not Covered

The following skilled nursing care services are not covered:

- Skilled nursing facility care that primarily:
    - Gives assistance with daily living activities
    - Is for rest or for the aged
    - Treats drug addiction or alcoholism
- Convalescent care
- Sanitarium-type care
- Rest cures

Hospice Care

The Empire EPO covers up to 210 days of hospice care once in a Covered Individual's lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of a network hospital, or at home, as long as it is provided by a network hospice agency.

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations:

- Hospice care services, including:
  - Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
  - Medical care given by the hospice doctor
  - Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference
  - Physical, occupational, speech and respiratory therapy when required for control of symptoms
  - Laboratory tests, X-rays, chemotherapy and radiation therapy
  - Social and counseling services for the patient's family, including bereavement counseling visits until one year after death
  - Transportation between home and hospital or hospice when Medically Necessary
  - Medical supplies and rental of durable medical equipment
  - Up to 14 hours of respite care in any week

Home Health Care

IF YOU NEED HOME HEALTH CARE

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive coverage for home health care and home infusion therapy when you use an In-Network provider. Benefits and plan maximums are shown in the Benefits Summary chart.

Remember, in order to receive maximum benefits, you need to precertify home health care through Empire's Medical Management Program. If you use a home health care agency in Empire's network, the agency must call Medical Management for precertification. If you use a home health care agency in the BlueCard PPO network, you need to call Medical Management. (The agency can call to precertify home health care for you, however, in order to receive maximum benefits, you need to make sure that they call.)

Home infusion therapy, which is a service sometimes provided during home health care visits, is only available In-Network. If you use an Empire network home infusion supplier, the supplier must call Medical Management for precertification. While a BlueCard PPO supplier can call to precertify your treatment, you need to make sure that they call.

An Empire network home health care agency or home infusion supplier cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-342-9816.

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations:

- Up to 200 precertified home health care visits per year. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as Medically Necessary and approve a written treatment plan.
- Home health care services include:
  - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
  - Part-time home health aide services (skilled nursing care)
  - Physical, speech or occupational therapy, if restorative
  - Medications, medical equipment and supplies prescribed by a doctor
  - Laboratory tests

What's Not Covered

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care
- Out-of-Network home infusion therapy

Physical, Occupational, Speech or Vision Therapy

IF YOU NEED THERAPY

You receive benefits through Empire's EPO for outpatient physical, occupational, speech and vision therapy by a network provider. There are no benefits under the Plan for Out-of-Network services.

You must call Empire's Medical Management Program at 1-800-982-8089 to precertify all physical, occupational, and speech therapy. This will ensure that you receive maximum benefits.

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations:

- Physical therapy, physical medicine or rehabilitation services, or any combination of these on an inpatient or outpatient basis up to the Plan maximums if:

- Prescribed by a physician,
- Designed to improve or restore physical functioning within a reasonable period of time, and
- Approved by Empire's Medical Management Program.

Outpatient care must be given at home, in a therapist's office or in an outpatient facility by an In-Network provider; inpatient therapy must be short-term.

- Occupational, speech or vision therapy, or any combination of these on an outpatient basis up to the Plan maximums if:
  - Prescribed by a physician or in conjunction with a physician's services,
  - Given by skilled medical personnel at home, in a therapist's office or in an outpatient facility,
  - Performed by a licensed speech/language pathologist or audiologist, and
  - Approved by Empire's Medical Management Program, except vision therapy.

What's Not Covered

The following therapy services are not covered:

- Therapy to maintain or prevent deterioration of the patient's current physical abilities
- Tests, evaluations or diagnoses received within the 12 months prior to the doctor's referral or order for occupational, speech or vision therapy

Behavioral Healthcare

IF YOU NEED BEHAVIORAL HEALTHCARE

Your behavioral healthcare benefits cover outpatient treatment for alcohol or substance abuse, inpatient detoxification, inpatient alcohol and substance abuse rehabilitation, and inpatient and outpatient mental health care from In-Network providers only. You will not receive Benefits from the Plan for any of these services if you go Out-of-Network.

To help ensure that you receive appropriate care, you need to precertify all behavioral healthcare services in advance. When you call the Behavioral Healthcare Management Program at 1-800-626-3643 to precertify In-Network services, a counselor will refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services.

If you do not call to precertify behavioral healthcare, or if you call but do not follow their recommended treatment plan, covered benefits may be denied or reduced as follows:

- 50% up to $5,000 per inpatient admission for mental health or alcohol/substance abuse detoxification
- 50% for each outpatient mental health visit
- 50% for each outpatient alcohol and substance abuse facility or provider visit
- 50% for each professional mental health care visit made during an inpatient stay

REMEMBER	**When you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call the Behavioral Healthcare Management Program at 1-800-626-3643 within 48 hours or as soon as is reasonably possible.** **If you want to know if a provider or facility is covered In-Network, call the Behavioral Healthcare Management Program.** **If you do not agree with a certification decision made by the Behavioral Healthcare Management Program, you can file an appeal. For more information see "Appeals and Grievances" in the Medical Management Program chapter.**

Mental Health Care

What's Covered

Covered services are listed in the Benefits Summary chart. The following are additional covered services and limitations:

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management
- Care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.
- Treatment in a comprehensive care center for eating disorders.

Treatment for Alcohol or Substance Abuse

What's Covered

In addition to the services listed in the Benefits Summary chart, the following services are covered:

- Family counseling services for alcohol or substance abuse at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the Plan may receive one counseling visit per day.
  - Visits for family counseling are deducted from the 60 visits available for outpatient treatment.

What's Not Covered

The following behavioral healthcare treatment services are not covered:

- Care that is not Medically Necessary

Vision Care – Empire

IF YOU NEED VISION CARE

The Empire EPO offers vision care coverage only when you use In-Network providers. There are no Out-of-Network benefits for Empire vision care. To find a participating provider in your area, simply call 1-877-923-2847 between 8:00 a.m. and 8:00 p.m. weekdays, 9:00 a.m. and 4:00 p.m. Saturdays. Then contact the provider to make an appointment.

What's Covered

Empire vision care benefits include one comprehensive eye exam, subject to a $5 co-payment every 24 months for each covered member. Eye exams must be conducted in a single visit.

What's Not Covered

The following Empire vision care services are not covered:

- Frames, lenses or contact lenses
- Treatment of eyes and eye disease, including ophthalmologic care (covered under your medical plan)
- Replacement of lost, stolen, broken or duplicate eye wear
- Eye examinations required by an employer
- More than one eye exam and set of eyewear per person in each 24-month period
- Corrective eye surgery for near/far sightedness (i.e. PRK, LASIK)
- Special procedures such as orthoptics training

MEDICAL MANAGEMENT PROGRAM

To ensure that your health expenditures are only for appropriate care, your Empire BlueCross BlueShield EPO program manages medical Benefits for you and your covered family members through its Medical Management Program. You must comply with this program in order to receive the maximum Benefits. Empire's Medical Management Program staff will work with both you and your Provider to confirm the necessity of the services you receive and to help you make sound health care decisions and maximize your coverage.

A. How the Medical Management Program Helps You and Your Family

When you call the Medical Management Program at 1-800-982-8089, a team of managed benefits professionals can help you to:

- Learn more about your health care options.
- Choose the most appropriate health care setting or service (i.e., Hospital or Ambulatory Surgery unit).
- Avoid unnecessary hospitalization and the associated risks, whenever possible.
- Arrange for any required (and covered) discharge services.

Typical Medical Management services include:

- Planned and emergency Hospital admission review.
- Ongoing hospitalization review.
- Review inpatient and Same Day Surgery.
- Review high risk pregnancies.
- Perform individual case management.
- Review of routine maternity admissions.
- Voluntary second surgical opinions referrals.
- Pre-certification for care in Skilled Nursing Facilities.
- Pre-certification for Home Health Care.

B. Individual Case Management services:

If you or your Covered Dependents face a chronic or catastrophic Illness or Injury, the Medical Management Program's individual case management staff can also provide assistance and support. Empire's Nurses can help you and your family find the most appropriate, cost-effective alternative to help control your medical costs while assuring quality medical care. The case manager provides a single source for the patient, provider, and insurer — assuring that treatment, level of care, and facility are appropriate to the your needs. For example, the case manager can help with cases such as:

- cancer
- stroke
- AIDS
- chronic Illness
- hemophilia
- spinal cord and other traumatic injuries.

You may request individual case management services, or Medical Management Program staff may initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided by the Empire EPO might be desirable, appropriate and cost-effective. If you would like case management assistance following an Illness or Surgery, contact Empire's Medical Management Program at 1-800-982-8089.

C. When Calling the Medical Management Program:

When you or someone on your behalf call the Medical Management Program, you should be prepared to provide the following information:

- Patient's name, birth date, and sex.
- Patient's address and telephone number.
- Patient's Empire identification card number.
- The name and address of the Hospital/facility.
- Date of patient's proposed admission to the Hospital or facility.
- Name and telephone number of the admitting doctor.
- Reason for admission and nature of the services to be performed.

When the vendor or Provider is required to call Empire's Medical Management Program for precertification, be sure they know about the precertification requirement and that they have the Medical Management telephone number.

PRECERTIFICATION

A. When to Notify the Medical Management Program

In order for you to precertify hospital admissions and certain services and receive the maximum available Benefits, you or someone on your behalf must call the Empire Medical Management Program at 1-800-982-8089 in the following instances:

- at least two weeks before any planned Surgery or Hospital admission. This applies to Ambulatory Surgery as well as inpatient Surgery.
- within 48 hours of an emergency Hospital admission. (You do not have to call if the emergency room sends you home.)

- for a Hospital admission relating to illness or injury to newborns;
- within the first three months of a pregnancy and no more than one business day after the actual delivery.
- before you receive:
  - inpatient physical therapy,
  - Same-Day Surgery for Medically Necessary cosmetic/ reconstructive surgery, outpatient transplants and ophthalmologic or eye-related procedures;
  - cardiac rehabilitation;
  - Hospice care;
  - Occupational or speech therapy;
  - Outpatient physical therapy;
  - Skilled nursing facility care;
  - Air ambulance service
- before you receive Home Health Care or home infusion therapy services.[2]
- before you receive certain equipment or supplies, e.g. prosthetics
- before you receive MRIs/MRA's.[3]

See the Schedule of Medical Benefits chapter for more information on when you must precertify or call Empire at 1-800-982-8089.

B. Penalties If Services Are Not Precertified

If you do not comply with Medical Management requirements, Benefits may be reduced by 50% up to $5,000 for each admission, treatment or procedure. This Benefit reduction also applies to certain Same-Day Surgery and professional services rendered during an inpatient admission. If the admission or procedure is not precertified and Empire subsequently determines that it is not Medically Necessary, no Benefits will be paid.

C. Initial Decisions

Empire will comply with the following timeframes in processing precertification, concurrent and retrospective review of requests for services.

- *Precertification Requests*. Precertification means that you must contact Empire's Medical Management Program for approval before you receive certain health care services. Empire will review all requests for precertification within three (3) business days of receipt of the necessary information but not to exceed 15 calendar days from

[2] It is the Network Supplier's responsibility to call Empire for precertification of all In-Network Home Health Care, Home infusion therapy services.

[3] It is the Provider's responsibility to call Empire for precertification of all In-Network MRI/MRA services.

the receipt of the request. If Empire does not have enough information to make a decision within three (3) business days, Empire will notify you in writing of the additional information it needs, and you and your provider will have 45 calendar days to respond. Empire will make a decision within three (3) business days of its receipt of the requested information, or if no response is received, within three (3) business days after the deadline for a response.

- *Urgent Precertification Requests*. If the need for the service is urgent, Empire will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of its receipt of the request. If the request is urgent and Empire requires further information to make its decision Empire will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. Empire will make a decision within 48 hours of its receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.
- *Concurrent Requests*. Concurrent review means that Empire reviews your care during your treatment to be sure you get the right care in the right setting and for the right length of time. Empire will complete all concurrent reviews of services within 24 hours of its receipt of the request.
- *Retrospective Requests*. Retrospective review is conducted after you receive medical services. Empire will complete all retrospective reviews of services already provided within 30 calendar days of its receipt of the claim. If Empire does not have enough information to make a decision within 30 calendar days, Empire will notify you in writing of the additional information it needs, and you and your provider will have 45 calendar days to respond. Empire will make a decision within 15 calendar days of its receipt of the requested information, or if no response is received, within 15 calendar days after the deadline for a response.

If Empire's Medical Management Program does not meet the above time frames, the failure should be considered a denial. You or your doctor may immediately appeal if a request is denied.

All denials of medical Benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of Medical Necessity, or because the service has been determined to be experimental or investigational, Empire's Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. See the section below titled "Appeals and Grievances" for more information.

If Empire's Medical Management Program denies Benefits for care or services without discussing the decision with your doctor, your doctor is entitled to ask Medical Management to reconsider their decision. A response will be provided by telephone and in writing within one business day of making the decision.

EMPIRE CLAIMS INFORMATION (IN-NETWORK MEDICAL CLAIMS)

A. How to File a Claim for In-Network Medical Benefits

Empire's EPO makes healthcare easy by paying providers directly when you stay In-Network. Therefore, when you receive care from providers or facilities in the Empire or BlueCard PPO networks, you generally do not have to file a Claim, as the provider files the Claim directly with Empire or the local Blue Cross/Blue Shield plan. However, you will have to file a Claim for reimbursement for covered services if you have a medical emergency out of Empire's service area. To obtain a claim form, call Empire's Member Services.

Send completed forms to:

Hospital Claims:
Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Institutional Claims Department

Medical Claims:
Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Medical Claims Department

Tips for Filing a Claim

- File claims within 18 months of date of service.
- Visit *www.empireblue.com* to print out a claim form immediately or contact Member Services at 1-800-342-9816 to have one mailed to you.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

If You Have Questions About a Benefit Payment

Empire reviews each Claim for appropriate services and correct information before it is paid. Once a Claim is processed, an Explanation of Benefits (EOB) will be sent directly to you if you have any responsibility on the Claim other than your co-payment amount or if an adjustment is performed on your Claim.

B. Time Limit For Filing Claims

Claims for In-Network medical Benefits must be filed within 18 months of the date of service to receive Benefits.

C. Notice of Claims Decisions

If Empire reduces or denies a claim payment, you will receive a written notification or an Explanation of Benefits (EOB) citing the reasons your Claim was reduced or denied.

The notification will give you:

- The specific reason(s) for the denial
- References to the pertinent plan provisions on which the denial is based
- A description of any additional material or information necessary for you to establish the Claim and an explanation of why this material or information is necessary
- An explanation of claims review procedures

If you have any questions about your Claim, your Plan Administrator may be able to help you answer them. You may also contact Empire Member Services at 1-800-342-9816 or in writing for more information. When you call, be sure to have your Empire I.D. card number handy, along with any information about your Claim. Send written inquiries to:

Empire BlueCross BlueShield
EPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

If Empire denies your Claim, in whole or in part, you have the right to appeal. See the section below entitled "Appeals and Grievances" for more information.

D. Appeals and Grievances

Your Right to Appoint a Representative

You may appoint a representative to act on your behalf if you are not able to submit an appeal or grievance on your own. Call Empire's Member Services for a form. When completed forms are returned, your representative's name will be noted on Empire's files.

Appeals

An appeal is a request to review and change an Adverse Benefit Determination made by Empire's Medical Management Program or Behavioral Health Management Program that a service is not Medically Necessary or is excluded from coverage because it is considered experimental or investigational. Appeals may be filed by telephone or in writing.

Grievances

A grievance is a verbal or written request to review an Adverse Benefit Determination concerning an administrative decision not related to medical necessity. For example, a claim was denied by Empire because the member did not obtain precertification for services.

Level 1 Appeals

A Level 1 Appeal is your first request for review of the initial reduction or denial of services. You have 180 calendar days from the date of the notification letter to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge receipt of your appeal in writing within 15 calendar days from the initial receipt date.

Qualified clinical professionals who did not participate in the original decision will review your appeal.

Empire will make a decision within the following timeframes for 1st Level Appeals:

- *Precertification*. Empire will complete its review of a precertification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- *Concurrent*. Empire will complete its review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- *Retrospective*. Empire will complete its review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Empire will provide a written notice of its determination to you or your representative, and your Provider, within two business days of reaching a decision.

If Empire's Medical Management Program does not make a decision within 60 calendar days of receiving all necessary information to review your appeal, Empire will approve the service.

If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal.

Expedited Level 1 Appeals

You can file an expedited Level 1 Appeal and receive a quicker response if:

- You want to continue healthcare services, procedures or treatments that have already started
- You need additional care during an ongoing course of treatment
- Your Provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Expedited Appeals may be filed by telephone and in writing.

Please note that appeals of claims decisions made after the service has been provided cannot be expedited. When you file an expedited appeal, Empire will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum timeframes:

- You or your Provider will have reasonable access to our clinical reviewer within one business day of Empire's receipt of the request.
- Empire will make a decision within two business days of receipt of all necessary information but in any event within 72 hours of receipt of the appeal.
- Empire will notify you immediately of the decision by telephone, and within 48 hours in writing.

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you have exhausted all internal appeal options.

If Empire's Medical Management Program does not make a decision within 2 business days of receiving all necessary information to review your appeal, Empire will approve the service.

Level 2 Appeals and Timeframes

If you are dissatisfied with the outcome of your Level 1 Appeal, you may file a Level 2 Appeal with Empire within 60 business days from the receipt of the notice of the letter denying your Level 1 Appeal. If your Level 2 Appeal is not submitted within that timeframe, Empire will not review it and the decision on the Level 1 appeal will stand. Appeals may be filed by telephone and in writing.

Empire will make a decision within the following timeframes for 2nd Level appeals:

- *Precertification*. Empire will complete its review of a precertification appeal within 15 calendar days of receipt of the appeal.
- *Concurrent*. Empire will complete its review of a concurrent appeal within 15 calendar days of receipt of the appeal.
- *Retrospective*. Empire will complete its review of a retrospective appeal within 30 calendar days of receipt of the appeal.

REMEMBER	**A Level 1 Appeal submitted beyond the 180-calendar-day limit will not be accepted for review.** **A Level 2 Appeal submitted beyond the 60-business-day limit will not be accepted for review.**

Level 1 Grievances

A Level 1 Grievance is your first request for review of Empire's administrative decision. You have 180 calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the 180-calendar-day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge your grievance in writing within 15 calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance, and a description of any additional information required to complete the review.

Empire will make a decision within the following timeframes for 1st Level Grievances:

- *Pre-service (services have not yet been rendered)*. Empire will complete its review of a pre-service grievance (other than an expedited grievance) within 15 calendar days of receipt of the grievance.
- *Post-service (services have already been rendered)*. Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

Level 2 Grievances

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire within 60 business days from receipt of the notice of the letter denying your Level 1 Grievance. If the Level 2 Grievance is not submitted within that timeframe, Empire will not review it and the decision on the Level 1 Grievance will stand. Empire will acknowledge receipt of the 2nd Level Grievance within 15 days of receiving the grievance. The written acknowledgement will include the name, address and telephone numbers of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

Empire will make a decision within the following timeframes for 2nd Level Grievances:

- Pre-service. Empire will complete its review of a pre-service grievance within 15 calendar days of receipt of the grievance.
- Post-service. Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

Expedited Grievances

You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within 72 hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two business days in writing.

Decisions on Grievances

Empire's notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire's decision
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision

How to File an Appeal or Grievance

To submit an appeal or grievance, call Empire's Member Services at 1-800-342-9816, or write to the following address with the reason why you believe the administrative decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

Empire BlueCross BlueShield
Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

PRESCRIPTION DRUG PROGRAM

The Welfare Fund offers a prescription drug program through a prescription benefits manager ("PBM") to complement your medical coverage under the Plan. If you are eligible to receive medical Benefits, you are eligible to participate in the prescription drug program. You do not need a separate prescription drug Enrollment.

Through the prescription drug program, you and your Eligible Dependents may purchase prescription drugs from a participating pharmacy or a non-participating pharmacy. Your out-of-pocket expenses will be smaller if you choose a participating pharmacy (i.e, a pharmacy that has an agreement with the PBM), and larger if you choose a non-participating pharmacy. The Fund Administrator can give you the names of participating pharmacies.

A. Your Prescription Drug Program ID Card

You will receive a prescription drug program identification card from the Fund Office that lists your name and various identifying codes. This card is the key to having your prescriptions filled at a participating pharmacy. All you have to do is present the prescription from your doctor, your prescription drug identification card and the appropriate co-payment to your participating pharmacist. If you fail to present your prescription drug identification card to the participating pharmacy at the time you purchase your prescription, you must pay the full charge for your prescription, then file a claim for reimbursement. You will be reimbursed as if you had purchased your prescription from a non-participating pharmacy.

B. Generic vs. Brand Name Drugs

The prescription drug program requires mandatory dispensing of generic instead of brand name prescription drugs whenever generic drugs are available. What is a generic drug? The generic name of a drug is its official chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand named drugs must meet the same standards for safety, purity, strength and effectiveness.

The prescription form from your doctor will contain a box marked "DAW," which means "Dispense as Written." If your doctor initials this box, the pharmacist can only dispense the brand name drug prescribed by your doctor. If your doctor has not marked this box, you can ask the pharmacist to fill the prescription with a generic drug (if one is available). You would then pay the lower co-payment for generic drugs. Ask your physician to prescribe generic drugs whenever possible. This saves both you and the Plan money.

C. Deductibles and Co-Payments

There is a deductible of $50 each Calendar Year for each Covered Individual. This deductible is in addition to the annual medical benefits deductibles.

In addition to the deductible, you are also responsible for a co-payment for each prescription.

- For generic drugs
  - purchased at a participating pharmacy, the co-payment is the greater of 10% of the drug cost or $5, or
  - purchased through the PBM mail order program, the co-payment is the greater of 8% of the drug cost or $12.50.
- For brand name drugs,
  - purchased at a participating pharmacy, the co-payment is the greater of 20% of the drug cost or $10, or
  - purchased through the PBM mail order program, the co-payment is the greater of 17% of the drug cost or $25.00.

