AMENDMENT NO. 1
TO THE RESTATED PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION
OF THE GLASSWORKERS AND GLAZIERS
HEALTH AND WELFARE FUND TRUST

Effective July 1, 2003 the Restated Plan Document and Summary Plan Description of the Glassworkers and Glaziers Health and Welfare Fund Trust are hereby amended as follows:

ARTICLE V. GENERAL EXCLUSIONS AND LIMITATIONS section 5.01 General Exclusions and Limitations. is hereby amended by the restatement of subsection 11. as follows:

11. for expenses resulting from a motor vehicle accident when a Participant is at fault, to the extent of no-fault or medical payments coverage in the minimum amount of ~~$50,000~~ $25,000, regardless of whether or not a Participant has such auto insurance coverage, unless medical payments coverage of ~~$50,000~~ $25,000 is not available, in which case the exclusion shall be in the maximum amount of medical payments coverage offered by the Participant's auto insurance carrier.

ARTICLE VI. COORDINATION OF BENEFITS section 6.01 Coordination of Benefits. is hereby amended by the restatement of subsection b. No-Fault Automobile Insurance. as follows:

b. ~~No Fault~~ Automobile Insurance. Benefits under This Plan will be coordinated, after the exclusion of $25,000 in charges or such lesser amount as may be available as described in section 5.01, 11., with a Participant's automobile medical payments coverage or with any other automobile insurance applicable to the state in which the Participant resides and is insured. ~~with minimum coverages required under the Colorado Auto Accident Reparations Act (No-Fault) as amended:~~

~~1. If a "No-Fault" policy provides coverage in excess of the minimum required by State law,~~

~~then benefits will be coordinated with the coverage which is in effect.~~

~~2.~~ ~~The benefits of This Plan will not be available to a Participant to the extent of minimum benefits required by the "No Fault" law for injuries suffered while operating or riding in a motor vehicle owned by the Participant if said vehicle is in operation on the public highways of the State of Colorado and such vehicle is not covered by No Fault Automobile Insurance as is required by law. However, This Plan does not coordinate benefits relating to any other person injured in a motor vehicle accident if the injured person is a non-owner operator, passenger or a pedestrian and such other person is not covered by No Fault Automobile Insurance.~~

~~3.~~ ~~Upon the expiration of the Colorado no fault law, effective July 1, 2003, This Plan will continue to exclude benefits to a Participant for the first $50,000 of incurred medical/hospital expenses resulting from a motor vehicle accident when the Participant is at fault, regardless of whether or not the Participant has no fault or other medical payments coverage, unless coverage in such amount is not available, in which case the exclusion shall be in the maximum amount of medical payments coverage offered up to $50,000. Benefits will be coordinated with any coverage which is in effect in excess of $50,000.~~

Effective November 1, 2003 the Restated Plan Document and Summary Plan Description of the Glassworkers and Glaziers Health and Welfare Fund Trust are hereby amended as follows:

ARTICLE III. COMPREHENSIVE MEDICAL BENEFITS section 3.03 Other Benefit Maximums. is hereby amended by the restatement of subsection a. Calendar Year Benefit Maximums. and subsection b. Specific Benefit Maximums. as follows:

a. Calendar Year Benefit Maximums. The maximum benefit payable on behalf of a Participant in a calendar year shall not exceed the following maximums:

1. all outpatient services rendered by PPO and Non-PPO providers for mental and nervous disorders and Substance Abuse, up to **thirty (30) visits**, not to exceed one (1) treatment per day;

2. **thirty (30) visits** for chiropractic care.

3. **$150** for routine physical examinations.

4. **$200** for orthotics prescribed by or determined to be Medically Necessary by a Physician for a Dependent child.

b. Specific Benefit Maximums. The specific benefit maximums for transplants, as described in section 3.08, n. shall be as follows:

1. **$200** per day transplant procedure for lodging and meals, for one (1) companion of the Participant, or two (2) companions if the Participant is a minor;

2. **$10,000** per transplant procedure for transportation, lodging and meals for one (1) companion of the Participant, or two (2) companions if the Participant is a minor; and

3. **$10,000** per transplant procedure for procurement of donor organ or tissue.

4. **$200** for a routine mammogram as described in 3.08, h., 6.

