

**UFCW UNIONS AND PARTICIPATING
EMPLOYERS HEALTH AND WELFARE FUND**

PLAN JS

December 2008

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There are terms used throughout this booklet which have special meaning in relation to your Plan benefits. Such terms are italicized and are defined in the "Definitions" section on page 00.

Dear Participant,

The United Food and Commercial Workers *Unions* and *Participating Employers* Health and Welfare Fund (referred to as "UFCW Unions and Participating Employers Health and Welfare Fund" or "the Fund") was established as a result of collective bargaining between your *union* and your *participating employer*. The contribution rate paid by your *participating employer* determines the level of benefits you receive. An equal number of Trustees have been appointed by the *unions* and the *participating employers*. The Trustees administer the Fund and serve without compensation. Their authority, established under a trust agreement, includes the right to make rules about your eligibility for benefits and the level and type of benefits available. The Trustees may amend the rules and benefit levels at any time. You do not have a vested right to any benefits under the Plan and benefits may be changed or eliminated by the *Trustees* at any time. The *Trustees* also have the power to interpret, apply and construe the provisions of the Plan and make factual determinations regarding its construction, interpretation and application. Any decision made by the Board of *Trustees* is binding upon *participating employers*, employees, participants, beneficiaries, and all other persons who may be involved with or affected by the Plan. While the *Trustees* intend to continue the benefits described in this booklet, they reserve the right to amend or terminate the Plan at any time. If the Trustees terminate the Plan, your rights and the distribution of assets will be determined under the terms of the Trust and applicable law. You will be notified of any material modifications (changes) to this Summary Plan Description (SPD) as required by federal law.

The Trustees delegate authority to professionals who help them manage the Plan:

- An **administrative manager** (referred to in this booklet as "the *Fund office*") receives *participating employer* contributions, keeps eligibility records, pays claims, and assists Plan participants in getting their benefits. Some benefits are paid directly by the Fund; others are provided by insurance carriers or other providers to whom the Fund pays premiums. Benefits payable are limited to Plan assets for all Fund provided benefits.
- An **investment manager** invests the Fund's assets to achieve a reasonable rate of investment return.
- **Fund counsel** provides legal advice.
- An independent **certified public accountant** audits the Fund each year. Periodic payroll audits are also performed for each *participating employer*.

If there are any differences between this booklet—which is intended only as a summary explanation of your benefits—and the formal agreements between the Fund and insurance carriers or providers of service, the formal agreements will govern.

It is important that you verify coverage with the *Fund office* before incurring expenses under the *Plan* so that you can confirm that you or your dependents are covered under the *Plan* for the services you are seeking. Please remember that no one other than the *Fund office* can verify your coverage. Do not rely upon any statement regarding coverage or benefits under the *Plan* made by your *participating employer* or *Union* representative.

It is also extremely important that you keep the *Fund office* informed of any change in address or desired changes in dependents and/or beneficiary. This is your obligation and you could lose benefits if you fail to do so. The importance of a current, correct address on file in the *Fund office* cannot be overstated. It is the **ONLY** way the *Trustees* can keep in touch with you regarding *Plan changes* and other developments affecting your interests under the *Plan*.

We hope you always enjoy good health. However, if the need for coverage arises, we believe you'll share with us the satisfaction of knowing you have the protection of this Plan.

Sincerely,

THE BOARD OF TRUSTEES

NOTICE - NO FUND LIABILITY

Use of the services of any hospital, clinic, doctor, or other provider rendering health care is the voluntary act of the participant or dependent, even in cases where the Fund limits coverage to certain providers. Some benefits may only be obtained from providers designated by the Fund. This is not meant to be a recommendation or instruction to use those providers.

You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Fund. Providers are independent contractors, not employees of the Plan. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

Benefits under this Plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them.

OVERPAYMENT

If the *Fund* pays benefits in error, such as where the *Fund* pays you or your dependent more benefits than you are entitled to, or if the Fund advances benefits that you or your dependent are required to reimburse either because you have received a compensable Workers' Compensation claim or have received a third party recovery (see "Subrogation" and Advance Benefits for Workers' Compensation Claims"), the *Fund* shall be entitled to recover such benefits. The *Fund* may recover these benefits by offsetting all future benefits otherwise payable by the *Fund* on your behalf or on behalf of your dependents. For example, if the overpayment or advancement was made to you as the *Fund* participant, the *Fund* may offset the future benefits payable by the *Fund* to you and your dependents. If the overpayment or advancement was made to your dependent, the *Fund* may offset the future benefits payable by the *Fund* to you and your dependents. The *Fund* also may recover any overpaid or advanced benefits by pursuing legal action against the party on whose behalf the benefits were paid. By accepting benefits under the terms of this Plan, you and your dependents agree to waive any applicable statute of limitations defense available to you and your dependents regarding the enforcement of any of the Fund's rights to reimbursement.

The *Fund* shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the *Fund* on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the *Fund* under this section, and any such amount shall be deemed to be held in trust by you or your dependent for the

benefit of the *Fund* until paid to the *Fund*. By accepting benefits from the Fund, you and your dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the *Fund* in reimbursing it for all of its costs and expenses related to the collection of those benefits.

In the event you, or if applicable, your dependent or beneficiary, fail to reimburse the Fund and the Fund is required to pursue legal action against you or your dependent or beneficiary to obtain re-payment of benefits advanced against the Fund, you or your dependent or beneficiary shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement.

You or your dependent or beneficiary shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you became obligated to repay the Fund through the date that the Fund is paid and the full amount owed.

FACTS ABOUT THE PLAN

Plan Name

United Food and Commercial Workers (UFCW) Unions and Participating Employers Health and Welfare Fund

Plan Sponsor

Board of Trustees of the UFCW Unions & Participating Employers Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451

Employer Identification Number

52-6044428

Plan Number

502

Type of Plan

This is a welfare plan designed to provide health care benefits such as: Medical, Hospitalization, Surgical, Major Medical, Life, Accidental Death and Dismemberment, Weekly Disability (“sick pay”), Prescription Drug, Dental, and Optical care.

Type of Administration

Contract administration - The Board of Trustees has contracted with Associated Administrators, LLC, for administrative management services. You may contact the Administrative Manager at the following addresses:

Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
(800) 638-2972
or

4301 Garden City Drive, Suite 201
Landover, MD 20785-2210
(301) 459-3020

Name of Plan Administrator

Board of Trustees of the UFCW Unions and Participating Employers Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451

Agent for Service of Legal Process

Associated Administrators, LLC, or any Trustee at this address:

UFCW Unions & Participating Employers
Health and Welfare Fund
4301 Garden City Drive, Suite 201
Landover, MD 20785-2210

Contributions and Self Payments:

Sources of contribution to the Fund are *participating employers* pursuant to the terms of their collective bargaining agreements, and self-payments and/or payroll deductions made by Plan participants.

Funding of Benefits

All assets are held in trust by the Board of Trustees. Insurance premiums are paid by the Trust Fund, and insurance companies or HMOs pay part of the benefits. Benefits are also partially paid from the accumulated assets of the Trust. For benefits provided by insurance companies or HMOs, the benefits are guaranteed by and paid under the insurance or HMO contract and the insurance company or HMO provides claims processing and administrative services related to those benefits. A current Summary Annual Report (available from the *Fund office*) gives details of Plan funding of benefits. The Fund's assets are held by PNC Bank, N.A. The Fund has contracted with ING/ReliaStar Financial Corporation to provide Life Insurance and Accidental Death & Dismemberment benefits, Spectera/United Optical to provide Optical benefits, Group Dental Service to provide Dental benefits and NMHC to administer Prescription Drug benefits. InforMed provides utilization management services to review and approve hospital admissions and durations of stay and to recommend or require second opinions in certain situations.

Fiscal & Plan Year

January 1 - December 31

Board of Trustees

<i>Union Trustees</i>		Employer Trustees
James Lowthers, Chairman UFCW Local 400 4301 Garden City Drive Landover, MD 20785		Steve Wood, Secretary The Kroger Company 620 Elm Hill Pike Nashville, TN 37214
Margaret Bohon UFCW Local 27 21 West Road Towson, MD 21204		George Anderson The Kroger Company P.O. Box 14002 Roanoke, VA 24038
Michael Earman UFCW Local 400 4301 Garden City Drive Landover, MD 20785		John Dougherty SuperValu, Inc. 10461 Manchester Road Kirkwood, MO 63122
Richard Eventoff UFCW Local 27 21 West Road Towson, MD 21204		Julie McWilliams Shoppers Food Warehouse 4600 Forbes Boulevard Lanham, MD 20706

SCHEDULE OF BENEFITS -- SUMMARY

Group A		
	Benefits	Eligible Persons
Life	\$5,000	Participant Only
Accidental Death & Dismemberment	\$5,000	Participant Only

BASIC BENEFITS AND MAJOR MEDICAL BENEFITS

Your hospital/medical/surgical coverage includes two types of benefits: Basic and Major Medical. “Basic” Benefits are paid at 100%, up to the lesser of the *Usual, Customary, and Reasonable (“UCR”)* charge or the limit specified in the following Schedule of Benefits. **The annual deductible does NOT apply to Basic Benefits.** Eligible balances remaining after Basic Benefits have been paid are processed under the Major Medical benefit. Major Medical coverage is paid at 80% up to the *UCR* or the limit specified in the Schedule of Benefits.

A \$100 annual deductible per calendar year applies, which means that you are responsible for the first \$100 of eligible charges in each calendar year. The deductible applies to each covered family member. The table below describes the Basic Benefits paid under this Plan.

BASIC BENEFITS

Type of Expense	Benefit Amount	Persons Eligible
Hospitalization	Daily room & board, up to 70 days per disability, up to the semi-private room rate, to a maximum of \$180 per day.	Participant & Eligible Dependents, Retiree & Eligible Dependents
Miscellaneous Hospital Expense	A flat \$300 plus 75% of next \$2,000 of covered expenses.	Participant & Eligible Dependents, Retiree & Eligible Dependents

Type of Expense	Benefit Amount	Persons Eligible
In-Hospital Medical Expense	\$20 maximum per day.	Participant & Eligible Dependents, Retiree & Eligible Dependents
In-Hospital Consultation	\$30, up to limit of three consultations per year.	Participant & Eligible Dependents, Retiree & Eligible Dependents
Physical Exam	\$50 every 24 months. No annual deductible applies.	Participant Only
Well Baby Care	Up to 8 visits at 100% of the <i>UCR</i> for certain services from birth through age 6. No annual deductible applies.	Eligible Dependents of Participants and Retirees
First Aid Benefit	\$22.50 for initial non-surgical treatment for <i>injuries</i> sustained as the result of an accident if treated by a doctor in an outpatient setting in lieu of a hospital setting.	Participant & Eligible Dependents, Retiree & Eligible Dependents
Sudden & Serious	\$200 if treated in an emergency room. Condition must be such that seeking immediate treatment was deemed medically necessary.	Participant & Eligible Dependents, Retiree & Eligible Dependents
Outpatient Surgery Facility Fee	\$200 basic benefit paid as facility fee if surgery is performed in an outpatient facility, or an outpatient surgical center of a hospital, in lieu of the hospital, for treatment of <i>injuries</i> resulting from an accident or medical emergency.	Participant & Eligible Dependents, Retiree & Eligible Dependents

**MAJOR MEDICAL
BENEFIT**

Major Medical Expenses	\$100 per family member deductible, 80% of <i>Usual, Customary, and Reasonable (UCR)</i> fees paid up to the lifetime maximum of \$250,000.	Participant & Eligible Dependents, Retirees & Eligible Dependents
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If Basic benefits are applicable, they will be paid first, with the balance being paid under Major Medical. See description of types of procedures covered under Major Medical.

Rehabilitation Benefit	Rehabilitation benefit through InforMed covered under Major Medical. See page 107 for specifics.	Participant & Eligible Dependents, Retirees & Eligible Dependents
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Retirees and Eligible Dependents who become eligible for Medicare are required to join a Medicare HMO reviewed by the Fund (if one operates in their area) in order to maintain Fund benefits.
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Group B

Benefits	Eligible Persons
Weekly Disability 66 2/3% of your gross regular straight time pay for 26 weeks per disability. Benefits begin on the 3 rd day after the onset of the disability; however, Weekly Disability will not begin until all available sick pay benefits through your employer (such as sick days) are exhausted.	Participant Only
Prescription Drug Benefits provided through NMHC Rx.. \$.50 per prescription co-payment, payable to the pharmacy.	Participant & Eligible Dependents, Retirees (dependents of Retirees not covered).

Group C

	Benefits	Eligible Persons
Optical	<p>Benefits insured by United Optical. Exam, frames, and lenses covered once every two years.</p> <p>Contacts may be chosen in lieu of regular eye exam and glasses. Services for contacts must be provided by a United <u>Optical Center</u> if there is one in your area (not an individual participating provider). See Optical section on page 75.</p>	<p>Participant & Eligible Dependents, Retirees (dependents of Retirees not covered)</p> <p>.</p>
Dental	<p>Benefits insured by Group Dental Service, Inc. Some services provided at no charge; others provided with a co-payment payable by you to the participating dentist. Periodontic and Orthodontic treatment covered with co-payments required by you. See Dental section on page 81.</p>	<p>Participant & Eligible Dependents, Retirees (dependents of Retirees not covered)</p> <p>.</p>

Making the Most of Your Medical Benefits

This booklet is more than a basic description of your coverage -- it also helps you find ways to make better use of your benefits. The Fund pays a large portion of the cost of most medical coverage for you and your eligible dependents. Many people take this for granted, not realizing that wasteful and inefficient use of their benefits costs them time and money in the long run.

Rising Medical Costs: Who Pays the Bill?

Health care costs have been rising rapidly. Why? The reasons are complicated, but the experts agree on one important point: each year, vast amounts of time, money, and needless risk could be saved through better use of medical services. Who pays the bill for rising costs and inefficiency? We all do, because insurers and providers pass these costs on to consumers--you and the Fund.

Consumer Awareness

By taking a few simple steps, you can shorten *hospital* stays, lessen the risk of unnecessary surgery, and reduce your expenses. For example:

- Avoid weekend *hospital* admissions
- Get second surgical opinions
- Take advantage of outpatient surgery options
- Have admissions pre-certified
- Use generic drugs

Health Care Cost Containment Corporation

The UFCW Unions & Participating Employers Health and Welfare Fund, along with many other funds, participates in the Health Care Cost Containment Corporation of the Mid-Atlantic Region, Inc. (HCCCC). The HCCCC is designed to benefit participating funds by reducing health care costs for participants and their families. Through bargaining, the HCCCC is able to achieve greater economies of scale and significant cost savings because of increased bargaining power in the health care marketplace.

ELIGIBILITY

Initial Eligibility

Both full time and part time employees are eligible to participate in this Plan if you are employed by a *participating employer* and covered by a collective bargaining agreement between that employer and United Food and Commercial Workers *Union* Local 27 or 400 which provides for contributions to the Fund for coverage under this Plan. The level of benefits is determined by the amount of the contribution.

There is a mandatory waiting period for participants (as specified in your collective bargaining agreement) which must be completed **before** your employer is required to make the first contribution to the Fund on your behalf. Full timers have different waiting periods from part timers. Once this waiting period has been completed, eligibility for benefits begins as follows:

Group A Benefits: You will become eligible for Group A benefits on the first day of the calendar month following the month in which your employer makes the first contribution to the Fund on your behalf.

Group B Benefits: You will become eligible for Group B benefits three months after you are eligible for Group A benefits.

Group C Benefits: Participants will become eligible for Group C benefits three months after you are eligible for Group B benefits.

Check your collective bargaining agreement for the specifics about the waiting period that applies to you.

If you are absent from work on the day your eligibility would otherwise begin, you will not be eligible for any benefits until the day you actually return to work covered by the Plan (provided your employer made the contribution on your behalf for that month). However, if you actually began work covered by the Fund, but you are not *actively at work* on the day your eligibility would otherwise begin due to *Sickness or Injury*, you will be treated as being *actively at work* for purposes of eligibility for all benefits under the Fund except Life benefits, Accidental Death & Dismemberment benefits, and Weekly Disability Benefits.

Because there are different waiting periods for each Group of benefits, you may be eligible for one Group of benefits, but not another, during an absence from work.

For example, if you satisfy the eligibility requirement for Group A benefits but are absent on the day Group B benefits *would have started*, you will not be

eligible for Group B benefits until you return to work--but you will continue to be eligible for Group A benefits up to the limits of the Plan (if you continue to meet the other eligibility requirements).

Transfers -- Part Time/Full Time

If you transfer from part time to full time or full time to part time, you will become eligible for the benefits of your new classification on the first day of the month following the date of the transfer, provided you have otherwise satisfied the initial eligibility requirements.

Retiree Eligibility

If you are an active participant in this Plan and retire, you will no longer be eligible for benefits from this Plan as an active participant. However, you can exercise your rights to continue benefits under the provisions of the Consolidated Omnibus Budget Reconciliation Act (*COBRA*) as described in this booklet. If you do not elect *COBRA* coverage at the time of your retirement, and instead elect retiree coverage, you will not be eligible to elect *COBRA* coverage when your retiree benefits terminate. However, your dependents will be given an opportunity to elect *COBRA* if their retiree dependent coverage under the Plan terminates as the result of a qualifying event.

If you are an active participant in this Plan, retire from the UFCW *Unions* and *Participating employer* Pension Fund or the FELRA & UFCW Pension Fund, and elect to waive your *COBRA* rights, you may continue to be eligible for benefits from this Plan as a retired participant. You are eligible for certain retiree benefits beginning with the effective date of your retirement. Former participants who retire on a deferred vested pension are not eligible for health and welfare benefits from this Plan. If, after you retire, you become employed for more than 40 hours per month by any employer who provides health and welfare benefits and pays at least 80% of the total cost, your retiree health benefits will be suspended until you are no longer employed.

Retirees are eligible only for the following benefits: medical, hospital, surgical, major medical, optical, dental, and prescription benefits described in this booklet. Retiree dependents are eligible only for medical, hospitalization, surgical and major medical benefits; they are NOT eligible optical, dental and prescription benefits.