The prescription drug program requires mandatory dispensing of generic drugs instead of brand name drugs when generic drugs are available. If you elect a brand name drug that has a generic alternative, you will be required to pay the brand name drug co-payment plus the price difference between the brand name drug and the generic drug. For example, assume you have already met the $50 annual deductible and you elect to fill a prescription at a participating pharmacy using a brand name drug although a generic drug is available. You will be required to pay the price difference. Let's say that the cost of the brand name drug is $60 and the generic drug costs $30. If you elected to purchase the brand name drug, you would be responsible for paying the co-payment for the brand name drug, or $12 (the higher of 20% of $60 or $10), plus the difference in price between the brand name drug and the generic drug, or $30 ($60 – $30 = $30). So, in this example your out-of-pocket expense is $42 (a $12 co-payment plus $30). If, instead, you had filled the prescription with the generic drug, you would have only paid the $5 co-payment (the higher of 10% of the $30 cost of the generic drug or $5).

VERY IMPORTANT INFORMATION: You must present your prescription drug identification card to a participating pharmacist when filling your prescription in order to qualify for this payment discount. If you do not, or if you go to a non-participating pharmacist, you will be responsible for paying the pharmacy the full amount charged for the prescription. Afterward, you can submit a Claim for reimbursement of the Allowed Amount.

D. Prescription Supply Limitations

Except in the case of maintenance drugs, which are described below, the Plan limits an individual prescription (including refills) to the greater of a 30-day supply or 100 units (e.g. pills). After that, you must present a new written prescription.

For maintenance drugs (i.e., prescription medications that a person is generally required to take for an extended period of time), you are required to fill a 90-day prescription through the PBM's mail order program, though the cost is only 2½ times the retail co-payment. Here's how it works. Let's say you order a 90-day mail order supply of a generic drug that costs (at a participating pharmacy) $30 for a 30-day supply. Normally, the co-payment would be $5 (because $5 is greater than 10% x $30 = $3) per 30-day supply. But under the special co-payment rules for mail order maintenance drugs, the co-payment for the 90-day supply is $12.50 (2½ x $5), not $15 (3 x $5).

VERY IMPORTANT INFORMATION: Your physician must write the prescription for a 90-day supply. A prescription written for a 30-day supply with 2 refills is not acceptable and will not be filled under the 2 ½ co-payment discount.

E. Reimbursement for Prescriptions

If you fill your prescription at a non-participating pharmacy, or if you fail to present your prescription drug identification card when filling your prescription at a participating pharmacy, you will need to submit a Claim form for reimbursement, together with a copy the bill for the prescription, to the Fund Office. You can obtain the correct form from the Fund Administrator.

F. What's Covered

The Plan provides benefits for certain medically necessary drugs when duly dispensed by a pharmacy pursuant to a physician's written prescription, including certain compound drugs, specialty drugs and the following items, unless included within the categories or items listed in the section below entitled "What's Not Covered". For more information about the prescription drugs that are covered under the Plan, you should contact the Fund Administrator.

AIDS / HIV Medications	Hypnotic / Sedatives	Lancets	Prenatal vitamins
Ambien / Sonata	Immunosuppressive (Transplant)	Legend Drugs w/OTC alts	Protease Inhibitors
Anti-Anxiety	Injectable Chemotherapy	Methotrexate	State Controlled Drugs (DEA V)
Anti-Depressants	Insulin	Methylphenidate (Ritalin)	Urine Testing Supplies
Anti-psychotics	Insulin Needles & Syringes	Migraine Nasal	Vitamins (Iron & B12)
Anti-Viral	Insulin Pump Needles	Migraine Pills	Wellbutrin 150mg
Diabetic Blood Testing	Lamisil / Sporanox	Oral Anti-Fungals	Yohimbine (Yocon)
Glucometers		Oral Chemotherapy	

G. What's Not Covered

Charges for the following items are not covered:

Accutane
Acne Products
Alcohol Swabs
Anabolic Steroids (Androgens)
Anorexics (weight loss)
Bee Sting Inj. / ANA KITS
Biologicals
Caverject / Edex
Children's vitamins w/fluoride
Copaxone
Cosmetic Products
Dental Products
Diaphragms
Differin
DME
Emergency Contraceptives
Enbrel
Fertility Drugs
Fluoride
Foams and Devices
Folic Acid 1MG
Glucagon (injectable)
Growth Hormones
Hair Growth Agents
Hematopoietic Growth Factors (Colony)
Hematopoietic Mixtures
Immunizations
Implantable Contraceptives
Injectable Contraceptives
Injectable Vitamins
Injectables (Non-insulin)
Interferons
Iron
Lancet Devices
Migraine Injectables
Muse
Non-diabetic Needles & Syringes
Novopen
Nutritional Supplements
Oral Contraceptives
Over The Counter drugs
Retin-A
Smoking Deterrents
Viagra, Cialis, Levitra and other erectile dysfunction drugs or medications

In addition to the above, the Plan does not cover charges for:

- Any drugs administered by a physician or in a doctor's office or clinic.
- Unauthorized refills.
- A medication that is to be taken by or administered to, in whole or in part, a Covered Individual while a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution.
- Drugs labeled "Caution - Limited by Federal Law to Investigational Use" or experimental or investigational drugs even though the covered person is charged.
- Expenses incurred prior to or after an individual's eligibility under the Plan or not submitted within 12 months from the date of service.
- Any medication for which the cost is recovered under any Workers' Compensation or occupational disease law, any state or governmental agency, or from any third party, or any medication furnished by any other drug or medical service for which no charge is made to the Covered Individual.

Please contact the Fund Administrator if you have any questions or need more information about your prescription drug program.

DENTAL BENEFITS

If you are an active Employee and are eligible to receive medical Benefits, you are eligible for Dental Benefits. You do not need a separate dental Enrollment. No Dental Benefits are available under the Plan if you are a retiree.

Under the Plan, each time you go to a Dentist, you will have a choice of how you want to receive your Benefits. You can use your own Dentist regardless

of whether he or she is affiliated with any plan. Or you can choose a Dentist from a pre-selected panel of Dentists and receive services at no cost or very low cost to you and your family.

The Plan will cover up to a maximum of $2,000 of your costs for each Covered Individual per Calendar Year.

Please Note: Effective April 1, 2011, the annual limit of $2,000 for Dental Benefits that are considered Essential Health Benefits is eliminated for Children under the age of 19. Please understand that the elimination of this annual limit only applies to essential benefits and is not adding to the coverage already provided. In addition, certain of the limits set forth below will continue to be applied to all Covered Individuals. For example, the $2,000 Lifetime Benefit on Orthodontic services remains in place for all Covered Individuals, including Children who are under the age of 19.

A. Using Your Own Dentist

The covered Dental services are described below. The Plan will pay up to the Allowed Amount for each covered service (up to the annual maximum described above), but will never pay more than the amount charged by your Dentist. For most services, the Benefit will generally cover a portion, but not all, of your costs.

The following list is relatively technical. For further details, you should contact the Fund Administrator.

- Examination: One examination every six months.
- X-rays.
- Preventive: Cleaning once every six months (including scaling and polishing). For covered dependents under age 19, includes two fluoride treatments per Calendar Year.
- Restorative: Amalgam, acrylic, composite or plastic fillings.
- Endodontics: Root canal therapy treatment plan, clinical procedures, follow-up care and pulp capping.
- Periodontics: Annual maximum for periodontic treatment is $180 per covered person.
- Oral surgery: Extractions, alveoplasty, including local Anesthesia and routine post-operative care.
- Crowns: One restoration every 36 months for full and partial gold, acrylic, porcelain or stainless steel crowns.
- Prosthodontics: Full or partial dentures, bridgework, abutments and maintenance.
- Orthodontics: Initial examination, x-rays, appliances and active treatment. There is a $2,000 Lifetime Benefit, to be distributed over no less than 3 years.

B. Using a Panel Dentist

Using a panel Dentist will limit and may even eliminate your Out-of-Pocket costs. In addition to the services listed above, other procedures provided by panel Dentists are available at discounted rates.

The Fund Administrator can give you the names of panel Dentists. If your Dentist is not on the list, ask him or her to consider becoming a panel Dentist. The Fund Administrator can provide details on request.

C. What's Not Covered

Charges for the following Dental services are not covered under the Plan's Dental Benefit:

- Cosmetic dentistry (dental services primarily to improve appearance).
- Fraud.
- Service performed by a Dentist who is related to you by blood or marriage.
- Sealant or acrylic coatings on biting surfaces of teeth.
- Instruction in oral hygiene, plaque control or diet.
- Dental services furnished by or paid for by any government agency.
- Implantology.
- Costs arising from treatment for an Illness or Injury on the job. These charges are usually covered under the Workers' Compensation Act or similar law.
- Procedures performed in a Hospital or a Physician's office, unless needed as a result of Injury and if treatment is given within one year after the accident.
- For initial installation of denture or fixed bridgework for replacement of natural teeth, all of which were extracted before coverage began.
- Services that are not customarily performed, not reasonably necessary or are Experimental in nature.
- Treatment started before coverage began.

D. Payment for Dental Benefits

There are two claim forms — one for services received from a panel Dentist and one for care received from any other Dentist. Obtain the correct form from the Fund Administrator. You fill out the top portion and have your Dentist fill out the bottom portion. Mail the forms to the address shown on the form.

Before Benefits are paid, you or your Dentist may be asked to submit additional information. You should comply as soon as possible.

To find out in advance how much the Plan will reimburse, have your Dentist fill out the claim form describing the services he or she plans to provide and check off the box marked "Dentist's Pre-Treatment Estimate." Submit it to the Fund Administrator and you will receive a statement within 15 calendar days indicating the amount that will be covered.

If a panel Dentist treats you, payment is sent directly to the Dentist. If you receive care from a non-panel Dentist, payment will be sent to you unless you assign the Benefits to the Dentist.

E. How Long the Coverage Lasts

Benefits begin at the same time as your medical coverage and will be continued for 30 days for selected procedures for you or your dependents if treatment began before your coverage ended. Consult the Fund Administrator for a list of covered services.

Please contact the Fund Administrator if you have any questions or need more information about your Dental Benefits program.

OPTICAL BENEFITS

If you are an active Employee and are eligible to receive medical Benefits, you are eligible for Optical Benefits. You do not need a separate optical Enrollment. No Optical Benefits are available under the Plan if you are a retiree.

The two ways of using the Optical Benefits are described below. In either case, you and your Eligible Dependents can receive Benefits once every Calendar Year.

A. Panel Opticians

The Fund Administrator has a list of optical centers, private opticians and optometrists who have agreed to provide you with an eye examination (by an optometrist) and a basic pair of glasses at no cost to you. However, there may be a charge for contact lenses, bi- or tri-focals, transitional lenses, tinted lenses, or brand name frames. In order to limit the amount of your out-of-pocket expenses, you can get a list of participating opticians and an optical voucher from the Fund Administrator. Before services are rendered or you buy glasses, ask the panel optician if there are any additional costs beyond those covered by the voucher.

Note: New Jersey law prohibits private opticians and optometrists from providing eye examinations. Therefore, for services in New Jersey, the Plan's Optical Benefits are limited to eyeglasses only.

B. Individual Reimbursement for Services or Supplies From Non-Panel Opticians

If you or your dependents have eligible expenses, you will be reimbursed up to $100 once each Calendar Year. This Benefit does not accumulate if you do not use it. To get reimbursed, submit an itemized bill with an optical expense claim form to the Fund Administrator.

Please Note: Effective April 1, 2011, the annual limit of $100 for Optical Benefits that are considered essential benefits is eliminated for Children under the age of 19. Please understand that the elimination of this annual limit only applies to essential benefits and is not adding to the coverage already provided.

The following are eligible expenses:

- Eye examination by an optometrist (restricted to a Benefit of $25) or ophthalmologist.
- Replacement or repair of broken frames.
- Purchase of prescription eyeglasses, including prescription sunglasses and contact lenses.

C. What's Not Covered

The following services are not covered:

- Vision expenses for covered services resulting from an on-the-job Injury or from a disease for which Benefits are payable under the Workers' Compensation Act or similar law.
- Vision expense for covered services in a Hospital operated by the Federal government in which you or your family would not be charged a fee.
- Any doctor's fee for treating an eye Illness or Injury. These expenses are covered under your medical plan.

LIFE INSURANCE BENEFITS

In the event of your death from any cause — on the job or off — while you are eligible to receive Benefits, proceeds from a life insurance Benefit will be paid to your named beneficiary. The life insurance Benefit is $2,000 on your life only. Your dependents are not eligible for coverage.

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper form and filing it with the Fund Administrator.

EXCLUSIONS: EXPENSES NOT COVERED BY THE PLAN

This chapter applies to all Benefits under the Plan including, without limitation, hospital or medical services and supplies or expenses, prescription drug, dental and optical benefits. The Board of Trustees and/or its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this Summary Plan Description, the Trust Agreement and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Fund, including, but not limited to, determining the applicability of all Exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

GENERAL EXCLUSIONS

In addition to services, charges, expenses and supplies mentioned under "What's Not Covered" in other chapters of this Summary Plan Description, the Plan does not cover the following:

1. Alternative Health Care Services: Expenses for alternative health care including, but not limited to acupuncture and/or acupressure, faith or spiritual healing, hypnosis, biofeedback, massage therapy, naturopathy, or homeopathic services or supplies.
2. Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
3. Cosmetic Services: Expenses for or related to hospitalization, surgery and/or treatment to improve or preserve physical appearance, but not physical function, as determined by the Plan Administrator or its designee (e.g., Empire), including expenses for or related to complications that result from any such surgery and/or treatment. The Plan does cover Medically Necessary reconstructive services, including Reconstructive Surgery and treatment. To determine the extent of this coverage, see the Schedule of Medical Benefits chapter of this Summary Plan Description.
4. Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.
5. Drugs, Medicine and Nutrition: Expenses for
    - Pharmaceuticals requiring a prescription that:
        - have not been approved by the U.S. Food and Drug Administration (FDA); or
        - are not approved by the FDA for the condition, dose, routine and frequency for which they are prescribed; or
        - are Experimental and/or Investigational, as defined below.

- Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin.
- Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except for those nutritional supplements noted elsewhere in this Summary Plan Description, and except for prenatal vitamins or minerals requiring a prescription.
- Prescription drugs or medicines that are related to, or approved by the FDA for use in connection with, any procedure, treatment, condition, etc. that is not covered by the Plan.

6. Educational Services: Expenses for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, etc., even if they are required because of an Injury, Illness or disability of a Covered Individual.
7. Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by a Contributing Employer or if Benefits are otherwise provided under this Plan or any other plan that a Contributing Employer contributes to or otherwise sponsors, such as HMOs.
8. Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan Benefit limitation, Annual Maximum Plan Benefits, or Limited Maximum Plan Benefits as described in the Medical Expense Coverage chapter of this Summary Plan Description.
9. Expenses Exceeding Usual and Customary Charges: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Usual and Customary Charge as defined in the Definitions chapter of this Summary Plan Description.
10. Expenses for Which a Third Party Is Responsible: Expenses for services or supplies which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to Third Party Liability in the Duplicate Coverage chapter of this Summary Plan Description for an explanation of the circumstances under which the Plan will advance the payment of Benefits until it is determined that the third party is required to pay for those services or supplies.
11. Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided:
    - before the patient became covered under the Plan; or
    - after the date the patient's coverage ends, except under those conditions described in the chapter of this Summary Plan Description entitled "When Coverage Ends."

12. Experimental and/or Investigational Services: Expenses for
    - Technology, treatments, procedures, drugs, biological products or medical devices that in the judgment of the Plan Administrator or its designee (e.g., Empire) are:
        - Experimental or investigative
        - Obsolete or ineffective
    - Any hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:
        - Not of proven benefit
        - Not generally recognized by the medical community (as reflected in published medical literature)

    Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Plan Administrator or its designee (e.g., Empire) may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:
    - There is final market approval by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.
    - Published peer-review medical literature must conclude that the technology has a definite positive effect on health outcomes
    - Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects)
    - Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used.
13. Failure to Follow Medical Advice:
    - Expenses incurred by any Covered Individual who fails to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee (e.g., Empire).
    - Expenses incurred by any Covered Individual who leaves the Hospital/Facility against the medical advice of the attending Physician within 72 hours after admission.

- Expenses incurred by any Covered Individual during travel if a Physician or other health care Provider has specifically advised against such travel because of the health condition of the Covered Individual.

14. Government-Provided Services: Expenses for services when Benefits for them are provided to the Covered Individual:
    - Services covered under government programs, except Medicaid or where otherwise noted
    - Government hospital services, except:
        - Specific services covered in a special agreement between Empire and a government hospital
        - United States Veterans' Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Empire will provide benefits until the government hospital can safely transfer the patient to a participating hospital.
15. Hair Replacement Procedures, Medications and Devices (Wigs): Expenses for hair transplantation and other procedures to replace lost hair or to promote the growth of hair, for the use of Minoxidil, Propecia, Rogaine, or other Prescription Drugs or medicines used to promote the growth of hair, or for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces, except that the Plan will provide Benefits for a single wig, toupee or hairpiece if it is required to replace hair lost as a result of chemotherapy.
16. Hearing Care: Expenses for the purchase, servicing, fitting and/or repair of hearing aid devices, including, but not limited to, hearing aids and cochlear implants.
17. Illegal Act: Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of the commission or attempted commission, by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. The Plan Administrator's discretionary determination that this Exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
18. Inappropriate Billing: Expenses for
    - Services usually given without charge, even if charges are billed;

- Services performed by hospital or institutional staff which are billed separately from other hospital or institutional services, except as otherwise specified.

19. Medically Unnecessary Services: Services, treatment or supplies determined by the Plan Administrator or its designee (e.g., Empire) not to be Medically Necessary as defined in the Definitions chapter of this Summary Plan Description.
20. Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required as a result of an Injury, Illness or disability of a Covered Individual.
21. No-Cost Services: Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
22. No-Fault Automobile Insurance: Expenses for any services or supplies that are covered by mandatory automobile no-fault insurance.
23. Occupational Illness or Injury: Expenses for services covered under Workers' Compensation or occupational disease law or similar statutory programs.
24. Personal Comfort Items: Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Facility or to bed at home, guest meals, television, VCR, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
25. Physical Examinations, Tests for Employment, School, etc.: Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party.
26. Services Provided by Relatives: Expenses for services provided by any Physician or other health care Provider who is the parent, Spouse, sibling (by birth or marriage) or Child of the patient or Covered Individual.
27. Services Provided Outside the United States: Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for Emergency Care as defined in the Definitions chapter of this Summary Plan Description.
28. Services at Home: Expenses for services performed at home, except for those services specifically noted elsewhere in this Summary Plan Description as available either at home or as an emergency.

29. Smoking Cessation or Tobacco Withdrawal: Expenses for nicotine gum or patches, or other products, services or programs intended to assist an individual to stop smoking.

30. Telephone Calls: Any and all telephone calls for any purpose whatsoever.

31. Transplantation (Organ and Tissue): Expenses relating to

    - Human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplantation, post operative services and drugs or medicine.
    - Nonhuman (Xenografted) organ and/or tissue Transplants or implants, except heart valves.
    - Insertion and maintenance of an artificial heart or other organ or related device, except heart valves and kidney dialysis.
    - Services provided to the person who donates the organ or tissue, unless the person who receives the transplant is a person covered by this Plan.

32. Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a healthcare Provider, Covered Individual, or family member of a Covered Individual.

33. War or Similar Event: Expenses incurred for Injury or Illness received as a result of war, either declared or undeclared, except as required by law.

34. Weight Management and Physical Fitness: Expenses for

    - Medical or surgical treatment of obesity including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, and any complications thereof, except as provided by the Plan regarding morbid obesity (a weight of at least 100 pounds more than normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight).
    - Medical or surgical treatment of severe underweight, including, but not limited to, high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.
    - Memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs.

CLAIMS INFORMATION

HOW MEDICAL BENEFITS ARE PAID

A. Payment of Medical Benefits in General

1. All Plan Benefits are considered for payment on the receipt of a written proof of claim. A completed claim form usually contains the necessary proof of claim but sometimes additional information or records may be required. However, if medical services are provided through the Empire or BlueCard PPO networks, your healthcare Provider will generally submit proof of claim directly to Empire or the local Blue Cross/Blue Shield plan.
2. Generally, Plan Benefits payable on account of expenses for a Hospital/Facility will be paid directly to the institution providing the services. Likewise, Plan Benefits payable on account of expenses for Surgery will be paid directly to the surgeon or anesthesiologist providing the services. However, if, at the time you submit your claim, you furnish evidence acceptable to the Plan Administrator or its designee that you or your covered Dependent paid some or all of those charges, Plan Benefits may be paid to you up to the amount you paid for those services. When Deductibles, Coinsurance or Copayments apply, you are responsible for paying your share of the charges.
3. If medical services are provided through the Empire network, the healthcare Provider may submit the proof of claim directly to the Plan, or may complete the necessary claim form and return it to you for submission to the Plan. However, you will be responsible for payment to the In-Network Provider of any applicable Copayment.
4. The Fund will not pay any interest on delayed or late payments, regardless of the cause of the delay or late payment.

B. Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan Benefits on account of expenses incurred by or on behalf of the Dependent Child(ren) covered by the Plan either to the healthcare Provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received an QMCSO, it will pay Plan Benefits on account of expenses incurred by or on behalf of the Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information regarding QMCSOs, see the Eligibility chapter of this document.

