I.B.T. LOCAL NO. 145

HEALTH SERVICES & INSURANCE PLAN

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1-203-375-6088

www.teamsters145.org

Board of Trustees

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THE BOARD OF TRUSTEES RESERVES THE RIGHT TO MODIFY, SUSPEND, OR TERMINATE THIS PLAN AT ANY TIME.

IMPORTANT EXPLANATION OF RIGHTS TO COBRA CONTINUATION COVERAGE MAY BE FOUND ON PAGE 13.

SUMMARY PLAN DESCRIPTION FOR PLAN D

July 1, 2023 EDITION

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CONTACT INFORMATION

Fund Office	
Local 145 Health Services & Insurance Plan	Call 1-203-375-6088 for benefits and eligibility, including COBRA, or visit the Plan's website at www.teamsters145.org.
Weekly Accident & Sickness Benefits	Call 1-203-375-6088 for benefits and eligibility.
Aetna Life Insurance Company	
Medical	Call the toll-free Member Services number on your ID card, 1-866-658-2455, for claims questions and to notify Aetna about an in-patient hospital stay or to find a PPO network provider.
Pharmacy	Call 1-888-792-3862 toll-free to locate a network pharmacy or to find out about the prescription drug formulary list.
Mail Order	To find out about the mail order pharmacy call 1-800-227-5720 toll-free.
Dental	Call the toll-free Member Services number on your ID card 1-877-238-6200 for claim questions and to find a PPO Dental Plan network provider (your out-of-pocket expense may be higher if your dentist does not participate with Aetna).
Employee Assistance Program	Call 1-888-238-6232 toll-free Employee Assistance Program (EAP) services.
PrudentRx Speciality Drugs	The PrudentRx Co-Pay Program assists members by helping them enroll in manufacturer co-pay assistance programs. PrudentRx can be reached at 1-800-578-4403
Visit Aetna's website	**You can also obtain information regarding your benefits by visiting www.aetna.com.**
Vision	
Davis Vision	Call 1-800-999-5431 or visit www.davisvision.com for information about your vision benefits.

PLAN NOTICE OF PRIVACY PRACTICES

The Plan protects your protected health information in accordance with its Notice of Privacy Practices. You can receive a copy of that Notice by contacting the Plan office at 1-203-375-6088 or at 1-800291-6795 or find a copy on the Plan's website at www.teamsters145.org .

RELATED PLAN DOCUMENTS

You must read this document together with the following Aetna documents which explain the Plan's Medical, Pharmacy, Mail Order Pharmacy and Dental Benefits:

- Aetna Choice POS II Plan Booklet
- Schedule of Benefits for Aetna Choice POS II Plan
- PPO Dental Plan Booklet
- Schedule of Benefits for PPO Dental Plan

These documents are referred to collectively as the "Aetna Plan Booklets" in this SPD. If you need any of these Aetna documents, please contact the Plan office or visit the Plan's website at www.teamsters145.org.

You also must read this document together with the Davis Vision Benefit Brochure. If you need any of these documents, please contact the Plan office or visit the Davis Vision website at www.davisvision.com.

ELIGIBILITY RULES

The I.B.T. Local No. 145 Health Services & Insurance Plan D ("Plan") has been established pursuant to a trust agreement for employees of Ashcroft, Inc. ("Ashcroft") who are represented for collective bargaining purposes by I.B.T. Local Union No. 145 ("Union"). The Plan is administered in accordance with federal law by a Board of Trustees, which consists of two Union designated trustees and two Employer designated trustees.

This Plan provides Health Benefits and Weekly Accident and Sickness Benefits for these covered employees and Health Benefits for their eligible Dependents, subject to the rules, descriptions, definitions, exclusions and limitations set forth in this Summary Plan Description ("SPD") booklet, which includes the Aetna Plan Booklets and the Davis Vision Brochure (see page 3). Benefits under this Plan are available and provided based on the contributions made and received for the hours of work covered under the collective bargaining agreement between Ashcroft and the Union.

No medical examination is required of any covered employee ("Member") or eligible Dependent to secure these benefits. Benefits are available in accordance with eligibility rules to Members and their eligible Dependents.

Eligibility – New employees of Ashcroft who are covered under a collective bargaining agreement between Ashcroft and the Union which obligates Ashcroft to contribute to the Plan on their behalf become eligible for Plan coverage on the ninetieth (90) day of such full-time employment with Ashcroft.

Employee Contribution – Members shall make a weekly premium contribution toward the cost of Plan coverage through a pre-tax salary reduction arrangement under the Ashcroft Section 125 plan or at the employee's election made in accordance with the Ashcroft Section 125 plan with after-tax dollars through payroll deduction beginning in the payroll period of the 90th day. Your employer will notify you of the amount of that contribution.

You must continue to make this weekly premium contribution while on leave status. This contribution is due on the first day of the month. If you plan an unpaid leave of absence, please consult an Ashcroft Human Resources representative concerning your contribution obligation.

Standard Termination – Eligibility will terminate immediately if:

- The Member quits or retires from covered employment or is discharged from covered employment for just cause; or
- The Member terminates covered employment for any reason before having completed at least six months of continuous covered employment; or
- The Member, who is on leave of absence from covered employment, fails to make the required contribution for coverage within thirty days of the due date.

If, after completing six (6) or more months of continuous covered employment, a Member's employment is terminated for a reason other than a decision to quit or a discharge for cause (including a termination resulting from the Member's death), then the Member and/or the Member's dependents will remain eligible for benefits for a period of ninety (90) calendar days following the date of the termination. During this 90-day automatic extension of coverage period, the Member is not obligated to make the weekly premium contribution described above. Your employer will make the full contribution during this 90 day period.