Your continued eligibility for benefits as a retiree depends on the benefit level which the Trustees from time to time offer to retirees and the conditions which the Trustees may place on continuing eligibility. The benefit level in effect when you retire is not guaranteed. For you to continue receiving these benefits, the employer you worked for when you retired must continue to be a *participating employer* in the Plan. The Trustees may change the level of benefits or may implement a requirement that you pay a certain amount toward your benefits in

the form of a co-payment to the Plan. If such a co-payment is adopted, you will have to make your payments on time to continue coverage.

Medical benefits for eligible retired participants and their eligible dependents 65 and over are provided through Medicare. Also, benefits for eligible participants disabled 24 months or more or eligible for Medicare because of End Stage Renal Disease are provided through Medicare. Your Fund coverage is automatically converted to a Medicare Supplemental Program which covers some of the costs associated with Medicare Coverage. You must enroll for Medicare by contacting the Social Security Administration. Once Medicare processes your claim, it is usually sent directly to the Medicare Supplemental Program for processing. Medicare and the Fund's Medicare Supplemental Program together provide medical coverage similar to the coverage you had before age 65. Retirees and Eligible Dependents who become eligible for Medicare are also required to join a Medicare HMO reviewed by the Fund Office (if one operates in their area) in order to maintain Fund benefits.

All participants and eligible dependents that are eligible for Medicare should be aware of the provisions relating to "coordination of benefits" that apply when a participant or eligible dependent has coverage under two or more group plans. See page 41 for a detailed explanation of the rules regarding Medicare and coordination of benefits.

Enrollment Card

In order to actually begin receiving benefits under the Plan once you are eligible, you must complete a Fund enrollment card and file it with the *Fund office*. You can get an enrollment card from your *participating employer*, the *Fund office*, or your *union* representative. Failure to enroll promptly will cause a delay in the start of your benefits. If you have dependent coverage, you must list your dependents on your enrollment card in order for those dependents to be entitled to coverage under the Plan.

Only eligible dependents listed on the enrollment card are entitled to dependent coverage.

If the Fund receives a *Qualified Medical Child Support Order ("QMCSO")* and a participant fails to enroll a child covered under the *QMCSO*, the Fund will allow the custodial parent or state agency to complete the enrollment card. Provided they meet the requirements, the Fund will accept "notices" from state governments for a *QMCSO* in lieu of a court-ordered *QMCSO*. See page 24 for more information about *QMCSO*.

Continued Eligibility

Once you are initially eligible, you become and remain a participant as long as you are: a) employed by a *participating employer* who is making contributions to the Fund on your behalf and b) covered by a collective bargaining agreement with a participating *union*. The level of benefits is determined by the contribution. A participant is considered to be employed:

1. during periods of *active work*
2. during paid vacations
3. while on jury duty
4. while collecting Weekly Disability benefits from this Plan
5. while collecting Workers' Compensation benefits from a *participating employer*, not to exceed your entitlement to Weekly Disability benefits
6. during periods of leave covered under the Family and Medical Leave Act

Loss of Eligibility (Date Benefits Terminate) -- Participants

A participant will cease to be eligible for benefits upon:

1. termination of employment
2. transfer to a job classification not covered by a collective bargaining agreement
3. layoff
4. military service
5. leave of absence, unless your eligibility is extended due to a provision in your collective bargaining agreement
6. unpaid vacation for which no contributions are made to the Fund
7. exhaustion of all Weekly Disability benefits provided by this Plan
8. absence due to an accident or *sickness* compensable under Workers' Compensation to a level exceeding your Weekly Disability entitlement. If you are absent due to a Workers' Compensation injury or *sickness* which does not exceed your Weekly Disability entitlement, your eligibility may be continued pursuant to your collective bargaining agreement
9. end of the employer's obligation to make contributions pursuant to the collective bargaining agreement
10. retiree's loss of eligibility for a pension from the UFCW Unions & Participating Employers Pension Fund or FELRA & UFCW Pension Fund
11. death

If an active participant or his/her dependent loses eligibility as a result of a Qualifying Event, he/she will be entitled to exercise the COBRA rights. See page 29 for details.

If loss of eligibility occurs for reasons 4, 5, 6, 7 or 8, you may elect to continue eligibility by making self-payments directly to the Fund. See "Self Payments" on page 38.

Date Benefits Terminate

If you lose your eligibility, your benefits terminate as follows:

Accidental Death and Dismemberment benefits: Terminate on the same day your loss of eligibility occurs.

Hospital and Medical benefits: Terminate on the last day of the calendar month in which you lose eligibility or the first day of the month in which your employer fails to make a contribution on your behalf, whichever occurs first. However, if you are in the hospital when loss of eligibility occurs, these benefits will continue until you are discharged or until the benefits are exhausted, whichever occurs first.

Life Benefits: Terminate 31 days following the loss of eligibility. See page 67 for information about the Life Conversion privilege which allows you to convert Life benefits to an individual policy.

Weekly Disability, Dental, Optical, and Prescription Drug benefits: Terminate on the same day employment terminates or on the first day of the month in which your employer fails to make a contribution on your behalf, whichever occurs first.

Reinstatement (Following a Loss of Eligibility)

- If you lose eligibility due to termination of employment with a *participating employer*, but are re-employed by the same or another *participating employer* *within 30 days*, you will continue your eligibility for the benefits you **would have received** if your new employer had made a contribution on your behalf for that month.
- If you lose eligibility due to a layoff, military service, or an approved leave of absence you will be reinstated effective the first of the month in which you return to active employment, provided your employer makes a contribution on your behalf.
- If you lose eligibility for any reason *other than* layoff, military service, or approved leave of absence, and the period of separation is 31 days or longer, you must again meet the Plan's initial eligibility requirements.

Certificate of Prior Coverage

If you or your covered dependents lose eligibility for any reason including loss of COBRA coverage, you and your dependents will receive what is called a "Certificate of Prior Coverage" from the *Fund office*. The certificate verifies that you had group health coverage for a certain period of time (whatever that amount of time was for you).

The Health Insurance Portability and Accountability Act of 1996 eliminated the ability of a new employer to exclude certain conditions from coverage if the

participant was covered under another group plan for 12 months prior to coming to work with the new employer. Therefore, you should keep the Certificate of Prior Coverage with your other important papers so you may show it to a new employer. Federal law requires that the certificate be sent to all participants who lose active coverage. A copy of the Fund's procedures for requesting a HIPAA Certificate of Creditable Coverage can be obtained without charge from the Fund office. If you need a Certificate of Coverage, write to the Fund office at:

Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: Certificate of Coverage

Pre-Existing Condition Exclusions

The Fund does not impose a general pre-existing condition exclusion except as noted for dependent children under Legal Custody (see "Legal Custody" section on page 25). There are certain specific pre-existing exclusions for dental work required as the result of an injury which occurred before the patient was covered under the Fund and for prosthetics appliances if the condition requiring them began before coverage began under the Fund. Claims relating to these conditions may be excluded, but for no longer than 12 months. If you had prior health coverage, it is possible that no pre-existing condition exclusion will apply.

Pre-Existing Condition Exclusion Period

This provision applies **only** to those items identified as pre-existing conditions elsewhere in this booklet. Those conditions are excluded from coverage for a period of 12 months (18 months if you or your dependent did not enroll when first eligible). A pre-existing condition is a condition *other than pregnancy* for which medical treatment, advice, diagnosis or care was recommended or given within six months prior to your first day of employment (the first day of eligibility if you or your dependent enrolls late).

Reduction for Credited Coverage

The 12-month pre-existing condition exclusion period will be reduced by any period of "Creditable Coverage" you have. Creditable Coverage is generally other health coverage that you had before you enrolled in this plan, as long as you did not go 63 days or longer without coverage. Creditable Coverage means coverage for the cost of medical care whether provided directly, through insurance, reimbursement, or otherwise and as required by federal law. Periods of coverage preceding a break in coverage of 63 days or more do not count as a Creditable Coverage. Waiting periods do not count as Creditable Coverage, but neither do they count as a break in coverage. Creditable Coverage is determined without regard to the particular benefits offered under the prior coverage, except that prior coverage consisting solely of Excepted Benefits (as described in the next paragraph) is not Creditable Coverage.

Excepted Benefits means coverage solely for one or more of the following: accident, accidental death and dismemberment, disability, income, liability, automobile, medical payment, on-site medical clinics, Workers' Compensation, limited dental benefits, limited vision benefits, long-term care benefits, coverage for only a specified *sickness* or disease, supplemental benefits such as Medicare Supplemental insurance, and any other benefits as defined under Section 773(c) of ERISA.

No pre-existing condition exclusion will be imposed on a newborn child who is covered with any Creditable Coverage within 30 days of birth, as long as the child does not have a break in coverage of 63 days or more. No pre-existing condition exclusion will be imposed on a child under the age of 18 who is adopted or placed for adoption if the child was covered under any Creditable Coverage within 30 days of adoption or placement for adoption, as long as the child does not incur a break in coverage of 63 days or more. However, the pre-existing condition exclusion will apply to children who are covered under the Legal Custody provisions. If you and your dependents do not enroll for benefits when you are first eligible, the pre-existing condition exclusion period that applies to you and your dependents will be 18 months instead of 12 months. However, if you or your dependents enroll in a special enrollment (generally, within 30 days of losing other coverage or within 30 days of acquiring a new dependent), the 12 month period will apply. Only the specifically identified benefits will be subject to the exclusion.

Demonstration of Creditable Coverage

If the pre-existing condition exclusion applies, you or your dependent must provide the *Fund office* with evidence of your *Creditable Coverage* in order to reduce the 12 month (or 18 month) pre-existing exclusion period. To do this, you or your dependent must present a "Certificate of Prior (or Creditable) Coverage" to the *Fund office*. This certificate of coverage would have been issued to you by your prior plan or insurance company soon after you lost your prior coverage. If the prior plan or insurance company did not issue you a Certificate of Coverage, the *Fund office* will help you obtain one. Federal law gives you and your dependents the right to request a Certificate of Creditable Coverage from the prior plan or insurance company in most cases. If you do not have a certificate, and cannot obtain one when it is needed, you may establish Creditable Coverage with the *Fund office* by presenting it with other documentation to the *Fund office*. To do this, you must present documentation of Creditable Coverage during the period in question and tell us, in writing, the period of Creditable Coverage. For dependents, you must state the period of Creditable Coverage in writing and cooperate with the Fund's efforts to verify that coverage.

Determination of Pre-Existing Exclusion Period

If the Fund receives a claim for something which may fall under a pre-existing exclusion, the *Fund office* may contact you for additional information to see if the exclusion applies. You should respond promptly to avoid delaying the processing of your claim and send the *Fund office* any Certificates of Coverage or evidence of such coverage. The Fund will determine, within a reasonable time after receiving the certificates or evidence, whether a pre-existing condition exclusion applies, and if so, for how long. If the Fund determines that all or part of the 12 month pre-existing condition exclusion applies, it will notify you of this decision and the reason(s) for it. If you disagree with the Fund's decision, you may appeal to the Board of Trustees as described in the "Appeal Procedures" section on page 131. You may also submit additional evidence of Creditable Coverage. The Fund may modify its initial determination of Creditable Coverage if it later determines that you or your dependent did not have the Creditable Coverage claimed. **You will not receive a notice if the Fund determines that you have enough prior Creditable Coverage such that no pre-existing exclusion will apply.**

DEPENDENT ELIGIBILITY

Full Timers

In general, full time participants are eligible to add dependents to their coverage after completing a year or more of continuous service. However, some groups may have a different waiting period – check your collective bargaining agreement to determine the length of the waiting period applicable to you.

Part Timers

In general, part time participants who have completed one year of continuous service are eligible to add dependents to their coverage, provided that **the dependent does not have other group coverage in effect. If the dependent does have other group coverage in effect, he or she may NOT be covered under the Fund.**

A dependent of a part time participant who has other group coverage in effect may not be covered under the Fund.

Retirees

Dependents of Retirees are only eligible for hospital, medical, surgical and major medical benefits under this Plan.

Who Is an Eligible Dependent?

Eligible dependents include your spouse and children only. The children covered are your biological children, stepchildren who reside in your household, legally adopted children, or children placed with you for adoption.

In order for children to be eligible for dependent coverage, they must be:

- under the age of 19, unless he or she is a full-time student (see section on “Student Coverage” on page 27)
- not married
- not employed on a regular full time basis, and
- dependent on you for support.

Stepchildren must reside with you. The Plan requires you to submit evidence of the dependent(s)' eligibility status—a birth certificate for your biological child, adoption papers or other proof of adoption or placement for adoption acceptable to the *Trustees* for your adopted child, and a marriage license for your spouse. In the case of a stepchild, a copy of the divorce decree indicating custody is required as evidence.

Qualified Medical Child Support Order ("QMCSO")

The Fund will provide dependent coverage to a child if it is required to do so under the terms of a *QMCSO*. The Fund will provide coverage to a child under a *QMCSO* even if the participant does not have legal custody of the child, the child is not dependent upon the participant for support, and regardless of

enrollment season restrictions which otherwise may exist for dependent coverage. If the Fund receives a QMCSO and the participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained from the *Fund office*, free of charge.

A QMCSO may require that weekly disability benefits payable by the Fund be paid to satisfy child support obligations with respect to a child of a participant. If the Fund receives such an order/notice, the order/notice meets the requirements of a QMCSO, and benefits are currently payable or become payable in the future while the order/notice is in effect, the Fund will make payments either to the Child Support Agency or to the recipient listed in the order/notice.

Coverage for Children Adopted or Placed for Adoption with a Participant

The Fund will provide dependent coverage for a child who is placed for adoption with a participant regardless of whether the adoption is finalized. A child will be considered to be placed for adoption with a participant if the participant assumes a legal obligation for the total or partial support of a child in anticipation of the adoption of that child. The child's placement with the participant will be considered terminated when the participant no longer has a legal obligation to support the child. The participant will be required to supply evidence to the Fund that a child for whom dependent coverage is requested has actually been placed with the participant for adoption. Pre-existing medical conditions that would otherwise be excluded from coverage will not apply to a child who is adopted or placed for adoption with the participant.

Legal Custody

Participants having legal custody of children will be entitled to dependent coverage for such children subject to all of the following requirements:

- Children who are eligible dependents as a result of legal custody will not be entitled to benefits until the first of the month following six months after legal custody has been awarded by the court;
- Pre-existing medical conditions are subject to the preexisting condition exclusion (see page 21).
- The participant claiming legal custody must submit a notarized affidavit every six months while the custody arrangement remains in force;
- The participant must apply for coverage and the application must receive prior approval of the Board of Trustees.

Adding Existing Dependents to Your Coverage

If you did not choose to add your eligible dependents to your coverage when you were first eligible, you may add them at any time provided that you enroll them properly with the *Fund office* by completing an enrollment card and submitting

any required forms of proof (a copy of a birth certificate, for example, or a marriage license). **Coverage will be effective the first of the month following the date all the information was received by the *Fund office*.**

Adding New Dependents

To add a *newly eligible* dependent, contact the *Fund office* for an enrollment form. Your spouse and eligible stepchildren can be added for coverage on the first of the month following the date of marriage. Biological children can be added effective on the date of their birth, and legally adopted children and children placed for adoption may be added effective the date of adoption or placement for adoption.

In order for a new dependent's coverage--including a newborn's coverage--to begin on the earliest date of eligibility, you must inform the *Fund office* within 30 days from the date he or she first became your dependent.

The participant must submit evidence acceptable to the *Fund office* to certify the eligibility status of each dependent. **Only eligible dependents listed on the most recent enrollment card will be entitled to dependent benefit coverage.** However, if the Fund receives a QMCSO and the participant fails to enroll the child covered under the QMCSO, the Fund will allow the custodial parent or state agency to complete the enrollment card.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), you may be eligible under certain circumstances to add coverage for yourself and your dependents, even if you turned it down when you first became eligible

If you turned down coverage for either yourself or for your dependents because you were covered under another group plan and then that other coverage ends, you may be able to enroll yourself and your dependents under the Fund, provided you do so within 30 days from the date your other coverage ends.

However, there are only a limited number of circumstances in which you can enroll in the Fund if you lose your previous health coverage. If the other coverage was COBRA coverage, you may request enrollment under this Fund only if the COBRA coverage is exhausted. For other group coverage that is not COBRA, you may request enrollment under this Fund if the other coverage was lost as a result of loss of eligibility or because employer contributions toward the other coverage ceased. You are not eligible to enroll under this program if the other coverage was lost because you stopped paying premiums.

NOTE: Only those eligible dependents listed on your most recent enrollment card will receive dependent coverage.

Loss of Eligibility -- Dependents

Dependents are no longer eligible for coverage on the earliest of the following events:

- The date your dependent becomes covered by the Fund as an employee;
- On the earliest of (1) the date of the spouse's divorce from the participant; (2) the date of the spouse's legal separation from the participant, or (3) after three years of physical separation from the participant;
- The last day of the year in which a dependent child reaches age 19, becomes employed on a full time basis, ceases to be dependent on you for support, ceases to be a full time student or the date the child gets married.
- The date of termination of your own coverage;
- The date the dependent becomes covered under any other group plan as an employee;
- If the dependent has other group coverage available, the first of the month following the date the participant's status changes from full time to part time.

Student Coverage

Coverage for a dependent child ceases at the end of the month in which she/he turns 19 unless the child is a full time student in an accredited college or university and the following requirements are met. Full time students who have waived their right to COBRA, or are not eligible for COBRA may continue coverage until the end of the year in which they turn 23. If your child either 1) did not become a full time student, or 2) you failed to certify him/her as a student, or 3) you failed to re-certify him/her each school year, coverage will terminate at the end of the month in which he or she either turned age 19, ceased to be a full time student, or the end of the month in which the most recent student certification form expires, whichever is earlier..

Student coverage for dependents of active Participants includes Medical, Optical, Dental, and Prescription Drug benefits. Student coverage for dependents of Retirees includes medical benefits only.

Note: In order to receive student coverage, your dependent must have already been covered under the Fund prior to turning age 19.

To continue coverage as a student, your child must waive his/her COBRA rights and you and your child must complete a "Student Certification" form and send it to the *Fund office* **before the first of the month following your dependent's 19th birthday**. The certification must be re-submitted annually. If your

dependent child enrolls in school after losing eligibility, contact the *Fund office* for the proper procedure – you may still enroll your child, but there may be a waiting period for coverage to begin again.

Coverage will terminate on the last day of the calendar month in which your child marries, ceases to be financially dependent on you for support, ceases to be a full time student, or the end of the calendar year in which he/she turns age 23.