C. When You Must Repay Plan Benefits

If it is found that the Plan Benefits paid by the Plan are too much because:

1. some or all of the medical expenses were not paid or payable by you or your Covered Dependent; or
2. you or your Covered Dependent received the money to pay some or all of those medical expenses from a source other than the Plan; or
3. you or your Covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or Injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the medical expenses for which Plan Benefits were paid; or
4. the Plan, for any reason whatsoever, erroneously paid Benefits to which you or your Covered Dependent were not entitled under the terms and provisions of the Plan,

then the Plan will be entitled to a refund from you or your Covered Dependent or your healthcare Provider of the difference between the amount of Plan Benefits actually paid by the Plan for those expenses and the amount of Plan Benefits that should have been paid by the Plan for those expenses based on the actual facts.

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.

For additional information on the procedures that may be followed by the Plan to recover these amounts, see the provisions regarding Third Party Liability and Remedies Available to the Plan in the chapter discussing Duplicate Coverage of Medical Expenses.

FACILITY OF PAYMENT

If the Plan Administrator or its designee determines that you cannot submit a Claim or prove that you or your Covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the health care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Claims Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

HOW TO FILE A CLAIM FOR OUT-OF-NETWORK MEDICAL BENEFITS, OR FOR PRESCRIPTION DRUG, DENTAL, OPTICAL OR LIFE INSURANCE BENEFITS

A. Where to Get Claim Forms

You can get claim forms from the Plan Administrator at:

Publishers'-Pressmen's Benefits Fund
1501 Broadway, Suite 1724
New York, NY 10036
Telephone number (212) 869-5994

REMEMBER: All Claims for In-Network medical Benefits, including requests for precertification, must be submitted to Empire. For more information about Claims or requests, including appeals and/or grievances relating to determinations made by Empire, see the chapter entitled Medical Management Program.

B. How to Complete a Claim Form

1. Complete the Employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
2. The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Provider can complete the health care Provider part of the medical/dental/optical benefits claim form, or you can attach the bill for professional services if it contains all of the following information:
   - A description of the services or supplies provided.
   - Details of the charges for those services or supplies.
   - Diagnosis.
   - Date(s) the services or supplies were provided.
   - Patient's name.
   - Provider's name, address, phone number, professional degree or license, and federal tax identification number.
3. Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan.
4. Complete a separate claim form for each person for whom Plan Benefits are being claimed.

C. Where to Send the Claim Form

Send the completed claim form and any other required information to:

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

or to the address shown on the claim form.

TIME LIMIT FOR FILING CLAIMS

All claims for Out-of-Network medical Benefits, prescription drug Benefits, dental Benefits or optical Benefits must be submitted to the Plan within eighteen (18) months from the date of service. All claims for life insurance benefits must be submitted to the Plan within eighteen (18) months from the date of death. No Plan Benefits will be paid for any Claim not submitted within these periods.

NOTICE OF CLAIMS DECISIONS

A. Claims for Out-of-Network Medical Benefits, Prescription Drug, Dental or Optical Benefits

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 Fund 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 Fund 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.

B. Claims for Life Insurance Benefits

If you or your beneficiary file a Claim for Life Insurance Benefits, the Fund will make a decision on the Claim and notify you or your beneficiary of the decision within 45 days after Receipt of a Claim. If the Fund requires an extension of time due to matters beyond its control, they are permitted an additional 30 days. The Fund will notify you, your authorized representative, your beneficiary or the executor of your estate, as applicable, before the

expiration of the original 45-day period of the reason for the delay and when the decision will be made. A decision will be made within the 30-day extension period.

C. 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:

1. The specific reason(s) for the denial or other Adverse Benefit Determination;
2. Reference to the specific Plan provision(s) on which the decision was based;
3. 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;
4. 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;
5. When appropriate, a copy of any internal rule, guideline, protocol or similar criterion that was relied upon in making the decision. Alternatively, the notice may indicate that such rule, guideline, protocol or criterion was relied upon in making the decision and that a copy is available at no cost at your request.
6. For a Claim involving a determination of medical necessity, experimental treatment or similar exclusions, the notice will indicate that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, is available at no cost at your request.

REVIEW PROCEDURE IF YOUR CLAIM FOR OUT-OF-NETWORK MEDICAL BENEFITS, PRESCRIPTION DRUG BENEFITS, DENTAL BENEFITS, OPTICAL BENEFITS OR LIFE INSURANCE BENEFITS IS DENIED

***The following review procedure only applies to Claims for Out-of-Network Medical Benefits, Prescription Drug Benefits, Dental Benefits, Optical Benefits and Life Insurance Benefits. Empire has its own claims review procedure for In-Network Medical Benefits, which is discussed in the Medical Management Program chapter of this booklet – Empire Claims Information (In-Network Medical Claims).*

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. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on your Claim, without regard to whether their advice was relied upon in deciding your Claim.
4. 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.
5. 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.
6. If your Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.
7. 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.

8. 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.

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.

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.

DUPLICATE COVERAGE OF MEDICAL EXPENSES

HOW DUPLICATE COVERAGE OCCURS

A. This chapter describes the circumstances when you or your covered Dependents may be entitled to medical Benefits under this Plan and may also be entitled to recover all or part of your medical expenses from some other source. It also describes the rules that apply when this happens.

B. There are several circumstances that may result in you and/or your covered Dependents being reimbursed for your medical expenses not only from this Plan but also from some other source. This can occur if you or a covered Dependent is also covered by:

   1. Another group health care plan; or

   2. Medicare or some other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law; or

   3. Workers' compensation.

C. Duplicate recovery of medical expenses can also occur if a third party is financially responsible for your medical expenses because that third party caused the Injury or Illness giving rise to those expenses by negligent or intentionally wrongful action.

D. This Plan operates under rules that prevent it from paying Benefits which, together with the Benefits from any other source described in Sections B or C above, would allow you to recover more than 100% of medical expenses you incur. In many instances, you may recover less than 100% of those medical expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its Benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party.

COORDINATION OF BENEFITS (COB): COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

A. When and How Coordination of Benefits (COB) Applies

   1. For the purposes of this Coordination of Benefits subchapter, the word "plan" refers to any group medical policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical services incurred by the Covered Individual or that provides

medical services to the Covered Individual. A "group plan" provides its benefits or services to Employees, retirees or members of a group who are eligible for and have elected coverage.

2. Many families that have more than one family member working outside the home are covered by more than one medical plan. If this is the case with your family, you must let this Plan (or its insurer) know about all of your coverages when you submit a claim.

3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first, as if the other plan (called the secondary plan) did not exist. The secondary plan may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical expenses incurred. Sometimes, the combined benefits that are paid will be less than the total expenses.

B. Which Plan Pays First: Order of Benefit Determination Rules

1. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), which are commonly used by insured and self-insured plans. Any group plan that does not have COB rules or does not use these same rules always pays its benefits first.

2. If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent/Dependent

The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.

There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

(1) secondary to the plan covering the person as a dependent; and
(2) primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired Employee);

then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired Employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the Calendar Year pays first; and the plan that covers the parent whose birthday falls later in the Calendar Year pays second, if:

(1) the parents are married;
(2) the parents are not separated (whether or not they ever have been married); or
(3) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the Dependent Child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

The word "birthday" refers only to the month and day in a Calendar Year; not the year in which the parent was born.

If the specific terms of a court decree state that one parent is responsible for the Dependent Child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the Dependent Child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any Benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

(1) The plan of the custodial parent pays first;
(2) The plan of the spouse of the custodial parent pays second;
(3) The plan of the non-custodial parent pays third; and
(4) The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a dependent (that is, as an employee, former Employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first, and the plan that covered the person for the shorter period of time pays second.

To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

The start of a new plan does not include a change:

(1) in the amount or scope of a plan's benefits;
(2) in the entity that pays, provides or administers the plan; or
(3) from one type of plan to another (such as from a single employer plan to a multiple employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

C. How Much This Plan Pays When It Is Secondary

1. When this Plan pays second, it will pay, with respect to each claim submitted for payment, no more than 100% of "Allowable Expenses" less whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in Benefits than it would have paid had it been the plan that paid first.

2. "Allowable Expense" means a Medically Necessary health care service or expense, including Deductibles, Coinsurance or Copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

    - The difference between the cost of a semi-private room in a Hospital or other health care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.
    - If any of the coordinating plans determine benefits on the basis of Usual and Customary Charges, any amount in excess of the highest Usual and Customary Charge is not an Allowable Expense.
    - If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
    - If one coordinating plan determines benefits on the basis of Usual and Customary Charges and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the Allowable Expense for all plans.
    - When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Medical Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second.

3. Allowable Expenses do not include expenses for services received because of an occupational sickness or injury or expenses for services that are excluded or not covered under this Plan.

D. Administration of COB

1. To administer COB, the Plan reserves the right to:

    - exchange information with other plans involved in paying claims;
    - require that you or your healthcare Provider furnish any necessary information;
    - reimburse any plan that made payments this Plan should have made; or
    - recover any overpayment from your Hospital, Physician, Dentist, other healthcare Provider, other insurance company, you or your Dependent.

2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be Benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the Benefits available to you, you should file a claim under each plan that covers the person for the medical expenses that were incurred. However, any person who claims Benefits under this Plan must provide all of the information the Plan needs to apply the COB rules.
4. If this Plan is secondary, this Plan will pay secondary medical benefits only when the coordinating primary plan pays medical benefits.
5. If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan.
6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan only to the extent they would have been payable if this Plan were the primary plan.
7. If this Plan is secondary; if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan; and if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant shall execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

MEDICARE AND OTHER GOVERNMENT PROGRAMS

A. Medicare

1. Entitlement to Medicare Coverage: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.
2. Medicare Participants Who Retain or Cancel Coverage Under This Plan: If you, your covered Spouse or Dependent Child becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan.

- If you, your Spouse and/or your Dependent Child are covered by this Plan and by Medicare, and you retain your coverage under this Plan, as long as you remain actively employed, your health care coverage will continue to provide the same Benefits and your contributions for coverage will remain the same. This Plan pays first and Medicare pays second.
- If you cancel your coverage under this Plan, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the following chapter on When Your Medical Coverage Ends for further information about COBRA Continuation Coverage.

3. Coverage Under This Plan and Medicare When You Become Totally Disabled: If you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to be actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second. Nevertheless, the Plan continues to pay first if your Spouse and/or Dependent Child is entitled to Medicare because of their Total Disability as long as you are actively employed.

4. Coverage Under This Plan and Medicare When You Have End-Stage Renal Disease: If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of:

   - the month in which Medicare ESRD coverage begins; or
   - the first month in which the individual receives a kidney transplant.

   Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

   Medicare imposes a three-month period at the onset of end stage renal disease before Medicare becomes effective. Medicare waives this waiting period if the patient enrolls in a self-dialysis training program within the first three months of the diagnosis of end stage renal disease or receives a kidney transplant within the first three months of being hospitalized for the transplant.

   If there is a waiting period, this Plan continues to be the primary payor for the three-month waiting period. Whether or not there is a waiting period, this Plan will remain the primary payor for the 30-month period after Medicare becomes effective. Medicare is the primary payor after the 30-month period.

B. Medicaid

If a Covered Individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

C. TRICARE

If a Covered Individual is covered by both this Plan and TRICARE, this Plan pays first and TRICARE pays second.

D. Veterans Affairs Facility Services

1. If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or Facility on account of a military service-related Illness or Injury, Benefits are not payable by the Plan.
2. If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or Facility on account of any other condition that is not a military service-related Illness or Injury, Benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Usual and Customary.

E. Motor Vehicle No-Fault Coverage Required by Law

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

F. Other Coverage Provided by State or Federal Law

If a Covered Individual is covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

WORKERS' COMPENSATION

A. This Plan does not provide Benefits if the medical expenses are covered by workers' compensation or occupational disease law.

B. If a Contributing Employer contests the application of workers' compensation law for the Illness or Injury for which expenses are incurred, this Plan will pay Benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your Covered Dependent must execute a Subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee in its sole and absolute discretion.

THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent or wrongful act (see the

exclusion of "Expenses for Which a Third Party Is Responsible" in the chapter titled "Exclusions: Expenses Not Covered By the Plan"), but it will advance payment on account of Plan Benefits (hereafter called an "Advance"), subject to the Plan's right to reimbursement to the full extent of any Advance payment if and when there is any recovery from any third party:

1. even if the recovery is not characterized or otherwise specifically identified in a claim, lawsuit, settlement, judgment or otherwise as being paid on account of or as reimbursement of the medical expenses for which the Advance was made;
2. even if the recovery is not sufficient to make the Employee and/or Covered Dependent or ill or injured person whole pursuant to state law or otherwise; and
3. without any reduction for legal or other expenses incurred by any Employee and/or Covered Dependent or ill or injured person in connection with the recovery against the third party or that third party's insurer;

except as may be expressly agreed to by the Plan Administrator or designated delegee in its sole discretion.

B. Reimbursement and/or Subrogation Agreement

1. The covered Employee and any ill or injured Covered Dependent on whose behalf the Advance is made must sign and deliver a reimbursement and/or Subrogation agreement (hereafter called the "Subrogation Agreement") in a form provided by or on behalf of the Plan. If the ill or injured Covered Dependent is a minor or incompetent to execute that Subrogation Agreement, that person's parent (in the case of a minor) or Spouse or legal representative (in the case of an incompetent adult) must execute that Subrogation Agreement on request by or on behalf of the Plan.
2. If the Subrogation Agreement is not executed at the Plan's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of a Subrogation Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not a Subrogation Agreement has been executed, the covered Employee and the ill or injured Covered Dependent each agree that they:

1. will reimburse the Plan from all amounts paid or payable by any third party or that third party's insurer for the entire amount advanced; and
2. do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or Subrogation rights; and

3. notify and consult with the Plan Administrator or its designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the Injury or Illness that resulted in the Advance, or entering into any settlement agreement with that third party or third party's insurer based on those acts; and
4. inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

REPAYMENT OF MEDICAL BENEFITS (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 covered Employee and/or Covered 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 or Injury only to the extent not paid by the third party and only after you and your Covered Dependent(s) (and your or their attorneys, if applicable) has entered into a written subrogation and reimbursement agreement with the Fund.

By accepting Benefits related to such Illness or Injury, you and your Covered Dependent(s) agree:

- that the Fund has established a first lien on any recovery awarded to or received by you (or your Covered Dependent(s), legal representative or agent);
- to notify any third party responsible for your or your Covered Dependent(s) Illness or Injury of the Fund's right to reimbursement for any claims related to such illness or injury;
- to hold any reimbursement or recovery awarded to, payable to, or received by you (or your Covered Dependent(s), legal representative or agent) in trust on behalf of the Fund to cover all Benefits paid by the Plan with respect to such Illness or Injury and to reimburse the Fund promptly for the Benefits paid, even if you or your Covered Dependent(s) are not fully compensated ("made whole") for your loss;
- that the Fund has the right of first reimbursement against any award, recovery or other proceeds of any claim against the other person (whether or not you or your Covered Dependent(s) is made whole) and that the Fund's claim has first priority over all other claims and rights;
- to reimburse the Fund 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 proceeds payable by or received from a third party, whether by demand, lawsuit, settlement, insurance or otherwise, must be turned over to the Fund as reimbursement up to the full amount of the Benefits paid.

- that the Fund'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 or your Covered Dependent(s) elect not to pursue your claim(s) against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims;
- to assign, upon the Fund's request, any right or cause of action to the Fund;
- not to take or omit to take any action to prejudice the Fund's ability to recover the Benefits paid, and to cooperate in doing what is reasonably necessary to assist the Fund in obtaining reimbursement;
- to cooperate in doing what is necessary to assist the Fund in recovering the Benefits paid or in pursuing any award or recovery;
- to forward any recovery or proceeds to the Fund 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 Covered Dependent(s), in any court for the amount of Benefits paid on behalf of you or your Covered Dependent(s) 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 Fund'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 Fund may permit you to turn over less than the full amount of benefits paid and recovered, as it determines in it sole discretion. Any reduction of the Fund's claim is subject to prior written approval by the Fund.

REMEDIES AVAILABLE TO THE PLAN

The Fund shall have the right to recover from you, your Covered Dependents (and/or any other person, entity or trust in possession of such funds sought by the Fund) all (a) Benefits paid by the Plan on your or your Covered Dependent's behalf for injuries or disabilities that you or your Covered 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 Covered Dependent were not, for any reason whatsoever, entitled. The Fund may seek such recovery through subrogation and/or any other equitable or legal relief available under state or federal law.

The Fund may also enforce its right to reimbursement by:

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

We strongly recommend that, if you or your Covered Dependents 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 will not pay for, or reduce its claim for reimbursement by, any of the fees or expenses your attorney might charge.

WHEN COVERAGE ENDS
EXTENSION AND CONTINUATION OF COVERAGE

EXTENSION AND CONTINUATION OF COVERAGE IN GENERAL

A. Your Plan does not provide Plan Benefits for any medical, prescription drug, dental or optical expenses incurred after coverage ends. However, under certain circumstances:

1. Your coverage may be extended for certain expenses after coverage ends; and

2. Your coverage may be continued for a limited period of time under certain circumstances.

B. This chapter explains when and how this extension and continuation of coverage occurs.

C. Continuation of coverage applies only to medical, prescription drug, dental and optical coverage. It does not apply to life insurance coverage.

EXTENSION OF COVERAGE

A. Extension of Coverage During Total Disability

If your medical coverage ends because your employment terminates, and if on that date:

- you or a covered Spouse or Dependent Child is Totally Disabled (as defined in the Definitions chapter); and
- you or that covered Spouse or Dependent Child is not otherwise covered by Medicare or by any other group or individual health insurance policy or health care plan;

all hospital and medical Benefits will be extended for the Disabled person on an approved leave of absence for disability, subject to the terms and provisions of this Plan, for up to 24 months after your medical coverage ends, provided the Disabled person continues to be Totally Disabled, unless you, that covered Spouse and/or Dependent Child are covered by any other group or individual health care insurance policy or health care plan or by Medicare, in which case the extension of medical coverage will not apply. After the first 24 months of disability, your COBRA coverage extends Benefits for another five months. These Benefits will stop 29 months from the onset of your disability or the date your employer stops making contributions to the Fund on your behalf, whichever occurs later. This continuation of coverage rule also applies if you are receiving Workers' Compensation benefits, except the 29 months will be measured from the onset of your Workers' Compensation benefits.

Prescription drug, dental and optical Benefits stop six (6) months after contributions are no longer being made on your behalf.

B. Extension of Medical Coverage When Treatment is in Progress

If, during the 31 days before your medical coverage ends because your employment terminates, you or a covered Spouse or Dependent Child are under the care of a Physician, but are not Totally Disabled, the Plan will cover that treatment for up to 3 months after your medical coverage ends, unless you or that covered Spouse or Dependent Child are covered by Medicare or by any other group or individual health insurance policy or health care plan.

C. Right of Plan to Require a Physical Examination

The Plan reserves the right to have the person who is Totally Disabled or undergoing treatment under the care of a Physician examined by a Physician selected by the Plan Administrator or its designee at any time during the period that Benefits are extended under this provision. The cost of such an examination will be paid by the Plan.

D. COBRA Continuation Coverage as an Alternative

As an alternative, under certain circumstances, you, a covered Spouse and/or Dependent Child can choose to continue coverage on payment for the cost of that coverage. See the following subchapter on Continuation of Coverage (COBRA) for further information.

E. Application Only to Medical Coverage

This extension of Benefits applies only to the medical coverage.

CONTINUATION OF COVERAGE (COBRA) VERY IMPORTANT NOTICE

This section contains important information about COBRA continuation coverage, which is a temporary extension of group health coverage (i.e., medical, dental, optical and prescription drug benefits) under the Plan under certain circumstances in the event that you or your family members lose your coverage. The right to elect COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

This notice generally explains continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your continuation coverage rights under the Plan. For more information about your rights and obligations under federal law, you should review the entire Summary Plan Description.

COBRA continuation coverage is administered by the Fund Office. You can contact the Fund Office at the address and telephone number listed in this booklet.

A. COBRA Continuation Coverage – In General

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, your spouse and your dependent children 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.

If you are an Employee, you will become a qualified beneficiary if you lose coverage under the Plan because one of the following qualifying events happens:

- Your work hours are reduced so that you are no longer eligible for coverage under the Plan's Benefit program.
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your Spouse's work hours are reduced so that you are no longer eligible for coverage under the Plan's Benefit program,
- Your Spouse's employment ends for any reason other than his or her gross misconduct,
- Your Spouse dies, or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee's work hours are reduced,
- The parent-Employee's employment ends for any reason other than his or her gross misconduct,
- The parent-Employee dies,
- The parents become divorced or legally separated, or
- The Dependent Child's eligibility for coverage under the Plan ends because he or she no longer qualifies as a "Dependent Child."

Dependent Children who are born to or placed for adoption with a covered Employee during the period of the Employee's continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. Once the newborn or adopted Child is enrolled in continuation coverage pursuant to the Plan's rules, the Child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a Dependent Child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the Child's birth or adoption).

B. Notice of COBRA Qualifying Event

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

When the qualifying event is the end of employment or reduction in work hours, or the death of the Employee, your employer must notify the Fund Office of the qualifying event. You should also inform the Fund Office promptly in writing upon the occurrence of any of these events so as to avoid confusion as to the status of your health coverage.

You Must Give Notice of Some Qualifying Events.

For the other qualifying events (i.e., divorce or legal separation of the Employee and Spouse, or a Dependent Child losing eligibility for coverage as a Dependent Child), you (or your family member) must notify the Fund Office 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 Benefits Fund Office at 1501 Broadway, Suite 1724, New York 10036, (212) 869-5994. 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.

The Employee or family member (or any representative acting on behalf of either) can provide notice on behalf of himself as well as other family members affected by the qualifying event.

C. How is COBRA Coverage Provided?

Once the Fund Office 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, and parents may elect COBRA continuation coverage on behalf of their Dependent Children.