ARTICLE III. COMPREHENSIVE MEDICAL BENEFITS section 3.05 Deductible. is hereby restated as follows:

3.05 Deductible. The Deductible is the amount of Covered Charges which first must be incurred during each calendar year by an Eligible Participant before Comprehensive

Major Medical Benefits are payable. The Deductible and applicable provisions consist of:

a. Preferred Provider Deductible. There is a **$500** cash Deductible requirement for each Eligible Participant, including Participants who reside outside the State of Colorado and are actively working in the glazing industry. A family's covered medial expenses will be charged with no more than three (3) times the single Deductible amount in any calendar year.

   The Deductible applies to all Covered Charges, except PPO Physician office visit charges. All charges incurred at the time of an office visit and billed by the PPO Physician will not be subject to the Deductible (including mammograms, orthotics, immunizations and routine physical examination benefits).

b. Non-Preferred Provider Deductible. There is a **$1,000** cash Deductible requirement for each Eligible Participant. A family's covered medical expenses will be charged with no more than three (3) times the single Deductible amount in any calendar year.

The Deductibles for PPO and Non-PPO providers are accumulated separately.

Any Covered Charges incurred in the last three (3) months of the calendar year for which benefits are not payable because of the cash Deductible requirements may be used to satisfy all or part of the Deductible for the subsequent calendar year provided the cash Deductible must be satisfied within a period of twelve (12) consecutive months.

In the event of an accident involving more than one (1) Eligible Participant in the same family, the cash Deductible requirement must be satisfied only once in the calendar year in which the accident occurred. The cash Deductible will not be required to be satisfied in the next calendar year with respect to the total Covered Charges incurred by Eligible Participants in the same family, as a result of such accident.

ARTICLE III. COMPREHENSIVE MEDICAL BENEFITS section 3.07 Percentage of Covered Charges Payable. is hereby restated as follows:

3.07 Percentage of Covered Charges Payable. Subject to the lifetime maximum amount and after satisfaction of any required Deductible or Copayment the Plan will pay benefits as follows. **The $15,000 coinsurance maximum is a combined amount, satisfied by PPO and Non-PPO Covered Charges.**

a. Preferred Provider Covered Charges. The Plan will pay **80% of the first $15,000** (coinsurance maximum) of Covered Charges incurred by any Eligible Participant provided by a Preferred Provider and 100% in excess of such amount for the remainder of the calendar year.

b. Non-Preferred Provider Covered Charges. Subject to the satisfaction of any required Deductible, the Plan will pay **60% of the first $15,000** (coinsurance maximum) of Covered Charges incurred by any Eligible Participant, thereafter the Plan will pay 100% of Covered Charges for the remainder of the calendar year.

With respect to outpatient mental or nervous disorders, including Substance Abuse services rendered by a Non-Preferred Provider, the Plan will pay **50% of Covered Charges** up to the calendar year maximum amount described in section 3.03, a., 1.

Exception: In the event that covered services are rendered for a life threatening emergency by a Non-Preferred Provider when the Participant is traveling outside the network area and such services cannot be rendered by a Preferred Provider, covered charges shall be allowed in accordance with the Preferred Provider level of benefits.

c. Routine Mammograms and Immunizations, and Foot Orthotics. Covered Charges for routine mammograms and foot orthotics for a Dependent child, are paid at 100% up to the maximums set forth in section 3.03, a. and b. Routine

immunizations are paid at 100%. The Deductible and Copayment requirements are waived.

d. Pediatric Preventive Health Care. After satisfaction of the $25 copayment, Covered Charges rendered by Preferred Provider Physician are paid at 100%. The Deductible requirement is waived.

ARTICLE III. COMPREHENSIVE MEDICAL BENEFITS section 3.08 Covered Charges. is hereby amended by the restatement of subsection h. Diagnostic X-ray and Laboratory. as follows:

h. Diagnostic X-ray and Laboratory. Benefits will be payable for charges incurred for necessary X-ray and laboratory examinations for diagnosis of a bodily injury or sickness including the following:

1. allergy testing;

2. basal metabolism determination;

3. audiograms;

4. electrocardiograms;

5. routine screening of a papanicolaou type smear will be allowed once each calendar year;

6. charges for routine mammograms will be allowed, in accordance with the following guidelines, up to a maximum benefit payable of ~~$60~~ **$200**:

   (a) Female participant age thirty-five (35) to age thirty-nine (39) - one (1) baseline mammogram, and

   (b) Female participant age forty (40) and over - one (1) mammogram each year;

7. routine immunizations; and

8. one (1) routine physical examination per Participant per calendar year subject to the

Calendar Year Maximum Benefit described in section 3.03.