Student coverage is considered alternative coverage in lieu of COBRA continuation coverage. You do not have to pay for student coverage, but you do have to pay for COBRA continuation coverage. Because student coverage is offered as an alternative to COBRA coverage, when student coverage ends (for whatever reason), the student will not be eligible for COBRA coverage.

Coverage of Disabled Dependents

An unmarried child age 19 or over who is incapable of self-support due to a mental or physical disability, and who is dependent upon you for support, may continue to be covered for all dependent benefits offered by this Plan provided:

- a) the person was your dependent before age 19,
- b) the disability began before age 19,
- c) the disability is certified by a physician,
- d) the child elects to waive COBRA rights, and
- e) you continue to be eligible for dependent coverage under the Plan. The *Fund office* may require you to submit evidence of the dependent's continuing disability.

CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")

This Section applies to Active Participants and their Dependents, as well as to the Dependents of Retirees. It does not apply to Retirees.

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that the Plan offer eligible participants and their eligible dependents the opportunity to pay for a temporary extension of health coverage at group rates in instances where coverage under the Plan would otherwise end, in accordance with the provisions of federal law.

Participant's Rights

Eligible participants who lose eligibility or who experience an increase in premiums for either of the following reasons can continue coverage:

- 1) Termination of employment (except for gross misconduct)
- 2) Reduction in hours of employment

The Fund offers COBRA coverage to qualified beneficiaries even when the beneficiary has other coverage at the time the COBRA election is made. If a participant obtains coverage, including Medicare, after he or she has elected COBRA under the Fund, COBRA through the Fund may be terminated.

Spousal Rights

The dependent spouse of an eligible participant will have the right to continue coverage for himself or herself if he or she loses eligibility or experiences an increase in premiums for any of the following reasons:

- 1) the death of the participant
- 2) termination of the participant's employment, other than for gross misconduct, or reduction in the participant's hours of employment
- 3) divorce or legal separation from the participant, or
- 4) the participant becomes eligible for *Medicare*.

Dependent Children's Rights

The dependent child of a participant will have the right to continue coverage for himself or herself if he or she loses eligibility or experiences an increase in premiums for any of the following reasons:

- 1) the death of the participant
- 2) termination of the participant's employment, other than for gross misconduct, or reduction in the participant's hours of employment
- 3) divorce or legal separation of the participant
- 4) the participant becomes eligible for *Medicare*, or
- 5) the dependent child ceases to satisfy the Fund's eligibility rules for dependent coverage.

Coverage may be continued for any eligible dependent who is properly enrolled on the day before the event resulting in loss of eligibility (listed above). Even if the participant rejects COBRA continuation coverage, each eligible dependent has the **independent** right to elect or reject *COBRA* continuation coverage. An election on behalf of a minor dependent child can be made by the child's parent or legal guardian.

Newborn or Adopted Children

If you or your eligible dependent spouse gives birth to a child, adopt a child or if a child is placed for adoption with you, you may elect *COBRA* continuation coverage for that child provided you first complete a Fund enrollment card and file it with the *Fund office*. Coverage for the newborn or adopted child will continue until such time as coverage for dependent children who were properly enrolled in the Fund on the date before the event resulting in loss of eligibility would otherwise end.

Notification Requirements

The *participating employer* must notify the Fund, in writing, within 30 days of the participant's death, termination of the participant's employment, reduction in working hours, the participant's entitlement to *Medicare*, or the *participating employer's* initiation of bankruptcy proceedings. The participating employer's failure to provide timely notice may subject it to federal excise taxes.

The participant or eligible dependent must inform the Fund, in writing, within 60 days of a divorce or legal separation, or a dependent child's loss of dependent status under the Fund. The participant or eligible dependent who is determined to have been disabled at the time of or within the first 60 days of continuation coverage must notify the *Fund office* within 60 days of the date that the Social Security Administration determines that he or she is disabled and within 30 days of any final determination that he or she is no longer disabled.

If the participant or eligible dependent fails to notify the *Fund office* within 60 days of the date that coverage would otherwise cease, the right to elect *COBRA* continuation coverage will be forfeited.

If you become eligible for *COBRA* Continuation Coverage, the 18-month coverage period may be extended for your spouse or beneficiaries for an additional 18 months if a second qualifying event occurs within the 18-month period of *COBRA* Continuation Coverage. However, in no event will *COBRA* Continuation Coverage extend beyond 36 months. Such second qualifying events include the death of the participant, divorce or separation from the participant or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund. On the other hand, because the plan eligibility rules permit an employee and his or her dependents to remain covered after the employee becomes eligible for Medicare, eligibility for Medicare may not be a

second qualifying event. An event constitutes a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. Further, an extension can be granted only to those qualified beneficiary dependents who elected COBRA continuation coverage as a result of the first qualifying event and who are still enrolled in COBRA continuation coverage at the time of the second qualifying event. You must notify the Fund office in writing and in accordance with the notification procedures described below in order to extend the period of continuing coverage.

All notifications under *COBRA* must comply with these provisions. Both the participant and the affected dependent are jointly responsible for this notice. Notice should be mailed or hand delivered to the Fund Office, Attention: COBRA Department, UFCW Unions and Participating Employers Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451.

The written notice of a Qualifying Event must include the following information: name and address of affected participant and/or beneficiary, participant's Social Security number, date of occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example, a copy of the divorce decree, separation agreement, death certificate, or dependent's birth certificate). Once the Fund receives timely notification that a Qualifying Event has occurred, *COBRA* coverage will be offered to the participant and dependents, as applicable.

Participants and beneficiaries covered under *COBRA* Continuation Coverage must provide notice of a second Qualifying Event or Disability to the Fund within 60 days of the date of occurrence of the second Qualifying Event or the date of disability determination, and before the end of the 18-month *COBRA* Continuation Coverage period. The written notice must conform to the requirements for providing notices described above. The notice must include evidence of the second Qualifying Event or disability (for example a copy of the divorce decree, separation agreement, death certificate, Medicare eligibility/enrollment, dependent's birth certificate, or SSA disability determination).

Failure to provide the Fund notice of a disability or second qualifying event within 60 days will result in the loss of the right to extend coverage.

The *Fund office* will notify the participant or eligible dependent within 14 days of receipt of notification of any of these events of the right to continue coverage. The participant or eligible dependent must elect COBRA continuation coverage within 60 days of the date that coverage would otherwise end, or if later, within 60 days from the date that the *Fund office* first sent notice of the right to elect COBRA continuation coverage to the participant or eligible dependent. This

election must be made in writing and returned to the *Fund office* within the 60 day election period. Failure to notify the Fund on time will result in forfeiture of COBRA rights.

Financial Responsibility for Failure to Give Notice

If a participant or dependent does not give written notice within 60 days of the date of the Qualifying Event, or a participating employer within thirty days of the Qualifying Event, and as a result, the Plan pays a claim for a person whose coverage terminated due to a Qualifying Event, then that person or the participating employer, as applicable, must reimburse the Plan for any claims that should not have been paid. If the person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the person was his or her dependent.

Notification Regarding Change of Address

It is very important that participants and beneficiaries keep the Fund informed of their current addresses. If you or a covered family member experiences a change of address, immediately inform the Fund office.

Length of Coverage

Coverage may continue under COBRA as follows:

- 1.) Coverage for you and your dependent(s) may be continued for up to 18 months, if coverage terminates due to your termination of employment (for reasons other than gross misconduct), or your reduction in hours. The 18-month period of continuation coverage may be extended an additional 11 months for you and your eligible dependent(s) if, within 60 days from the date of the event described in (a) or (b) above, the Social Security Administration determines that you were disabled. The self-pay premium for the 11 month extension will be increased by about 50%. Proof of disability must be provided to the Fund within 60 days from the date the Social Security Administration makes the determination and within the initial 18-month period of continuation coverage. If, during the initial 18 month period, the Social Security Administration determines that the person is no longer disabled, the 11 month extension does not apply. If the Social Security Administration determines that the person is no longer disabled after the initial 18 month period, the period of continuation coverage ends with the first month that begins more than 30 days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed 29 months.

Other NON-DISABLED family members are also eligible for the 11 month extension. Newborn children, children placed for adoption, and newly adopted children will be treated as individual qualified beneficiaries.

- 2.) Coverage for your eligible dependent may be continued up to a maximum of 36 months, if coverage terminated due to:
 - a. the participant's death
 - b. the participant's divorce or legal separation; or
 - c. a dependent child's ceasing to satisfy the Fund's rules for dependent status.
- 3.) If a participant becomes entitled to *Medicare*, and within 18 months of becoming entitled to *Medicare*, he/she becomes entitled to *COBRA* due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the participant's dependent may be continued for up to 36 months from the date the participant became entitled to *Medicare*.

To get an extension of *COBRA* continuation coverage as described above, you must notify the *Fund office*.

Termination of Coverage

Continuation coverage will terminate on the first of the following dates:

1. The date a required premium is due and is not paid on time by you;
2. The date you or your eligible dependent becomes covered by another group health plan other than TRICARE (as an employee or otherwise) which does not contain any pre-existing exclusion or limitation affecting you or your eligible dependent;
3. You become covered by *Medicare* benefits;
4. In the event of divorce, you remarry and are enrolled for coverage under your spouse's plan;
5. The Fund no longer provides group health plan coverage for similarly situated participants or dependents;
6. If your *participating employer* ceases to maintain any group health plan for its employees through this Fund, your continuation coverage will end on the date your employer establishes a new plan, or joins an existing plan, that makes health coverage available to a class of employees formerly covered under this Plan.
7. The date your eligible dependent becomes covered by *Medicare*. This does not apply in situations where the "qualifying event" is the *participating employer's* bankruptcy proceeding under the United States Bankruptcy Code.
8. The date the applicable period of continuation coverage is exhausted; or
9. The first month that begins more than 30 days after the date of the Social Security Administration's determination that you or your eligible dependent is no longer disabled, in situations where coverage was being extended for 11 months, provided the period of continuation coverage does not exceed 29 months.

If your former *participating employer* alters the level of benefits provided through the Fund to similarly situated active employees, your coverage also will change.

You or your eligible dependent must notify the *Fund office* immediately if you become covered by any other plan of group health benefits. Notice should be sent to the Fund's COBRA Department at 911 Ridgebrook Road, Sparks, MD 21152-9451. You must repay the Fund for any claims paid in error as a result of your failure to notify the *Fund office* of any other health coverage.

Under COBRA, the participant or eligible dependent may continue coverage for **Medical, Drug, Optical, and Dental benefits** (you cannot continue the Life Benefit, the Accidental Death & Dismemberment Benefit, or the Weekly Disability Benefit). You must continue every one of those benefits for which you were eligible prior to your loss of coverage (in other words, you cannot choose to continue only optical and medical, for example, or any other combination). You may **only** elect to continue benefits which were already in place at the time of the event resulting in the loss of eligibility. The cost that you must pay to continue benefits is determined annually and will be contained in the notice of right to elect continuation of coverage sent to you by the *Fund office*.

The Trustees will determine the premium for the continuation coverage. The premium will not necessarily be the same as the amount of the monthly contribution that a participating employer makes on behalf of a covered employee. The premium will be fixed, in advance, for a 12-month period. The COBRA premium will be changed at the same time every year for all COBRA beneficiaries. Therefore, the premium may change for an individual beneficiary before he or she has received 12 months of COBRA coverage.

The cost that you must pay to continue benefits is 102% of the cost of coverage, as determined annually by the Fund. The cost will be specified in the notice of right to elect continuation of coverage sent to you by the Fund office. However, the COBRA premium for an 11-month disability extension period (if applicable) is increased to 150% of the cost of coverage. If your former employer alters the level of your benefits provided through the Fund to similarly situated active employees, your coverage and cost will also change.

Payment of Premiums

You must make the initial payment either at the time of your election of continuation coverage or within 45 days of the election. **Ongoing payments are due by the first day of the month for which coverage is to be continued** (for example, if you want coverage for October, payment is due on October 1st). If you fail to make your premium payment within 30 days of the due date, *COBRA* coverage is terminated.

You will not be billed; it is your responsibility to remit payments to the *Fund office*. Late payments can result in termination of coverage. You are responsible for the payment of any required premium.

Important! Timely retroactive payments must be made to the date of loss of eligibility.

Claims *incurred* following the date of the event which resulted in the loss of eligibility, but before the eligible participant or dependent has elected continuation coverage, will be held until the election has been made and premiums have been paid in full. If the participant or eligible dependent does not make a timely election and pay the premiums, no Fund coverage will be provided. Coverage under this Plan will remain in effect only while the monthly premiums are paid fully and on time.

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, 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. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 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/2002act_index.asp. This program is offered by the federal government and the Fund office has no role in its administration.

Other Rights

This notice describes your rights under COBRA. It is not intended to describe all of the rights available under ERISA, the Health Insurance Portability and Accountability Act (HIPAA), the Trade Act of 2002, and other laws.

Contact for Additional Information

If you have questions or wish to request additional information about COBRA coverage or the health plan, please contact the Fund office as follows:

COBRA Department
UFCW Unions and Participating Employers Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(800) 638-2972

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

This Section only applies to Active Participants. It does not apply to Retirees.

The Family and Medical Leave Act of 1993 ("*FMLA*") requires *participating employers* with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for his/her own *sickness* or to care for a seriously ill child, spouse, or parent.

In compliance with the provisions of the *FMLA*, your *participating employer* is required to maintain pre-existing coverage under the Plan during your period of leave under the *FMLA* just as if you were actively employed. Your coverage under the *FMLA* will cease once the *Fund office* is notified or otherwise determines that you have terminated employment, exhausted your 12 week *FMLA* leave entitlement, or do not intend to return from leave. Your coverage will also cease if your *participating employer* fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the *Fund office* is notified or otherwise determines that you are not returning to employment following a period of *FMLA* leave, you may elect to continue your coverage under the *COBRA* continuation rules, as described in the previous section. The qualifying event entitling you to *COBRA* continuation coverage is the last day of your *FMLA* leave.

If you fail to return to covered employment following your leave, the Fund may recover the value of benefits it paid to maintain your health coverage during the period of *FMLA* leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the *FMLA*. If you fail to return from *FMLA* for impermissible reasons, the Fund

may offset payment of outstanding medical claims *incurred* prior to the period of *FMLA* leave against the value of benefits paid on your behalf during the period of *FMLA* leave.

**CONTINUATION OF COVERAGE UNDER THE
UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT
RIGHTS ACT OF 1994 ("USERRA")**

This Section only applies to Active Participants. It does not apply to Retirees.

As required under the Uniformed Services Employment and Re-Employment Rights Act ("USERRA") the Fund provides you with the right to elect continuous health coverage for you and your eligible dependent(s) for up to 24 months, beginning on the date your absence from employment begins due to military service, including Reserve and National Guard Duty, as described below. Contact the *Fund office* for more information if this may apply to you.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible dependent(s) under the provisions of *USERRA*. The period of coverage for you and your eligible dependent ends on the earlier of:

1. the end of the 24-month period beginning on the date on which your absence begins; or
2. the day after the date on which you are required but fail to apply under *USERRA* for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

After 31 days, you must pay the cost of coverage unless your *participating employer* elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in accordance with the provisions of *USERRA* by the same method the Fund uses to determine the cost of COBRA continuation coverage (see page 29).

You must notify your *participating employer* or the *Fund office* that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must contact *the Fund office* and elect continuation coverage for yourself or your eligible dependent(s) under the provisions of *USERRA* within 60 days from the date your military service

begins. Payment of the *USERRA* premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of the election of your *USERRA* coverage.

Ongoing payments must be made by the last day of the month for which coverage is to be provided. You will not be billed; it is your responsibility to send payments to the *Fund office*. Late payments can result in termination of coverage. You are responsible for payment of the required premiums.

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under *USERRA*.

SELF-PAYMENTS

This Section only applies to Active Participants. It does not apply to Retirees.

If you are granted a leave of absence in writing by a *participating employer*, you may elect to continue coverage for yourself and for your eligible dependents who are properly enrolled in the Fund prior to your absence by making self-payments directly to the Fund. If you are eligible for benefits under *COBRA* or *USERRA*, or both, and you waive such coverage, you may also choose to continue coverage for yourself and for your eligible dependents by making self payments directly to the Fund. If you choose to self pay, coverage will be continued for all the benefits for which you were eligible on the day **prior** to your loss of eligibility.

If you elect to continue eligibility by making self payments, you must meet the following conditions:

1. You must elect to continue eligibility by making self payments within 30 days following your loss of eligibility. The self payment period must start with the month immediately following the month in which eligibility was lost. Failure to elect to make self payments on time will cause a loss of eligibility and benefits will terminate.
2. Self payments must be made monthly in an amount determined by the Board of Trustees. Amounts depend on your status (full or part time, individual or family coverage) as of your last day worked. Self payments must be received by the *Fund office* **on or before the first day of each month for which continued eligibility is desired**. Failure to make payments on time will terminate your eligibility for benefits as of the last

day of the most recent calendar month for which a self payment was accepted.

3. To begin this procedure, call the *Fund office* to find out the amount of the payment required. Mail your check or money order and a copy of your written leave of absence, if applicable, to the *Fund office*.
4. Timely self payments will be accepted until you return to active employment covered by the Plan or until your leave of absence expires, but in no case more than 12 months following your loss of eligibility. You will not be entitled to COBRA coverage when your self-pay coverage ends.
5. Self-payments will no longer be necessary when you return to work and your *participating employer* resumes contributions on your behalf. If you return to work in the middle of a month, your employer will not begin contributions until the following month; therefore, you still must self-pay for the month in which you return to work.

COORDINATION OF BENEFITS

General Information

Coordination of Benefits applies when a participant, dependent or retiree is entitled to benefits under any other kind of group health coverage in addition to the Fund. When duplicate coverage exists, the "primary" plan typically pays benefits according to its Schedule of Benefits and the "secondary" plan pays a reduced amount. **The Fund will never pay, either as primary or secondary plan, benefits which, when added to the benefits payable by the other plan for the same service, exceed 100% of the Usual, Customary and Reasonable (UCR) charge.** This provision applies whether or not a claim is filed under Medicare or any other group plan. The Fund is authorized to obtain information about benefits and services available from Medicare or other plans in order to implement this rule.