D. How Long Does COBRA Coverage Last?

COBRA continuation coverage is a temporary continuation of your health coverage under the Plan. When the qualifying event is the death of the Employee, your divorce or legal separation, or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the Employee's work hours, COBRA continuation coverage generally lasts for only a total of 18 months (except as described below, when an 18-month period of COBRA coverage can be extended). However, if the qualifying event is the end of employment or reduced hours of employment,

and the Employee became entitled to Medicare benefits less than 18 months *before* the qualifying event (termination or reduced hours), COBRA continuation coverage for qualified beneficiaries *other than* the Employee lasts until 36 months after the date of the Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Dependent Children can last up to 36 months after the date of Medicare entitlement, which would be 28 months of continuation coverage after the date of the qualifying event (36 months minus 8 months).

As noted, there are two ways an 18-month period of COBRA continuation coverage can be extended, as follows:

Disability Extension of 18-month Period of Continuation Coverage. If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of your COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Written notice of the SSA Disability determination (along with a copy of the SSA determination) must be sent to the Plan Administrator at the Publishers'-Pressmen's Benefits Fund Office at 1501 Broadway, Suite 1724, New York 10036, (212) 869-5994, within 60 days of the latest of (i) the date of the SSA determination, (ii) the date of your initial qualifying event, (iii) the date on which you lost coverage under the Plan due to the initial qualifying event, or (iv) the date on which you are informed of these procedures for providing this notice. Your written notice must include: (i) the covered Employee's name, (ii) the qualified beneficiary's(ies') name(s), (iii) the name of the person who has been determined to be disabled by SSA, and (iv) the date of the determination. You can contact the Fund Office to obtain the appropriate form to provide this required notice. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

If the SSA determines that the individual is no longer disabled, this extended period of COBRA coverage will end as of the last day of the month that begins more than 30 days after the SSA has determined that the individual is no longer disabled. The disabled individual or a family member is required to notify the Fund Office within 30 days of any such determination. In addition, the extended coverage may also be terminated for any of the reasons set forth below in the section entitled Early Termination of Continued Coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage. If your family member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and

Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Fund Office. This extension may be available to the Spouse and Dependent Children receiving continuation coverage if the Employee or former Employee dies, gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if that event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you (or your family member) must make sure that the Fund Office is notified in writing of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator at the Publishers'-Pressmen's Benefits Fund Office at 1501 Broadway, Suite 1724, New York 10036, (212) 869-5994. Your written notice must identify: (i) the Employee, (ii) the second qualifying event, (iii) the date on which the event occurred, and (iv) the names of the Covered Individuals whose coverage under the Plan will be lost due to the event. You can contact the Fund Office to obtain the appropriate form to provide this required notice. In addition, you must include with the notice a copy of the Employee's death certificate, divorce decree or proof of legal separation, or a copy of the Child's birth certificate or other proof of age, as applicable depending on the qualifying event. The Employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event.

E. 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. Election Forms must be post-marked within that 60-day period and must be received by the Fund Office. 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 family members). If you do not timely elect (and pay for) COBRA continuation coverage, your health coverage under the Plan will end.

Special Second Election Period for TAA Eligible Individuals

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("TAA Eligible Individuals"). Under the new tax provisions, TAA Eligible Individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage.

TAA Eligible Individuals who did not previously elect continuation coverage during the original 60-day COBRA election period that applied to the TAA-related loss of coverage may elect continuation coverage during a second 60-day election period. This second 60-day election period begins on the first day of the month in which he or she is determined to be a TAA Eligible Individual, provided that such election may not be made later than 6 months after the date of the TAA-related loss of coverage. TAA Eligible Individuals may elect continuation coverage for themselves and their eligible family members. Any continuation coverage elected will begin with the first day of the second 60-day election period, and not on the date the coverage originally was lost. However, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has a 63-day break in coverage under the Health Insurance Portability and Accountability Act (HIPAA).

If you have questions about these new tax provisions or you are not sure whether you are a TAA Eligible Individual, contact the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at *www.doleta.gov/tradeact*.

F. Paying for COBRA Coverage

Individuals who continue coverage under COBRA must pay up to 102% of the Fund's cost of coverage, except in cases of extended continuation coverage due to disability, in which case you will be required to pay 150% of the cost of 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.

There will be a grace period of 45 days to pay the first premium payment, which must include the premiums due for all months starting with the date your active coverage ended and continuing through your date of payment. If this payment is not made within 45 days of the date of your COBRA election, you (and your family members) will not be entitled to COBRA continuation coverage.

After the 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 family'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.

G. Early Termination of Continuation Coverage

The law provides that continuation coverage may be cut short prior to the end of the applicable 18, 29 or 36 month period for any of the following reasons:

- The premium for continuation coverage is not timely paid (within the applicable grace period).
- The group health coverage provided to you is terminated (and the Plan sponsor is not required by COBRA to provide you with other group health coverage that it maintains, if any).
- The individual first becomes, after the date of the COBRA election, covered under another group health plan (as an employee or otherwise) that does not contain any pre-existing condition exclusion or limitation applicable to the individual.
- The individual becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA coverage.
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. In this case, coverage will end as of the month that begins more than 30 days after the date of such final determination. You are required to notify the Plan Administrator in writing within 30 days of any such final determination.
- If you fail to follow the Fund's policies and procedures and take actions that would result in termination of an active employee's coverage for cause. (For example, if you submit false claims to the Fund.)
- When the Contributing Employer that employed you prior to the qualifying event has stopped contributing to the Fund and the employer makes group health coverage available to (or starts contributing to another multiemployer plan for) a class of the employer's employees who were formerly covered by the Plan.

H. 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 the Regional and District EBSA Offices are available through EBSA's website.

I. Keep the Fund Informed of Changes

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

CONTINUATION OF COVERAGE (USERRA)

If you are on active duty for less than 31 days, you will continue to receive health care coverage under the Plan during that period in accordance with the

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active duty for 31 days or longer, USERRA permits you to continue your (and your Dependent's, if any) health care coverage under the Plan, at your own expense, for a period of time up to the lesser of: (1) 24 months, or (2) the period of the military service. (However, coverage will not be provided for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected illnesses or injuries.)

In order to be eligible for USERRA continuation coverage, you are required to notify your employer, as far in advance as is reasonable under the circumstances, that you are leaving for military service, unless circumstances or military necessity make notification impossible or unreasonable.

The amount that you will be required to pay for continuation coverage will be 102 percent of the cost to the Fund for coverage of a similarly situated participant or Dependent who is not receiving continuation coverage. This continuation right operates in the same way as COBRA, and the same election and payment rules apply to USERRA continuation coverage as apply under COBRA. In other words:

- You must elect continuation coverage within 60 days of your loss of coverage under the Plan as a result of your separation from employment due to military service;
- Your initial premium payment for continued coverage must be paid no later than 45 days after the date of your election. If you do not make your first premium payment within this 45-day period, you will lose all rights to USERRA continuation coverage under the Plan and your coverage will terminate (as of the date it would otherwise terminate under the Plan's rules).
- After you make your first payment for continuation coverage, subsequent payments are due on the first day of the monthly coverage period for which the payment applies.
- You will be given a grace period of 30 days to make each periodic payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made.
- If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan and your coverage will terminate as of the last date for which you made a timely payment.

The Plan's rules regarding the procedures for electing and paying for COBRA continuation coverage apply to USERRA continuation coverage. Please review the section on COBRA above for more details regarding the election of, and payment for, continuation coverage.

In addition, you and your Dependents may be eligible for health care coverage under the TRICARE health care program for active duty military and their families. The Plan will coordinate coverage with TRICARE.

Even if you do not elect to continue coverage during your military service, you may be entitled to have your coverage reinstated when you return to employment with a Contributing Employer following your honorable discharge from the uniformed services, provided that you return to employment within the time periods prescribed by law. Specifically, if you receive an honorable discharge and return to work with a Contributing Employer, your eligibility for coverage under the Plan will be reinstated on the day you return to work as long as you return within one of the following time frames:

- 90 days of the date of discharge, if the period of service was 180 days or more;
- 14 days of the date of discharge, if the period of service was at least 31 days but less than 180 days; or
- one day after discharge (allowing 8 hours for travel) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits may be extended up to two years.

No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of illness or injury connected with your military service.

Your employer is required to notify the Fund Office within 30 days after you are reemployed following military service; however, it's a good idea for you to also notify the Fund Office.

If you have any questions about taking a leave of absence for military service, please speak directly with your employer. If you have any questions about how such a leave of absence affects your benefits under the Plan, please contact the Fund Office. Coverage will be provided only as required by law. If the law changes, your rights and benefits will change accordingly, notwithstanding anything in this document to the contrary.

CERTIFICATE OF CREDITABLE COVERAGE

A. When your or your Dependent's coverage under the Plan ends, you and/or your Dependents 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 Dependent(s) 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 Dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered Dependents 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 Dependent(s) had prior health coverage that may reduce an exclusion for pre-existing conditions that may apply to you and/or your covered Dependents under the other group health plan or health insurance policy.

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

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

C. In addition, a Certificate of Creditable Coverage will be provided to you and/or any covered Dependent 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: Robert A. Costello - Plan Administrator

Be sure to include your (or your Dependent'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.

OTHER INFORMATION

NAME OF THE 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

A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants upon written request to the Plan Administrator, and is available for examination by Plan Participants.

EMPLOYER IDENTIFICATION NUMBER

13-6116945

PLAN NUMBER

501

SOURCE OF FUNDING

This Plan is funded by Contributing Employers and Employees in accordance with their Collective Bargaining Agreements and participation agreements.

TYPE OF PLAN

The Plan is a Taft-Hartley, multi-employer, employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Plan offers medical, prescription drug, dental, optical, life insurance benefits to eligible employees and their family members. All of the benefits provided by the Plan are self-insured.

TYPE OF ADMINISTRATION

The Board of Trustees has overall responsibility for administering the medical, prescription drug, dental, optical and life insurance benefits under the Plan. The Trustees have contracted with C&R Consulting, Inc. to serve as the Fund's third party administrator. Empire BlueCross BlueShield administers In-Network medical benefits, but does not insure or otherwise guarantee any of the Benefits under the Plan.

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 Trustees or the Plan Administrator at the following address:

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

PLAN TRUSTEES:

The Trustees of the Plan are:

Andrew Gutterman
The New York Times
620 8th Avenue, 18th Floor
New York, NY 10018

Jeffrey Zomper
The Daily News
4 New York Plaza, 7th Floor
New York, NY 10004

John M. Heffernan, President
New York Newspaper Printing
Pressmen's Union Number Two
1501 Broadway, Suite 1712
New York, NY 10036

Joseph Connor
New York Newspaper Printing
Pressmen's Union Number Two
1501 Broadway, Suite 1712
New York, NY 10036

Michael Tortora
New York Newspaper Printing
Pressmen's Union Number Two
1501 Broadway, Suite 1712
New York, NY 10036

COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained under the terms of collective bargaining agreements between the 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.

PLAN YEAR

The Plan's fiscal records are kept on a Plan Year that is the twelve-month period beginning each April 1 and ending on the following March 31.

STATEMENT OF ERISA RIGHTS

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 Plan 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 Medical Management Program chapter and the Claims Information chapter of this Summary Plan Description, which provide 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. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the 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.

PLAN AMENDMENTS OR TERMINATION OF PLAN

The Trustees reserve the right, within their sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, or any duly authorized agent(s) of the Trustees, in such manner as may be duly authorized by the Trustees.

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

Neither you, your beneficiaries, nor any other person have or will have a vested or non-forfeitable right to receive Benefits, directly or indirectly, under the Plan.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

The Plan Administrator (or, where applicable, any duly authorized delegee of the Plan Administrator) shall have the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan and any other documents (including, but not limited to insurance policies) and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator (or, where applicable, any duly authorized delegee of the Plan Administrator) shall have the sole and absolute discretionary authority to:

- take all actions and make all decisions (including factual decisions) with respect to the eligibility for, and the amount of, Benefits payable under the Plan to Employees or Participants or their beneficiaries;
- formulate, interpret and apply rules, regulations, and policies necessary to administer the Plan in accordance with its terms;
- decide questions, including legal or factual questions, relating to the calculation and payment of Benefits, and all other determinations made, under the Plan;
- resolve and/or clarify any factual or other ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents; and
- process, and approve or deny, Benefits Claims and rule on any Benefits Exclusions and determine the standard of proof in any case.

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of their designees are not engaged in the practice of medicine, nor does 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.

INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN (VERY IMPORTANT INFORMATION)

You or your Covered Dependents are responsible for furnishing any information you or they may have that may affect eligibility for coverage under the Plan. This includes, but is not limited to:

1. Change of name.
2. Change of address.
3. Birth, adoption, marriage, divorce, legal separation, or death of you or any covered Spouse or Dependent Child.
4. Any information regarding the status of a Dependent Child, including, but not limited to:
    - The Dependent Child reaching the Plan's limiting age;
    - The Dependent Child becoming eligible to enroll in other employer-provided group health coverage (other than a plan of another parent's employer); or
    - The existence (or cessation) of any physical or mental Handicap.
5. Medicare enrollment or disenrollment.
5. The existence of other medical coverage.

Notices of the foregoing information should be sent, in writing, to the Plan Administrator at the address shown above.

VERY IMPORTANT INFORMATION: If you or a Dependent fail to submit any requested information or proof, make a false statement, or furnish fraudulent or incorrect information, 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) by duly authorized representatives of the Fund office, the Trustees or any of their designees in their sole and absolute discretion.

In addition, if you or your dependent commits fraud or makes an intentional misrepresentation or otherwise provides false information to the Plan (including, for example, in an application for coverage under the Plan, in connection with a benefit claim or appeal, or in response to any request for information by the Plan Administrator or a claims administrator), the Plan Administrator or the Trustees may terminate your coverage retroactively upon 30 days notice. Failure to disclose that you or your dependents are covered under another group health plan under

which you or your dependents are entitled to receive reimbursement of a claim submitted to the Plan, failing to notify the Plan of life events (such as divorce) that render a person ineligible for coverage, or providing false information or making false statements in order to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan. Coverage may also be terminated retroactively and without notice (unless required by law) if the Plan Administrator determines that a Spouse or Dependent is ineligible for coverage under the Plan and such retroactive termination would not be considered a rescission or is a permissible rescission under the Affordable Care Act.

If the Fund makes payment for benefits that are in excess of expenses actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or fraud or ineligibility for coverage or for any other reason (including for example, your failure to notify the Fund office regarding a change in family status), the Fund reserves the right to recover such overpayment (plus processing fees, administrative charges, interest, any attorneys' fees and all other costs incurred by the Fund to collect such amounts) through whatever means are necessary, including, without limitation, deduction of the amounts from future claims and/or by legal action.

HEADINGS DO NOT MODIFY PLAN PROVISIONS

The headings of chapters and subchapters (APPEARING IN BOLD TEXT WITH SOLID CAPITAL LETTERS) and of sections, paragraphs and subparagraphs (appearing in Bold Text with Upper and Lower Case Letters) are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents and index can be constructed for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

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.

DEFINITIONS

The following are definitions of specific terms and words used in this Summary Plan Description or that would be helpful in understanding covered or excluded health care services. **These definitions do not, and should not be interpreted to, extend coverage under the Plan.**

Administrator

See the definition of Plan Administrator.

Adverse Benefit Determination

An Adverse Benefit Determination is any denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination shall include any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Plan Participant's, dependent's or beneficiary's eligibility to participate in the Plan. It shall also include any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

Allowable Expense

A health care service or expense, including Deductibles, Coinsurance or Copayments, that is covered in full or in part by any of the plans covering a Plan Participant, except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by the Plan is not an Allowable Expense. Examples of expenses or services that are not Allowable Expenses appear in the Duplicate Coverage chapter of this Summary Plan Description.

Allowed Amount

The Allowed Amount refers to the maximum allowed reimbursement for a given service or supply available under your contract. The Allowed Amount can reflect: (1) the amount specified in an agreement between either the Provider or the facility and Empire or another Blue Cross/Blue Shield plan, (2) the Usual and Customary Charges as determined by Empire or another Blue Cross/Blue Shield plan, (3) the amount specified in a statute or regulation, or (4) based on a fee schedule of allowances.

Ambulatory Surgery

See the definition of Same-Day Surgery.

Authorized Representative

An Authorized Representative is a person or organization who demonstrates to the satisfaction of the Claims Administrator, in its sole and absolute discretion, that he, she or it has been authorized to act on behalf of a Plan Participant, dependent or beneficiary with respect to a Claim, or appeal of an Adverse Benefit Determination regarding a Claim.

Behavioral Health Care Management Program

A program which manages Benefits for the treatment of mental health care and alcoholism/substance abuse. In order to receive Benefits for such treatment, you must receive approval from the program and must consult In-Network Providers.

Benefit, Benefit Payment, Plan Benefit

The amount of money payable for a claim, based on the Usual and Customary Charge, after calculation of all applicable Deductible(s), Coinsurance and Copayment(s), and after determination of the Plan's Exclusions, limitations and maximums.

Benefit Period

A period of three consecutive months during which any coverage will be provided after an active Employee's eligibility had been established. These periods commence on January 1, April 1, July 1 and October 1 of any Calendar Year.

BlueCard® Program

The BlueCard Program helps reduce your costs when you obtain emergency care outside of the geographic area served by Empire from a provider who participates with another Blue Cross and/or Blue Shield Plan ("local Blue Plan"). Just show your Empire ID card to a participating provider and comply with the other terms in the certificate of coverage when receiving these services.

When you obtain healthcare through the BlueCard Program, the portion of your claim that you are responsible for ("member liability") is, in most instances, based on the **lower** of the following:

- the billed amount that the participating provider actually charges for covered services, or
- the negotiated price that the local Blue Plan passes on to Empire.

Here's an example of a negotiated price and how it benefits you:

- A provider's standard charge is $100, but he/she has a negotiated price of $80 with the local Blue Plan. If your coinsurance is 20%, you pay $16 (20% of $80) instead of $20 (20% of $100).

The negotiated price may reflect:

- a simple discount from the provider's usual charges, which is the amount that would be reimbursed by the local Blue Plan;

- an estimated price that has been adjusted to reflect expected settlements, withholds, any other contingent payment arrangements and any non-claim transactions with the provider; or
- the provider's billed charges adjusted to reflect average expected savings that the local Blue Plan passes on to Empire. If the negotiated price reflects average savings, it may vary (more or less) from the actual price than it would if it reflected the estimated price.

Plans using the estimated price or average savings methods may adjust their prices in the future to ensure appropriate pricing. However, the amount you pay is considered the final price. A small number of states have laws that require that your member liability be calculated based on a method that does not reflect all savings realized, or expected to be realized, by the local Blue Plan on your claim, or that requires that a surcharge be added to your member liability. If you receive covered healthcare services in any of these states, member liability will be calculated using the state's statutory methods that are in effect at the time you receive care.

If you have any questions about the BlueCard Program, contact Empire's Member Services.

BlueCard® PPO Program

Nationwide, Blue Cross and Blue Shield plans have established Preferred Provider Organization (PPO) networks of physicians, hospitals and other healthcare providers. As an EPO member, you have access to these networks through the BlueCard PPO Program to receive in-network benefits for covered services. By presenting your Empire I.D. card to a provider participating in the BlueCard PPO Program, you receive the same benefits as you would receive from an Empire network provider. The suitcase logo on your I.D. card indicates that you are a member of the BlueCard PPO Program. Call 1-800-810-BLUE (2583) or visit *www.bcbs.com* to locate participating providers.

BlueCard® Worldwide Program

The BlueCard Worldwide program provides hospital and professional coverage through an international network of healthcare providers. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here's how to use BlueCard Worldwide:

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®1 Access Number.
- Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as co-payments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.

- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any co-payment and amount above the allowed amount.

Board of Trustees

The Board of Trustees is the Board of Trustees of the Publishers'–Pressmen's Welfare Fund or any duly appointed Committee thereof.

Calendar Year

The 12-month period beginning January 1 and ending December 31. All annual Deductibles and Annual Maximum Plan Benefits are determined during the Calendar Year. See also the definition of Plan Year.

Child(ren)

See the definition of Dependent Child(ren) under the Dependent Definitions heading.

Claim

A Claim is a written or electronic request for a Plan benefit, including, without limitation, a written or electronic request for pre-certification for benefits, made by a Claimant in accordance with the Plan's procedure for filing benefit claims.

Claimant

A Claimant is a Plan participant, dependent, beneficiary or Authorized Representative of such individuals who submit a Claim.

Claims Administrator

The Claims Administrator is the person or entity charged with making benefit determinations.

- For determinations based on eligibility for benefits and/or timeliness of Claims filed, the Plan Administrator shall serve as the Claims Administrator.
- For all determinations regarding pre-certification, Empire shall serve as the Claims Administrator.
- For all determinations regarding In-Network medical Claims, Empire shall serve as the Claims Administrator.
- For determinations regarding Out-of-Network medical Claims, prescription drug Claims, optical Claims, dental Claims and life insurance Claims, the Plan Administrator shall serve as the Claims Administrator.

Coinsurance

That portion of Eligible Medical Expenses for which the covered individual has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan's Deductible, but in some instances, the covered individual is responsible for paying a higher percentage of those expenses, and in other instances, no coinsurance applies.

Concurrent Review

A managed care program designed to assure that Hospital/Facility admissions and length of stay, Surgery and other health care services are Medically Necessary by having Empire conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Facility.

Contributing Employer

An employer who is required to contribute to the Fund pursuant to a Collective Bargaining Agreement with the New York Newspaper Printing Pressmen's Union No. Two or an employer acceptable to the Trustees who is required to contribute to the Fund pursuant to a participation agreement or similar agreement.

Coordination of Benefits (COB)

The rules and procedures applicable to the determination of how Plan Benefits are payable when a person is covered by two or more group health care plans. See the chapter on Duplicate Coverage of Medical Benefits, which sets forth the Plan's COB rules and procedures.

Copayment, Copay

The dollar amount you are responsible for paying when you incur an Eligible Medical Expense for certain services or supplies.

Covered Dependent

The eligible Spouse or Dependent Child(ren) who have Enrolled for coverage under the Plan, until such time as his, her or their coverage ends in accordance with the terms and provisions of the Plan.