If the Member is rehired and begins work at any time during this 90-day extension period, the Member will not need to satisfy the waiting period described in the Eligibility provision above to be eligible for Plan coverage. However, if the rehired Member's employment is terminated again *within six (6) months* for a reason other than a decision to quit or a discharge for cause (including death or layoff), the rehired Member's automatic extension period following the later termination will be reduced by the number of

days of extended coverage the Member received following the initial termination. This *will not* affect the Member's eligibility for or rights to elect COBRA Continuation Coverage (see discussion on p. 13), but it *will* affect the date on which the Member is required to pay the necessary premium to purchase that coverage.

> *Example*: A Member with three years of continuous covered employment is terminated due to a lay-off on April 15th. He is rehired 45 days later, on May 31st, and then laid off 3 months after that, on August 31st. Because he was rehired and resumed working during the 90-day automatic extension period, he is eligible for Plan coverage immediately on his June 1st return to work. However, after the second lay-off he will receive only 45 days of extended coverage (not 90), through October 15th. If the Member elects to purchase COBRA Continuation Coverage, he will be obligated to pay the required premium beginning on October 16th.

If a contributing Employer, under the terms of the collective bargaining agreement with the Union, recalls a laid-off Member who previously satisfied the 90 day waiting period described above, that Member's benefits will resume when the Member returns to work.

In the event of a labor dispute (either a strike or a lockout), benefits coverage will continue for up to sixty (60) days, subject to the termination rules stated above. If the labor dispute continues beyond sixty (60) days, coverage will terminate.

Eligible Dependents –
The following family members are eligible for Plan coverage:

- your spouse from a legally recognized marriage; and
- your children under age 26, as defined below.

For purposes of Plan coverage, "Child" means your natural child, stepchild, or legally adopted child or a child who has been placed with you by an authorized child placement agency or a court for purposes of legal adoption by you who is under age 26.

A natural or adopted child will be considered covered under the Plan if the child's official State birth certificate or a final adoption decree signed by a judge names the Member as a parent, or a court order or agency placement order confirms that the Member has permanent legal custody.

A "stepchild" means a child of your spouse. For a stepchild to be covered, you must provide an official State marriage license and an official State birth certificate showing the member's spouse to be one of the child's parents.

Your grandchildren or foster children are not considered dependent children for purposes of coverage under this Plan unless the child has been legally adopted by you or placed with you for adoption as described above.

The Plan also covers unmarried children over age 26 who are (A) incapable of self-sustaining employment due to a physical or mental Disability that commenced while the child was eligible for Plan benefits and (B) "dependent" on you and (C) lives with you. You must submit proof of a dependent child's incapacity to the Plan Office no later than 31 days after the date he or she turns 26 years of age. Written proof of the continued existence of such incapacity shall be furnished from time to time upon request (annually).

Qualified Medical Child Support Order – According to federal law, a Qualified Medical Child Support Order ("QMCSO") is a child support order of a court or state Support administrative agency that usually results from a divorce or legal separation, that has been received by the Plan, and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;

- States the period for which the QMCSO applies; and
- Identifies each health plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a Dependent child, except as required by a State's Medicaid-related child support laws. For a State administrative agency order to be a QMCSO, State statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by State law.

If a court or State administrative agency has issued an order with respect to health care coverage for any of the employee's Dependent children, the Plan Office will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the Dependent child, and any other party acting on behalf of the Dependent child. If an order is determined to be a QMCSO, and if the employee is covered by the Plan, the Plan Office will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent child(ren).

No coverage will be provided for any Dependent child under a QMSCO unless the applicable contributions for that Dependent child's coverage are paid, and all of the Plan's requirements for coverage of that Dependent child have been satisfied.

If you are covered under this Plan as a result of a QMCSO, effective April 1, 2009, you may possess special enrollment rights as a result of the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"). For further detail about possible CHIPRA special enrollment rights, please refer to page 15 of this SPD.

Reporting Change in Family or Coverage Status – After coverage becomes effective, Members must notify the Plan Office of any change in family or coverage status by reason of marriage, birth or adoption of a child, death, divorce, legal separation, or a spouse's termination of coverage under another employer plan. Members should provide these changes to the Plan Office within 30 days from the date of the change. Failure to file the required information may delay benefit payments or result in benefit overpayments (see p.13). If you or your dependents receive any erroneous benefits overpayments from the Plan, you and your dependents shall repay those amounts to the Plan. Plan approval of any change in coverage request or student status information that was submitted untimely will apply prospectively from the date that the request was received at the Plan Office.

Eligibility Determinations – A decision made by the Board of Trustees regarding a particular individual's eligibility for Plan coverage under these Eligibility Rules shall be final, binding, and conclusive. Eligibility decisions made by the Board of Trustees can be appealed by following the same procedure described in the How to Claim Benefits section found on page 19 of this SPD.

BENEFITS SUMMARY

Summary for Plan D

Do not rely on this benefit chart alone. Read the explanations under Plan Coverage below and refer to those documents for a full description of the benefits available.