If one plan does not have a coordination of benefits rule, it will be primary. Otherwise, the plan which covers you as an employee provides your "primary" coverage; plans which cover you as a dependent provide "secondary" coverage. If a participant is covered as an employee under more than one plan, the plan with the earliest *effective date* of coverage is the primary plan.

Where both parents are covered by different plans, and the parents are not separated or divorced, and the claim is for a dependent child, the primary plan is the plan of the parent whose birthday falls earliest in the year. If both parents have the same birthday, the plan which has covered a parent longer pays first. However, if the other plan does not have a birthday rule and instead has a rule based on the gender of the parent and as a result of this, the two plans do not agree which is primary, the plan of the father will pay first.

If two or more plans cover a child whose parents are separated or divorced, benefits will be paid as follows:

If a court determines financial responsibility for a child's health care expenses, the plan of the parent with that responsibility will pay first ("primary"). If such determination has NOT been made or if the responsibility is divided equally, benefits are paid in the following order:

- a. The plan of the natural parent with legal custody pays first;
- b. the plan of the step-parent (if any) who is married to the custodial parent pays second;
- c. the plan of the natural parent who does **not** have legal custody pays third;
- d. the plan of the step-parent (if any) who is married to the **non-custodial** parent pays last.

The Fund has the right to collect any excess payment directly from the parties involved or by offsetting future benefit payment from the Fund on the participant's behalf if he or she failed to notify the *Fund office* about the availability of other employer health coverage. This right of offset does not keep the Fund from recovering erroneous payments in any other manner.

Coordination of benefits saves the Fund money by making sure other plans pay benefits when they are available.

Military Personnel

Participants who are retired from active military service are entitled to benefits from this Plan for themselves and their eligible dependents even though they may be provided benefits under the TRICARE Program. Participants married to active duty military personnel are entitled to benefits from this Plan for themselves and any eligible dependents not in active military service. Notwithstanding the foregoing, benefits will be provided to participants and eligible dependents as required under federal law.

Medicare - Coordination of Benefits

All **WORKING** participants and eligible dependents age 65 and over must be entitled to coverage under any group health plan under the same conditions as any participant or dependent under 65. A group plan may not be "secondary" to Medicare for working participants and their eligible dependents age 65 and over by covering only those medical expenses that Medicare does not cover (unless Medicare is awarded as a result of End Stage Renal Disease). Therefore, the Plan will serve as the primary (first) payer of medical costs for working participants and their eligible dependents age 65 or older, with Medicare providing secondary coverage--**unless you elect otherwise** (see next section).

After you have submitted your claim through the Fund, if there were expenses not covered by the Plan, Medicare may reimburse you if those expenses are covered by Medicare. To get reimbursement from Medicare you must enroll for Medicare. Also, to get coverage under Part B of Medicare, you must enroll and pay a monthly premium (which is deducted from your monthly social security check).

Electing Medicare As Your Primary Coverage.

If you are 65 or older, you are entitled to elect Medicare as your primary coverage in lieu of this Plan. However, a participant or eligible dependent age 65 or over will **automatically** continue to be covered by this Plan as the primary plan unless you (1) notify the *Fund office*, in writing, that you do not want the coverage to continue or (2) cease to be eligible for the coverage. If you elect your coverage under Medicare to be primary, the Plan cannot, under law, pay benefits secondary to Medicare. If the participant is under 65 and totally and permanently disabled (and therefore eligible for Medicare), Medicare will

provide primary coverage. If your covered dependent is Medicare-eligible and you are an actively working participant (not a retiree), the Fund will provide primary coverage for your dependent and Medicare will be secondary.

If you or your eligible dependent(s) are entitled to Medicare on the basis of age or disability and you become entitled to *Medicare* based on ESRD, and the Plan is currently paying benefits as primary, the Plan will remain primary for the first 30 months of your entitlement to *Medicare* due to ESRD to the extent required by law. If the Plan is currently paying benefits secondary to *Medicare*, the Plan will remain secondary upon your entitlement to *Medicare* due to ESRD.

Coordination of Benefits with an HMO (or any other Plan)

If you have primary coverage through your work under an HMO and secondary coverage under the Fund as a dependent, **you must follow the rules of the HMO in order to have remaining balances considered for payment as the secondary payer.** If you go outside your HMO network for services (or otherwise fail to follow the rules of the HMO), and you submit a bill to the Fund for secondary payment, it will be denied.

The same holds true for any other group plan. **If you fail to follow the rules of any primary plan, including an HMO, the Fund will not pay benefits as either primary or secondary.**

The Fund also has the right to collect an excess payment directly from the parties involved, from the other plan, or **by offset against any future benefit payment from the Fund** on the dependent's behalf, if he or she failed to inform the *Fund office* of the availability of the other employer's health coverage. This right of offset does not keep the Fund from recovering erroneous payments in any other manner. To ensure that the Fund pays your benefits properly, you must keep the Fund informed of any and all coverage for your and your eligible dependent.

SUBROGATION

Were you or your eligible dependent injured in a car accident or other accident for which someone else is liable? If so, that person (or his/her insurance) may be responsible for paying your (or your eligible dependent's) Medical and Weekly Disability expenses, and these expenses would not be covered under the *Fund*.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the *Fund* will pay you (or your eligible dependent) benefits based on the understanding that **you are required to reimburse the *Fund* in full** from **any** recovery you or your eligible dependent may receive, no matter how it is characterized. The *Fund* advances benefits to you and your dependents only as a service to you. You must reimburse the *Fund* if you obtain any recovery from another person or entity.

You and/or your dependent are required to notify the *Fund* within ten days of any accident or injury for which someone else may be liable. Further, the *Fund* must be notified within ten days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident in any lawsuit initiated to protect the *Fund's* claims.

If you or your dependent receive **any** benefit payments from the *Fund* for any *injury* or *sickness*, and you or your dependent recover any amount from any third party or parties in connection with such *injury* or *sickness*, you or your dependent must reimburse the *Fund* from that recovery the total amount of all benefit payments the *Fund* made or will make on your or your dependent's behalf in connection with such *injury* or *sickness*.

Also, if you or your dependent receive any benefit payments from the *Fund* for any *injury* or *sickness*, the *Fund* is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such *injury* or *sickness*, to the extent of any and all related benefit payments made or to be made by the *Fund* on your or your dependent's behalf. This means that the *Fund* has an independent right to bring an action in connection with such *injury* or *sickness* in your or your dependent's name and also has a right to intervene in any such action brought by you or your dependent, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

The *Fund's* rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the *injury* or *sickness*, and regardless of whether you and/or your dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The *Fund's* right of reimbursement and subrogation provide the *Fund* with first priority to any and all recovery in connection with the *injury* and *sickness*, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the *Fund's* right of reimbursement and subrogation. The *Fund's* rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery. The *Fund* shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the *Fund* on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the *Fund* under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the *Fund* until paid to the *Fund*. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the *Fund* in reimbursing it for *Fund* costs and expenses.

Consistent with the *Fund's* rights set forth in this section, if you or your dependent submit claims for or receive any benefit payments from the *Fund* for an injury or sickness that may give rise to any claim against any third party, you and/or your dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" affirming the *Fund's* rights of reimbursement and subrogation with respect to such benefit payments and claims. This Agreement must also be executed by your or your dependent's attorney, if applicable. Alternatively, if you or your dependent or a representative of you or your dependent (including your attorney) fail or refuse to execute the required "Subrogation, Assignment of Rights, and Reimbursement Agreement" and the *Fund* nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute your or your dependent's agreement to the *Fund's* right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the *Fund* arose, and your or your dependent's

agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* on any payment amount or recovery that you or your dependent recovers from a third party.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, you or your dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your dependent or your attorney may receive as a result of the accident or *injury*, no matter how these amounts are characterized or who pays these amounts, as provided in this Section.

Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the *Fund* in its exercise of its rights of reimbursement and subrogation, including notifying the *Fund* of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery. You or your dependent also must do nothing to impair or prejudice the *Fund's* rights. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the *Fund office* immediately. Where you or your eligible dependent chooses not to pursue the liability of a third party, the acceptance of benefits from the *Fund* authorizes the *Fund* to litigate or settle your claims against the third party. If the *Fund* takes legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the *Fund* in seeking its recovery, and in providing relevant information with respect to the accident.

You or your dependent must also notify the *Fund* before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the *Fund* has advanced you, you will still be required to repay the *Fund*, in full, for any benefits it has paid. The *Fund* may withhold benefits if you or your dependent waives any of the *Fund's* rights to recovery or fail to cooperate with the *Fund* in any respect regarding the *Fund's* subrogation rights.

If you or your dependent refuse to reimburse the *Fund* from any recovery or refuse to cooperate with the *Fund* regarding its subrogation or reimbursement rights, the *Fund* has the right to recover the full amount of

all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against your future benefit payments under the Plan. “Non-cooperation” includes the failure of any party to execute a Subrogation, Assignment of Rights, and Reimbursement Agreement and the failure of any party to respond to the *Fund’s* inquiries concerning the status of any claim or any other inquiry relating to the *Fund’s* rights of reimbursement and subrogation.

If the *Fund* is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the *Fund*, you or your dependent shall pay all costs and expenses, including attorneys’ fees and costs, incurred by the *Fund* in connection with the collection of any amounts owed the *Fund* or the enforcement of any of the *Fund’s* rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the *Trustees* from time to time from the date you become obligated to repay the *Fund* through the date that the *Fund* is paid the full amount owed.

This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the *Fund* money (which saves you money too) by making sure that the responsible party pays for your injuries.

ADVANCE BENEFITS FOR WORKERS' COMPENSATION CLAIMS

If you suffer an *injury* or *sickness* that is work-related, you must file a claim for Workers' Compensation benefits with your employer. If you apply for Workers' Compensation and your claim is denied by either your employer or your employer's insurance carrier, you may apply to this Plan for *weekly disability* or medical benefits. The Plan will pay benefits provided that:

1. You file a claim with the Fund on time.
2. You submit a copy of the written denial from your employer or your employer's Workers' Compensation carrier. The denial must state that the claim is not compensable under Workers' Compensation. If the claim is denied for any other reason, the Fund will not cover it.
3. You appeal the denial of your Workers' Compensation claim to the Workers' Compensation Commission for final adjudication within 30 days from the date the claim is denied.
4. You take all procedural action necessary to pursue your appeal with the Workers' Compensation Commission.
5. If you fail to file an appeal with the Commission within 30 days from the date the claim is denied, all benefits terminate and payments made by the Plan to you and/or your provider must be immediately returned by you.
6. You notify the *Fund office* of the date of your hearing (when scheduled), and you attend the hearing.
7. You obtain approval from the Fund prior to any settlement of your appeal. If you accept a settlement in connection with your Workers' Compensation claim, the Fund will consider this an indication that your claim is work-related and will require that you reimburse the Fund, in full, for any benefits it has paid on your behalf relating to your Workers' Compensation claim.
8. If the Workers' Compensation Commission denies your claim as being non-compensable, all benefits terminate and payments made by the Plan to you and/or your provider must be immediately returned by you.
9. If the Workers' Compensation Commission denies your claim for *any reason OTHER than being non-compensable under the Workers' Compensation laws of that state, you must repay the Fund for what it has paid*. If the Commission denies your claim as being non-compensable and you don't appeal that denial, you may keep any payments the Fund has advanced to you. However, if you decide to pursue your claim after that denial and you receive any recovery, whether by judgment, settlement, or compromise, you must repay the Fund the payments advanced to you.
10. You must sign the Fund's forms agreeing to comply with these procedures.

If the Fund is required to pursue legal action against you to obtain repayment of the benefits advanced by the Fund, you shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the

Fund's rights to reimbursement. In the event of legal action, you shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed.

CONSUMER TIPS

Use Generic Drugs

Both generic drugs (drugs that go by their chemical names) and brand name drugs must meet the same government standards for safety and effectiveness. But because brand name drugs are patented and sold by only one pharmaceutical company, they are more expensive--up to ten times as much as generic drugs.

Many drugs are available as generics. Ask for a generic whenever possible.

Avoid Weekend *Hospital* Admissions

Most *hospitals* don't schedule *surgery* on weekends (unless it's an emergency). If you're admitted on a Saturday, and your medical procedure won't take place until Monday, you're staying--and paying--longer than you need to. Check with your doctor or *hospital* about admission times for non-emergency procedures. The *Fund* will not pay for admissions not certified by InforMed.

Get a Second Opinion

Unnecessary *surgery* is one of the chief contributors to the rising cost of health care. The Mandatory Second Surgical Opinion Program and the voluntary second opinion benefit give you the peace of mind that comes from having a second--and sometimes a third--medical opinion on your elective *surgery*. Getting another opinion can also alert you to alternative forms of treatment so you can choose from several options.

Use Participating Doctors for the Lowest Charges

Using providers who participate with OneNet PPO can save you as much as 30 - 50% on your charges. Make sure to call OneNet at (800) 342-3289 or check online at www.onenetppo.com to when choosing a provider of medical service and verify with the provider that it participates with OneNet.

OneNet PPO, LLC
If You Have Chosen an HMO Option for Providing
Your Medical Benefits, the OneNet PPO Does Not Apply to You

OneNet PPO, LLC is a network of *hospitals, physicians*, and other health care providers which offer medical and *hospital* services at reduced rates. OneNet discounts claims when you use a participating provider, but **OneNet is not your insurance carrier**. Your coverage is provided through the *Fund*.

Find a participating provider by going at www.onenetppo.com or call OneNet Member Services at (800) 342-3289. OneNet Member Services will help you locate a participating provider and can verify that a provider you selected still participates with OneNet. Check that the provider still participates with OneNet PPO when you make your appointment since information changes frequently. At your appointment, show your *Fund* ID card and tell the *physician* or *facility* that you participate with OneNet. **Write “AL0006” on your itemized bill.** This number tells OneNet that who you are and where to send your claim after they have discounted it. Then either you or your provider should send your medical claim directly to OneNet PPO:

OneNet PPO, LLC
P.O. Box 936
Frederick, MD 21705-0936

OneNet will re-price the claim and forward it on to the Fund office.

If you did NOT use a OneNet PPO provider, send your claim to the Fund office for processing at the address shown on page 152.

Remember, nothing else changes. What is excluded under your coverage continues to be excluded even if a PPO provider performed that service. Should you choose to have a procedure that is not covered, you may still receive a discount on most services by using a OneNet provider. Check with the *physician* before having the procedure.

You still must:

- continue to get InforMed pre-certification and second opinions
- use Value Options for mental health and substance abuse problems
- use dentists within Group Dental Service
- use opticians within United Optical

A OneNet provider should **not** require payment for covered *services* at the time of service unless the service provided is an uncovered benefit or if your *deductible* has not been met. If the provider attempts to collect payment for covered *services* at the time of your visit, remind the provider that payment will be made by the *Fund* after OneNet re-prices the billing. The amount of the

reduced charge which the patient is responsible for paying will be shown on the *Explanation of Benefits (EOB)* which is sent to you after your claim has been processed.

INFORMED Utilization Manager Services

InforMed (pronounced “In-for-MED”) is a cost containment program designed to control *inpatient hospital* costs by reducing unnecessary admissions. InforMed helps you and your *physician* find alternative treatment settings that are safe and effective.

All eligible participants and all eligible dependents are required to have *hospital* admissions certified. You must contact InforMed before admission to a *hospital* for elective *surgery* and within 24 hours after an emergency admission. If you fail to do this, the *Fund* will not pay for any of your stay or for any of the services related to your stay.

InforMed certification is required to determine the *medical necessity* of procedures. InforMed does NOT certify that you are eligible for benefits, that the procedure or *hospital* stay is a covered service under this Plan, or the amount of coverage provided by this Plan. You must verify eligibility and coverage with the *Fund office*. InforMed provides advisory opinions using medically recognized standards. At no time will InforMed interfere with the delivery of high quality care to you. You should contact InforMed when you need to be admitted or require services for:

1. Elective (Non-Emergency) Admission (Certification Required Prior to Admission)
 - Call InforMed -- **(866) 290-8147**.
 - An approval letter will be sent to you prior to admission.
2. Emergency Admission (Requires Certification within 24 Hours of Admission)
 - Be sure you or a member of your family advises the *hospital* of your participation in the InforMed program and that InforMed is notified within 24 hours of admission.
 - Emergency room visits do not require certification.
3. Ambulatory or Out-Patient Surgery
 - For surgical procedures performed at the outpatient center of a *hospital* or at an ambulatory surgical center, follow the steps for Elective (Non-Emergency) Admissions above.

4. Rehabilitation Benefits

- All inpatient rehabilitative care admissions must be approved by InforMed. Follow the steps for elective (Non-Emergency) Admissions above.

Concurrent Care

InforMed will monitor your stay while in the *hospital* to assure an appropriate length of confinement. InforMed acts in its position as advisor to the *Fund* to recommend the appropriate number of days for your *hospital* stay. If your medical condition requires an extension of your *hospital* stay, InforMed will authorize it.

Review Procedures

1. Reconsideration (Peer-to-Peer)

If a length of stay for a hospitalization, procedure, or treatment is not certified, you (or your physician on your behalf) have the right to request a reconsideration. This service is offered to provide peer-to-peer telephone discussion between your *physician* and a InforMed Medical Director regarding the *medical necessity* of the treatment or services being rendered.

2. Expedited Appeals

Your *physician* may appeal InforMed's decisions on an expedited basis by calling InforMed's Utilization Review Department if your services meet the Department of Labor's definition of "urgent." How does the Department of Labor define "urgent?" The Department of Labor specifies that whether a claim is a "claim involving urgent care" is to be determined by an individual acting on behalf of the health benefits plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a *physician* with knowledge of the claimant's medical condition determines is a "claim involving urgent care" shall be treated as a claim involving urgent care. A board certified *physician* in the same specialty as the attending *physician* will review the appeal. The consultant *physician* will be made available to the attending *physician* by phone and by fax to make the appeal process as efficient as possible. Your *physician* will be notified of the decision (by telephone) within 24 hours. Written verification will be sent to the *physician*, facility, patient, and the *Fund* within one business day of the decision.

If you or your attending *physician* or facility disagrees with the outcome of an expedited appeal, he/she may initiate a standard appeal within 30 days from the date of InforMed's non-certification notification.

3. Standard Reviews

All requests for review to InforMed must be made within 180 days from the date you are notified of InforMed's decision. A written or verbal request for a standard review may be initiated by the patient or the attending *physician* or

facility on the patient's behalf and should be accompanied by any relevant medical information or records.