Covered Individual

The eligible Employee or individual who has Enrolled for coverage under the Plan.

Credited Shift

A shift for which an active Employee receives compensation from a Contributing Employer or (ii) a shift lost because of sickness after the first seven days up to one year, or (iii) a shift lost because of an occupational accident or injury for which an active Employee of a Contributing Employer has received benefits under Workers' Compensation and for which contributions are made on the Employee's behalf to the Fund, or (iv) a shift lost because of a non-occupational accident after the first day up to one year.

Custodial Care

Care and services (including room and board needed to provide such care or services) given mainly for personal hygiene or to perform the activities of daily living. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of Custodial Care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating, or taking drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care.

Customary Charge

See the definition of Usual and Customary Charge.

Deductible

The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay Benefits.

1. Individual Deductible: The amount one Covered Individual must pay before the Plan begins to pay Benefits for that person.
2. Family Deductible: The amount that a family of two or more members must pay before the Plan begins to pay Benefits for the family members.

Dental

As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics.

Dependent Definitions

Dependent Child(ren)

A. For the purposes of this Plan, Dependent Children are any of your biological children, your legally adopted children, any children placed with you for adoption, or any children for whom you are legally obligated to provide medical coverage under a qualified medical child support order (QMCSO), whether married or unmarried, regardless of their student or employment status and regardless of whether your home is their principal place of residence or whether you support them financially, provided the child has not reached his or her 26th birthday, unless the child is eligible to enroll in other employer-provided group health coverage (other than a plan of another parent's employer). **You will be required to complete and sign a certificate that the child is not eligible for coverage under another employer-sponsored health plan (other than a plan of another parent's employer).**

B. Coverage of a Dependent Child ends on December 31st of the year that a Dependent Child:

   1. reaches his or her 26th birthday; or

   2. becomes eligible to enroll in other employer-provided group health coverage (other than a plan of another parent's employer); or

   3. enters military or similar service anywhere.

C. Coverage of a Dependent Child may continue after the Dependent Child has reached his or her 26th birthday for any unmarried Child who is mentally or physically Handicapped and is:

   1. incapable of self-sustaining employment as a result of that Handicap; and

   1. dependent chiefly on you and/or your Spouse for support and maintenance.

Eligible Dependent

Your lawful Spouse and your Dependent Child(ren). An Eligible Dependent may be Enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility chapter for further information. Once an Eligible Dependent is duly Enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a Covered Dependent, and remains a Covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Spouse

An individual to whom a Plan Participant is legally married under federal law.

Disabled

See the definitions of Totally Disabled and Handicapped.

Disability-Pension Retiree

An Employee who has satisfied the eligibility requirements set forth in the Pressmen's-Publishers' Pension Plan for a Disability Pension, and who has an immediate right to receive a Disability Pension from the Pressmen's-Publishers' Pension Fund at the time such Employee lost his eligibility for health benefits as an active Employee.

Early Retiree

An Employee who has satisfied the eligibility requirements set forth in the Pressmen's-Publishers' Pension Plan for an Early Retirement Pension, and who has an immediate right to receive an Early Retirement Pension from the Pressmen's-Publishers' Pension Fund at the time such Employee lost his eligibility for health benefits as an active Employee.

Elective Hospital Admission, Service or Procedure

Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligibility Period

A period of three consecutive months during which an Employee's work history and his Employee contributions are reviewed to determine his eligibility for coverage under the Plan. These periods commence on September 1, December 1, March 1 and June 1. The Eligibility Period includes Credited Shifts in the payroll weeks ending in that period.

Eligible Dependent

See the definition under the Dependent Definitions heading.

Eligible Medical Expenses

Expenses for medical services or supplies, but only to the extent that:

1. they are Medically Necessary, as defined in this Definitions chapter; and
2. the charges for them are Usual and Customary, as defined in this Definitions chapter; and
3. coverage for the services or supplies is not excluded, as provided in the Exclusions chapter and elsewhere in this Summary Plan Description under the headings "What's Not Covered"; and
4. the Limited Maximum and/or Annual Maximum Plan Benefits for those services or supplies have not been reached.

Emergency Care

Medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's life or health would be placed in serious jeopardy.
- There would be a serious dysfunction, disfigurement or impairment of a bodily function, organ or part.
- In the event of a behavioral health problem, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Employee

Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed by a Contributing Employer.

Enroll, Enrollment

The process of completing and submitting a written enrollment form indicating that coverage by the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if the Employee is or will be covered by the Plan. See the Eligibility chapter for details regarding the mechanics of enrollment.

Exclusions

Specific conditions, circumstances, and limitations, as set forth in the Exclusions chapter and elsewhere in this Summary Plan Description under the headings "What's Not Covered", for which the Plan does not provide Plan Benefits.

Experimental and/or Investigational

A. The Plan Administrator or its designee has the sole discretion and authority to determine if a service or supply is or should be classified as Experimental or Investigational. A medical, surgical, diagnostic, psychiatric, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device will be deemed to be Experimental or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, that service or supply was determined to be:
    1. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the "United States Pharmacopeia Dispensing Information" or the "American Hospital Formulary Service" as appropriate for the proposed use; or
    2. subject to review and approval by any institutional review board for the proposed use; or
    3. the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
    4. not demonstrated through prevailing peer-review medical literature to be safe and effective for treating or diagnosing the condition or Illness for which its use is proposed.

B. The Plan Administrator or its designee, in its judgment and discretion, may deem an Experimental and/or Investigational service or supply covered under this Plan for treating a life-threatening Illness, Injury or condition, if it is determined by the Plan Administrator or its designee that the Experimental and/or Investigational service or supply, at the time of the determination:
    1. is proved to be safe with promising efficacy; and
    2. is provided in a clinically controlled research setting; and

3. uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health (NIH),

For the purpose of this definition, the term "life-threatening" is used to describe illnesses, injuries or conditions that are more likely than not to cause death within one year of the date of the request for treatment.

Food and Drug Administration (FDA)

The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Full-Time Salaried Employee

A person employed as a full-time salaried employee by a Contributing Employer and either (i) holds the office of President or Secretary of the New York Newspaper Printing Pressmen's Union No. Two, or (ii) is employed in any of the operations covered by a collective bargaining agreement with the New York Newspaper Printing Pressmen's Union No. Two.

Fund Administrator

Fund Administrator means the Board of Trustees, Publishers'-Pressmen's Welfare Fund, or any committee(s) or person(s) duly appointed by the Trustees to administer the Plan and Trust. The Board of Trustees shall be the "administrator" as that term is defined in Section 3(16) of ERISA.

Handicap or Handicapped (Physically or Mentally)

The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled; provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Hospital/Facility

A fully licensed acute-care general facility that has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
- A fully-staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care

- Assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies
- Diagnostic radiology facilities
- A pathology laboratory
- An organized medical staff of licensed doctors

For pregnancy and childbirth services, the definition of "hospital" includes any birthing center that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan.

For physical therapy purposes, the definition of a "hospital" may include a rehabilitation facility either approved by Empire or participating with Empire or another Blue Cross and/or Blue Shield plan other than specified above.

For kidney dialysis treatment, a facility in New York State qualifies for In-Network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York's. Out-of-Network benefits will be paid only for non-participating facilities that have an appropriate operating certificate.

For behavioral healthcare purposes, the definition of "hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral healthcare services. For alcohol and/or substance abuse received Out-of-Network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.

For certain specified benefits, the definition of a "hospital" or "facility" may include a hospital, hospital department or facility that has a special agreement with Empire.

Empire's EPO and the Plan do not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or mental health care.

Illness

Any bodily sickness or disease, including any congenital abnormality of a newborn Child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of a covered Employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan.

In-Network Benefits

Benefits for covered services delivered by In-Network Providers and Suppliers. Services provided must fall within the scope of their individual professional licenses.

In-Network Provider/Supplier

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- is in Empire's EPO network
- is in the PPO network of another Blue Cross and/or Blue Shield plan
- has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

Injury

Any damage to a body part resulting from trauma from an external source.

Inpatient Services

Services provided in a Hospital/Facility during the period when charges are made for room and board.

Itemized Bill

A bill from a Provider, Hospital or ambulance service that gives information that the Claims Administrator needs to settle your Claim. Provider and Hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A provider bill will also have the Provider's name and address and descriptions of each service, while a Hospital bill will have the subscriber's name and address, the patient's date of birth and the Plan Participant's Empire identification number. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled, and charges.

Legend Drugs

For the purposes of this Plan, Legend Drugs include:

1. Federal Legend Drugs: Any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. Drugs that require a prescription under state law but not under federal law.
3. Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Maintenance Care

Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care

Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Maximum Plan Benefits

The maximum amount of Benefits payable by the Plan on account of medical expenses incurred by any covered Plan Participant under this Plan and any previous medical expense plan provided by the Fund. The Limited Maximum Plan Benefits are sometimes referred to as "Lifetime" Benefits, but this reference does not denote, nor should it be construed to denote, any obligation by the Plan to pay any Benefits for the lifetime of the Plan Participant.

1. Limited Maximum Plan Benefits are the maximum amount of Benefits payable on account of certain covered medical services or supplies by the Plan during the entire time a Plan Participant is covered under this Plan. The services or supplies that are subject to Limited Maximum Plan Benefits and the limits of those Benefits are identified in the Schedule of Medical Benefits.
2. Annual Maximum Plan Benefits are the maximum amount of Benefits payable each Calendar Year on account of certain medical expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan.

Medical Management Program

A Managed Care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered. See the chapter entitled Medical Management Program.

Medically Necessary

Services, supplies or equipment provided by a Hospital or other Provider of health services that are:

- Consistent with the symptoms or diagnosis and treatment of the patient's condition, Illness or Injury,
- In accordance with standards of good medical practice,
- Not solely for the convenience of the patient, the family or the provider,
- Not primarily custodial, and
- The most appropriate level of service that can be safely provided to the patient.

The fact that a Provider may have provided, ordered, prescribed, recommended or approved a service, supply or equipment does not, in itself, make it Medically Necessary.

Medicare

The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act, as it is now amended and as it may be amended in the future.

Non-Participating Hospital/Facility

A hospital or facility that does not have a participation agreement with Empire or another Blue Cross and/or Blue Shield plan to provide services to persons covered under the Plan's Empire EPO contract. Or, a hospital or facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.

Nurse

A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who:

1. acts within the scope of his or her license; and
2. is not the patient or the parent, Spouse, sibling (by birth or marriage) or Child of the patient.

Office Visit

A direct personal contact between a Physician or other healthcare Provider and a patient in the Physician's or healthcare Provider's office for diagnosis or treatment associated with the use of the appropriate Office Visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT-4 coding. Neither a telephone discussion with a Physician or other health care Provider nor a visit to such person's office solely for services such as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an Office Visit for the purposes of this Plan.

Operating Area

Empire operates in the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.

Out-of-Network Providers/Suppliers

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- is not in Empire's EPO network
- is not in the PPO network of another Blue Cross and/or Blue Shield plan
- does not have a negotiated rate with another Blue Cross and/or Blue Shield plan

Outpatient Surgery

See the definition of Same-Day Surgery.

Outpatient Services

Services provided either outside of a Hospital/Facility setting or at a Hospital/Facility when room and board charges are not incurred.

Participating Hospital/Facility

A hospital or facility that:

- is in Empire's network
- is in the PPO network of another Blue Cross and/or Blue Shield plan
- has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

Pharmacist

A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physician

A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform Surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who:

1. acts within the scope of his or her license; and
2. is not the patient or the parent, Spouse, sibling (by birth or marriage) or Child of the patient.

Plan, This Plan

The program, Benefits and provisions of the Publishers'-Pressmen's Welfare Fund as described in this Summary Plan Description.

Plan Administrator

See the definition of Fund Administrator.

Plan Participant

The Employee or individual who has Enrolled for coverage under the Plan. As used in this document, this term does not include the Spouse or Dependent Child(ren) of the Plan Participant.

Plan Year

The twelve-month period from April 1 to March 31. See also the definition of Calendar Year.

Post-Service Claim

A Post-Service Claim is a Claim for a benefit under the Plan after the services have been provided.

Precertified Services

Services that must be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs before services are provided in order to be fully covered by the Plan. For example, planned inpatient surgery, MRIs and MRAs. Failure to precertify may result in a reduction or denial of benefits.

Pre-Service Claim

A Pre-Service Claim is a Claim for a benefit under the Plan for which the Plan conditions the receipt of the benefit, in whole or in part, on approval of the benefit before services have been provided (i.e.- pre-certification).

Prevailing Charge

See the definition of Usual and Customary for the definition of Prevailing Charge as it relates to the determination that a healthcare Provider's charge is Usual and Customary.

Provider

A hospital or facility (as defined earlier in this chapter), or other appropriately licensed or certified professional healthcare practitioner (e.g. Physician, Dentist, or Nurse) legally authorized to practice or provide certain healthcare services under the laws of the state or jurisdiction where the services are rendered. The Plan will pay benefits only for covered services within the scope of the practitioner's license and provided that the practitioner is not the patient or the parent, Spouse, sibling (by birth or marriage) or Child of the patient.

For behavioral healthcare purposes, "provider" includes care from psychiatrists, psychologists or certified social workers (with three or more years of post-degree supervised experience), providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders.

For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

Receipt of Claim

A Claim is considered received by the Plan when the request contains enough information to permit a determination of eligibility of the person seeking a benefit;

adequate information of the activity involved to determine if the service or event is covered by the Plan; and sufficient information, or authorization to obtain information, to permit the Plan to make the dollar payment to the appropriate party. A verbal request for coverage will be considered received on the day of the conversation only if a Claim is received by the Plan within 48 hours of the time of the conversation.

Reconstructive Surgery

A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental Injury, infection, disease or tumor, or for breast reconstruction following breast cancer surgery.

Same-Day Surgery

Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a hospital.

Spouse

See the definition under the Dependent Definitions heading.

Subrogation (Repayment of Medical Benefits)

This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability subchapter in the chapter on Duplicate Coverage of Medical Expenses for an explanation of how the Plan may use the right of Subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's Injury or Illness, so that the Plan may recover medical Benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Surgery

Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan Benefits.

Treatment Maximums

Maximum number of treatments or visits for certain conditions.

Totally Disabled, Total Disability

The inability of a covered Employee to perform all the duties of his or her occupation with his or her employer as a result of a non-occupational Illness or Injury, or the inability of a Covered Dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of Handicap.

Urgent Claim

An Urgent Claim is a Claim for medical care or treatment that, if the time periods for making non-urgent care determinations are applied, could seriously jeopardize the life or health of a Plan Participant or Covered Dependent or the ability of the Plan Participant or Covered Dependent to regain maximum function. A Claim will also be considered an Urgent Claim if, in the opinion of a Physician with knowledge of the Plan Participant's or Covered Dependent's condition, failure to obtain the care or treatment which is the basis of the Claim would subject the Plan Participant or Covered Dependent to severe pain that cannot be adequately managed without such care or treatment.

Usual and Customary Charge

A. The charge for Medically Necessary services or supplies will be determined by the Plan Administrator or its designee to be the lowest of:

   1. The usual charge by the healthcare Provider for the same or similar service or supply; or

   2. With respect to Empire, the charge set forth in the agreement between the healthcare Provider and Empire or another Blue Cross/BlueShield plan or the Plan; or

B. The "Prevailing Charge" of most other healthcare Providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Claims Administrator who shall use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity.

C. The Plan will not always pay Benefits equal to or based on the healthcare Provider's actual charge for health care services or supplies, even after the patient has paid the applicable Deductible and Coinsurance. This is because the Plan covers only the Usual and Customary Charge for healthcare services or supplies.

D. The Usual and Customary Charge is sometimes referred to as the U & C Charge, and may sometimes be called the reasonable and customary charge, the R & C charge, or the usual, customary and reasonable charge, the UCR charge.

You, Your

When used in this document, these words refer to the Employee who is covered by the Plan. They do not refer to any Dependent of the employee.

NOTES

NOTES

PRESSMEN'S-PUBLISHERS'

PENSION FUND

SUMMARY PLAN DESCRIPTION

May 1, 2012

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INTRODUCTION

The Pressmen's - Publishers' Pension Plan (the "Plan") was established as a defined benefit plan, effective October 1, 1955, to help you build toward financial security at your retirement. This is one of the most important long range goals for you and your family.

The Plan is administered by a joint Board of Trustees (the "Trustees") consisting of representatives of the Union ("Labor Trustees") and representatives of the Contributing Employers ("Management Trustees"). The Trustees, or any of their duly authorized designee(s), reserve the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply and interpret the Plan, the Trust Agreement and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan or the Trust (and the investment of Plan assets). All determinations made by the Trustees, or any of their duly authorized designee(s), with respect to any matter arising under the Plan, the Trust Agreement or any other Plan documents shall be final and binding on all affected Plan participants (and their Beneficiaries).

Please note that no individuals, other than the Trustees, or their duly authorized designee(s), have any authority to interpret the Plan, the Trust Agreement, or any other Plan documents, or to make any promises to you about the Plan or your benefits under the Plan.

This booklet is called a "summary plan description" ("SPD") and summarizes the key provisions of the Plan. This booklet has been written, as much as possible, in everyday language to summarize the benefits, rights and obligations you have under the Plan. We hope you will find this information helpful and will discuss it with your family.

Please remember that the purpose of this booklet is only to provide a brief, easy-to-understand summary of those Plan provisions which are of most immediate interest to you and does not constitute a contract or promise of future employment. You must consult the actual plan document for the definitive plan language governing your rights. In the event of any conflict between the Plan and this booklet, or if any point is not covered in this booklet, the actual plan document will govern.

A copy of the Plan is available for your inspection during regular business hours in the Plan Administrator's office and a copy will be provided for you to keep upon request. If you have any questions after reading this booklet, or if you would like to discuss the details further, call, visit or write the Fund Office at:

Pressmen's - Publishers' Pension Fund
1501 Broadway, Suite #1724
New York, NY 10036
Phone: (212) 869-5994
Mr. Robert A. Costello, Administrator

We urge you to read this SPD carefully and that you retain it for future reference.

WHAT DOES THE PRESSMEN'S - PUBLISHERS' PENSION PLAN MEAN TO ME?

The Pressmen's - Publishers' Pension Plan provides the following features, some or all of which may be applicable to you and your beneficiaries:

- A monthly income when you retire . . . in addition to your Social Security benefits
- Normal Retirement may be possible as early as age 62 if you have 20 years of Credited Service
- Early Retirement may be possible as early as age 59 if you have 20 years of Credited Service
- Disability Retirement
- Vesting in your accrued pension benefits if you leave the employment of employers contributing to the Plan after 5 years of Vested Service (Effective for those employed on or after April 1, 1999) (vesting is after 10 years of service for those who terminated employment prior to April 1, 1999)
- Benefits payable to your surviving spouse upon your death
- Different optional forms of payment of your pension benefit

Certain benefits under the Plan are insured by the Pension Benefit Guaranty Corporation (the "PBGC") - an agency of the US Government. Further details about this insurance coverage are discussed later in this booklet.

WHEN DO I BECOME A MEMBER OF THE PLAN?

If you are a journeyman, apprentice, or junior pressman of an employer in New York City or its vicinity who is working, or has worked, under a collective bargaining agreement with New York Newspaper Printing Pressmen's Union Number Two (i.e., working for a "Contributing Employer" under a "Collective Bargaining Agreement"), you are an "Employee" in "Covered Employment" and will automatically become a participant in the Plan on your first day of Covered Employment. Full-time salaried officers or employees of the Union for whom the Union has an obligation to contribute to the Plan pursuant to a written agreement and who were in the bargaining unit before or after their tenure in the Union office also are eligible to participate in the Plan.

WHO PAYS FOR MY BENEFITS?

Each Contributing Employer (or in the case of full-time salaried officers or employees of the Union, the Union) makes periodic contributions to the Plan, the amount of which are determined by the Collective Bargaining Agreement. A complete list of all Contributing Employers may be obtained upon written request to the Plan Administrator and is available for examination at the Fund Office. You may also request from the Plan Administrator, in writing, confirmation as to whether a particular employer contributes to the Plan.

The Collective Bargaining Agreement and the Plan documents may require you to make contributions to the Plan. Currently, participants are required to make contributions of $1.06 per shift.

Such participant contributions are always vested, can be returned upon your written request if you terminate employment with a Contributing Employer before you satisfy the vesting period required to receive a pension (see page 15), and may be provided to your beneficiary if you die prior to satisfying the pension vesting requirements (see page 12).

The assets of the Plan are held in trust and are held by the Plan's custodians and are managed by the Plan's investment managers.

WHAT WORDS HAVE SPECIAL MEANING?

Throughout this booklet, you will come across certain words or terms which are used frequently and which you should know. These terms will help you understand your benefits better. Remember to keep them in mind as you read the rest of this booklet.

Plan Year - April 1 through March 31.

Vesting Service - Your Vesting Service determines your **right** to receive benefits. For each year of "Credited Service" (see page 4) prior to 1956 and for each calendar year thereafter commencing with your date of employment in which you are credited with 1,000 Hours of Service (see page 4) for a Contributing Employer, you earn one year of vesting service. If you are credited with less than 1,000 Hours of Service in a calendar year, you do not earn any vesting service for that year.

You become vested in your pension benefits after completing 5 years of Vesting Service if you are working, or have worked, as an Employee for a Contributing Employer on or after April 1, 1999. If your last day of work with a Contributing Employer was prior to April 1, 1999, you must have accumulated 10 years of Vesting Service in order to be vested in your pension benefits.