BENEFIT DESCRIPTION	PLAN COVERAGE
Hospital & Medical Benefits Including: Inpatient and Outpatient Hospital, Emergency Room, Surgical, Lab & X-Ray, Mental Health/Substance Abuse & Other Medical Benefits	Please refer to the Aetna Plan Booklets referenced on page 3 for complete details on the Hospital & Medical Benefits. The booklets can also be found on the Plan's website at www.teamsters145.org.
Prescription Drug Benefits and Mail Order Pharmacy	Please refer to Aetna Plan Booklet(s) for complete details on the Prescription Drug and Mail Order Pharmacy programs. You may also visit the Health Plan's website at www.teamsters145.org for this booklet.
Employee Assistance Program ("EAP") Services	Please refer to the EAP website at www.resourcesforliving.com (Username: LOCAL145, Password: eap) for complete details on this benefit. You may also visit the Health Plan's website at www.teamsters145.org for information.
Dental Benefits	Please refer to the Aetna PPO Dental Plan booklet and the Schedule Of Benefits for PPO Dental Plan for complete details on the dental benefits. You may also visit the Health Plan's website at www.teamsters145.com for this booklet.
Vision Care Benefits	Benefits are provided through Davis Vision. Please refer to the Davis Vision brochure for complete details on vision care coverage. You may also visit the Davis Vision website at www.davisvision.com or the Plan's website at www.teamsters145.org .
Weekly Accident and Sickness Benefits The Plan Office administers this benefit.	The Plan Office administers Weekly Accident and Sickness Benefits. Refer to page 8 in this document. Benefits are provided in the amount of $275 (minus appropriate taxes) per week for up to twenty-six (26) weeks once a covered Disability lasts eight (8) days.

DISABILITY BENEFITS

WEEKLY ACCIDENT AND SICKNESS BENEFITS (MEMBERS ONLY)

Subject to the definitions, exclusions and limitations listed in this SPD, the following Weekly Disability Benefit will be payable to you if, while insured under the Plan (excluding the 90 day extension period), you become totally disabled.

Weekly Accident and Sickness Benefits (Members Only) –Two thirds (2/3) of earnings up to a maximum of $275 per week (minus appropriate taxes) for up to twenty-six (26) weeks. Employer paid holidays will be excluded from this benefit payment. You will be required to continue to pay your weekly benefit contribution while on an eligible leave of absence from covered employment with your employer. Your employer will provide you with that payment information. For purposes of the Weekly Accident and Sickness Benefit, "Disability" means that you are (1) completely unable to perform any and every substantial and material duty pertaining to your occupation or employment; and (2) under the regular care of a Doctor.

These benefits will be payable to you as of the eighth day of your Disability if your Disability is due to either a accident or illness which is unrelated to your employment, and will continue during your Disability for a maximum of twenty-six (26) weeks for any one continuous period of Disability due to the same or related cause or causes. Because this benefit is intended to serve as partial compensation during the period that you are unable to work, your eligibility for it will terminate if you quit, are laid off, or are discharged for just cause from covered employment at any time during that 26-week period.

Successive periods of Disability resulting from the same cause or from related causes shall be considered as one continuous period of Disability when separated by less than two (2) weeks of continuous active employment.

It is not necessary for you to be confined to your home to collect benefits, but you must be under the care of a Doctor, who will document your Disability due to illness or injury unrelated to your employment.

You should promptly report your absence from covered employment to the Plan. The Plan Office will require you to answer some questions and request certain documentation concerning your illness as a result of it. Based on the information supplied, the Plan will determine the period of your absence for which it will provide coverage and notify you regarding issuance of your salary continuation benefits. Please note that if the Plan determines the period of your absence from covered employment can be shortened by rehabilitation, partial work, reduced work, or other means, it will approve part of your time and expect you and your physician to cooperate with the Plan and your employer to return you to health and to work. Disputes regarding the Plan's determination of your eligibility for this benefit are subject to the appeal process described in the How to Claim Benefits section of this SPD.

Pregnancy Related Disabilities – If you are totally disabled and medically unable to work because of pregnancy, childbirth or miscarriage, your Weekly Accident and Sickness Benefits are payable from the eighth day of Disability on the same basis and for the same time period as any other Disability.

Exclusions – This benefit is not payable if your Disability is due to:

- an injury arising out of or in the course of your employment; or
- an illness entitling you to loss of income benefits under any Workers' Compensation law, occupational disease law or similar law.

PLAN ADMINISTRATION

GENERAL LIMITATIONS

Please refer to the Aetna Plan Booklets incorporated by reference into this SPD for a detailed explanation of the definitions, limitations, and exclusions that apply to the Medical, Pharmacy, Dental and EAP Benefits payable under this Plan. Vision Care Benefits are described in the Davis Vision brochure.

Weekly Accident and Sickness described in this SPD is subject to the definitions, limitations and exclusions stated in this SPD, and is payable only when determined by the Plan to be Medically Necessary. Coverage is provided only for services and supplies which are listed in these Booklets as being covered.

SUBROGATION

"Subrogation" means that Plan's right to recover any Weekly Accident or Sickness Benefit payments made because of an injury to you or your Dependent(s) caused by a third part's wrongful act or negligence and that you or your Dependnets later recover from the third party, the third party's insurer, or from your own uninsured/underinsured motorist's coverage. "Third party" means another person or organization. If you or your Dependents are injured because of a third party's wrongful act or negligence:

1. The Plan will pay benefits for that injury, subject to the conditions that you and your Dependents:
    a. Agree to the Plan being subrogated to any recovery or right of recovery that you and your Dependents may have against that third party, the third party's insurer, or your own uninsured/underinsured motorist's coverage;
    b. Take no action which would prejudice the Plan's subrogation rights; and
    c. Cooperate in taking whatever action is reasonably necessary to assist the Plan in any recovery.
2. The Plan will be subrogated only to the extent of Plan benefits paid because of that injury.