The request for review will be completed by a board certified *physician* consultant in the same or similar specialty as your attending *physician* who will render a decision. Notification of InforMed's decision will be sent to you, your *physician*, the facility and the *Fund* within 30 days following the receipt of your request and all the necessary documentation. The clinical rationale, clinical criteria, and copies of any other documents relevant to your request for review will be made available to you, your attending physician or the medical facility upon the patient's written request.

Appeal to the Board of Trustees

You have the right to appeal to the Board of *Trustees* if you are not satisfied after exhausting InforMed's internal review process. If you wish to do so, submit your appeal to the Board of *Trustees* within 180 days from the date you receive InforMed's decision to uphold its non-certification.

If you do not wish to go through InforMed's internal review procedure, you may appeal directly to the Board of *Trustees*. Write to the Board of *Trustees* stating the reason for your appeal within 180 days from the date of InforMed's original decision to deny your certification. See "Review of A Denied Claim/Appeal Process," page 131, for more information.

DURABLE MEDICAL EQUIPMENT NETWORK (“DME”)

Durable Medical Equipment (DME) is covered by the *Fund* through the DME program administered by InforMed. Use *the Durable Medical Equipment* provider determined by InforMed to receive the best possible cost savings for these benefits. The DME network provides for the rental and/or sale of equipment for:

- Respiratory Therapy
- Monitoring (fetal, uterine, other)
- Rehabilitation
- Total Parenteral Nutrition and intravenous supplies and pumps
- Standard in-home medical equipment
- Pediatric equipment/services

Because InforMed has contracted special fees with these suppliers, the *Fund* (**and YOU**) will save an estimated 20-30%. Most *Durable Medical Equipment* is covered under your Comprehensive Medical Benefits at 80%, so the lower the total cost, the less YOUR 20% out-of-pocket expense will be.

To use the DME network, you or your *physician's* representative should call InforMed at (800) 638-6265 as soon as you know you will need *durable medical equipment*. InforMed will oversee the appropriateness and quality of the equipment you need, coordinate delivery and set-up or installation, and perform any necessary follow-up. The supplier will forward the bill to InforMed. InforMed will examine, and, if necessary, re-price the claim and forward it to the *Fund office* for processing.

If you do not use the DME network, you may be responsible for an increased share of the cost. Equipment purchased outside the DME network will be covered **only** up to the *usual, customary, and reasonable (UCR)* charge as determined by InforMed.

MANDATORY SECOND SURGICAL OPINION PROGRAM

In addition to cost effectiveness, the Mandatory Second Surgical Opinion Program (MSSOP) offers you several important benefits. Beyond the possibility of avoiding unnecessary *surgery*, you gain the peace of mind that comes from a second or, if necessary a third, surgical consultation. A second opinion can also alert you to alternative forms of treatment.

The MSSOP covers in full the cost of a second or third opinion after your surgeon has recommended an elective surgical procedure. Related *diagnostic* services, like x-ray and pathology, are also covered up to the limits of your Plan. A second opinion is required of all participants for the following 11 procedures when performed on an elective, non-emergency basis:

1. Cholecystectomy (gallbladder removal)
2. Hysterectomy
3. Tonsillectomy/Adenoidectomy
4. Laminectomy, Discectomy, Spinal Fusion
5. *Diagnostic* Arthroscopy (endoscopic examination of joint interior)
6. Radical and Modified Radical Mastectomy
7. Ano-rectal *Surgery* - Hemorrhoidectomy
8. Coronary Artery By-Pass
9. Bunionectomy
10. Ligation and Stripping of Varicose Veins
11. Submucous Resection

If your surgeon performs any of these procedures, **and you don't get a second opinion prior to surgery**, the *Fund office* will only consider 75% of the allowable charge of your surgeon's bill for processing. In other words, instead of considering the entire bill and processing it under the rules of the Plan, the *Fund* will only consider 75% of the bill and then pay the appropriate percentage from there. Thus, you will be responsible for at least 25% of the total bill **if you don't obtain a second opinion**.

Remember, this program is in effect only for elective, non-emergency *surgery*. You don't need to have a second opinion under the following circumstances:

- When your *surgery* is an emergency or when you are admitted from the emergency room.
- When unplanned *surgery* becomes necessary during a *hospital* stay.

You and your dependent(s) should seek a voluntary second surgical opinion for any elective *surgery*, as well as for the required procedures. Benefits are provided for second opinions for all elective *surgery*.

How MSSOP Works

Follow the same procedure for both mandatory and voluntary second surgical consultations.

For example, you consult your *physician* about a stomach ailment. After an examination and *diagnostic* testing, he or she recommends gallbladder removal *surgery*. Because this is one of the 11 procedures, you must get a second opinion before the *surgery*. Call InforMed:

Toll Free.....(866) 290-8147

InforMed provides *physician* referrals and can answer any questions you have about the program. Tell the InforMed representative you would like to arrange a second opinion. Seek a *physician* in the appropriate specialty. If you need the name of a *physician*, InforMed will suggest *physicians* in the specialty who have offices in your area.

If the two consultations result in a difference of opinion, you may elect at that time whether or not to have the *surgery*. However, if you wish, the *Fund* will pay for a third opinion, arranged through InforMed.

Important

- You must request second surgical opinion benefits, mandatory and voluntary, WITHIN 90 DAYS of your initial consultation.
- *Surgery* must be performed within six months of the second opinion consultation to be eligible for full benefits.
- **If your primary insurance coverage is through Medicare or another health insurer, the program does not apply to you.**
- The *physician* submitting the second opinion cannot be affiliated with the *physician* who will perform the *surgery*.

HEMOCARE PROGRAM

HomeCare benefits are provided through the *Fund*, not insured.

Benefit claims are *administered* by InforMed.

HomeCare extends *hospital* services that would normally be provided on an *inpatient* basis into the home. HomeCare services provided **in lieu of** hospitalization are covered as a basic benefit at 100%, up to the *UCR*. Any amount paid by the *Fund* for HomeCare counts toward your overall lifetime maximum. You and your eligible dependents are eligible to receive benefits through HomeCare after early discharge from the *hospital* or in place of *in-hospital* care if such treatment is deemed cost effective by InforMed. Additionally, some other HomeCare services (not in lieu of *inpatient* hospitalization) may be covered under your Comprehensive Medical Benefits, **provided that they have been approved by InforMed.**

If you believe you need HomeCare, have your *physician* contact InforMed. InforMed will discuss your treatment with the *physician* and determine whether the services are *medically necessary*. InforMed's determination is also made based on whether the patient's condition is stabilized. Use of HomeCare benefits will not reduce the number of *in-hospital* days available to you.

HomeCare must be provided through a participating HomeCare provider. HomeCare services and supplies include:

Occupational and inhalation therapy, medical social services, nutritional guidance, home health aide visits, prescription drugs, medical-surgical supplies, x-ray and lab tests, *durable medical equipment*, *ambulance services* (when *medically necessary*). InforMed may authorize intermittent nursing care, physical therapy, speech therapy, and homemakers.

You and your eligible dependents are also eligible to receive benefits for *physician* HomeCare visits not to exceed an average of one visit per day during the period HomeCare benefits are provided. When you have *physician* HomeCare visits, payment by the Plan is made in an amount up to but not exceeding the *UCR* for the treatment provided.

Exclusions

The HomeCare program will not cover the following:

1. Domestic or housekeeping services unrelated to patient care; home food service (meals-on-wheels); nursing home or skilled nursing facility care; any visits, services, medical equipment or supplies not approved as part of the plan of treatment;
2. *Physician* services if rendered to you or your eligible dependent as a *hospital inpatient*; *physician* HomeCare visits for care normally considered as part of post-surgical care;

3. *Physician* HomeCare visits for care unrelated to the plan of treatment; and services for which the *physician* does not customarily bill the patient.
4. Care provided by a relative.

**For additional information about HomeCare, contact InforMed
at (866) 290-8147**

HOSPICE CARE SERVICES

Hospice Care benefits are provided through the *Fund*, not insured.

Benefit claims are administered by InforMed

The first 30 days of inpatient hospice care are covered at the same rate as other inpatient hospital services. These 30 days are counted as part of the overall inpatient hospital maximum. Inpatient hospice beyond 30 days will be covered under Major Medical benefits.

For terminally ill participants or eligible dependents whose prognosis of probable survival is six months or less and who are receiving palliative, not curative, care, covered services include intermittent nursing care by a registered or licensed practical nurse, physical therapy, speech therapy, occupational therapy, services of a licensed medical social worker, home health aide visits, prescription drugs, lab tests and x-ray services, medical-surgical supplies, oxygen, *durable medical equipment*, *physician* home visits, *ambulance* and wheelchair transportation to or from the *hospital* for palliative treatment or admission as an *inpatient*. Your family may receive counseling and submit a claim to the *Fund office*. The *Fund* pays up to \$500 for family counseling prior to the participant's death and up to \$100 for bereavement visits to the family (parents, spouse, brothers, sisters, children) within three months after the death of a participant or eligible dependent who received plan-approved *hospice* benefits.

Pre-certification is required and services must be approved by InforMed.

For additional information about Hospice Care, contact InforMed at:

(866) 290-8147

COST AWARENESS (“AMATEUR AUDIT”) REWARD PROGRAM

The *Fund* wants to catch not just billing mistakes, but bills for services that are unnecessary. If you help the *Fund* find a mistake, you may get half of what is recovered--up to \$1,000. In order to receive your money, you must submit documentation that your action *resulted in the correction of the bill*. This does not apply to processing errors by the *Fund*, to OneNet PPO discount changes, or to coordination of benefits in progress.

Medical, Surgical, and *Hospital* bills are open to this “amateur auditor” reward. Day-to-day *hospital*, medical, and surgical billings, for such things as the scheduling of tests, surgical assistants, administration of prescriptions, etc., can lead to costs which you--and the *Fund*--might consider avoidable. Take your complaint to the provider, and if the provider agrees, we can eliminate some unnecessary expenses.

Here’s what to do:

1. Try to keep track of medical services rendered to you (tests, medication, etc.). Always ask that a copy of an itemized bill be sent directly to you.
2. If there is an error on your bill, or if you believe you’ve been charged for anything you consider unnecessary, ask for an explanation from the provider. If the provider agrees, have the provider’s office correct your bill.
3. In order to receive the award, **you must contact the provider and initiate the correction. Be sure to note the names of everyone you speak with and the date you contacted him or her.** If you call the *Fund office* about an error, we will attempt to have it corrected, but it will not count for an amateur audit award.
4. Send the original bill and the corrected bill to the *Fund office* with an explanation of your “audit.” You must submit documentation that ***your audit*** resulted in correction of the billing error (for example, send a copy of the old bill containing the error along with the corrected bill with the name of the person you spoke with to initiate the correction). We’ll give you half of what we recover, up to \$1,000.

Note: If your hospital bill is paid twice because of Coordination of Benefits, it sometimes takes a long time to correct the mistake. The Fund does not pay the Amateur Auditor’s Award when the other carrier is in the process of correcting its mistake.

Remember, the key to qualifying for the award is that you are able to show the ***YOUR*** action resulted in the bill **being corrected**. If you call the *Fund office* (rather than the provider) to point out the error, we’ll be happy to help you have it corrected, but it **will not** qualify for the award.

COMPUFACTS

CompuFacts, the *Fund's* independent auditor, helps the *Fund* recover money by checking *hospital* bills to be sure they are correct. When CompuFacts discovers an error on a bill, they will contact the *hospital* to have the bill corrected, saving you and the *Fund* money. When the *Fund* saves money by not paying for incorrect charges, there is more money available for your benefits. Also, if your total bill is lower, any amount for which you are responsible is also lower.

The *Fund* sends *hospital* bills which are over \$12,000 (and occasionally smaller ones, if the *Fund* suspects an error) to CompuFacts. In order for CompuFacts to review your bill, it must obtain your records from the *hospital*. If necessary, CompuFacts will send you an authorization form to sign and return giving your permission to release your records to CompuFacts. You must sign and return the authorization to CompuFacts.

PARTICIPANT HOTLINE

The Trustees have established toll-free telephone lines directly to Participant Services so you may ask about your coverage before you go for services and can find out how your claims will be processed.

Call the *Fund office* before you receive care to be sure you get the necessary care at the best rates. You should have a clear understanding of what will be paid under the Fund.

Call the Fund office at:

(800) 638-2972

LIFE BENEFIT

Insured by ING/ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, MN 55440

This Section applies to Active Participants ONLY. It does not apply to Retirees

If you die while covered under the Plan, the amount of Life Benefit in the schedule of benefits is payable to the person you have named as your beneficiary.

The beneficiary for Life Insurance and for the Accidental Death portion of Accidental Death and Dismemberment Insurance is the most recent designation made by the participant as shown on file with the *Fund office*. You may change your beneficiary at any time by filling out and signing an enrollment form and giving it to the *Fund office*.

Beneficiary Designation

You may name any person you choose to be your beneficiary.

1. Contact the *Fund office* for an enrollment form.
2. Complete and sign the form.
3. Return the form to the *Fund office*.

Only enrollment forms which are properly completed, signed, and received by the *Fund office* **prior to a participant's death** will be honored.

A beneficiary may also be designated in an entered court order, provided that such order contains a clear designation of rights. The designation in a court order will only be effective when it reaches the *Fund office* and provided that the *Fund* has not made payment or taken other action before the designation was received. A beneficiary designation in a court order that meets these requirements will supersede any prior or subsequent conflicting beneficiary designation that is filed with the *Fund office*.

Waiver of Rights

A beneficiary may waive his/her rights to benefits in an entered court order, provided the court order contains a clear waiver of rights. The waiver will become effective only when it reaches the *Fund office* and provided that the *Fund* has not made payment or taken other action before the designation was received. A waiver in a court order that meets these requirements will supersede any prior conflicting beneficiary designation that is filed with the *Fund office*. If the beneficiary waives his/her rights, and you die without naming a new beneficiary, the *Fund* will pay the death benefit in the following order:

1. Your surviving spouse
2. Your surviving natural and adopted children
3. Your surviving parents
4. Your surviving brothers and sisters
5. Your estate.

If you die without naming a beneficiary, or your beneficiary pre-deceases you, your death benefit will be paid pursuant to the above order.

If you and your spouse or designated beneficiary die at the same time, or simultaneously as determined by relevant state law, as a result of *injuries* sustained or resulting from the same accident or event, your spouse or designated beneficiary will be deemed to have pre-deceased you for purposes of this life benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Insured by the ING/ReliaStar Financial Corporation

P.O. Box 20

Minneapolis, MN 55440

This Section applies to Active Participants ONLY. It does not apply to Retirees.

This benefit is payable if you suffer any of the losses below as a result of and within 90 days from the date of an accident occurring while covered under the Plan.

For Loss of	Benefit Amount (See Schedule of Benefits)
Life	Full Amount Paid to Your Beneficiary
Both Hands or Both Feet or Sight of Both Eyes	Full Amount Paid to You
Any combination of Foot, Hand, or Sight of One Eye	Full Amount Paid to You
One Hand, One Foot, or Sight of One Eye	Half the Amount Paid to You

Benefits during all periods of coverage under the policy will be paid for no more than one loss for which the full amount is payable, nor for more than two losses or which half the amount is payable. The benefit for accidental death is in addition to the life insurance.

If the Fund receives a *QMCSO* directing that accidental death and dismemberment benefits be paid to satisfy a participant's child support obligations and benefits are currently payable or become payable while the *QMCSO* is in effect, the Fund will make payments to either the state agency or alternate payee listed in the *QMCSO*.

Not Covered

ING/ReliaStar does not pay benefits for loss directly or indirectly caused by any of these:

- Suicide or intentionally self-inflicted *injury*, whether you are sane or insane.
- Physical or *mental sickness*

- Bacterial infection or poisoning. **Exception:** Infection from a cut or wound caused by an accident is covered.
- Riding in or descending from an aircraft as a pilot or crew member.
- War or act of war.
- *Injury* suffered while in the military service for any country.
- *Injury* which occurs during a crime you commit or try to commit.
- Use of any drug, narcotic or hallucinogenic agent which is illegal, which is not prescribed by a doctor, which is not taken as directed by a doctor or the manufacturer.

Beneficiary Designation

Your beneficiary for the Accidental Death portion of Accidental Death and Dismemberment Insurance is the person last designated by you as shown by the record on file with the *Fund office* unless a beneficiary has been designated or waived in a court order as explained below. In accordance with the terms of the group policy, you may change your beneficiary at any time by notifying the insurance company through the *Fund office*.

A beneficiary also may be designated in an entered court order, provided that such order contains a clear designation of rights. The designation in a court order will only be effective when it reaches the *Fund office* and provided that the Fund has not made payment or taken other action before the designation was received. A beneficiary designation in a court order that meets these requirements will supersede any prior or subsequent conflicting beneficiary designation that is filed with the *Fund office*.

A beneficiary may waive his/her rights to benefit in an entered court order, provide the court order contains a clear waiver of rights. The waiver will become effective only when it reaches the *Fund office* and provided that the Fund has not made payment or taken other action before the designation was received. A waiver in a court order that meets these requirements will supersede any prior conflicting beneficiary designation that is filed with the *Fund office*. If you die without naming a new beneficiary, the Fund will pay the death benefit in the following order:

1. Your surviving spouse
2. Your surviving children
3. Your surviving parents
4. Your surviving brothers and sisters
5. Your estate

If the beneficiary you designate dies before you or if you fail to designate a beneficiary, your Accidental Death benefits will be paid to the first survivor in the order listed above.

Group Policy Information

The group policy has been issued to the UFCW Unions and Participating Employers Health and Welfare Fund. Life and Accidental Death and Dismemberment benefits are guaranteed pursuant to this group policy. The group policy is on file and may be examined at the *Fund office*.

This is a description of the insurance issued under, and subject to, the terms, conditions, and provisions of the group policy. The group policy controls in all instances. This section merely summarizes and explains the pertinent provisions of the group policy and it does not constitute a contract of insurance.

LIFE CONVERSION PRIVILEGE
Upon Termination of Insurance

This Section applies to Active Participants ONLY. It does not apply to Retirees.