Hour of Service - You are credited with an Hour of Service for each hour within a calendar year for which: (1) you are directly or indirectly paid or entitled to payment by a Contributing Employer for the performance of duties (or, if federal law does not require your employer to report time worked in your position in hourly increments, you will be credited with 10 hours per day or 50 hours per week), (2) each hour for which you are paid or entitled to payment (to a maximum of 8 hours per day, 40 hours per week, and 501 hours during any single continuous period (as calculated under applicable law)) on account of which you perform no duties due to vacations, holidays, illness, incapacity (including disability), layoff, jury duty, military service, leave of absence and similar periods of paid nonworking time, or (3) for each hour for which back pay has either been awarded or agreed to by a Contributing Employer. Performance will be credited for the calendar year in which the work was performed, or the year to which back pay pertains, as applicable, and all other categories will be credited in the year in which you receive compensation for that category. Notwithstanding any of the foregoing, you shall not receive credit towards an Hour of Service for any time for which you receive payment under Worker's Compensation, unemployment compensation, or disability insurance laws, or as reimbursement for medical or medically related expenses.

Credited Shift – A Credited Shift is a shift (1) for which you received compensation from a Contributing Employer, (2) you lost due to sickness (after 7 days of sickness and up to one year), (3) you lost due to a non-occupational accident (up to one year), or (4) you lost because of an occupational accident or injury and for which (a) you received Worker's Compensation and (b) a Contributing Employer made contributions to the Plan on your behalf.

If you were employed by a Contributing Employer on August 8, 1978, you shall be credited with 5 Credited Shifts for each week during the period from August 9, 1978 to November 4, 1978.

Credited Service - Your Credited Service is used to calculate the amount of your benefits by counting the amount of your Credited Shifts.

A. Prior to January 1, 1956:

   An Employee who worked at least 156 Credited Shifts in either 1954 or 1955 for a Contributing Employer, or for a firm which would have come within the category of a Contributing Employer if the Plan had been in effect, received credit for all service rendered prior to 1956 as an Employee. However, an Employee who had at least 20 years of Credited Service in the industry and who worked more than 50 Credited Shifts in either 1954 or 1955, received credit as an Employee for all service

rendered prior to 1956, regardless of whether he worked 156 Credited Shifts in either 1954 or 1955.

B. After December 31, 1955:

An Employee's yearly Credited Service shall be computed in accordance with the number of Credited Shifts he completes ***during each calendar year*** as follows:

Credited Shifts	Credited Service
208 or more*	1 year (1.0)
161 to 207	¾ year (.75)
116 to 160	½ year (.50)
75 to 115	¼ year (.25)
74 or less	no credit (0.00)

***Credited Shifts in excess of 208 in any one calendar year may not be carried over or applied to any other calendar year.**

Military Service Credit – An Employee who qualifies for and obtains re-employment pursuant to applicable Federal law (e.g., the Uniformed Services Employment and Reemployment Rights Act (USERRA)) with a Contributing Employer upon his completion of military service shall receive 5 Credited Shifts for each week of the Employee's period of military service (up to a maximum of 5 years).

WHEN MAY I RETIRE?

Normal Retirement Age

"Normal Retirement Age" means the earlier of:

(i) age 65 (and 5 years of participation for those who became Employees on or after June 1, 2001); or

(ii) age 62 and completion of 20 years of Credited Service.

An Employee is entitled to a "Full Pension" upon retirement from a Contributing Employer after reaching "Normal Retirement Age".

For Employees who retired from a Contributing Employer on or after January 1, 2006, if you qualify for a Full Pension and have 20 years of Credited Service, you will receive a monthly pension benefit of $1,550. If you qualify for a Full Pension but have less than 20 years of Credited Service, your monthly pension benefit will be equal to $77.50 multiplied by the number of years of your actual Credited Service. If you qualify for a Full Pension and have more than 20 years of Credited Service, you will receive an additional monthly benefit (in other words, in excess of $1,550) calculated by multiplying $40 by the number of years of Credited Service in excess of 20 years.

Note: Table F outlines the Full Pension Benefit available for each year of Credited Service for those Employees who became eligible for a Full Pension and retired from a Contributing Employer on or after January 1, 2006.

If you became eligible for a Full Pension prior to January 1, 2006 and began collecting your pension before that date, your pension amount would differ from the amounts on Table F. Please refer to prior SPDs and Summary of Material Modification Notices for more information.

Vested Deferred Retirement

If you leave the industry (i.e., from the employment of all Contributing Employers) on or after April 1, 1999, after you become vested by completing at least 5 years of Vesting Service, you will be entitled to a monthly benefit when you reach Normal Retirement Age. If you left the industry prior to April 1, 1999, you must have completed 10 years of Vesting Service to qualify for this retirement benefit. The amount of this benefit is based on the Full Pension benefit formula in effect when you leave the industry. Additionally, if you left Covered Employment on or after October 1, 1979 and before January 1, 1997, you are entitled to an additional monthly benefit of $36. If you have completed at least 20 years of Credited Service, you may choose to have your monthly payments begin when you reach "Early Retirement Age" at a reduced amount as described in the Early Retirement section, below.

Early Retirement

If you are between 59 and 62 years old with at least 20 years of Credited Service ("Early Retirement Age") and you want to retire before age 62, you may apply for an "Early Retirement" benefit.

Your benefits will be determined in the same manner as the Normal Retirement benefit in effect on the date you terminate employment with all Contributing Employers, but will be reduced by .6% for each full month by which the benefits start to be paid before age 62. This reduction accounts for the longer period over which your Early Retirement benefits are expected to be paid.

Disability Retirement

If you are between 55 and 65 years old with at least 15 years of Credited Service, or if you have completed 20 years of Credited Service regardless of age, and you become totally and permanently disabled while employed by a Contributing Employer so that you are unable to continue in or secure employment of any kind, you may apply for a Disability Pension. To be eligible for a Disability Pension, you must receive a Social Security Disability Award. (Your application for a Disability Pension must be filed with the Fund Office within 12 months after you receive a Social Security Disability Award from the Social Security Administration.) Your Disability Pension benefit will be effective on the date of disability set forth in your Social Security Disability Award notice or, if later, the date you became eligible for a Disability Pension.

The Trustees are authorized to make determinations as to whether you are disabled based on such proofs of disability as the Trustees may require. However, if you have qualified for and received a permanent and total disability retirement award from the Social Security Administration due to an on-the-job accident incurred in the course of your employment with a Contributing Employer, you will be considered disabled under the Plan, subject to the requirements set forth herein.

The amount of your Disability Pension will be determined based upon the amount of Normal Retirement pension benefit you would be eligible for if you retired on the date of disability, but it will not be reduced as for Early Retirement. You may select the form in which you will receive payment just as if you were receiving any other type of pension benefit under the Plan.

WHEN MUST I BEGIN COLLECTING MY BENEFIT?

You must begin your pension benefit payments ON THE SIXTIETH (60th) DAY AFTER THE LAST DAY OF THE Plan Year in which the later of the following dates occurs:

(i) you reach age 65 or qualify for a Normal Retirement, whichever occurs earlier;

(ii) the tenth anniversary of the year in which you started participating in the Plan; or

(iii) the date on which you last worked for a Contributing Employer.

In any event, you must begin your pension benefit payments no later than the April 1 following the calendar year in which you (1) reach age 70½, or (2) actually stop working for a Contributing Employer, whichever is later.

HOW WILL MY PENSION BE PAID OUT WHEN I RETIRE?

When you notify the Fund Office that you wish to retire, you will be provided with a description of the types of pensions and methods of payment available to you, including a comparison of the relative value of each of the payment forms, so that you can compare the financial effect of selecting one of the following forms of payment. Keep in mind that at the time that you apply to receive your benefit, if the actuarially determined value is equal to or less than $5,000, it will be paid to you in the form of a single lump sum.

If You Are Single . . .

If you have no spouse when you retire, you will normally receive a monthly pension for your lifetime only, but if you die prior to 60 monthly payments being paid, your designated beneficiary (or your estate if no such beneficiary is designated) will receive in a lump sum payment, the difference between 60 monthly payments of your calculated benefit and the number of payments that you received prior to your death. This form of benefit is called your *single life pension with five years certain payment.*

If You Are Married . . .

If you are married when you retire, your monthly pension amount will be reduced and, after your death, one-half (50%) of your pension (that you would otherwise have received during your lifetime) will be paid to the spouse to whom you were married at the time that your pension benefit began for the rest of his or her lifetime. (Please note that this rule applies if you are married at the time of your retirement and remain married for a total period of one year.) This way of payment provides valuable protection for your spouse and is called the *50% Joint and Survivor Benefit*.

Alternatively, you may elect to provide for your spouse a survivor payment equaling either 75% or 100% of your monthly pension payment. These are called a *75% Joint and Survivor Benefit* and a *100% Joint and Survivor Benefit*, respectively. Because these alternative arrangements will usually result in benefit payments being paid over a longer period of time than under the single life pension with five years certain payment, the amount of your benefit (that you would otherwise have received during your lifetime) is reduced by an actuarial factor described below. The factor that is used takes into account both your spouse's age and your age at the time of your retirement, and the percentage of benefit elected. The current factors used by the Plan are shown on Tables C, D and E at the end of this booklet. After you elect a form of benefit payment, you may revoke it in writing and select another form of payment anytime during the election period.

If You Are Married And Reject Survivor Benefits . . .

If you wish, even if you are married when you retire, you may choose to receive your pension in the form of a single life pension with five years certain payment, provided that your spouse consents to such form of benefit in writing on a form prepared by the Plan Administrator prior to the first day of the month in which your pension payment will begin. This consent must be witnessed by a notary public.

SAMPLE CALCULATIONS

Normal Retirement

Assuming that you retire in 2012 at age 62 with 36 years of Credited Service, your Full Pension monthly benefit would be determined as follows:

(a) $77.50 x the first 20 years = $1,550 plus,

(b) $40 x 16 years (i.e., years in excess of 20 years) = $640

(c) total monthly benefit = (a) + (b) = $1,550 + $640 = $2,190

If you are not married when you retire, or you and your spouse **both** reject the 50% Joint and Survivor Benefit in favor of the single life pension with five years certain payment, you will receive this amount ($2,190.00, as shown in the example above) each month for the rest of your life, with the first 60 months' payments guaranteed.

If you are married when your retirement benefits are scheduled to commence, you will receive the 50% Joint and Survivor Benefit (unless you and your spouse **both** decline that form of benefit in writing). The amount you will receive during your lifetime will be reduced (as compared to the single life pension with five years certain payment) in order to pay for benefits to your spouse during his or her lifetime in the event that you predecease your spouse. For example, if you are age 62 and your spouse is five years younger than you, you will receive 91.89% (see Table C) of $2,190.00, or $2,012.39 per month, for the rest of your life. After your death, your surviving spouse would receive one-half of your $2,012.39 benefit, or $1006.19, per month for the rest of his/her life.

However, if you elect the 75% Joint and Survivor Benefit, you will receive 88% (see Table D) of $2,190.00, or $1,927.20 per month, for the rest of your life. After your death, your surviving spouse would receive three-quarters of your $1,958.88 benefit, or $1,445.40, per month for the rest of his/her life.

Finally, if you elect the 100% Joint and Survivor Benefit, you will receive 84.44% (see Table E) of $2,190.00, or $1,849.24 per month, for the rest of your life. After your death, your surviving spouse would receive the same amount as your benefit, or $1,849.24, per month for the rest of his/her life.

Vested Deferred Retirement

If you last worked for a Contributing Employer in 1997, after completing 15 years of Credited Service, and wish to retire in 2012 at age 65, your single life pension with five years certain payment is $937.50. This amount is determined by looking at the pension benefit in effect at the time that you left Covered Employment in 1997 ($1,250 for 20 years of Credited Service), adjusted for the amount of Credited Service that you actually earned (15 years of Credited Service ÷ 20 years of Credited Service = .75).

Note: You must review the plan document (on file in the Fund Office) in effect at the time that you left Covered Employment to determine the appropriate monthly pension benefit for the calculation of your Vested Deferred Retirement benefit.

Early Retirement

If you qualify for Early Retirement and begin receiving benefits before age 62, your Full Pension will be reduced by six-tenths of one percent (0.6%) for each month your actual retirement date precedes age 62. This reduction is necessary because it is expected that your monthly benefits will be paid over a longer period of time if you retire early. The following schedule shows sample early retirement factors for a given age:

Your Age When Retirement Benefits Start	Early Retirement Reduction Factor
59 years, 0 months	78.4%
60 years, 0 months	85.6%
61 years, 0 months	92.8%

Note: Early retirement reduction factors will reflect your actual age in years and months.

Sample Calculation for Early Retirement

Suppose you want to retire in 2012 during the month in which you turn age 59 after 40 full years of Credited Service. Your benefit payable to you at age 59 would be determined as follows:

Age 62 with 40 Years Benefit		Early Retirement Factor (36 months prior to age 62)		Your Age 59 Single Life Pension with 5 Years Certain Payments
$2,350	x	78.4%	=	$1,842.40

In this example, if you are married when you retire, you will receive the 50% Joint and Survivor Benefit unless you and your spouse elect otherwise. Under such payment method, if your spouse is also age 59, you will receive 94.39% of $1,842.40, or $1,739.04, per month for the rest of your life. After your death, your surviving spouse will receive $869.52 (one-half of $1,739.04) for the rest of his or her life.

Disability Retirement

If the Social Security Administration were to award you a Disability Award in 2012 in the month after you turned age 55, and you completed 15 years of Credited Service before you became disabled, your Disability Retirement payment would be determined by multiplying the benefit rate in effect in 2012 by the number of years of Credited Service, as shown below:

$77.50 x 15 Years of Credited Service = $1,162.50

Your single life pension with five years certain payment would be a monthly payment of $1,162.50.

Call the Plan Administrator at (212) 869-5994 for further information on calculating the Joint and Survivor Benefit for a Disability Retirement.

WHEN IS MY PENSION PAYABLE?

The date on which your pension is payable is the first day of the month following the *latest* of the following dates:

1. the date on which you were totally and permanently disabled; or
2. the date on which all disability payments to which you were eligible under the Pressmen's - Publishers' Welfare Fund, if any, are terminated; or
3. the date on which you last worked for a Contributing Employer (except that if your eligibility depends on the inclusion of time credited for a

period in which you are on qualified paid vacation just prior to your termination date, you must wait until such vacation period is complete); or

4. the date on which your submitted application for benefits is approved (see "How Do I File A Claim For Benefits" on page 17); provided, however, that if you file an application after age 65, your pension will be retroactively effective to your Normal Retirement Age, or, if earlier, the date on which you last worked for a Contributing Employer, and your monthly benefit will be increased to reflect the payments that you missed or, if you so elect, you will receive a lump sum reflecting such missed payments.

WHAT IF I SHOULD DIE?

After I Retire?

If you were married when your retirement benefits began and your marriage lasted at least one year, and you and your spouse did not elect otherwise in writing, your surviving spouse will automatically receive the 50% Joint and Survivor Benefit. If you elected the 75% Joint and Survivor Benefit or 100% Joint and Survivor Benefit, your surviving spouse will receive the survivor benefit elected.

If you were single when your retirement benefits began, or if you and your spouse elected in writing the single life pension with five years certain payment, and you die **before** receiving 60 payments, your beneficiary (or your estate if your beneficiary predeceases you or you fail to name a beneficiary) will receive the actuarially determined present value of the remaining payments in a lump sum. If you die **after** receiving at least 60 monthly payments under this form of payment, no further benefits are payable.

Before I Retire, while Actively Employed?

If you die while actively employed by a Contributing Employer, your surviving spouse (provided that you were married for at least one year at the time of your death) will be entitled to a "Spouse's Benefit."

If you die **after reaching Early Retirement Age**, this benefit will be equal to 50% of the monthly benefit you would have been entitled to if you had retired on the day immediately preceding your death and elected the 50% Joint and Survivor Benefit. This Spouse's Benefit, if any, will begin on the first day of the month following the month in which you die.

If you die **before reaching Early Retirement Age** (because you were not yet 59 or had not completed 20 years of Credited Service), this benefit will be equal to 50% of the monthly benefit you would have been entitled to if you had left active employment on the date of your death, survived to age 59 or, if you had not completed 20 years of Credited Service, age 65, and retired with the 50% Joint and Survivor Benefit and then died on the day after you retired. The Spouse's Benefit, if any, will begin on the first day of the month following the date you would have reached age 59 or, if you had not completed 20 Years of Service, age 65.

Before I Retire, But After Leaving Covered Employment?

If you die after you have terminated employment, your surviving spouse (provided that you were married for at least one year at the time of your death) will be entitled to a "Spouse's Benefit," which will be determined as follows:

If you terminated your employment with all Contributing Employers prior to April 1, 1999 after you completed 10 years of Vesting Service (or 5 years of Vesting Service if you terminated employment on or after April 1, 1999) and you then die before the date your pension was scheduled to begin, your surviving spouse will be entitled to the following "Spouse's Benefit:"

(a) if you die **after reaching Early Retirement Age**, this benefit will be equal to 50% of the monthly benefit you would have been entitled to if you had retired on the day immediately preceding your death and elected the 50% Joint and Survivor Benefit. This Spouse's Benefit, if any, will begin on the first day of the month following the month in which you die.

(b) if you die **before reaching Early Retirement Age** (because you were not yet 59 or had not completed 20 years of Credited Service), this benefit will be equal to 50% of the monthly benefit you would have been entitled to if you had left active employment on the date of your death, survived to age 59 or, if you had not completed 20 years of Credited Service, age 65, and retired with the 50% Joint and Survivor Benefit and then died on the day after you retired. The Spouse's Benefit, if any, will begin on the first day of the month following the date you would have reached age 59 or, if you had not completed 20 Years of Service, age 65.

Here are examples of the Spouse's Benefit for an Employee who dies before he retires, while actively employed or after termination of employment:

Example 1: Let's assume that your spouse is the same age as you. Suppose you were to die in 2012 in the month that you had just turned age 60, having completed 20 years of Credited Service. Your age 62 single life pension with five years certain payment is therefore $1,550.00 per month (the Full Pension amount in effect in 2012).

Age 62 Single Life Benefit		Early Retirement Factor		50% Joint & Survivor Benefit Factor		Your Age 60 Benefit
$1,550.00	x	85.6%	x	94.19%	=	$1,249.71

Since you would have received a benefit of $1,249.71 per month if you had retired on the day of your death, your spouse is entitled to one-half of this or $624.86 per month, beginning after the month in which you died.

Example 2: If, however, you had died in 1997 at the age of 49, having completed 20 years of Credited Service, your age 62 single life pension with five years certain payment would be $1,250.00 per month (the Full Pension amount in effect in 1997).

Age 62 Single Life Benefit		Early Retirement Factor		50% Joint & Survivor Benefit Factor		Your Age 60 Benefit
$1,250.00	x	78.4%	x	94.39%	=	$925.02

Since you would have received a benefit of $925.02 per month if you had retired on the day of your death and survived to age 59, your spouse is entitled to one-half of this or $462.51 per month, beginning in the month in which you would have reached age 59.

If your spouse is not the same age as you, as assumed in Examples 1 and 2 above, then the amount your spouse will be entitled to receive will be different because the actuarial factor that is used takes into account both your spouse's age and your age. The following example illustrates this difference.

Example 3: Assume that your spouse is 6 years younger that you, age 54. Suppose you were to die in 2012 in the month that you had just turned age 60, having completed 20 years of Credited Service. Your age 62 single life pension with five years certain payment is therefore $1,550.00 per month (the Full Pension amount in effect in 2012).

Age 62 Single Life Benefit		Early Retirement Factor		50% Joint & Survivor Benefit Factor		Your Age 60 Benefit
$1,550.00	x	85.6%	x	92.13%	=	$1,222.38

Since you would have received a benefit of $1,222.38 per month if you had retired on the day of your death, your spouse is entitled to one-half of this or $611.19 per month, beginning after the month in which you died.

LUMP-SUM DEATH BENEFITS

Optional Lump-Sum Death Benefit

If you die while actively employed by a Contributing Employer after having completed at least one year of Credited Service and you have not received any pension benefits under the Plan, your designated primary beneficiary (or, if none, then your designated secondary beneficiary or, if none, then your estate) will be entitled to a death benefit determined by multiplying the normal monthly pension benefit, pro rated for your years of Credited Service, by 60. If you and your spouse qualify for the Spouse's Benefit described earlier, your spouse will not receive this Optional Lump-Sum Benefit unless your spouse rejects the Spouse's Benefit.

If the amount of the benefit payable to your beneficiary (or your spouse) has an actuarially determined value equal to or less than $5,000, it will be paid in the form of a single lump sum.

For example:

Let's assume that you die in 2012 at age 60 while actively employed by a Contributing Employer, but after completing 14 years of Credited Service. Your beneficiary would be entitled to receive the following Optional Lump-Sum Benefit:

Years of Credited Service		Monthly Benefit Accrual		Death Benefit Multiple		Optional Lump-Sum Death Benefit
14	x	77.50	x	60	=	$65,100

Additional Lump-Sum Death Benefit

In addition, if you are eligible for either the Optional Lump-Sum Death Benefit described above or the Spouse's Benefit, the Plan will provide to your primary beneficiary (or, if none, then your secondary beneficiary or, if none, then your estate) a death benefit based on the following schedule:

Years in which you completed at least 160 Credited Shifts as of the Date of Death	Amount of Death Benefit
Less than 1 year	$ 0
1 year	$ 500
2 years	$ 900
3 years	$1,300
4 years	$1,700
5 years or more	$2,000

Contribution Benefit

If you have contributed any money to the Plan, your spouse, named beneficiary, or estate (in that order) will be entitled to a contribution benefit payment in addition to any other payments received under the Plan. This contribution benefit payment will be determined by adding interest on the amounts you contributed to the Plan and then subtracting any other death and retirement benefit paid as a result of your participation in the Plan.

Death While Performing Qualified Military Service

In the event that you die on or after January 1, 2012 while you are on leave from a Contributing Employer and performing qualified military service (within the meaning of Section 414(u) of the Internal Revenue Code), then for purposes of the Spouse's Benefit and the Lump-Sum Death Benefit described above, you will be treated as if you had died while actively employed by a Contributing Employer.