You are required to notify the Plan promptly of any third party or uninsured/underinsured motorist coverage claim for damages which you may have on account of any injury for which the Plan has paid or may pay benefit.

In addition, you are required (1) to notify the Plan promptly of any recovery that you or your Dependents obtain on that claim, whether that recovery is by way of court award or out-of-pocket settlement or compromise, and (2) to reimburse the Plan out of that recovery to the extent of benefits paid by the Plan. If the Plan is required to take legal action to enforce these subrogation rights, you and your Dependents shall be liable for the attorney's fees and court costs incurred in doing do.

Even if you or your Dependents are not "made whole" by it, the Plan's right of subrogation shall be satisfied out of any recovery obtained prior to deductions of any type, including for attorneys' fees.

Please note that the Aetna Plan Booklet describes the Plan's Subrogation right of recovery for any Medical or Dental Benefits paid on behalf of you or your dependents for which a third party may be responsible.

ERRONEOUS OVERPAYMENTS OR MISREPRESENTATIONS OR FRAUD

If you or your dependents receive any erroneus benefit overpayments from the Plan, you and your dependents shal repay those amounts to the Plan. If the Plan is required to take legal action, then you and your dependents shall be liable for all collection costs, including interest on the overpayment, attorney's fees and court costs. The Plan may apply subsequent benefits otherwise payable to recoup any erroneous benefit overpayments.

You should be aware that persons who submit fraudulent or misleading claims to the Plan, i.e., provide misleading information of any type or false information or other fraudulent representations, are subject under federal law (29 U.S.C. § 1131) to a criminal penalty of one (1) year imprisonment and/or a $5,000 fine. The Plan Trustees also reserve the right to suspend or terminate any such person's participation in the Plan and to take any other appropriate measure. Please note that the Aetna Plan Booklet describes the Plan's right to recovery of any Erroneous Overpayments of Medical Benefits made on behalf of you are or your Dependents.

WORKERS' COMPENSATION BENEFITS

No Vision Care, Dental, or Weekly Accident or Sickness benefits are payable by the Plan on claims connected with an injury or illness which arises out of or in connection with employment.

Where a claim is made for Workers' Compensation, the Plan will not process a claim related to the same Disability until the Workers' Compensation Commission rules that there is no basis for any Workers' Compensation claim. However, the Plan will pay benefits when Workers' Compensation claims rulings are delayed or contested, provided that you enter into a subrogation agreement with the Plan to reimburse the Plan immediately upon receipt of payment of a Workers' Compensation claim. Where the Workers' Compensation claim is settled by stipulation or agreement, you cannot claim benefits for the same Disability from the Plan. If benefits are paid in error or because you failed to report the Workers' Compensation claim, you must reimburse the Plan for any erroneous payments plus all costs of collection, including interest, attorney's fees and court costs.

Please note that the Aetna Plan Booklet describes the Plan's treatment of Medical or Dental Benefits payable under this Plan that may relate to a claim for Workers' Compensation benefits.

NO VESTED BENEFITS

There is no vested right to any benefits under this Plan other than to those benefits which are available at the time a covered expense is incurred. The Board of Trustees reserves the right to terminate, suspend, or modify the Plan in whole or in part at any time. This means, among other things, that the Board of Trustees, in its sole discretion, may change the level and type of benefits available under this Plan from time to time. Benefits are paid only for incurred charges for which a claim is timely made. A claim is incurred only when a charge is incurred. The Plan reimburses for incurred charges, not for an incurred illness or injury.

In the event the Board of Trustees decides to terminate the Plan, the remaining funds will be allocated as follows. First, "run-off" claims (claims incurred on or before the Plan's termination date) will be paid. Second, any administrative expenses associated with the termination of the plan will be settled. Any remaining surplus will be dispersed by the Board of Trustees in such manner as will, in their opinion, provide for the benefit of the beneficiaries and their families. No portion of any of this surplus income will revert to any contributing employer.

GENERAL EXCLUSIONS

THERE ARE ADDITIONAL EXCLUSIONS IN THE BENEFIT SECTIONS.

Please note that the Aetna Plan Booklet describes the extent to which this Plan excludes certain services and supplies from coverage under its Medical and Dental Benefits. The Davis Vision brochure identifies exclusions from the Vision Benefits.

In addition to the specific exclusions and limitations listed in the various sections of this booklet, which outline the provisions of the various benefits, this Plan does not provide benefits for:

- Services and supplies which are Experimental, Investigational, or not provided in accordance with U.S. professional medical standards;
- Charges for services or supplies that are paid for directly or indirectly by any local, state, or Federal Government agency (except Medicare, Medicaid, Veterans Administration, Department of Defense, and CHAMPUS);
- Charges for which there is no legal obligation to pay or for which no charge would be made if the individual had no insurance coverage (*e.g.* where the individual's primary payer is a health

maintenance organization ("HMO"), the Plan excludes charges which exceed the amount the HMO provider can charge the individual);

- Services or supplies furnished by immediate relatives (spouse, parent, child, brother, sister, or grandparents by blood, marriage, or adoption) or by household Members;
- Charges for services and supplies for which a primary plan would have been responsible in the absence of coverage provided for under this Plan;
- Expenses incurred as a result of an injury or illness for which you are eligible to receive any Workers' Compensation Benefits whether or not you claim or receive such benefits, or for which payment is made by reason of a settlement or other agreement or proceeding in regard to a claim or potential claim under such a law;
- Any portion of a provider's fee or charge that is ordinarily due from the Member but has been waived. If a provider routinely waives (does not require the Member to pay) a deductible or coinsurance, the Plan will calculate the actual provider fee or charge by reducing it by the amount waived by the provider;
- Expenses incurred as a result of illness or injury sustained during the commission of a criminal act under federal or state law, as determined by the Plan;
- Charges for vitamins, even if prescribed by a Doctor;
- Administrative or late charges, including interest, billed by providers of care;
- Expenses incurred for services or supplies while not covered by this Plan; and
- Services or supplies not listed as covered in this booklet.