If your insurance is terminated because of loss of eligibility, you may convert your group life insurance without medical examination or other evidence of insurability to any life insurance policy then customarily issued by ING/ReliaStar, except term insurance, at this address:

ING/ReliaStar Financial Corporation
P.O. Box 20
Minneapolis, MN 55440-0020

You can get a conversion form from the *Fund office*. You may convert within 31 days after loss of eligibility and you will pay the premium applicable:

- to the form and amount of the policy at your age; and
- to the amount you select, up to the amount for which you were insured under the Plan.

If you have been insured under this Plan for five consecutive years or longer, and your insurance is terminated due to termination of the Plan, you have the same conversion privilege as described above, except that the amount of life insurance is reduced by the amount of any life insurance you are eligible for under a new group plan within 31 days of termination, or \$5,000, whichever is less. Your group life insurance is payable if you die within the 31 day period allowed for conversion whether or not you have applied for an individual policy.

Claims Procedure for Life and AD&D

Life and/or Accidental Death and Dismemberment Claims must be submitted in writing to the *Fund office* within 20 days after the date of loss upon which the claim is based, or as soon afterwards as reasonably possible.

The *Fund office* will then provide the proper claim forms. Life Insurance claims must be accompanied by a Board of Health Certificate of Death certified by the proper authorities. Accidental Death and Dismemberment Claims must include a physician's statement attesting to the loss. ING/ReliaStar may, at its expense, examine the participant during the pendency of a claim. It may also, where not forbidden by law, conduct an autopsy in case of death. For more about how to file a claim, see "Claims Filing and Review Procedure" on page 124.

ING/ReliaStar Life Insurance Company

ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, MN 55440

ReliaStar certifies that the Group Policy below has been issued to policyholder below. The Group Policy is on file and may be examined at the office of the policyholder.

Policy Number **GL-13228-4**
Policyholder: **UFCW Unions & Participating Employers**
 Health and Welfare Fund

This section of the SPD is a certificate of insurance issued under and subject to the terms, conditions, and provisions of the Group Policy. Such Policy controls in all instances. This certificate merely summarizes and explains the pertinent provisions of the Group Policy and does not constitute a contract of insurance.

This certificate replaces any and all insurance certificates that may have been issued previously to the Plan or its participants under the Group Policy and is subject to the terms of the Group Policy.

ReliaStar may, at its expense, examine the insurance as it may reasonably require during the pendency of a claim. It may also, where not forbidden by law, make an autopsy in case of death.

WEEKLY DISABILITY BENEFIT

Paid Directly from Fund Assets

This Section applies to Active Participants ONLY. It does not apply to Retirees.

Weekly Disability (sometimes called “Accident & Sickness” benefits or “sick pay”) are paid directly from the Fund’s assets to an eligible participant who is actively at work and becomes disabled as a result of a non-work-related sickness or accident to the extent that he or she can perform none of the usual and customary duties with a *participating employer*, subject to the following conditions:

**You must be seen by a
*physician IN-PERSON.***

1. A completed initial claim form (one which has been approved by the Board of Trustees), must be completed and received by the *Fund office* within 90 days from the date your disability begins. Continuation forms are sent to approximately every six weeks (or as needed) and must be returned within four weeks of the date sent by the *Fund office*. If the form is not returned within that time, you will not receive further Weekly Disability benefits for that disability.
2. The disability must be verified in writing on the claim form by a *physician* legally licensed to practice medicine, a Certified Alcohol Counselor, or a Master’s Level Social Worker who is approved by Value Options. If you have chosen one of the HMOs to provide your medical benefits, a Certified Alcohol Counselor or Master’s Level Social Worker who has been approved by your HMO may verify your disability in writing on the claim form. If you are enrolled in Kaiser Permanente HMO, your claim form may also be signed by a Certified Registered Nurse Practitioner (CRNP) or a Physician’s Assistant (PA).
3. Requests for further information must be returned within two weeks or your claim will be closed.
4. You must be seen **IN PERSON** by a physician either in his/her office, at your home, or at the hospital. Telephone consultations do not satisfy this requirement.
5. Your *participating employer* must complete its section of the form.
6. All questions on the claim form must be answered. Incomplete forms will be returned for completion. No copies or fax transmissions will be accepted. The *Fund office* must receive an original claim form.
7. No disability will be considered as beginning until after your last day worked.
8. No disability will be considered as beginning more than three days prior to the first visit to a physician during the disability period. Telephone consultations will not be accepted. The “three day prior” rule will be waived if your physician has been treating you on an ongoing basis for that

same disability and he/she provides documentation to the *Fund office* that you are disabled from working.

9. No supplemental benefit will be paid for the waiting period before benefits begin or to supplement the difference between what you receive from a Workers' Compensation award and what you would have been paid under the Weekly Disability benefit from this Plan.

For example, if you become ill with bronchitis on a Monday and do not report to work for the entire week, but do not see your physician until that Saturday, you will not be entitled to a disability claim for the entire week you missed work. Your disability will be considered beginning three days prior to your first visit to the doctor, plus the normal waiting period. Your claim will be considered as starting on the original disability date if you meet the conditions described in number eight, above.

10. Requests for additional information from the Fund must be returned within two weeks from the date mailed by the Fund.
11. The fact that a claim for benefits from a source other than the Fund has been filed or is pending does not excuse these report requirements (e.g., Workers' Compensation or auto insurance).
12. Benefits are not payable if the disability is due to an injury or sickness which, as determined by the Trustees, is:
 - a. compensable under Workers' Compensation legislation, occupational disease act legislation, employer's liability laws or other similar legislation, or your Personal Injury Protection (PIP) insurance for lost wages. See "Exclusions & Limitations" on page 109 for a more detailed explanation),
 - b. caused by war or acts of war,
 - c. self-inflicted,
 - d. the responsibility of some other person or entity,
 - e. sustained in the commission of a felony or willful misconduct, including the use of illegal substances (except when you are already in a treatment program approved by Value Options at the time of the *injury* or *sickness*, or, if your medical benefits are provided through an HMO, under the treatment of a certified psychologist or psychiatrist, or a Certified Alcohol Counselor or a Master's Level Social Worker who has been approved by your HMO and the Weekly Disability form is completed by a Value Options physician).
 - f. once you have retired or are receiving Social Security or permanent disability benefits from the Social Security Administration.
13. Benefits will not be payable for any period of time for which you have a compensable Workers' Compensation claim, even if the disability under your Workers' Compensation claim is different from the disability for which you seek weekly disability benefits.

14. Benefits will not be payable for days used as vacation days or other time paid by the *participating employer*.
15. Successive periods of disability due to the same or related causes will be considered as one period of disability unless they are separated by a 60 day period during which you are not absent from work because of disability. Successive periods of disability due to entirely unrelated causes are considered one disability unless they are separated by complete recovery and return to active work.
16. An initial claim form must be filed for any recurrence of a disability regardless of the length of time you returned to work. Continuation forms are not acceptable.
17. The Fund reserves the right and opportunity to examine the person whose *injury* or *sickness* is the basis of a claim as often as the Fund may reasonably require during pendency of the claim.
18. Lack of knowledge of coverage does not excuse these requirements.
19. No benefits will be paid to any participant who owes money to the Fund. Failure to repay amounts owed may result in suspension of Optical, Dental and Prescription benefits. Subsequent amounts payable under the Weekly Disability or Medical Benefits may be deducted from amounts owed.
20. If the Fund receives a *QMCSO* directing that Weekly Disability benefits be paid to satisfy a participant's child support obligations, and benefits are currently payable or become payable while it is in effect, the Fund will pay either the state agency or alternate payee listed in the *QMCSO*.
21. You may not be paid Weekly Disability payments for the same dates for which you are paid Social Security Disability Award (SSDA) payments or Pension payments from either the Fund (the UFCW Unions & Participating Employers Pension Fund, FELRA & UFCW Pension Fund, the Atlanta UFCW Pension Fund, or the UFCW Unions International Pension Fund).
22. You must be actively receiving treatment from a physician to improve the condition which is causing your disability.
23. There is no supplemental benefit paid during the three-day waiting period.

Benefit Amount

The weekly benefit amount up to a maximum of 26 weeks of disability will be 66 2/3% of your gross regular weekly straight time pay. Benefits begin on the third day of disability. The daily benefit amount will be 1/7 of the weekly benefit amount. Premium hours will not be counted in determining the benefit amount, but shift premiums will be counted.

Example of benefit amount computation:

1st 26 weeks: Hourly rate = \$7.00
\$ 7.00 X 40 = \$280.00 gross straight time pay
\$280.00 X 2/3 = \$186.66 weekly benefit amount

Nervous and Mental Claims

Disabilities arising from a nervous condition or *mental* sickness must be verified by a board eligible or board certified psychiatrist or licensed or certified Ph.D. psychologist. Contact Value Options at (800) 454-8329 for referral to an appropriate psychiatrist or psychologist. The Fund will reimburse you for any uncovered balance you may owe for your initial visit upon receipt of a bona fide paid-in-full receipt from the psychiatrist or psychologist.

If an initial claim for a disability arising from a nervous condition or mental sickness was certified by a medical doctor who is not a board eligible or board certified psychiatrist, only the first six days after the appropriate waiting period will be paid. If you are hospitalized as a result of the condition, the six day limit will be waived. Subsequent claims due to the same disability **must** be verified by a board eligible or board certified psychiatrist or licensed or certified Ph.D. psychologist.

Benefit Exhaustion

You will not lose eligibility for other benefits while you are receiving your Weekly Disability Benefits from the Fund. However, if you exhaust your Weekly Disability Benefits and contributions are not made thereafter by your employer, you will lose eligibility and benefits will terminate as described on page 19. If you secure a leave of absence from your employer, benefits may be continued under COBRA as described on page 29. If you waive your COBRA rights, you can continue benefits by making self-payments as described on page 38.

Claims Procedure

1. To receive a benefit from the Fund you must get a claim form from your employer or the *Fund office*.
2. Complete the participant section of the form and sign it.
3. Have your doctor complete the physician section of the form. **ONLY** the doctor can complete it. If the return to work date is unknown, the doctor should estimate a date.
4. Have your employer representative complete the employer section of the form. **ONLY** the employer representative can complete it.
5. Corrections to the form must be initialed by the person making the change or the form will be returned.

6. Mail the form to: *Fund Office*, P.O. Box 1064, Sparks, MD 21152-1064 within 90 days from the date of the disability.
7. If you remain disabled, you may be required to submit a continuation form periodically for the duration of your disability. If a continuation form is required, it will be sent to you by the *Fund office*.
8. If you fail to return your continuation form on time, all future benefits related to that disability will terminate.

How to Pick Up Your Check

Disability claims are paid weekly and not at any other time. Your checks will be mailed to you each Friday unless you decide to pick them up at the *Fund office*. If you want to pick up your check, notify the *Fund office* in advance, by 4:30 p.m. on Wednesday by calling (410) 683-6500 or (800) 638-2972. Only the participant may pick up the check. You must present photo identification.

Withholding Income Taxes

A form reporting the total benefits paid in a calendar year will be sent to you each year by the Fund or by your employer. A copy will also be sent to the Internal Revenue Service. You may request that taxes be withheld from your weekly benefit check provided:

1. You submit a signed IRS Form W-4S to the administrative manager.
2. The amount to be withheld is not less than \$4 per day or \$20 per week.
3. The amount you wish to have withheld will not reduce the weekly benefit amount to \$10 or less.
4. Withholding on partial weeks is pro-rated.

If the Fund provides you with Weekly Disability Benefits during any calendar year, the Fund or your employer will furnish you with a W-2 form by January 31 of the following year, indicating the amount of taxes withheld, if any. The Fund may be designated as the employers' agent for purposes of providing you with the W-2 form and sending Copy A of the form to the Social Security Administration. The Fund will not be liable for mistakes in carrying out these reporting requirements.

Social Security

Federal law requires that Social Security Tax (FICA) be withheld and forwarded to the federal government. Your employer also pays FICA on your Weekly Disability benefit payments. There are no forms necessary for FICA withholding.

Federal Unemployment Taxes

Federal law requires that unemployment taxes (FUTA) be forwarded to the federal government. Your employer pays FUTA on your Weekly Disability payments. There are no forms necessary for FUTA withholding.

Workers' Compensation – Denied Claims

If you apply for Workers' Compensation and your claim is denied by either your participating employer or your participating employer's insurance carrier, you may apply this Fund for medical and weekly disability benefits. See the "Advance Benefits for Workers' Compensation Claims" on page 47 for the conditions of payment.

Modified/Light Duty

The Fund does not pay Weekly Disability benefits if you are partially disabled and return to work on modified or light duty.

OPTICAL BENEFITS

Benefits are provided and guaranteed pursuant to an insurance contract with Spectera/United Optical:
2811 Lord Baltimore Drive
Baltimore, MD 21244

The Fund will provide you and your eligible dependents with optical benefits once every two years. There will be no charge to you or your dependent when the services are rendered by a Spectera/United Optical Center or an *optometrist* participating in the Spectera/United Optical network. You can receive a list of network providers free of charge upon request from the Fund Office. The following optical benefits are covered:

1. A complete eye examination by a licensed optometrist
2. One pair of eyeglasses, if prescribed, including:
 - a. A choice from a wide selection of frames
 - b. Lenses: (1) Single vision, (2) Bifocal (TK, FT25, FT28, and Executive), (3) Trifocal (7x25 or 7x28).
3. Prescription and order for proper lenses.
4. Adjustments, not including breakage, made whenever necessary.
5. **Contact lenses:** Contact lens benefits are provided **instead of the regular eye exam and benefits** as described below:
 - a. One pair of spherical daily or extended wear (**not** disposable) contacts from United Optical's covered selection
 - b. Eye exam and follow-up visits
 - c. One contact lens care kit

Local 27 participants **must** use a United Optical **center** (not an individual provider) to receive the contact lens benefit. Local 400 participants who are within 10 miles of a United Optical **center** must use a United Optical center for the contact lens benefit. If a Local 400 participant lives outside the 10 mile radius, he or she may use a participating United Optical provider and will receive an \$80.00 reimbursement for the amount he paid for the contact lenses (\$80.00 is the total amount of reimbursement, including the eye exam, lenses, and any other charges related to contact lenses).

To get the reimbursement, Local 400 members must send a reimbursement request along with the paid receipt to:

Spectera Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
Fax: (248) 733-6060.

If you select non-covered contact lenses, you will receive a maximum of an \$80 reimbursement (provided you used a United Optical **center** to

obtain the contact lenses). **Benefits for contact lenses are provided once every two years in lieu of glasses.**

Exclusions and Limitations

1. Cosmetic items such as gradient tints, photosensitive lenses, progressive blended bifocals, and cataract lenses are not covered by the Plan but are available at discounted prices.
2. If you select a frame **not** covered by the Plan, it will be available to you at \$10 off the retail price of the frame for Local 400 members, or for the retail cost less a 20% discount for Local 27 members.

Claims Procedure – Local 27 Members

Call Spectera at (410) 265-6084 for an appointment at a United Optical center location near you.

1. Visit the United Optical center for your service.
2. Return to pick up your glasses or contact lenses.

Claims Procedure – Local 400 Members

1. Call United Optical's IVR (Integrated Voice Response) system toll free at (800) 839-3242. The system will answer "Spectera," which is the corporate name. Follow the voice prompts. Enter your social security number and zip code: the system will identify up to three participating providers in your area for each call.
2. Call the participating optometrist or United Optical center and make an appointment. **Be sure to tell them you are a UFCW Unions & Participating Employers Fund participant and that your vision care is provided through Spectera/United Optical.** The provider can then confirm your eligibility and benefit level before your appointment. If you have questions regarding your eligibility for benefits, stay on the line and you will be connected to a Customer Service Representative. If you wish, you may call Customer Service directly at (800) 638-3120.
3. Visit the optometrist or United Optical Center for your appointment.

IMPORTANT

Any services you receive from an optometrist or an optician who does not participate with Spectera/United Optical will NOT be covered under this Plan.

PRESCRIPTION DRUG BENEFIT

Benefits are provided through the Fund, not insured.

Provided through NMHC Health Solutions

You and your eligible dependents are eligible for Prescription Drug benefits.

The Fund will pay for *medically necessary* prescription drugs which require compounding, legend drugs, insulin, oral contraceptives and injectables. The prescriptions must be written by a *physician*. You pay a \$.50 co-payment for each prescription filled at a pharmacy which accepts your NMHC prescription ID card.

1. The prescription is filled by a participating pharmacy.
2. You present your ID card with the prescription to the pharmacist.
3. The participating pharmacist fills the prescription to a maximum of 34 days supply, or up to 100 days for approved maintenance drugs.
4. The cost of ingredients exceeding \$1,000.00 is approved by NMHC.
5. The prescription **is not** for over-the-counter drugs, appliances, devices, or for legend drugs whose usage has not been pre-approved by the FDA.
6. Syringes and needles may be available if approved by the *Fund Office*.
7. The prescription is *medically necessary* to treat *medically necessary* conditions.
8. Oral contraceptives are for the participant or participant's spouse only, limited to a three-month supply per prescription. Oral contraceptives for dependent daughters will not be covered unless they are *medically necessary* for reasons **other than** contraception, as certified by InforMed.
9. Refills must be authorized by your *physician*.
10. Prescriptions for cosmetic purposes will not be covered.
11. Injectables may be covered with the regular co-payment applying if obtained from a retail pharmacy. Office visits associated with an injectable are covered under Major Medical at 80% after satisfying the annual deductible. See the section on Specialty Medications regarding certain injectable medications which must be obtained through the Ascend program.
12. If, as a Medicare eligible retiree, you enroll in a Medicare Part D prescription plan, prescription benefits through this plan will be terminated.

Rules Concerning Your Prescription Benefit

1. Drugs for which a person is compensated under a Workers' Compensation law are not covered by the Plan.
2. No purchase should be made without your NMHC ID card.
3. The ID card is NOT TRANSFERABLE and may not be used by anyone other than the person to whom it has been issued.
4. The card is invalid and void if you are no longer working for a *participating employer*, or otherwise lose eligibility under the Plan.

5. If you use your card after eligibility is terminated, you must reimburse the Fund for amounts paid.
6. The Fund reserves the right to suspend your benefit or to place you on the direct reimbursement program of claim payment when abuse of the benefit is suspected.