ROLLOVERS

A lump sum benefit of $200 or more payable to your Spouse or non-spousal beneficiary may be paid by the Plan directly to another qualified retirement plan. Information about such rollovers may be requested from the Plan Administrator at (212) 869-5994.

CAN I LOSE ANY OF MY BENEFITS FROM THE PLAN?

Your Plan is a valuable tool for planning for your retirement years. As you work for a Contributing Employer, you continue to build service for vesting and for calculating your monthly pension benefit. Obviously, the longer you work in the industry, the greater your monthly pension will become. You should be aware of the following circumstances which could cause you to lose or forfeit your benefits under the Plan:

Termination - If you terminate your employment with a Contributing Employer before completing 5 years of Vesting Service (or 10 years if you terminated such employment before April 1, 1999), you may lose any Vesting Service and Credited Service you have accumulated in the Plan, even if you later return to work with a Contributing Employer.

Break in Service - If you have a "Break In Service" before becoming vested (that is, if you are credited with less than 500 Hours of Service in a calendar year), you will be treated as if you terminated your employment for purposes of the Plan. Subject to its being restored (see "Can I Get Back My Benefits If I Lose Them," see page 17), you will lose whatever Vesting Service and Credited Service you have in the Plan. However, beginning on January 1, 1987, if you did not complete 501 or more Hours of Service in a calendar year due to absence related to pregnancy or care for a child immediately following birth, placement for adoption, or actual adoption, then up to 501 Hours of Service for such calendar year will be credited, either (1) for the year in which the absence began if such credit is required to prevent a Break in Service for that year, or else (2) for the year following the year in which such absence began. A "Break in Service" also occurs, and all of your Credited Service earned through December 31, 1970 will be forfeited, if you have not completed at least 3 years of Vesting Service after December 31, 1970. (See "Special Contributions," below.)

Special Contributions - If you lose employment with a Contributing Employer, the Trustees may (in their sole and absolute discretion) allow you to contribute to the Plan on your own behalf to avoid a Break in Service. You will only be considered for this opportunity if: (1) you are unable to secure new employment with a Contributing Employer despite your diligent efforts; (2) you are not engaged in the management or ownership of a business in which printing is performed; and (3) you are not engaged in any employment which you would not terminate at the first availability of work with a Contributing Employer. You must apply in writing to the Trustees for this opportunity and begin such payments within 60 days of the termination of your employment with a Contributing Employer, and be prepared

to pay all amounts due since your termination date. Call the Fund Office for more information.

Suspension of Benefits - If you are receiving pension benefit payments, your pension benefit payments may be suspended if you return to work for a Contributing Employer. Such suspension occurs whenever: (1) after reaching Normal Retirement Age (defined on page 5), a person receiving a Full, a Vested Deferred or an Early Retirement Pension works five (5) or more credited shifts in any calendar month; (2) before reaching Normal Retirement Age, a person receiving an Early Retirement Pension works one credited shift in any calendar week without advance permission from the Trustees (as described below); or (3) a person receiving a Disability Pension works at all (i.e., regardless of whether that work is for a Contributing Employer). Any payment received for a month in which a suspension occurred must be returned to the Plan.

If you are receiving payments for an Early Retirement Pension and are less than 62 years old, you may submit to the Trustees a written request, providing the relevant information, to work one credited shift without having your pension payments suspended. Such request may be granted at the Trustees' sole and absolute discretion.

If your Disability Pension payments are suspended for the reasons described in this section, your payments will not resume until you again meet the qualifications for a Disability Pension or you become eligible for a Full or Early Retirement Pension.

If you return to Covered Employment and accrue additional Credited Service, your pension upon your next retirement date will be calculated by adding all of your Credited Service, and then reduced by the amount that was distributed to you before your benefits were suspended.

Recovery of Payments - There are times that you and your spouse will be required to furnish information or proof necessary to determine your right, or that of your spouse or beneficiary, to a Plan benefit. 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.

If you, your spouse, or a beneficiary fails to submit the requested information or proof, makes a false statement, or furnishes fraudulent or incorrect information that results in your receipt of a pension or similar payment that is in excess of the amount to which you are entitled under the Plan, or even if, for any other reason whatsoever (including, for example, clerical error), a payment is made to which you, your spouse, or your beneficiary are not entitled under the terms and provisions of the Plan, the Plan reserves the right to recover such overpayment, plus interest and costs, from you, your spouse or your beneficiary, through whatever means are necessary, including, without limitation, deduction of the excess amounts from future benefits payable and/or legal action.

CAN I GET BACK MY BENEFITS IF I LOSE THEM?

If you have terminated your employment or have had a Break In Service before becoming vested, you can get back your Vesting Service and Credited Service if you return to active employment and are credited with at least 1,000 Hours of Service in a calendar year, provided your Break In Service was less than the greater of (i) five years or (ii) the number of years of Vesting Service accrued before your Break In Service. However, if your Break In Service exceeded the limitations described in the preceding sentence, then if you should return to Covered Employment, you will be treated as a new Employee for purposes of the Plan (that is, you will lose whatever Vesting Service and Credited Service you had in the Plan before your Break in Service).

For example, if you terminated your employment in 1989 after completing 4 years of Vesting Service, your prior Credited Service and Vesting Service would be restored if you returned to active employment within 4 years (1993) and are credited with at least 1,000 Hours of Service in a calendar year beginning within the 5-year period following your termination. If, however, you returned to active employment 6 years after termination (1995), then you would be treated as a new employee and you would lose your prior Credited Service and Vesting Service.
Additionally, if your employment with a Contributing Employer terminates before you vest in your pension benefit, and you are not making any Special Contributions to the Plan (see page 15), you may apply in writing to the Trustees to receive a refund of money that you contributed to the Plan, if any, plus interest calculated in accordance with the Plan. If you submit this written request to the Trustees within one year of the day on which your employment with a Contributing Employer terminated, you must indicate that you do not anticipate re-employment with a Contributing Employer during that time. If you are re-employed after you withdraw your contributions from the Plan and you repay the entire amount withdrawn plus interest, you will receive credit for your prior service for purposes of eligibility and benefit determinations, subject to the rules regarding a Break In Service.

HOW IS THE PLAN ADMINISTERED?

The Board of Trustees administers the Plan and acts as a Plan fiduciary. They have the authority to make the rules and regulations necessary for the day-to-day operations of the Plan. In addition, the Plan Administrator has been appointed by the Board of Trustees to administer the Plan and act as a Plan fiduciary.

HOW DO I FILE A CLAIM FOR BENEFITS UNDER THE PLAN?

If you wish to file a retirement application (a "claim for benefits under the Plan"), please contact the Fund Office and you will be provided with all the forms necessary for the proper filing of your claim. There are certain notices that you must receive between 30 days and 180 days prior to the start of your pension. Please keep this time limit in mind when preparing for retirement and requesting your application.

Also, please remember that an application for a Disability Retirement pension must be filed with the Fund Office within 12 months after you receive a Social Security Disability Award from the Social Security Administration.

IF MY CLAIM IS DENIED, HOW DO I FILE AN APPEAL?

You (or your beneficiary) will receive notice of whether your claim for benefits is accepted or denied, in whole or in part, within 90 days of receiving your claim (or within 45 days if the claim is based on your disability).

For all claims other than Disability Retirement claims, the 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension before the end of the initial 90-day period.

In the case of a Disability Retirement claim, there may be two extension periods of up to 30 days each. In the event of such an extension, notice of the extension will be provided to you before expiration of the initial 45-day period (or before expiration of the first 30-day extension, in the case of a second extension). The notice will explain the circumstances requiring the extension and specifically explain the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be suspended from the date on which the extension notice is sent to you until the date on which you respond to the Plan's request for additional information and you will be afforded at least 45 days in which to provide the additional information.

If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination,
- the specific Plan provision(s) on which the decision was based,
- if applicable, what additional material or information is needed to process your claim and why such material or information is needed, and
- what procedures you should follow to get your claim reviewed again, and the time limits applicable to such procedures.

If your claim is based on your disability and the Plan relied on an internal rule, guideline, protocol or other similar criterion in making the determination, the notice will also include a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon your request.

Filing an Appeal - If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. To do so, you (or your authorized representative) must submit a written request for review to the Fund Office, by certified or registered mail, within 60 days after you receive the notice of denial (or within 180 days if your claim is for a Disability

Pension). (The Fund Office will forward your request for review to the Trustees.) Your request for review must state your reasons for the review, and you may submit additional information in support of your claim such as written comments, documents, records or other information relating to your claim. You may also request a hearing before the Trustees. If you do, you will be given no less than ten (10) days notice of the time and place of the hearing and you (or your authorized representative) may appear personally. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim (and, if your claim is for a Disability Pension, the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the adverse benefit determination).

The review will take into account all comments, documents, records and other information you submit relating to your claim.

A decision on review will be made by the Trustees (or a committee designated by the Trustees, which will not include the individual who made the initial claim decision (or a subordinate of such individual) at their next regularly scheduled meeting following receipt of your request for review, unless your request is received by the Fund Office less than 30 days before the next regularly scheduled meeting. If your request for review is received by the Fund Office less than 30 days before the next regularly scheduled meeting, no decision will be made until the second regularly scheduled meeting following receipt of your request for review. If special circumstances require an extension of time for processing your request for review, the decision may be made at the third meeting following receipt of your request for review, provided that you are notified in advance of any such extension. The notice will describe the special circumstances requiring the extension, and will inform you of the date as of which the decision will be made.

If an extension is required due to your failure to submit information necessary to decide the appeal, the time for making the decision on review will be suspended from the date on which the extension notice is sent to you until the date on which you respond to the Trustees' request for additional information.

You will be sent written notification of the decision on review no later than five (5) days after such decision is made. If your appeal is denied, in whole or in part, the notification of the decision on review will include:

- the specific reason(s) for the decision;
- specific references to the Plan provisions on which the decision is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records and other information relevant to your claim; and
- a statement of your right to bring a civil action under ERISA.

If your claim is for a Disability Pension, the notification of the decision on review will also include:

- a description of any rule, guideline, protocol or other similar criterion that was relied upon in making the decision, as well as a statement that such rule, guideline, protocol or other similar criterion will be made available to you free of charge upon request; and
- an explanation of the medical, clinical or scientific judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

All decisions on review are final and binding on all parties. You must exhaust this appeal process before you pursue a civil action regarding the denial, in whole or in part, of your claim for benefits.

WHAT INFORMATION SHOULD BE PRESENTED TO APPEAL A DENIAL OF BENEFITS?

The Plan generally determines the amount of your pension based on remittance reports and other information submitted by Contributing Employers for whom you work. While the Plan conducts random payroll reviews of Contributing Employers that sometimes provide information regarding the accuracy of remittance reports and other information submitted by employers, these reviews may not reveal every instance in which a Contributing Employer may have failed to provide complete and/or accurate information concerning your employment.

You have the right to inquire about your Credited Service at anytime. If you believe that you worked in Covered Employment that was not properly credited under the Plan or not reported at all, you have the right to submit a claim in accordance with the claims procedures set forth on pages 18-20. Please be reminded that, in the event of a discrepancy between the information received by the Plan from Contributing Employers (or obtained during payroll reviews) and the credit to which you believe you are entitled, it will be your responsibility to prove that the work in question was both actually performed by you for a Contributing Employer and was Covered Employment for which contributions were required to be made to the Plan. Therefore, it is important that you retain adequate records of your Covered Employment (i.e., pay stubs or other documentary evidence) that would assist you in demonstrating both the amount of work you performed for each Contributing Employer and that the work constituted Covered Employment. Please also remember that the longer you wait to file a claim to correct any issue, the more difficult it may be for you to provide, and for the Plan to verify, the necessary documentation.

WHO MAKES THE FINAL DECISION ABOUT HOW THE PLAN SHOULD BE INTERPRETED?

The Trustees (and/or their duly authorized designee(s)) have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply and

interpret the Plan, including this booklet, the Trust Agreement and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or Trust. Without limiting the generality of the foregoing, the Trustees and/or their duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable 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 or factual questions, relating to the calculation and payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet, the Trust Agreement or other Plan documents;
- Process and approve or deny benefit claims; and
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Trustees and/or their duly authorized designee(s) shall be final and binding upon all plan participants, beneficiaries and any other individuals claiming benefits under the Plan. The Trustees may delegate any other such duties or powers as they deem necessary to carry out the administration of the Plan.

IS THERE ANYTHING ELSE I SHOULD KNOW?

Continuance of the Plan

The Trustees fully intend to continue the Plan indefinitely and to meet any foreseeable situations that may occur.

However, the Trustees reserve the right, in their sole and absolute discretion, to amend, modify or terminate the Plan, in whole or in part, for any reason, at any time and with respect to participants who are or may become eligible and their beneficiaries. If the Plan is amended, modified or terminated, in whole or in part, the ability of employees to participate in the Plan and/or to receive benefits under the Plan, as well as the type and amount of benefits provided under the Plan, may be modified or terminated.

If the Trustees terminate the Plan, you will automatically become 100% vested in the benefit you accrued as of the Plan's termination date to the extent the Plan is then funded. This is true regardless of how much vesting service you have.

If the Plan merges with another pension plan, you will be entitled to receive a benefit immediately after such merger equal to the benefit that you were entitled to receive immediately prior to the merger.

Pension Benefit Guaranty Corporation

Your pension benefits under this multiemployer plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. A multiemployer plan is a collectively bargained pension arrangement involving two or more unrelated employers, usually in a common industry.

Under the multiemployer plan program, the PBGC provides financial assistance through loans to plans that are insolvent. A multiemployer plan is considered insolvent if the plan is unable to pay benefits (at least equal to the PBGC's guaranteed benefit limit) when due.

The maximum benefit that the PBGC guarantees is set by law. Under the multiemployer program, the PBGC guarantee equals a participant's years of credited service multiplied by (1) 100% of the first $11 of the monthly benefit accrual rate and (2) 75% of the next $33. The PBGC's maximum guarantee limit is $35.75 per month times a participant's years of credited service. For example, the maximum annual guarantee for a retiree with 30 years of credited service would be $12,870.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan becomes insolvent; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law; (2) benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the earlier of: (i) the date the plan terminates or (ii) the time the plan becomes insolvent; (3) benefits that are not vested because you have not worked long enough; (4) benefits for which you have not met all of the requirements at the time the plan becomes insolvent; and (5) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street, N.W., Suite 930, Washington, D.C. 20005–4026 or call 202–326–4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

Assignment of Benefits

For the protection of your interests and those of your beneficiaries, your benefits under the Plan, to the extent permitted by law, cannot be assigned, nor are they subject to garnishment or attachment, with the exception of the court order discussed below. Furthermore, creditors may not be able to attach your benefits in the Plan as a means of collecting debts even in the case of bankruptcy; however, your benefit may be reduced if a court order or requirement to pay arises from

(1) a judgment of conviction for a crime involving the Plan, (2) a civil judgment (or consent order or decree) that is entered by a court in an action brought in connection with a breach (or alleged breach) of fiduciary duty under ERISA, (3) a settlement agreement entered into by you and either the Secretary of the Department of Labor or the PBGC in connection with a breach of fiduciary duty under ERISA, or (4) as otherwise required under law. Benefit payments may be withheld in order to enforce this provision.

A Qualified Domestic Relations Order (QDRO) is a court order under domestic relations law assigning all or part of your pension benefits to your former spouse, your child, or other dependent, to provide child support, alimony payments and/or property rights to your former spouse. The procedures used by the Plan Administrator to determine whether a domestic relations order is a QDRO are on file with the Plan Administrator and may be provided to you upon written request. The Plan Administrator will notify you if it receives a QDRO that applies to your benefits. The Trustees have given the Plan Administrator the authority to review a domestic relations order submitted to the Plan to determine whether the order constitutes a QDRO. You may appeal an adverse determination to the Trustees.

It is important to note that any rights a former spouse has pursuant to a QDRO with respect to your pension will take precedence over those of any later spouse.

Plan Documents

This booklet is a summary of the material features of your Plan. We have tried to write this summary in clear, understandable and informal language. Please refer to the official Plan documents for more extensive information. **In the event of any conflict between this booklet and the Plan documents, the Plan documents will govern.**

You are entitled to examine the Plan documents, and the Plan Annual Report as soon as they are filed with the Secretary of Labor. These documents may be reviewed in the Pension Fund Office. If you would rather have a copy of these documents, send a written request to the Pension Fund. There will be a charge for copying of 25¢ per page.

ADDITIONAL INFORMATION

The Pressmen's - Publishers' Pension Plan is intended to be a **qualified defined benefit plan** under ERISA.

Plan Year: The Plan's fiscal year begins on **April 1** and ends on **March 31**.

Employer Identification Number: 13-6121627

Plan Number: 001

Plan Administration: Administered through:

Pressmen's - Publishers' Pension Fund
1501 Broadway, Suite #1724
New York, NY 10036
Phone: (212) 869-5994
Mr. Robert A. Costello, Administrator

This is also the agent for service of legal process; however, service of legal process may also be made upon any Trustee.

Plan Trustees:

Labor Trustees	**Address**
Mr. John M. Heffernan	New York Newspaper
Mr. Joseph Connor	Printing Pressmen's Union Number Two
Mr. Michael Tortora	1501 Broadway, Suite 1712 New York, NY 10036
Management Trustees	**Address**
Mr. Andrew Gutterman	The New York Times 620 8th Avenue, 18th Floor New York, NY 10018
Mr. Jeffrey Zomper	The Daily News 4 New York Plaza, 7th Floor New York, NY 10004

ERISA RIGHTS

As a participant in the Pressmen's - Publishers' Pension Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including summary plan description, 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.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including: insurance contracts; collective bargaining agreements; the latest annual report (Form 5500 Series); updated summary plan description; periodic actuarial reports received by the Plan for any plan year which has been in the Plan's possession for at least 30 days; quarterly, semi-annual, or annual financial reports prepared for the Plan by any Plan investment manager or advisor or other fiduciary which has been in the Plan's possession for at least 30

days; and any application filed with the Secretary of the Treasury requesting an extension under section 304 of the Act (or section 431(d) of the Internal Revenue Code of 1986) and the determination of such Secretary pursuant to such application. The Plan Administrator may make a reasonable charge for providing requested documents, including postage and copying charges.

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. Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

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

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

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

you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the 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 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.

Pressmen's - Publishers' Pension Fund
Actuarial Conversion Factors Effective April 1, 2006
Table C: Conversion from Single Life Pension with 60 Guaranteed Payments to 50% Joint & Survivor Pension