ARTICLE III. COMPREHENSIVE MEDICAL BENEFITS section 3.08 Covered Charges. is hereby amended by the restatement of subsection j. Prescription Drugs, Appliances, Nursing Care and Physician Assistant. as follows:

j. Prescription Drugs, Appliances, Nursing Care and Physician Assistant. Covered Charges include:

1. rental of a wheelchair, Hospital bed and other similar durable medical equipment. When determined by the Board of Trustees that purchase of durable medical equipment would be less expensive than the rental thereof, or such equipment is not available for the rental, such purchase may be authorized by the Board of Trustees.

2. insulin pumps, supplies and maintenance of such equipment subject to the following guidelines:

   Patient has Type I or II diabetes and has:

   (a) completed a comprehensive diabetes education program,

   (b) been on multiple daily injections of insulin (at least 3 per day) with frequent self-adjustments of insulin for at least 6 months,

   (c) documented in a written log the frequency of glucose self-testing (an average of 4 times a day during the 2 months prior to the pump), and

   (d) meets one (1) or more of the following while on a daily injection regimen:

      (1) HBA1c greater than 7%;

      (2) History of recurring hypoglycemia;

(3) Wide fluctuations in blood glucose before mealtimes;

(4) Dawn phenomenon with fasting blood sugars frequently exceeding 200mg;

(5) History of severe glycemic excursions.

Written documentation must be received from the physician addressing whether the patient meets these guidelines.

3. prosthetic devices, replacement excluded.

4. casts, splints, trusses, braces and crutches, and surgical dressings.

5. oxygen and rental of oxygen equipment.

6. services of a registered nurse (R.N.) or licensed practical nurse.

7. services by a Physician Assistant who is under the direct supervision of a Physician for the performance of medical services including the prescribing of a non-controlled substance when the Physician does not see the patient or become directly involved in the medical service being provided.

8. drugs and medicines dispensed by an institution covered by the Plan while the Participant is confined as an inpatient or is being treated as an outpatient, medicines received in a Physician's office, and injectable contraceptives prescribed and administered by a Physician (refer to Article IV for a description of outpatient prescription drug benefits).

9. foot orthotics for Dependent children when prescribed by or determined to be Medically Necessary by a Physician, up to the maximum amount described in 3.03, a., 4.

ARTICLE V. GENERAL EXCLUSIONS AND LIMITATIONS section 5.01 General Exclusions and Limitations. is hereby amended by the restatement of subsection 1. as follows:

1. for orthopedic shoes, or supportive devices for the feet, such as arch supports, heel lifts, etc., **except** orthotics for a Dependent child as specifically set forth is section 3.08, j., 9.

Effective December 1, 2003 the Restated Plan Document and Summary Plan Description of the Glassworkers and Glaziers Health and Welfare Fund Trust are hereby amended as follows:

ARTICLE III. COMPREHENSIVE MEDICAL BENEFITS section 3.07 Percentage of Covered Charges Payable. is hereby restated as follows:

3.07 Percentage of Covered Charges Payable. Subject to the lifetime maximum amount and after satisfaction of any required Deductible or Copayment the Plan will pay benefits as follows:

a. Preferred Provider and Ambulance Covered Charges. The Plan will pay **80% of the first $15,000** (coinsurance maximum) of Covered Charges incurred by any Eligible Participant provided by a Preferred Provider or for professional ambulance service as described in section 3.08, a., 4., and 100% in excess of such amount for the remainder of the calendar year.

b. Non-Preferred Provider Covered Charges. Subject to the satisfaction of any required Deductible, the Plan will pay **60% of the first $15,000** (coinsurance maximum) of Covered Charges incurred by any Eligible Participant, thereafter the Plan will pay 100% of Covered Charges for the remainder of the calendar year.