EXTENSION OF BENEFITS

AND NOTICES OF OTHER FEDERAL LAWS

Limited Extension of Medical/Prescription Drug Benefits for Disability – If you or a Dependent of yours is totally disabled due to a non-occupational illness or injury on the date that his/her eligibility for benefits under this Plan would terminate for a reason other than the Member quitting or being discharged for just cause from covered employment, the Plan will continue to pay limited Medical and Prescription Drug benefits for services and supplies related to that Disability for up to an additional 26 weeks, provided (1) the disabled Member or Dependent remains continuously and totally disabled due to that illness or injury, and (2) the disabled Member or Dependent does not become eligible at any time for group health coverage under another plan. The Plan's limited benefit will apply only to charges incurred for covered Medical Services and Prescription Drugs that relate directly to the Disability that qualifies the Member or Dependent for this extension of benefits. Eligibility for this limited benefit will terminate immediately if, at any time during that 26-week period, the Member or Dependent becomes no longer disabled, or becomes eligible for coverage under another group health plan. This limited extension of benefits is separate and distinct from, and not provided in lieu of, the Plan's Weekly Accident and Sickness benefit available to Members only.

A disabled Member or Dependent who qualifies for an extension of coverage under this provision still may elect to purchase COBRA Continuation Coverage in order to pay for services or supplies not covered under this limited benefit. In addition, a Dependent whose eligibility for overage under this Plan terminates due to the Member's Disability also may elect to purchase COBRA Continuation Coverage. See below for information about COBRA Continuation Coverage.

This limited extension of benefits period shall overlap the COBRA continuation coverage provision that appears below.

COBRA CONTINUATION OF BENEFIT COVERAGE

You should be aware that under a 1986 amendment to the Internal Revenue Code and the Employee Retirement Income Security Act ("ERISA") contained in the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), most employers sponsoring group health plans are required to extend health coverage (called "COBRA Continuation Coverage") at group rates in certain instances where coverage otherwise would end.

COBRA Continuation Coverage does not provide coverage under the Plan's Weekly Accident and Sickness Benefit. This benefit terminates the same time you terminate your employment.

Your Rights – COBRA Continuation Coverage allows you and your eligible dependents the following rights:

1. You have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in the hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you lose your group health coverage due to your retirement and you are eligible for retirees' coverage from your employer, then you will be requested to choose between COBRA Continuation Coverage and coverage under that retirees' plan.
2. If you are the spouse of an employee covered by the Plan, you have the right to choose COBRA Continuation Coverage for yourself if you lose group health coverage under the plan for <u>any</u> of the following four reasons (known as "qualifying events"):

   - The death of your spouse;
   - The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
   - Divorce or legal separation from your spouse; or

- Your spouse becomes eligible for Medicare.

3. In the case of a dependent child of an employee covered by the Plan, he or she has the right to COBRA Continuation Coverage if group health coverage under the Plan is lost for any of the following five reasons:

   - The death of a parent;
   - The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with his or her contributing employer;
   - Parents' divorce or legal separation;
   - A parent becomes eligible for Medicare; or
   - The dependent ceases to be a "dependent child" under the Plan.

In addition, certain dependents may have further rights to COBRA Continuation Coverage in the event that the employer files for bankruptcy under Chapter 11 of the Federal Bankruptcy Code.

Your Responsibilities – Under COBRA, the employee or a family member has the responsibility to inform the Plan within sixty (60) days of a divorce, legal separation, or the date on which a child loses dependent status under the Plan. Such notification must be in writing and should be mailed (postage prepaid) to the Plan Office. The Plan recommends that you send such notice by certified mail, return receipt requested, in order to preclude the possibility of a dispute over when the Plan received it. The Employer has the responsibility to notify the Plan within thirty (30) days of a covered employee's death, termination of employment, or reduction in hours.

When the Plan is notified that one of these events has happened, the Plan in turn will notify you that you have the right to elect COBRA Continuation Coverage. Under COBRA, you, your spouse, or dependent have at least sixty (60) days from the date you would lose coverage because of one of the qualifying events described above to inform the Plan that COBRA Continuation Coverage is desired. The sixty (60) day period begins to run on the later of the date of the qualifying event or the date of the notice of your continuation rights supplied to you by the Board of Trustees.

If you (or your spouse or dependent) do not elect COBRA Continuation Coverage, your group health insurance coverage under this Plan will end as specified on page 4 of this SPD.

If you (or your spouse or dependent) elect COBRA Continuation Coverage, the Plan is required to give you health coverage which, as of the time coverage is being provided, is identical to the health coverage provided under the Plan to similarly situated employees or family members. The law requires that you (or your spouse or dependent) be afforded the opportunity to maintain COBRA Continuation Coverage for three (3) years unless you lost group health coverage because of a termination of employment (for reasons other than gross misconduct on your part) or reduction in hours. In that case, the COBRA Continuation Coverage period is eighteen (18) months unless you (or your spouse or dependent) are disabled for purposes of Social Security benefits at any time during the first sixty (60) day of COBRA coverage, in which case the COBRA Continuation Coverage period is twenty-nine (29) months. You (or your spouse or your dependent) are required to give notice to the Plan that you (or your spouse or dependent) have been determined to be disabled within sixty (60) days after the date the determination is made for Social Security purposes and within the thirty (30) days of the date of any final determination that you (or your spouse or dependent) are no longer disabled.