Difference Between Spouse's Age and Participant's Age (Spouse - Participant)	Age of Participant											
	59	60	61	62	63	64	65	66	67	68	69	70
-25	0.8750	0.8687	0.8623	0.8557	0.8489	0.8420	0.8350	0.8278	0.8205	0.8130	0.8052	0.8000
-24	0.8769	0.8707	0.8644	0.8579	0.8513	0.8446	0.8377	0.8307	0.8235	0.8162	0.8086	0.8050
-23	0.8789	0.8728	0.8666	0.8603	0.8538	0.8472	0.8405	0.8337	0.8267	0.8195	0.8121	0.8100
-22	0.8809	0.8750	0.8689	0.8627	0.8564	0.8500	0.8434	0.8368	0.8300	0.8230	0.8159	0.8150
-21	0.8831	0.8773	0.8713	0.8653	0.8591	0.8528	0.8465	0.8400	0.8334	0.8267	0.8200	0.8200
-20	0.8853	0.8796	0.8738	0.8679	0.8619	0.8558	0.8497	0.8434	0.8370	0.8305	0.8250	0.8250
-19	0.8876	0.8821	0.8764	0.8707	0.8648	0.8589	0.8530	0.8469	0.8407	0.8344	0.8300	0.8300
-18	0.8900	0.8846	0.8791	0.8735	0.8679	0.8622	0.8564	0.8505	0.8446	0.8385	0.8350	0.8350
-17	0.8924	0.8872	0.8819	0.8765	0.8710	0.8655	0.8600	0.8543	0.8486	0.8428	0.8400	0.8400
-16	0.8950	0.8899	0.8848	0.8796	0.8743	0.8690	0.8636	0.8582	0.8528	0.8472	0.8450	0.8450
-15	0.8976	0.8927	0.8878	0.8827	0.8777	0.8726	0.8674	0.8623	0.8570	0.8517	0.8500	0.8500
-14	0.9004	0.8956	0.8908	0.8860	0.8811	0.8763	0.8714	0.8664	0.8614	0.8564	0.8550	0.8550
-13	0.9032	0.8986	0.8940	0.8894	0.8847	0.8801	0.8754	0.8707	0.8660	0.8612	0.8600	0.8600
-12	0.9060	0.9017	0.8973	0.8928	0.8884	0.8839	0.8795	0.8751	0.8706	0.8661	0.8650	0.8650
-11	0.9090	0.9048	0.9006	0.8964	0.8921	0.8879	0.8838	0.8796	0.8754	0.8712	0.8700	0.8700
-10	0.9120	0.9080	0.9040	0.9000	0.8960	0.8920	0.8881	0.8842	0.8802	0.8763	0.8750	0.8750
-9	0.9150	0.9113	0.9075	0.9037	0.8999	0.8961	0.8925	0.8888	0.8852	0.8815	0.8800	0.8800
-8	0.9182	0.9146	0.9110	0.9074	0.9038	0.9004	0.8969	0.8935	0.8902	0.8868	0.8850	0.8850
-7	0.9213	0.9179	0.9145	0.9112	0.9079	0.9046	0.9014	0.8983	0.8952	0.8921	0.8900	0.8900
-6	0.9245	0.9213	0.9181	0.9150	0.9119	0.9089	0.9060	0.9031	0.9003	0.8975	0.8950	0.8950
-5	0.9278	0.9248	0.9218	0.9189	0.9160	0.9132	0.9106	0.9080	0.9054	0.9029	0.9004	0.9000
-4	0.9310	0.9282	0.9254	0.9227	0.9201	0.9176	0.9151	0.9128	0.9105	0.9083	0.9061	0.9039
-3	0.9342	0.9316	0.9291	0.9266	0.9242	0.9219	0.9197	0.9176	0.9156	0.9136	0.9117	0.9099
-2	0.9375	0.9351	0.9327	0.9305	0.9283	0.9262	0.9243	0.9224	0.9207	0.9190	0.9173	0.9158
-1	0.9407	0.9385	0.9364	0.9343	0.9323	0.9305	0.9288	0.9272	0.9257	0.9242	0.9229	0.9217
0	0.9439	0.9419	0.9399	0.9381	0.9363	0.9347	0.9332	0.9319	0.9306	0.9294	0.9284	0.9276
1	0.9471	0.9452	0.9435	0.9418	0.9403	0.9389	0.9376	0.9365	0.9355	0.9346	0.9339	0.9334
2	0.9502	0.9485	0.9470	0.9455	0.9442	0.9430	0.9419	0.9410	0.9403	0.9397	0.9393	0.9391
3	0.9533	0.9518	0.9504	0.9491	0.9479	0.9470	0.9461	0.9455	0.9450	0.9447	0.9446	0.9447
4	0.9563	0.9549	0.9537	0.9526	0.9517	0.9509	0.9503	0.9499	0.9497	0.9496	0.9498	0.9502
5	0.9592	0.9580	0.9570	0.9560	0.9553	0.9547	0.9543	0.9541	0.9542	0.9544	0.9548	0.9555
6	0.9620	0.9610	0.9601	0.9594	0.9588	0.9584	0.9583	0.9583	0.9586	0.9590	0.9597	0.9606
7	0.9648	0.9639	0.9632	0.9626	0.9622	0.9621	0.9621	0.9624	0.9628	0.9635	0.9644	0.9656
8	0.9674	0.9667	0.9661	0.9657	0.9655	0.9656	0.9658	0.9663	0.9669	0.9678	0.9689	0.9703
9	0.9700	0.9694	0.9690	0.9688	0.9688	0.9690	0.9694	0.9700	0.9709	0.9719	0.9732	0.9747
10	0.9725	0.9721	0.9718	0.9717	0.9719	0.9722	0.9728	0.9736	0.9746	0.9758	0.9772	0.9789
11	0.9749	0.9746	0.9745	0.9745	0.9748	0.9753	0.9761	0.9770	0.9781	0.9795	0.9810	0.9828
12	0.9771	0.9770	0.9770	0.9772	0.9776	0.9783	0.9792	0.9802	0.9815	0.9829	0.9845	0.9864
13	0.9793	0.9793	0.9794	0.9798	0.9803	0.9811	0.9821	0.9832	0.9846	0.9861	0.9878	0.9898
14	0.9814	0.9815	0.9818	0.9822	0.9829	0.9837	0.9848	0.9860	0.9875	0.9891	0.9909	0.9930
15	0.9834	0.9836	0.9840	0.9845	0.9852	0.9862	0.9873	0.9887	0.9902	0.9918	0.9937	0.9959
16	0.9853	0.9856	0.9860	0.9866	0.9875	0.9885	0.9897	0.9911	0.9926	0.9944	0.9964	0.9986
17	0.9871	0.9874	0.9879	0.9886	0.9895	0.9906	0.9919	0.9933	0.9949	0.9968	0.9988	1.0011
18	0.9888	0.9892	0.9897	0.9905	0.9914	0.9926	0.9939	0.9954	0.9971	0.9989	1.0010	1.0034
19	0.9903	0.9908	0.9914	0.9922	0.9932	0.9944	0.9958	0.9973	0.9990	1.0009	1.0031	1.0054
20	0.9917	0.9923	0.9929	0.9938	0.9948	0.9961	0.9975	0.9991	1.0008	1.0027	1.0049	1.0072
21	0.9931	0.9936	0.9944	0.9953	0.9963	0.9976	0.9991	1.0007	1.0025	1.0044	1.0065	1.0088
22	0.9943	0.9949	0.9957	0.9966	0.9977	0.9990	1.0005	1.0022	1.0039	1.0058	1.0079	1.0103
23	0.9954	0.9961	0.9969	0.9978	0.9990	1.0003	1.0018	1.0035	1.0052	1.0071	1.0092	1.0115
24	0.9965	0.9971	0.9980	0.9990	1.0001	1.0015	1.0030	1.0046	1.0064	1.0082	1.0103	1.0127
25	0.9974	0.9981	0.9990	1.0000	1.0012	1.0025	1.0040	1.0057	1.0074	1.0093	1.0113	1.0136

If spouse is younger than participant, left hand column will be negative. If spouse is older than participant, left hand column will be positive.

Pressmen's - Publishers' Pension Fund
Actuarial Conversion Factors Effective April 1, 2006
Table D: Conversion from Single Life Pension with 60 Guaranteed Payments to 75% Joint & Survivor Pension

Difference Between Spouse's Age and Participant's Age (Spouse - Participant)	Age of Participant											
	59	60	61	62	63	64	65	66	67	68	69	70
-25	0.8219	0.8133	0.8045	0.7956	0.7865	0.7773	0.7679	0.7584	0.7487	0.7389	0.7288	0.7184
-24	0.8244	0.8159	0.8073	0.7985	0.7896	0.7805	0.7713	0.7620	0.7525	0.7429	0.7330	0.7228
-23	0.8270	0.8187	0.8102	0.8016	0.7928	0.7839	0.7749	0.7657	0.7565	0.7470	0.7374	0.7275
-22	0.8297	0.8216	0.8133	0.8048	0.7962	0.7875	0.7786	0.7697	0.7606	0.7514	0.7420	0.7323
-21	0.8325	0.8246	0.8164	0.8081	0.7997	0.7912	0.7825	0.7738	0.7650	0.7560	0.7468	0.7374
-20	0.8355	0.8277	0.8197	0.8116	0.8033	0.7950	0.7866	0.7781	0.7695	0.7607	0.7518	0.7427
-19	0.8386	0.8309	0.8231	0.8152	0.8072	0.7991	0.7909	0.7826	0.7742	0.7657	0.7571	0.7482
-18	0.8418	0.8343	0.8267	0.8190	0.8111	0.8033	0.7953	0.7873	0.7792	0.7709	0.7625	0.7539
-17	0.8451	0.8378	0.8304	0.8229	0.8153	0.8076	0.7999	0.7921	0.7843	0.7763	0.7682	0.7600
-16	0.8486	0.8415	0.8343	0.8270	0.8196	0.8122	0.8047	0.7972	0.7896	0.7820	0.7741	0.7675
-15	0.8521	0.8452	0.8383	0.8312	0.8240	0.8169	0.8097	0.8024	0.7951	0.7878	0.7803	0.7750
-14	0.8558	0.8491	0.8424	0.8355	0.8286	0.8217	0.8148	0.8078	0.8008	0.7938	0.7866	0.7825
-13	0.8596	0.8532	0.8466	0.8400	0.8334	0.8267	0.8201	0.8134	0.8067	0.8000	0.7931	0.7900
-12	0.8635	0.8573	0.8510	0.8447	0.8383	0.8319	0.8255	0.8192	0.8128	0.8064	0.7999	0.7975
-11	0.8675	0.8615	0.8555	0.8494	0.8433	0.8372	0.8311	0.8251	0.8190	0.8130	0.8068	0.8050
-10	0.8716	0.8659	0.8601	0.8543	0.8484	0.8426	0.8369	0.8311	0.8254	0.8197	0.8138	0.8125
-9	0.8759	0.8704	0.8648	0.8593	0.8537	0.8482	0.8427	0.8373	0.8319	0.8265	0.8211	0.8200
-8	0.8801	0.8749	0.8696	0.8643	0.8591	0.8539	0.8487	0.8436	0.8386	0.8335	0.8284	0.8275
-7	0.8845	0.8795	0.8745	0.8695	0.8645	0.8596	0.8548	0.8500	0.8453	0.8406	0.8359	0.8350
-6	0.8889	0.8842	0.8794	0.8747	0.8701	0.8655	0.8610	0.8565	0.8521	0.8478	0.8434	0.8425
-5	0.8934	0.8889	0.8845	0.8800	0.8757	0.8714	0.8672	0.8630	0.8590	0.8550	0.8510	0.8500
-4	0.8979	0.8937	0.8895	0.8854	0.8813	0.8773	0.8734	0.8696	0.8659	0.8622	0.8586	0.8549
-3	0.9025	0.8985	0.8946	0.8907	0.8869	0.8832	0.8797	0.8762	0.8728	0.8695	0.8662	0.8629
-2	0.9070	0.9033	0.8997	0.8961	0.8926	0.8892	0.8859	0.8828	0.8797	0.8768	0.8738	0.8709
-1	0.9116	0.9081	0.9047	0.9014	0.8982	0.8951	0.8922	0.8893	0.8866	0.8840	0.8814	0.8790
0	0.9161	0.9129	0.9098	0.9067	0.9038	0.9010	0.8983	0.8958	0.8934	0.8912	0.8890	0.8870
1	0.9206	0.9176	0.9147	0.9120	0.9093	0.9068	0.9044	0.9022	0.9002	0.8983	0.8966	0.8950
2	0.9250	0.9223	0.9197	0.9171	0.9147	0.9125	0.9105	0.9086	0.9069	0.9054	0.9040	0.9029
3	0.9293	0.9269	0.9245	0.9222	0.9201	0.9181	0.9164	0.9148	0.9135	0.9124	0.9114	0.9107
4	0.9336	0.9314	0.9292	0.9272	0.9253	0.9237	0.9222	0.9210	0.9200	0.9192	0.9187	0.9183
5	0.9378	0.9358	0.9339	0.9321	0.9305	0.9291	0.9279	0.9270	0.9264	0.9260	0.9258	0.9258
6	0.9419	0.9401	0.9384	0.9368	0.9355	0.9344	0.9335	0.9330	0.9326	0.9325	0.9327	0.9331
7	0.9458	0.9442	0.9428	0.9415	0.9404	0.9396	0.9390	0.9387	0.9387	0.9389	0.9393	0.9400
8	0.9497	0.9483	0.9470	0.9460	0.9452	0.9446	0.9443	0.9443	0.9445	0.9450	0.9458	0.9467
9	0.9534	0.9522	0.9512	0.9504	0.9498	0.9495	0.9495	0.9497	0.9502	0.9509	0.9519	0.9531
10	0.9570	0.9560	0.9552	0.9546	0.9543	0.9542	0.9544	0.9548	0.9555	0.9565	0.9577	0.9591
11	0.9605	0.9597	0.9591	0.9587	0.9586	0.9587	0.9591	0.9598	0.9607	0.9618	0.9631	0.9647
12	0.9638	0.9632	0.9628	0.9626	0.9627	0.9630	0.9636	0.9644	0.9655	0.9667	0.9683	0.9700
13	0.9670	0.9666	0.9664	0.9663	0.9666	0.9671	0.9678	0.9688	0.9700	0.9714	0.9731	0.9749
14	0.9701	0.9698	0.9697	0.9699	0.9703	0.9709	0.9718	0.9729	0.9742	0.9758	0.9775	0.9796
15	0.9730	0.9729	0.9730	0.9732	0.9737	0.9745	0.9755	0.9767	0.9781	0.9798	0.9817	0.9838
16	0.9758	0.9758	0.9760	0.9764	0.9770	0.9779	0.9790	0.9803	0.9818	0.9835	0.9855	0.9878
17	0.9784	0.9785	0.9788	0.9793	0.9801	0.9810	0.9822	0.9836	0.9852	0.9870	0.9891	0.9915
18	0.9808	0.9811	0.9815	0.9821	0.9829	0.9839	0.9852	0.9866	0.9883	0.9902	0.9924	0.9948
19	0.9831	0.9834	0.9839	0.9846	0.9855	0.9866	0.9879	0.9895	0.9912	0.9932	0.9954	0.9978
20	0.9853	0.9856	0.9862	0.9869	0.9879	0.9891	0.9905	0.9921	0.9939	0.9958	0.9980	1.0005
21	0.9872	0.9877	0.9883	0.9891	0.9901	0.9913	0.9928	0.9944	0.9963	0.9982	1.0004	1.0028
22	0.9890	0.9895	0.9902	0.9911	0.9922	0.9934	0.9949	0.9966	0.9984	1.0004	1.0026	1.0050
23	0.9907	0.9913	0.9920	0.9929	0.9940	0.9954	0.9969	0.9985	1.0004	1.0023	1.0045	1.0069
24	0.9922	0.9928	0.9936	0.9946	0.9957	0.9971	0.9986	1.0003	1.0021	1.0040	1.0061	1.0085
25	0.9936	0.9943	0.9951	0.9961	0.9973	0.9986	1.0002	1.0018	1.0036	1.0055	1.0076	1.0100

If spouse is younger than participant, left hand column will be negative. If spouse is older than participant, left hand column will be positive.

Pressmen's - Publishers' Pension Fund
Actuarial Conversion Factors Effective April 1, 2006
Table E: Conversion from Single Life Pension with 60 Guaranteed Payments to 100% Joint & Survivor Pension

Difference Between Spouse's Age and Participant's Age (Spouse - Participant)	Age of Participant											
	59	60	61	62	63	64	65	66	67	68	69	70
-25	0.7748	0.7646	0.7541	0.7434	0.7326	0.7218	0.7108	0.6997	0.6885	0.6772	0.6656	0.6538
-24	0.7778	0.7676	0.7573	0.7468	0.7362	0.7255	0.7147	0.7038	0.6928	0.6816	0.6703	0.6587
-23	0.7809	0.7709	0.7607	0.7504	0.7399	0.7294	0.7188	0.7081	0.6973	0.6863	0.6752	0.6638
-22	0.7841	0.7743	0.7643	0.7541	0.7439	0.7335	0.7231	0.7125	0.7020	0.6912	0.6803	0.6692
-21	0.7875	0.7779	0.7680	0.7581	0.7480	0.7378	0.7276	0.7173	0.7069	0.6964	0.6857	0.6749
-20	0.7910	0.7816	0.7719	0.7621	0.7522	0.7423	0.7323	0.7222	0.7121	0.7018	0.6914	0.6808
-19	0.7947	0.7854	0.7760	0.7664	0.7567	0.7470	0.7372	0.7274	0.7175	0.7075	0.6973	0.6870
-18	0.7986	0.7895	0.7802	0.7708	0.7614	0.7519	0.7423	0.7328	0.7231	0.7134	0.7035	0.6935
-17	0.8026	0.7937	0.7846	0.7755	0.7662	0.7570	0.7477	0.7384	0.7290	0.7196	0.7100	0.7002
-16	0.8067	0.7980	0.7892	0.7803	0.7713	0.7623	0.7533	0.7442	0.7352	0.7261	0.7168	0.7073
-15	0.8110	0.8025	0.7940	0.7853	0.7766	0.7678	0.7591	0.7503	0.7416	0.7327	0.7238	0.7146
-14	0.8154	0.8072	0.7989	0.7905	0.7820	0.7736	0.7651	0.7567	0.7482	0.7397	0.7311	0.7223
-13	0.8201	0.8121	0.8040	0.7959	0.7877	0.7795	0.7714	0.7632	0.7551	0.7469	0.7386	0.7302
-12	0.8248	0.8171	0.8093	0.8014	0.7935	0.7856	0.7778	0.7700	0.7622	0.7543	0.7464	0.7383
-11	0.8297	0.8222	0.8147	0.8071	0.7995	0.7920	0.7844	0.7769	0.7695	0.7620	0.7545	0.7467
-10	0.8347	0.8275	0.8203	0.8130	0.8057	0.7985	0.7913	0.7841	0.7770	0.7699	0.7627	0.7554
-9	0.8399	0.8330	0.8260	0.8190	0.8120	0.8051	0.7983	0.7915	0.7847	0.7780	0.7712	0.7642
-8	0.8451	0.8385	0.8318	0.8252	0.8185	0.8120	0.8055	0.7990	0.7926	0.7863	0.7798	0.7733
-7	0.8505	0.8442	0.8378	0.8315	0.8251	0.8189	0.8128	0.8067	0.8007	0.7947	0.7886	0.7825
-6	0.8560	0.8499	0.8439	0.8379	0.8319	0.8260	0.8202	0.8145	0.8088	0.8032	0.7976	0.7919
-5	0.8615	0.8558	0.8501	0.8444	0.8387	0.8331	0.8277	0.8224	0.8171	0.8119	0.8067	0.8013
-4	0.8671	0.8617	0.8563	0.8509	0.8456	0.8404	0.8353	0.8303	0.8255	0.8207	0.8158	0.8109
-3	0.8728	0.8677	0.8626	0.8575	0.8525	0.8477	0.8430	0.8384	0.8339	0.8295	0.8250	0.8206
-2	0.8785	0.8737	0.8689	0.8641	0.8595	0.8550	0.8506	0.8464	0.8423	0.8383	0.8343	0.8303
-1	0.8842	0.8796	0.8752	0.8708	0.8665	0.8623	0.8583	0.8544	0.8507	0.8471	0.8435	0.8400
0	0.8898	0.8856	0.8815	0.8774	0.8734	0.8696	0.8659	0.8624	0.8591	0.8559	0.8528	0.8498
1	0.8955	0.8916	0.8877	0.8839	0.8803	0.8768	0.8735	0.8704	0.8674	0.8647	0.8621	0.8596
2	0.9011	0.8974	0.8939	0.8904	0.8871	0.8840	0.8810	0.8783	0.8757	0.8734	0.8713	0.8694
3	0.9066	0.9033	0.9000	0.8968	0.8938	0.8910	0.8884	0.8861	0.8840	0.8821	0.8805	0.8790
4	0.9120	0.9090	0.9060	0.9031	0.9004	0.8980	0.8958	0.8938	0.8921	0.8907	0.8896	0.8886
5	0.9174	0.9146	0.9119	0.9093	0.9069	0.9048	0.9030	0.9014	0.9002	0.8992	0.8984	0.8979
6	0.9226	0.9200	0.9176	0.9154	0.9133	0.9115	0.9101	0.9089	0.9080	0.9075	0.9071	0.9070
7	0.9276	0.9254	0.9232	0.9213	0.9195	0.9181	0.9170	0.9162	0.9157	0.9155	0.9155	0.9158
8	0.9326	0.9305	0.9287	0.9270	0.9256	0.9246	0.9238	0.9233	0.9232	0.9233	0.9237	0.9243
9	0.9373	0.9356	0.9340	0.9327	0.9316	0.9308	0.9303	0.9302	0.9303	0.9308	0.9315	0.9324
10	0.9420	0.9405	0.9392	0.9381	0.9373	0.9368	0.9366	0.9368	0.9372	0.9379	0.9389	0.9401
11	0.9465	0.9452	0.9442	0.9434	0.9428	0.9426	0.9427	0.9431	0.9438	0.9447	0.9459	0.9473
12	0.9508	0.9498	0.9490	0.9484	0.9481	0.9482	0.9485	0.9491	0.9500	0.9511	0.9525	0.9541
13	0.9550	0.9542	0.9536	0.9533	0.9532	0.9534	0.9540	0.9548	0.9558	0.9572	0.9587	0.9605
14	0.9590	0.9584	0.9580	0.9579	0.9580	0.9584	0.9591	0.9601	0.9613	0.9628	0.9645	0.9665
15	0.9628	0.9624	0.9622	0.9622	0.9625	0.9631	0.9640	0.9651	0.9664	0.9680	0.9699	0.9720
16	0.9664	0.9662	0.9661	0.9664	0.9668	0.9675	0.9685	0.9697	0.9712	0.9729	0.9749	0.9772
17	0.9698	0.9697	0.9699	0.9702	0.9708	0.9716	0.9727	0.9740	0.9756	0.9775	0.9796	0.9820
18	0.9730	0.9731	0.9733	0.9738	0.9745	0.9754	0.9766	0.9780	0.9797	0.9817	0.9839	0.9863
19	0.9760	0.9762	0.9765	0.9771	0.9779	0.9789	0.9802	0.9817	0.9835	0.9855	0.9878	0.9903
20	0.9788	0.9791	0.9795	0.9802	0.9810	0.9821	0.9835	0.9851	0.9870	0.9890	0.9913	0.9938
21	0.9814	0.9818	0.9823	0.9830	0.9840	0.9852	0.9866	0.9883	0.9902	0.9922	0.9945	0.9969
22	0.9838	0.9842	0.9848	0.9856	0.9867	0.9879	0.9894	0.9911	0.9930	0.9950	0.9973	0.9997
23	0.9860	0.9865	0.9872	0.9880	0.9891	0.9905	0.9920	0.9937	0.9955	0.9976	0.9998	1.0022
24	0.9881	0.9886	0.9893	0.9903	0.9914	0.9927	0.9943	0.9960	0.9978	0.9998	1.0020	1.0044
25	0.9899	0.9905	0.9913	0.9923	0.9934	0.9948	0.9963	0.9980	0.9998	1.0018	1.0040	1.0064

If spouse is younger than participant, left hand column will be negative. If spouse is older than participant, left hand column will be positive.

TABLE F

PRESSMEN'S - PUBLISHERS' PENSION PLAN
Normal Retirement Full Pension Amounts
For Full Pensions effective on or after January 1, 2006

Years of Credited Service	Amount	Years of Credited Service	Amount
5	387.50	23	1,670.00
6	465.00	24	1,710.00
7	542.50	25	1,750.00
8	620.00	26	1,790.00
9	697.50	27	1,830.00
10	775.00	28	1,870.00
11	852.50	29	1,910.00
12	930.00	30	1,950.00
13	1,007.50	31	1,990.00
14	1,085.00	32	2,030.00
15	1,162.50	33	2,070.00
16	1,240.00	34	2,110.00
17	1,317.50	35	2,150.00
18	1,395.00	36	2,190.00
19	1,472.50	37	2,230.00
20	1,550.00	38	2,270.00
21	1,590.00	39	2,310.00
22	1,630.00	40	2,350.00

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