Effective April 1, 2004 the Restated Plan Document and Summary Plan Description of the Glassworkers and Glaziers Health and Welfare Fund Trust are hereby amended as follows:

ARTICLE III. COMPREHENSIVE MEDICAL BENEFITS section 3.08 Covered Charges. is hereby amended by the restatement of subsection h. Diagnostic X-ray and Laboratory. as follows:

h. Diagnostic X-ray and Laboratory. Benefits will be payable for charges incurred for necessary X-ray and laboratory examinations for diagnosis of a bodily injury or sickness including the following:

1. allergy testing;

2. basal metabolism determination;

3. audiograms;

4. electrocardiograms;

~~5. routine screening of a papanicolaou type smear will be allowed once each calendar year;~~

~~6. charges for routine mammograms will be allowed, in accordance with the following guidelines, up to a maximum benefit payable of **$200:**~~

~~(c) Female participant age thirty-five (35) to age thirty nine (39) -- one (1) baseline mammogram, and~~

~~(d) Female participant age forty (40) and over -- one (1) mammogram each year;~~

~~7. routine immunizations; and~~

~~8. one(1) routine physical examination per Participant per calendar year subject to the Calendar Year Maximum Benefit described in section 3.03.~~

ARTICLE III. COMPREHENSIVE MEDICAL BENEFITS section 3.08 Covered Charges. is hereby amended by the addition of subsection s. Routine Physical Examination Benefits. as follows:

s. **Routine Physical Examination Benefits.**

1. For the first two (2) years of life for a Dependent child, pediatric preventive health care services are payable by the Plan and are **not** subject to the **$150** calendar year maximum described in section 3.03, a., 3.

2. All other Participants will be entitled to a routine physical examination once each calendar year subject to the **$150** calendar year maximum described in section 3.03, a., 3. This benefit includes, but is not limited to:

   (a) Physician's charges for a complete history and physical examination; and

   (b) X-ray and laboratory charges for electrocardiogram, complete blood count, urinalysis, chest X-ray, etc.

3. routine screening of a papanicolaou type smear will be allowed once each calendar year;

4. charges for routine mammograms will be allowed, in accordance with the following guidelines, up to a maximum benefit payable of **$200**:

   (a) Female participant age thirty-five (35) to age thirty-nine (39) - one (1) baseline mammogram, and

   (b) Female participant age forty (40) and over - one (1) mammogram each year; and

5. routine immunizations.

<u>ARTICLE V. GENERAL EXCLUSIONS AND LIMITATIONS</u> <u>section 5.01 General Exclusions and Limitations</u>. is hereby amended by the restatement of <u>subsection 11</u>. as follows:

11. ~~for expenses resulting from a motor vehicle accident when a Participant is at fault, to the extent of no fault or medical payments~~

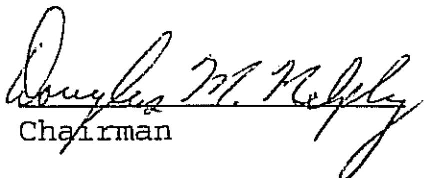
~~coverage in the minimum amount of $25,000, regardless of whether or not a Participant has such auto insurance coverage, unless medical payments coverage of $25,000 is not available, in which case the exclusion shall be in the maximum amount of medical payments coverage offered by the Participant's auto insurance carrier~~.

Charges for services or supplies resulting from injuries suffered by a Participant in an automobile accident up to $10,000 or such higher amount as may be available for reimbursement to a Participant under automobile medical payment insurance coverage, whether or not the Participant has such coverage.

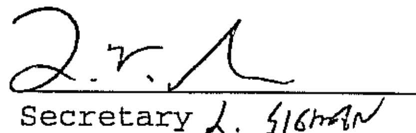
ARTICLE VI. COORDINATION OF BENEFITS section 6.01 Coordination of Benefits. is hereby amended by the restatement of subsection b. Automobile Insurance. as follows:

b. Automobile Insurance. Benefits under This Plan will be coordinated, after the exclusion of ~~$25,000~~ $10,000 in charges or such ~~lesser~~ higher amount as may be available as described in section 5.01, 11., with a Participant's automobile medical payments coverage or with any other automobile insurance applicable to the state in which the Participant resides and is insured.

The Chairman and Secretary of the Board of Trustees of the Glassworkers and Glaziers Health and Welfare Fund Trust do hereby certify that the foregoing Amendment was duly adopted at a meeting held on June 10, 2004.



Chairman



Secretary L. SIGMAN

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