If you, your spouse and/or your dependent elect and are receiving COBRA Continuation Coverage and another qualifying event occurs while you, your spouse and/or your dependent are covered, you, your spouse and/or your dependent may be entitled to extend continuation coverage. However, you, your spouse and/or your dependent must notify the Plan of any second qualifying event in order to be sure to retain the right to continue coverage for an additional period. A child that is born to or placed for adoption with the covered

employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. These qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Office, of the birth or adoption.

However, the law also provides that the COBRA Continuation Coverage provided to you and/or your spouse and dependent may be cut short for any of the following five reasons:

1. Your employer no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on a timely basis;
3. You and/or your spouse and/or dependent child become covered under another group plan which does not contain any exclusion or limitation with respect to any pre-existing condition;
4. You and/or your spouse become eligible for Medicare; or
5. You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition.

As stated above, if you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA Continuation Coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of the Health Insurance Portability and Accountability Act's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage. COBRA Continuation Coverage may also be cut short for any covered participant, e.g., you, your spouse and/or your dependent, when that participant becomes entitled to Medicare.

You do not have to show that you are insurable to elect COBRA Continuation Coverage. However, COBRA permits the Plan to charge you (or your spouse or dependent) a premium for COBRA Continuation Coverage. If you have any questions about COBRA or your right to continuation of your health care benefits under the Plan, please contact the Plan Office at 2505 Main St., Suite 233, Stratford, Connecticut 06615.

SPECIAL ENROLLMENT RIGHTS

Special Enrollments Under CHIPRA – As part of the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") that was enacted on February 4, 2009, the State Children's Health Insurance Program ("SCHIP") was extended through 2013 and remand the Children's Health Insurance Program ("CHIP"). CHIPRA created the following new special enrollment rights for qualified Members effective April 1, 2009:

1. If you or your Dependent become eligible for State-granted premium assistance, or, you or your Dependent's coverage terminates due to a loss of eligibility (as opposed to termination due to failure to pay premiums) under Medicaid, Connecticut's Healthcare for Uninsured Kids or Youth ("HUSKY") program, or a State Children's Health Insurance Program, you may request coverage under this Plan within sixty (60) days of this special-enrollment qualifying event by completing a Notification of Family Status Change Form and providing supporting documentation to the Plan Office.
2. If your Dependent becomes eligible to receive a premium subsidy from CHIP, you will be allowed under CHIPRA to disenroll your Dependent from this Plan by requesting this coverage change within sixty (60) days of this special-enrollment qualifying event by completing a Notification of Family Status Change Form and providing supporting documentation to the Plan Office.

USERRA Continuation Coverage – Under the terms of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), covered Members who take an approved leave of absence from their employment to engage in military service have the right to elect to continue their coverage under the Plan for a period not to exceed twenty four (24) months. A covered Member who elects

USERRA Continuation Coverage will be responsible for paying the premiums necessary to continue that coverage. Because USERRA is intended to supplement, not replace, COBRA, an election of USERRA Continuation Coverage will overlap the COBRA Continuation Coverage which appears above.

USERRA also entitles an employee who returns to covered employment following a military leave of absence to reinstate his/her Plan coverage, and that of his/her dependents, without being subject to any exclusions and/or waiting periods (*e.g.*, pre-existing condition limitations) that otherwise might apply. This prohibition does not apply to any injury or illness which the Veterans Administration determines is connected to that uniformed service.

Certain other provisions of USERRA specifically apply to covered Members actively engaged in uniformed service as of its October 13, 1994, effective date. If that circumstance applies to you, or if you have any questions about USERRA or your right to USERRA Continuation Coverage under the Plan, please contact the Plan Office at 804 Fairfield Avenue, Bridgeport, Connecticut 06604.

FAMILY MEDICAL LEAVE

Rights and Responsibilities Under the Family Medical Leave Act of 1993 – The Family and Medical Leave Act of 1993 ("FMLA") generally applies to employers with 50 or more employees. Check with your human resource office to find out whether your employer is covered by FMLA. Contributing employers covered by the FMLA shall be obligated to accord all covered employees who have been employed for at least one year and for 1,250 hours over the previous 12 months all rights under the FMLA and regulations promulgated there under by the Federal Government. Such rights include, but are not limited to, your right to have your employer continue, under the same terms, your health benefits coverage under the Plan in the event that you are required to take unpaid leave for any of the following reasons: (1) to care for your child after birth, or placement for adoption or foster care; (2) to care for your spouse, son, daughter, or parent, who has a serious health condition; or (3) for a serious health condition that makes you unable to perform your job. You must contact your employer as soon as you learn that you may need to take leave under any of the above circumstances. If you have any other questions regarding your rights and responsibilities under FMLA you may contact your employer and/or the Plan Office.

DEFINITIONS

In an effort to be as specific as possible in explaining your Plan coverage, the following definitions have been developed. While many of the definitions are general in nature and some assign meaning to relatively common terms within the health insurance field, others are applicable only to the Plan. Except as otherwise specified, the definitions in this section apply generally throughout this booklet, and are capitalized wherever they appear. Please also note that the Aetna Plan Booklet contains Definitions that relate specifically to your Medical Benefits covered under this Plan.

Accidental Injury – Physical bodily injury resulting from an external force, blow or fall, or the ingestion of foreign body or harmful substance, such as iodine or bleach, requiring immediate medical treatment. Accidental Injury also includes animal and insect bites, sunstrokes, and poison ivy reactions. An injury to the teeth while eating is not considered an Accidental Injury.