Claims Procedure

1. Upon becoming eligible for benefits, you will receive a white ID card which shows your name. Keep the card in your wallet or purse so you have it when you need it.
2. Take your prescription to a participating pharmacy.
3. Present your NMHC prescription card.
4. Pay the pharmacist the appropriate co-payment.

If You Forget Your Card

If you forget your ID card when you have your prescription filled, you must pay the full cost of the prescription to the pharmacy and request a reimbursement. Contact the *Fund office* for the proper forms to complete. You will be reimbursed for the amount which *would have been* reimbursed to the participating pharmacy. When your reimbursement is processed, the check will be made out to you. **Claims for reimbursement will only be considered for prescriptions filled within one year from the date the claim was submitted.**

Lost Card

If you lose your ID card you can get another, at a cost of \$1.00, by contacting the *Fund office*.

Address for NMHC

You should first contact the *Fund office* with any questions concerning your prescription benefit. However, if you need to contact NMHC, the address is:

NMHC Health Solutions
P.O. Box 1170
Port Washington, NY 11050

Specific Drug Restrictions

- Prescriptions for drugs such as **Retin-A** which may be prescribed for cosmetic reasons will be covered up through age 25. At age 26 or older, such prescriptions require a Prior Authorization. Contact NMHC Rx to request that a Prior Authorization form be sent to your doctor.
- Erectile dysfunction medications such as **Viagra, Cialis, and Levitra** will be covered to a maximum of 8 tablets per month. You must contact NMHC Rx at (888) 354-0090 in order to initiate the prior authorization process. NMHC Rx will fax your physician a form to indicate your diagnosis which will reflect your approval or denial of your prescription.

- **Depo Provera** is covered as follows: the medication is covered under NMHC. Your first office visit (including the charge for administration of the shot) is covered under Major Medical. Subsequent office visit charges are not covered, however, subsequent charges for administering the shot will be covered under Comprehensive Medical. Oral contraceptives will not be covered for a three-month period following administration of a Depo Provera injection.

Specialty Medications/Ascend Program

Prescriptions for specialty medications are provided through NMHC's Ascend program, and not through your local pharmacy. Specialty medications are generally self-injectable (excluding insulin) and oral medications for oncology or transplants.

Under the Ascend program, you will order your specialty drugs over the phone by calling (800) 850-9122. If you have a new prescription, you can contact NMHC Rx Ascend for further instructions. The medication will be mailed by priority overnight mail directly to your door. NMHC Rx also has a pharmaceutical consulting staff available to answer any questions you may have about your medication.

Quantity Limitations

There are dispensing limits and prior authorization requirements on the following medications. The Fund's prescription drug manager, NMHC Rx, developed these guidelines based on the FDA's and the manufacturers' recommended dosages. They were established to help ensure the safe and effective use of these medications. See the next page for a list of the drugs which have a quantity limit.

Quantity Limitations

Nausea and Vomiting Medication		Dispensing Limit/30 days	
Anzemet		5 tablets	
Kytril		10 tablets	
Zofran 4mg, 8mg and ODT		15 tablets	
Zofran 24mg		5 tablets	
Emend Pak		12 capsules	
Emend 80mg		8 capsules	
Emend 125mg		4 capsules	
Migraine Medication		Dispensing Limit/30 days	
Amerge		9 tablets	
Axert		12 tablets	
Frova		12 tablets	
Imitrex Tablets		9 tablets	
Imitrex Nasal Spray		12 sprays	
Imitrex Injectable		10 syringes	
Imitrex Injectable Kit		4 boxes/8 syringes	
Maxalt		12 tablets	
Zomig		6 tablets	
Relpax		6 tablets	
Anti-Inflammatory Medication		Dispensing Limit per Rx	
Toradol		20 tablets per 5 days	
Anti-Inflammatory Cox-2 Inhibitors		Dispensing Limit per Rx	
Celebrex 100mg		30 capsules/30 days	
Celebrex 200mg		30 capsules/30 days - Prior Authorization Required for Higher Doses	
Celebrex 400mg		Prior Authorization Required	
Sleeping Medication		Dispensing Limit/30 days	Annual Limits
Ambien and Sonata		15 tablets	120 tablets/year

For medications requiring a Prior Authorization, you, your physician, or your pharmacist will need to contact NMHC's customer service help to initiate the prior authorization process. NMHC will fax a form to your physician to complete and return. Based on the information provided, a determination will be made as to whether or not it has met the approval criteria. Once the determination has been made, both the pharmacy and your physician will be notified.

For prior authorizations, please call NMHC's Customer Service at (888) 354-0090. NMHC's address is 26 Harbor Park Drive, Port Washington, NY 11050.

DENTAL BENEFIT

Benefits are provided through Group Dental Service and are insured

The Plan provides benefits for dental services only when provided by a participating dentist except as described below. A list of participating providers can be provided, free of charge, upon request to the Fund Office. Any services rendered by a pedodontist (a dentist specializing in children's teeth), endodontist or a non-participating dentist will not be covered by this Plan. Children under age four are not eligible for dental benefits.

Claims Procedure

To make an appointment, call Group Dental Service at (301) 770-1480 or toll free at (800) 242-0450 between 8 a.m. and 6 p.m. Monday through Thursday and between 8 a.m. and 5 p.m. on Friday. Eligible participants or dependents will receive appointments in order of request for treatment.

When calling Group Dental Service, be ready to give the *participant's* name and Social Security Number. Note the name, address, and phone number of the provider/dentist. The appropriate co-payment should be paid to the dentist at the time of service -- there are no claim forms necessary.

Broken Appointments

Many participants and dependents need dental services, and broken appointments may keep another person from getting treatment due to scheduling limitations. Therefore, you will be charged \$10 per 1/2 hour of the scheduled appointment time unless the provider is notified of a cancellation 24 hours ahead of the scheduled appointment time. Until the broken appointment fee is paid, no further dental work will be done. You should plan to be at the dentist's office at least ten minutes before your appointment time. If a patient arrives ten minutes late for an appointment, it will be considered a broken appointment and the broken appointment charge will apply.

Important

Any services you receive from a general dentist, periodontist or orthodontist who does not participate with Group Dental Service will NOT be covered under the Fund.

IMPORTANT: Coverage under the Plan is provided only for the least costly, professionally adequate procedure to treat a condition. If you elect a more costly procedure, the Plan will only cover the less costly procedure and you will be responsible for the difference in cost.

- A. Basic Services: Provided at no charge to you
 - 1. Oral Exam
 - 2. Cleaning, including scaling and polishing (once every six months)

3. Dental x-rays as required
 4. Fluoride treatments to patients under the age of 13
 5. Local anesthesia
 6. Emergency treatment
 7. Dental fillings except gold
 8. Routine extractions by the general dentist
- B. Oral Surgery: Provided at no charge to you
1. All extractions
 2. Local or general anesthesia
 3. X-rays and alveolectomies associated with extraction of at least 3 teeth in a quadrant
- C. Prosthetics Services: Provided at no charge to you
1. Simple denture repairs
 2. Denture rebase
- D. Orthodontia Coverage: Up to once every five years for patients 11 years old or older
1. Diagnosis
 2. Models
 3. Photographs
 4. Cephalometric x-rays
 5. Tracings
 6. Active treatment up to 24 months including
 - a. Appliances and progress x-rays
 - b. Bracketing and Retention (follow up visits, replacement and repair not covered). Up to 10 visits in 18 months.
 7. Deductible \$ 425.00 per year
 8. Payment (upon completion of treatment) \$ 75.00
- E. Periodontia Services:
- | | Member Co-Pay |
|--|---------------------------|
| 1. Initial Exam | \$ 30.00 |
| 2. Radiographs, Full Mouth | 30.00 |
| 3. Radiographs, Single Film | 4.00 |
| 4. Diagnostic Casts, Per Set | 20.00 |
| 5. Hemisection | 110.00 |
| 6. Gingivectomy, Quadrant | 200.00 |
| 7. Gingivectomy, Tooth (1 to 3 teeth) | 55.00/tooth, Max \$100.00 |
| 8. Distal or proximal Wedge Procedure | 90.00 |
| 9. Gingival Flap Procedure with Root Planing, Quadrant | 200.00 |
| 10. Osseous Surgery, Quadrant | 325.00 |

11. Free Gingival Graft, Per Site	200.00
12. Scaling and Root Planing, Quadrant	70.00
13. Periodontal Maintenance, Per Visit	35.00

F. Additional Services

1. Full Denture*	\$ 30.00
2. Partial Denture*	30.00
3. Space Maintainer--Unilateral/Bilateral	10.00/20.00
4. Metal Crown	125.00
5. Porcelain Jacket	125.00
6. Porcelain Fused to Metal Crown	125.00

*Limit of one set of dentures in any five year period.

If gold is used in any of the previously mentioned procedures, there will be a surcharge. The patient will be advised of the surcharge **before** the procedure is performed. There is a replacement limit of one every five years for crowns, bridges, and dentures.

Exclusions and Limitations

The following exclusions and limitations apply to the Dental Benefit:

1. Prophylaxis, including scaling and polishing, is limited to once every six months.
2. Dentures are limited to one partial or complete denture set per arch within a five year period.
3. Orthodontia coverage, when provided, is limited to:
 - a. Diagnosis, including models, photographs, x-rays, and tracings.
 - b. Active fully banded treatment, including necessary appliances and progress x-rays.
 - c. Retention treatment following active treatment (not to exceed ten visits in any 18-month period).
 - d. Phase I (interceptive orthodontic treatment) is not covered.
 - e. Benefits will not be provided beyond a period of 24 consecutive months of active treatment, nor beyond a period of 18 consecutive months of retention treatment.
 - f. The Plan will not be liable for the replacement and/or repair of any appliance which was not initially furnished by GDS.
 - g. Benefits will be provided to a participant or eligible dependent not more than once within a five year period.
 - h. Patients must be age 11 years or older.
4. Covered services are limited to services provided by a participating dentist except under the following circumstances:
 - a. when authorized by Group Dental Service;
 - b. for covered retired personnel who permanently reside outside the GDS service area; or

- c. in the case of a dental emergency which occurs more than 50 miles from the participant's primary dentist if the participant or eligible dependent is temporarily away from home and outside the GDS service area.
5. Cosmetic services are excluded. Cosmetic services are those which are elective and which are not necessary for good dental health. Cosmetic services include, but are not limited to: alteration or extraction and replacement of sound teeth and any treatment of the teeth to remove or lessen discoloration (such as tooth bleaching or other procedures) except in connection with endodontic treatment.
6. Examination, evaluation, and treatment of temporomandibular joint ("TMJ") pain or dysfunction are excluded. Evaluation of TMJ is covered when it is incidental to another appointment. Medically necessary treatment of TMJ may be covered under Major Medical. Contact the *Fund office* for more information about TMJ coverage.
7. Replacement of dentures, bridgework, or any other dental appliances previously supplied by GDS due to loss or theft is not covered unless the participant or eligible dependent received the appliance more than five years prior to the date of the loss or theft.
8. Any ongoing service or treatment begun while the participant or eligible dependent was not covered by GDS will be handled on a case-by-case basis with the final determination, if there is a question, made by the Trustees. In general, GDS will cover the procedure but will require the individual to begin treatment with a participating GDS dentist. Therefore the individual will be charged the full co-payment (if applicable).
9. Hospitalization for any dental procedure is not covered.
10. Drugs, whether prescribed or over-the-counter, are not covered under your dental benefit (however, they may be covered under your prescription drug coverage through NMHC).
11. Dental implants are excluded.
12. Services rendered by a prosthodontic specialist and which are necessary for complete oral rehabilitation or reconstruction are not covered.
13. Appliances or treatment related to bite corrections are not covered.
14. Services for *injuries* or conditions which are covered under Workers' Compensation or employer's liability laws are not covered.
15. Services provided by any municipality, county or other political subdivision without cost to the participant or eligible dependent are not covered.

Grievance Procedures

Grievances or complaints may be directed verbally or in writing to the GDS administrative office at: 111 Rockville Pike, Suite 950, Rockville, MD 20850, telephone (800) 242-0450 within 180 days of the denied claim, grievance or complaint. A Member Service representative will personally handle your complaint and attempt to resolve it in an equitable and fair manner. You will be told, either verbally or in writing, about the disposition of your complaint within

twenty (20) days from the date it was received by GDS unless you agreed to extend this period.

Appeals Process

If you or your eligible dependent are dissatisfied with the result of the initial process or if the Member Services representative is unable to resolve your complaint, you may appeal to GDS. The Manager of Member Services will handle your complaint if it concerns administrative issues, fee disputes, communication of covered services, or a question of eligibility. If the complaint concerns quality of care, your appeal will be decided by the Director of Quality Assurance. In either case, the appeal must be made by a written request to the Member Services representative. The Manager of Member Services or the Director of Quality Assurance will attempt to reach a fair and equitable decision within 14 days following receipt of all the pertinent information. The decision shall be conveyed to you or your eligible dependent in writing. If you or your eligible dependent are dissatisfied with the result of the appeal to GDS, you may (but are not required to) appeal the decision by writing to the Board of *Trustees* of the Fund. **See the "Review of A Denied Claim" section for more information.**

MENTAL HEALTH & SUBSTANCE ABUSE BENEFIT

Benefits are provided through the Fund, not insured.
Closed Panel Services provided through Value Options

If You Have Chosen One of the HMO Options for Providing Your Medical Benefits, This Program Does Not Apply to You--Contact Your HMO to Determine Your Mental Health Coverage

ValueOptions provides you and your eligible dependent(s) with referrals to therapists and facilities for mental health and substance abuse services. ValueOptions reviews your treatment plan while you use your mental health and substance abuse benefit to make sure your care is medically necessary and appropriate. Services are completely confidential. No one has access to your clinical medical records without your written permission unless access is required by law.

Access to the ValueOptions panel of therapists is available by calling the ValueOptions 24-hour, 7-day-a-week referral service at (800) 454-8329. Referrals are available for both emergency/*hospital* care and for non-emergency/*outpatient* referrals. In an emergency, you or your therapist must call ValueOptions within 24 hours after admission to the *hospital*.

You are free to use any therapist or *hospital* you wish. **However, by using the panel, you will receive better coverage.** If you do not use a panel provider, you will be responsible for any uncovered charges. Participants and their dependent(s) who reside out of the area should call the Clinical Referral Line at (800) 454-8329 for referral to an eligible provider, and to get certification for treatment.

All treatment must be certified by ValueOptions. Whether you use a panel therapist or non-panel therapist, all mental health and substance abuse services must be certified by ValueOptions in order to be paid. Certification means that ValueOptions has determined the services proposed by the provider are both medically necessary and medically appropriate. If services are not reviewed and certified by ValueOptions, they may not be covered.

Benefits described in this summary are provided pursuant to the contract issued by ValueOptions of Maryland. In the case of any inconsistencies between this summary and the contract, the contract will govern. **Remember, all mental health claims must be filed with ValueOptions.**

When You Use a Panel Therapist

Call **ValueOptions** at (800) 454-8329 to locate a ValueOptions panel provider. In an emergency situation, go to your nearest emergency room. The in-network benefits will be available until stabilization and a transfer can be made to a

participating facility. For less urgent referrals, you will receive the names of one or two psychologists or independently licensed psychiatric social workers.

Inpatient mental health and substance abuse care is covered at 100% for up to 30 days of an inpatient *hospital* stay in a given 180-day calendar period. The lifetime maximum is \$250,000, which is part of the total lifetime maximum for Comprehensive Medical Benefits of \$250,000. **All care must be pre-certified, which means ValueOptions has reviewed and certified the *inpatient* care prior to admission.**

When You Use a Panel Therapist

Call **ValueOptions** at (800) 454-8329 to locate a ValueOptions panel provider. In an emergency situation, go to your nearest emergency room. The in-network benefits will be available until stabilization and a transfer can be made to a participating facility. For less urgent referrals, you will receive the names of one or two psychologists or independently licensed psychiatric social workers.

Inpatient mental health and substance abuse care is covered at 100% for up to 30 days of an inpatient *hospital* stay in a given 180-day calendar period. The lifetime maximum is \$250,000, which is part of the total lifetime maximum for Comprehensive Medical Benefits of \$250,000. **All care must be pre-certified, which means ValueOptions has reviewed and certified the *inpatient* care prior to admission.**

Outpatient care is covered at 50% **of the ValueOptions rate**. All care must be certified. The lifetime benefit maximum for outpatient care is \$250,000, which is part of the total lifetime Comprehensive Medical Benefit maximum of \$250,000.

If You Live Outside the Value Options Area

If you live outside the geographic area of the Value Options provider network, you can still receive the highest level of benefits by calling Value Options for a referral. If you choose not to call Value Options for a referral, or if you decide to see a non-panel provider for outpatient care, you must notify Value Options of that decision after your first appointment with the provider. Value Options will send a request for information (an "Outpatient Treatment Form") to the provider. The therapist must return the form to Value Options by your fifth visit in order for you to receive approval for ongoing treatment.

You are encouraged to use one of the Value Options panel of therapists and facilities for mental health care or substance abuse care. The psychiatrists, psychologists, licensed social workers, and facilities in the Value Options panel have been selected and credentialed to participate in the program. The program is designed to provide you with a high level of care, minimum out-of-pocket costs, and no claims paperwork when you obtain mental health and substance

abuse services through one of the Value Options providers. Panel providers are aware of Fund benefits and how to work with Value Options to certify both inpatient and outpatient care.

Benefits described in this summary are provided pursuant to the contract issued by Value Options of Maryland. In the case of any inconsistencies between this summary and the contract, the contract will govern. **Remember, all mental health claims must be filed with Value Options. Do NOT use OneNet PPO for mental health claims.**

Benefit Amount

When Using a Value Options Therapist (In-panel)*		
Inpatient Coverage	In-panel Provider	Amount
Mental Health	1 st 30 days room & board	100%
	Miscellaneous charges	80%
Substance Abuse	7 days detox room & board	100%
	Miscellaneous charges	80%
	30 days rehabilitation room & board	100%
	Miscellaneous charges	80%

Outpatient Coverage	In-Panel Provider	Amount
Mental Health	Unlimited visits	50%
Substance Abuse	45 visits or \$1000 maximum per calendar year	100% first 30 visits, 50% thereafter to \$1,000/year max

When NOT Using a Value Options Therapist (Out-of-Panel)*

Inpatient Coverage	Out-of-Panel Provider	Amount
Mental Health	1 st 30 days room & board Next 150 days	50% 40%
Substance Abuse	7 days detox room & board 30 days rehabilitation room & board	50% 100%

Outpatient Coverage	Out-of-Panel Provider	Amount
Mental Health	Unlimited visits	25%
Substance Abuse	45 visits or \$1000 maximum per calendar year	50% first 30 visits, 25% thereafter to \$1,000/year max

There is a 120 day or 120 visit lifetime maximum for substance abuse benefits (applies to inpatient and outpatient treatment, whether using a panel or a non-panel provider). Also, Mental Health and Substance Abuse Benefits paid count toward your Major Medical lifetime maximum, which is \$250,000 for Plan JS.