Calendar Year – The period from January 1 through December 31 of the same year. For new Members, Calendar Year is the effective date of their benefit eligibility through December 31 of the same year.

Dependent – *See* pages 5-6.

Disability – For purposes of Weekly Accident and Sickness Benefits, Disability means that 1) you are completely unable to perform any and every substantial and material duty pertaining to your occupation or employment; and 2) you are under the regular care of a Doctor.

For purposes of extended benefits in the case of dependents, disability means that 1) your dependent is completely unable to perform the normal activities of a person of like age and sex; and 2) your dependent is under the regular care of a Doctor.

Doctor – Unless otherwise limited, Doctor shall include, with respect to any particular medical care and services, a licensed Doctor of medicine (M.D.), a licensed Doctor of Osteopathy (D.O.) and any other holder of a certificate or license issued pursuant to law authorizing such holder or licensee to perform the particular medical or surgical services.

Members – Employees who are represented for collective bargaining purposes by I.B.T. Local No. 145 and whose employers have agreed to make contributions to the Plan on their behalf for the level of benefit coverage described in this SPD.

Workers' Compensation Benefits –Loss of Income Benefits available under any Workers' Compensation law, occupational disease law, employers' liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

HOW TO CLAIM BENEFITS

This section applies ONLY to claiming Weekly Accident or Sickness benefits or Vested Death Benefits under this Plan. Please refer to the Aetna Plan Booklet for information on how to claim Medical and Dental benefits under this Plan. Also, please refer to the Davis Vision brochure for information on how to claim vision benefits under this Plan.

Verification of Benefits – The Plan Office makes an eligibility benefit determination when a claim is submitted. While the Plan Office will answer telephone inquiries as to eligibility or the level and type of benefits available under the Plan, those answers given by Plan employees over the telephone are not binding on the Plan.

If you want a verification of eligibility or benefits, you may request such a verification in writing and the Plan Office will provide its written response to verify your eligibility and the level and type of benefits covered for a particular service or supply.

Definitions Applicable to this Section –

Adverse benefit determination – A denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a covered dependent's eligibility to participate in the Plan, and including, with respect to the Plan, a 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.

Claim for benefits – A request for Plan benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims.

Claimant – The covered participant that the claim for benefits references.

Notice or Notification – The delivery or furnishing of information to the participant about a claimant in a manner consistent with 29 CFR 2520.104b-1(b). It is our practice to address all notices to the participant even if the claimant is a dependent. Essentially, this means the ability to reasonably ensure actual receipt of the materials and specifically includes the normal mailing by U.S. mail.

Applying for Benefits – To apply for Weekly Accident and Sickness benefits, you must supply the Plan with a completed claim form and all other necessary documentation in support of your claim. You should submit those claims, requests for claim forms, and/or requests for assistance in completing claim forms to the following address:

I.B.T. Local No. 145 Health Services & Insurance Plan
2505 Main Street, Suite 233
Stratford, CT 06615
Telephone: (203) 375-6088
Fax: (203) 375-6106

Weekly Accident and Sickness Benefit claims must be filed within sixty (60) days of the onset of the Disability. A claim is filed for purposes of fulfilling this requirement when the properly completed claim forms are received by the Plan Office at the above address.

Calculating Time Periods – Benefit or appeal determination time periods applicable to the Plan begin at the time a claim for benefits or appeal is filed in accordance with these claims procedures, without regard to whether all information necessary to process the claim accompanies the filing. If the necessary information is not included, the Plan may request an extension including a request for the specific information. In such cases, the period for making the determination will be delayed from the date the notification is sent, until the date on which the claimant responds with the necessary information.

Notice of Benefit Determinations – The Plan shall provide a claimant with written or electronic notification of any adverse benefit determination including the following information:

- The specific reasons for the adverse benefit determination;
- Reference to the specific plan provision on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA § 502(a) following a review of the adverse benefit determination.

The Plan's procedures for Weekly Accident and Sickness Benefit claims are as follows:

- The Plan generally must notify a clamant of the plan's adverse benefit determination within a reasonable period of time, but not later than forty-five (45) days after the receipt of the claim.
- If matters beyond the control of the plan require an extension, the Plan may request up to an additional thirty (30) days for review, if the Plan notifies the claimant prior to the expiration of the original time period. The Plan's notice must include the circumstances underlying the request for the extension and the date when a decision is expected. If necessary information from the claimant has not been received, the Plan must notify the claimant of the specific information required and allow the claimant up to forty-five (45) days from the receipt of the notice to provide the information.

Please remember, the Disputed Claims Review Process about to be described applies ONLY to Plan eligibility issues and to claiming Weekly Accident or Sickness or Vested Death Benefits under this Plan. Please refer to the Aetna Plan Booklet(s) for information on how to claim Medical and Dental Benefits under this Plan and refer to the Davis Vision brochure for information on how to claim vision care benefits.

Disputed Claims Review Process – If you want to appeal an eligibility decision or a denied weekly accident and sickness benefit claim, you or a properly authorized representative acting on your behalf must send a written appeal to the Plan Office no later than 180 days after the date you received the notice of denial. However, in the case of an appeal involving urgent care, the appeal may be submitted telephonically to the Plan Office. The request must explain the reasons why you believe the Plan's initial decision was wrong and attach all documents which you think will help the Board of Trustees decide your appeal. To help you prepare the appeal, you may arrange with the Plan Office for an opportunity to review and copy, free of charge, all relevant materials and Plan documents under the control of the Plan Office relating to your claim, including those that involve any expert review(s) of your claim. If your written request for a review is not filed within the required 180-day period, you will lose the right to a review of the denial of your claim, and the Plan's initial decision will become final, binding and conclusive.

On all timely submitted appeals, the Plan will:

- Provide the claimant with a full and fair review which does not afford deference to the initial adverse benefit determination;
- Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- Provide that when an adverse benefit determination is based in whole or in part on a medical judgment (*i.e.* medical necessity, experimental/investigational), the Board of Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Provide that a health care professional involved in the appeal determination is not the same person involved in the initial adverse benefit determination, nor the subordinate of such individual;
- Provide for the identification of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination.

The Board of Trustees generally will make a decision upon review of a denied eligibility decision or a denied claim at their next regularly scheduled quarterly meeting following the date the Plan receives your request for review, except that in cases where a request for review is received less than thirty (30) days prior to a regularly scheduled quarterly meeting, the request may not be considered until the second regularly scheduled quarterly meeting following receipt. To the extent your appeal involves a question of medical judgment, the Trustees will consult with an appropriate health care professional to assist them in making their decision. If special circumstances require a delay in that decision, you will receive a notice of the reasons for the delay within the same time frame. Upon making a decision, the Board will send you a written decision which will explain the reasons for its decision and will refer to those provisions of the Plan on which it is based.

The Board of Trustees possesses the sole discretion to interpret those terms of the Plan that relate to the nature or extent of coverage or benefits, including eligibility determinations and payments with respect to benefits. Therefore, a decision made by the Board of Trustees on review of an eligibility determination or claim denial shall be final, binding and conclusive unless you exercise your right to an external review for dental and vision claims only. If the Board denies your appeal of a dental or vision claim, the Plan office will explain your external appeal rights, if available under the law. The Board of Trustees will abide by the decision of an independent review organization pursuant to the external review process.

PLAN INFORMATION

Type of Administration – The Plan is administered and maintained by a joint Board of Trustees. The Board of Trustees is governed by the Trust Agreement established and maintained in accordance with various Collective Bargaining Agreements.

Name and Address of Plan: I.B.T. Local No. 145 Health Services & Insurance Plan
2505 Main Street, Suite 233
Stratford, CT 06615
Telephone: (203) 375-6088
Fax: (203) 375-6106

The Plan number assigned by the Board of Trustees is 501.

The Plan's Employer Identification Number ("EIN") is 06-0711441.

Contributing Employers – You may make a written request to the Plan Office for information as to whether a particular employer or employee organization is a contributing employer with respect to this Plan and, if so, you may request the address of that contributing employer.

Reference to Collective Bargaining Agreements – The Plan is maintained pursuant to various collective bargaining agreements which provide for the rate of employer contributions to the Plan, the type of work and areas of work for which contributions are payable and certain other terms governing contributions. Copies of the applicable collective bargaining agreements are available for inspection at the Plan Office, and may be obtained by employees upon submission of a written request, and payment of a reasonable charge, to the Plan Office.

Type of Plan – This Plan provides Health, Vision Care, Dental Care, Prescription Drug and Employee Assistance (EAP) to eligible Members and their dependents ("Participants"). It also provides Disability Benefits to eligible Members. All benefits are provided by the Plan on a self-insured basis. The right is reserved for the Board of Trustees to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time. In the event that the Plan is terminated that Board of Trustees will distribute any surplus reserves in a manner consistent with the Plan's tax exempt status under Section 501(c)(9) of the Internal Revenue Code.

Source of Contributions to Plan and Identity of Any Organizations Through Which Benefits are Provided – Contributions to the Plan are made by individual Contributing Employers at the rates established by Collective Bargaining Agreements. The Plan provides benefits on a self-insured.

Names and Addresses of Members of the Board of Trustees:

Union Trustees	Employer Trustees
Mr. Dennis Novak, President I.B.T. Local No. 145 2505 Main St., Suite 233 Stratford, CT 06615	Ms. Sheila Nevins c/o Ashcroft, Inc. 250 East Main St. Stratford, CT 06615
Mr. Italo Bonacci I.B.T. Local No. 145 2505 Main St., Suite 233 Stratford, CT 06615	Ms. Malda Vneshta Bimbo Bakeries USA 10 Hamilton Ave. Greenwich, CT 06830

Name and Address of Person Designated as Agent for Service of Legal Process – Legal process may be served upon any of the Plan Trustees at the address stated in the preceding item.

Name and Address of Administrator – The Plan is administered by the Board of Trustees. The Board of Trustees employs a staff and maintains an Administrative Office to perform the routine administration of the Plan.

Date of End of Plan Year – All financial records of the Plan are kept on a fiscal year of July 1 to June 30.

Appeal Procedure – If a Participant is denied in whole or in part any benefits under this Plan, as specified in Section 503 of the Employee Retirement Income Security Act of 1974 ("ERISA"), remedies are available and are set forth in this plan description under the Disputed Claims Review Process section which begins on page 21.

YOUR RIGHTS UNDER ERISA

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

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

Obtain, upon written request to the Plan Office, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage – Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD at page 13 and the Aetna Plan Booklet on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions By Plan Fiduciaries – 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 the Plan, called Plan "fiduciaries," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under this Plan or otherwise exercising your rights under ERISA.

Enforce Your Rights – If your claim for benefits 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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, *for example, if it finds your claim is frivolous*.

Assistance with Questions – If you have any questions about your plan, you should contact the Plan Office. 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 Office, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.