All Benefits are paid based on the Value Options Per Diem (per day) rate schedule. The Per Diem is the maximum charge per day that Value Options will allow for a particular service.

Missed Appointments

You may cancel a scheduled appointment without penalty by contacting the therapist at least 24 hours prior to your appointment. If you do not cancel it at

least 24 hours in advance, the provider may charge his/her full fee, for which you are fully responsible.

If You Have Other Insurance Coverage

If you are covered by more than one medical plan, the rules governing Coordination of Benefits also apply to your mental health benefits. Coordination of Benefits is explained fully starting on page 40. Your treatment must have been certified by Value Options in order to qualify for payment as a secondary carrier.

Value Options Claim Filing

If you use a Value Options in-panel provider, you do not have to complete any claim forms—your provider will complete the necessary forms and submit them to Value Options for payment. You are responsible for paying any amount which is not covered under the Benefit Schedule when you receive the service.

If you use a non-panel provider, the provider may require that you pay in full at the time of service and request reimbursement from Value Options for the covered amount. To request reimbursement, send a completed claim form to:

Value Options
Mid-Atlantic Claims Region
P.O. Box 1347
Latham, NY 12110

Exclusions

The types of treatment listed below are not covered under this benefit:

- Psychological testing, except when conducted in conjunction with a diagnosed mental health disorder when testing is not available through the local school system.
- Marriage counseling.
- Treatment for obesity and weight reduction.
- Treatment for convalescent or custodial care.
- Any medical or surgical services provided concurrently or in connection with the treatment of mental health or substance abuse condition. The ICD-9 classifications will generally be used to determine whether a condition is medical or psychiatric in nature. An ICD-9 classification means the comprehensive listing of diagnoses by category found in the International Classification of Diseases, 9th Ed.

I. Medical Necessity Review of Treatment by Value Options, Inc.

Value Options will make a preliminary determination as to whether proposed treatment is medically necessary prior to treatment being provided. If, prior to treatment, Value Options determines that services are not covered based on any grounds other than *medical necessity*, Value

Options will mail the participant a written notice of a claim denial in the form set forth in Section III. If a participant wishes to appeal such a denial to the Board of *Trustees*, then he/she should follow the procedures set forth in Section IV below.

Value Options only certifies whether a covered service is medically necessary for purposes of deciding what benefit amount, if any, is payable under the Plan. Any decision regarding the need to obtain mental health or substance abuse care, like any other medical decision, is the responsibility of you or your treating provider. If Value Options determines that treatment is not medically necessary, it will mail the Participant a written claim denial in the form set forth in Section III. You or your treating provider, acting on your behalf, may request a Level I review of that determination by a Value Options Peer Advisor who was not involved in the earlier decision. A request for a Level I review should be made within two weeks of receiving the initial determination of the *medical necessity* from Value Options. When contacting Value Options to initiate a review, you or your treating provider should identify the participant (and the patient if he or she is your dependent), state that the participant is a beneficiary under the UFCW Unions and Participating Employers Health and Welfare Fund, and request a Level I review of *medical necessity* determination. Value Options will notify you and your treating provider in writing of the outcome of the Level I review. While you are not obligated to follow Value Options' Level I or Level II review procedure prior to appealing the denial to the Board of Trustees, if you do choose to appeal to Value Options, you must do so **before** submitting your appeal to the Board of Trustees.

If you or your treating provider, acting on your behalf, are dissatisfied with the Level I review determination given by Value Options, you may request a review of the determination within two weeks from the date of the Level I review notification from Value Options. Call Value Options immediately after you receive a denial for details regarding further review procedures.

If you are dissatisfied with a Value Options preliminary determination or a Level I or Level II review determination that treatment is not medically necessary, you may appeal such denial to the Board of *Trustees*, following the procedures set forth in Section IV below.

II. Value Options Review Procedures for Claim Denials for Services Already Provided

Value Options will make a preliminary assessment as to whether services which have been provided are covered prior to issuing a denial of a claim for services provided. Examples of these claims include, but are not limited to, review of the Value Options preliminary assessment as to the proper amount to be paid for treatment already provided, the preliminary assessment by

Value Options that no payment should be made to you or your provider for services rendered in cases where Value Options believes that either certification of *medical necessity* for that treatment has run out or treatment was never certified as medically necessary, that treatment was provided for a service pursuant to a diagnosis that Value Options believes to be excluded under the Plan, or that treatment was provided for a service despite the belief by Value Options that your benefits were exhausted prior to receiving such service.

After you receive the notice from Value Options of its preliminary assessment regarding your claim for services provided, you may have it reviewed by Value Options, through one level of review. If you do not wish to use the Value Options review procedure, you may treat that notice of its preliminary assessment regarding your claim for services provided as a denial of the claim and appeal directly to the Board of *Trustees* under the procedures set out in Section IV below. However, if you want to have your claim reviewed by Value Options, you must do so **before** appealing to the Board of *Trustees*.

You may ask Value Options for a review of the preliminary assessment regarding your claim for services provided by either calling the Value Options Service Operations Department at 800-454-8329 or by writing to Value Options at: **Value Options**, Mid-Atlantic Service Operations Department, P.O. Box 1347, Latham, NY 12110, within 60 days of receiving written notice from Value Options of the preliminary assessment that all or part of your claim should be denied. When contacting Value Options, you should state that you are a participant in the UFCW Unions and Participating Employers Health and Welfare Fund and are seeking review of its preliminary assessment that all or part of your claim for services provided should be denied. In a case in which Value Options determines after its review that services are not covered, Value Options will mail you a written notice of a claim denial on an *EOB* in the form set forth in Section III. If the outcome of the review is unfavorable, you may appeal such denial to the Board of *Trustees*, follow the procedures set forth in Section IV, below.

If Value Options denies your claim, it will notify you in writing within 15 days of the day the claim was made, unless special circumstances beyond the control of Value Options require an extension of time for rendering a final decision on your claim. If such an extension of time is needed, Value Options will give you written notice of the extension prior to the termination of the initial 15-day period. Such notice will indicate the circumstances requiring an extension of time, and the date by which Value Options expects to render a final decision on the claim. In no event shall extension exceed a period of 15 days from the end of the initial 15-day period.

III. Value Options--Denial of Claims

A written notice of your claim denial will be mailed to you on an *explanation of benefits (EOB)* by Value Options.

This notice of claim denial will contain the following information so you know why the claim was denied:

1. the specific reason for denial,
2. reference to the pertinent plan provision(s) on which the denial is based,
3. a description of additional materials you would need to perfect your claim, and
4. the steps to take if you want to appeal the denial of your claim to the Board of *Trustees* and the amount of time you have to do this, and
5. a notice of your right to bring suit under ERISA if you decide to appeal and your appeal is denied.

IV. Appeal to the Board of Trustees of Value Options Denial of Claims

When your claim has been denied by Value Options, you can appeal the denial directly to the Board of *Trustees*. If you decide to appeal the Value Options denial, you or your representative must make a written request to the Board of *Trustees* to appeal the claim denial within 180 days after you receive a written claim denial from Value Options. See the "Review of a Denied Claim" starting on page 131 for specific instructions.

BASIC BENEFITS

HOSPITAL BENEFITS

Provided through the Fund – these benefits are not insured. Benefit claims are processed by Associated Administrators, LLC

Hospital Room

The Fund will pay up to the Daily Room Benefit maximum in the Schedule of Benefits for any period of hospital confinement in a semi-private room for as many days as shown in the Schedule of Benefits. With respect to participants, periods of hospitalization not separated by 60 working days are considered the same disability unless the confinements are due to entirely unrelated causes. With respect to eligible dependents, periods of hospitalization not separated by 90 days are treated as one admission.

If you accept a private room because a semi-private room is not available, but decline a semi-private room when it becomes available, you are responsible for the difference in cost beginning on the date you decline a semi-private room.

Extent and Duration

When you or your eligible dependent is admitted to a *hospital* as a registered *inpatient*, you are eligible for benefits for the following *Hospital Services* when the services are furnished and billed as *Hospital Services*, and when consistent with the diagnosis and treatment of the condition for which hospitalization is required:

1. Room and board in semi-private accommodations and special care units is covered at 100% up to the semi-private room rate; the *deductible* does not apply;
2. General nursing care;
3. Use of the operating, delivery, recovery, or treatment room;
4. Anesthesia*, radiation, and x-ray therapy when administered by an employee of the *hospital*;
5. Dressings, plaster casts, and splints provided by the *hospital*;
6. Laboratory examinations;
7. Basal metabolism tests;
8. X-ray examinations;
9. Electrocardiograms and electroencephalograms;
10. Physiotherapy and hydrotherapy;
11. Oxygen provided by the *hospital*;
12. Drugs and medicines in general use,
13. Administration of blood and blood plasma and intravenous injections and solutions; and
14. Special Care Units.

In order for the services of an assistant surgeon to be covered under the Plan, the assistant surgeon must be a physician.

Maternity/Obstetrical

Benefits for obstetrical services are available to all female participants and eligible dependent spouses. These benefits include prenatal and postnatal care. Care shall be provided to any properly enrolled eligible newborn child or children from birth or to any newborn child or children adopted or placed for adoption with a participant. In lieu of obstetrical services provided by a *physician*, you may elect to receive benefits for non-surgical obstetrical care or services provided by a nurse-midwife who is a licensed registered nurse certified by the American College of Nurse Midwives. Obstetrical services are covered from your first day of eligibility. **Dependent daughters of participants are not eligible for obstetrical benefits.**

Maternity Benefits

Amounts payable for maternity benefits are shown on the Surgical Schedule. Maternity benefits are payable only to an eligible female participant or a dependent spouse of an eligible participant. Maternity coverage for dependent daughters is not covered.

Newborns and Mothers Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any *hospital* stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section delivery. 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 or 96 hours, as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for prescribing a length of stay which is not in excess of 48 hours (or 96 hours, if applicable).

Hospital Outpatient Expenses

For *sickness* and accidental *injuries* which require emergency hospital outpatient attention within 72 hours following an accident or the onset of a *medical emergency*, or for hospital care, treatment, or services at the time of a surgical operation when there is no charge for room and board, the Plan will pay up to a maximum of \$200 under the basic hospital benefit. The balance will be processed under Major Medical. Benefits are available for care received during the initial visit only. No other types of outpatient treatment are covered under this benefit regardless of cause.

Examples of covered outpatient hospital care are:

1. Use of special hospital procedure rooms to examine internal organs.

2. X-ray and lab tests which are required in order to make a complete and accurate diagnosis before a patient enters the hospital.
3. Use of blood cleansing machines (hemodialysis) for kidney patients.
4. Stopping the bleeding of hemophiliacs.

Extension of Benefits

Hospital benefits under the Plan will be payable if you or your eligible dependent are an inpatient at a hospital at any time within 90 days after your coverage under the Plan has terminated, provided you or your eligible dependents have been totally and continuously disabled and under the regular care of a physician from the date your coverage terminates to the date your hospital confinement begins.

SURGICAL BENEFITS

Provided through the Fund – these benefits are not insured Benefit claims are processed by Associated Administrators, LLC

Surgical services performed by a physician will be covered by the Fund, as a basic benefit, up to the maximum shown in the Surgical Schedule. Basic Benefits are payable for the most expensive operation when two or more operations are performed through the same incision. The amount payable for all related operations performed during one period of disability may not exceed the maximum in the Schedule of Benefits. Return to active work will end a period of disability.

Any balance remaining after the Surgical Benefit has paid will be processed under your Major Medical benefit.

Notice of Coverage for Reconstructive Surgery following Mastectomy

This Plan provides coverage for (1) reconstruction on the breast on which a mastectomy was performed (2) surgery and reconstruction on the other breast to provide a symmetrical appearance, and (3) prostheses and (4) treatment of physical complications of all stages of mastectomy, including lymphedemas. The benefits are subject to the Plan's usual *deductible* and co-insurance provisions. Federal law requires that participants be notified of this coverage annually.

Extension of Benefits

Surgical benefits under the Plan will be payable if you or your eligible dependent are an inpatient at a hospital at any time within 90 days after your coverage under the Plan has terminated, provided you or your eligible dependent has been totally and continuously disabled and under the regular care of a physician from the date your coverage terminates to the date your operation is performed.

SURGICAL SCHEDULE

Description of Operation	Maximum Basic Benefit for Each Operation. Balance processed at 80% up to the UCR under the Major Medical benefit.
ABDOMEN.	
Appendectomy, freeing of adhesions or surgical exploration of the abdominal cavity.....	\$ 562.50
Removal of, or other operation on, gall bladder.....	843.75
Gastro-enterostomy.....	843.75
Resection of stomach, bowel, or rectum.....	1125.00
AMPUTATION.	
Thigh, leg.....	703.14
Upper arm, forearm, entire hand or foot.....	562.50
Fingers or toes, each.....	84.39
BREAST. Removal of benign tumor or cyst:	
Hospital confinement.....	281.25
Simple Amputation.....	562.50
Radical Amputation.....	843.75
CHEST.	
Thoracoplasty, transthoracic approach to stomach, diaphragm, esophagus, smpatectomy, laryngectomy.....	1125.00
Removal of lung or portion of lung.....	1125.00
Bronchoscopy, esophagoscopy.....	225.00
Induction of artificial pneumothorax, initial refills Each (not more than 12).....	56.25
DISLOCATION.	
Reduction of hip or ankle joint, elbow or knee joint (patella excepted).....	196.89
Shoulder.....	140.64
Collar bone.....	112.50
Lower jaw, wrist, or patella.....	84.39
For a dislocation requiring an open operation, the maximum will be twice the amount shown above.	

EXCISION OR FIXATION BY CUTTING.

Hip joint.....	843.75
Knee or elbow joint, shoulder, semilunar cartilage.... wrist or ankle joint.....	703.14
Removal of diseased portion of bone, including cutterage (alveolar processes excepted).....	281.25

EAR, NOSE, OR THROAT.

Fenestration, one or Both ears.....	\$ 1125.00
Mastiodectomy, one or both sides, simple radical... Radical.....	562.50 843.75
Tonsillectomy, adenoidectomy, or both.....	168.75
Sinus operation by cutting (puncture of antrum excepted)	281.25
Submucous resection of nasal septum.....	281.25
Tracheotomy.....	421.89
Any other cutting operation.....	84.39

EYE.

Operation for detached retina or corneal transplant transplant.....	1125.00
Cataract, removal of.....	843.75
Any cutting operation <u>into</u> the eyeball (through the cornea or sclera) or cutting operation of the eye muscles..	562.50
Removal of eyeball.....	421.89
Any other cutting operation <u>on</u> eyeball.....	112.50

FRACTURE.

Treatment of thigh, vertebra, or vertebrae, pelvis (coccyx excepted).....	421.89
Knee, kneecap, upper arm, ankle, or Pott's fracture.....	281.25
Lower jaw (alveolar process excepted), collar bone, shoulder blade, forearm, wrist (Colle's), skull.....	140.64
Hand, foot.....	56.25
Fingers or toes, each.....	56.25
Nose.....	56.25
Rib or ribs, three or more.....	140.64
Fewer than three.....	56.25

Amounts shown above are for simple fractures. For a compound fracture, the maximum is one and one half times the amount above. For a simple fracture requiring an open operation, the maximum is twice the amount above (bone grafting or bone splicing or metallic fixation at point-of-fracture is considered an open operation).

GENITO-URINARY TRACT.

Removal of, or cutting into, Kidney.....	1125.00
Fixation of kidney.....	843.75
Removal of tumors or stones on ureter or bladder by cutting operations.....	562.50
by endoscopic means.....	196.89
Cystoscopy.....	140.64
Removal of prostate by open operation.....	843.75
Removal of prostate by endoscopic means.....	562.50

Circumcision.....	84.39
Variocele, hydrocele, orchidectomy, or epididymectomy Single.....	271.89
Bilateral.....	429.89
Hysterectomy.....	843.75
Other cutting operations on uterus and its appendages with abdominal approach.....	562.50
Cervix amputation.....	281.25
Dilation and curettage (non-puerperal), cervix cauterization or conization, polypectomy, or any combination of these..	140.64
Vaginal plastic operation for cystocele <u>or</u> rectocele.....	421.89
both cystocele <u>and</u> rectocele.....	562.50

GOITRE.

Removal of thyroid, subtotal.....	843.75
Removal of adenoma or benign tumor.....	562.50

HERNIA.

Single hernia.....	562.50
More than one hernia.....	703.14

JOINT. Incision into, tapping excepted.....	140.64
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LIGAMENTS AND TENDONS.

Cutting or transplant, simple.....	281.25
Multiple.....	421.89
Suturing of tendon, single.....	196.89
multiple.....	281.25

PARACENTESIS. Tapping.....	84.39
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PILONIDAL CYST OR SINUS. Removal.....	281.25
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RECTUM.	
Hemorrhoidectomy, external.....	140.64
Internal, or internal and external.....	281.25
Cutting operation for fissure.....	140.64
Cutting operation for thrombosed hemorrhoids.....	84.39
Cutting operation for fistula in anus, single.....	281.25
Multiple.....	421.89
SKULL.	
Cutting into cranial cavity (trephine excepted)	1125.00
Trephine.....	140.64
SPINE OR SPINAL CORD.	
Operation for spinal tumor.....	1125.00
Operation for removal of portion of vertebra or vertabrae (except coccyx, transverse, or spinous process).....	843.75
Removal of part or all of coccyx or of transverse of spinous process).....	281.25
TUMORS.	
Cutting operations for removal of one or more benign or superficial tumors, cysts, or abscesses (requiring hospital confinement).....	56.25
Malignant tumors of face, lip or skin.....	281.25
VARICOSE VEINS.	
Injection treatment, complete procedure, one or both legs.....	225.00
Cutting operation, complete procedure, one leg.....	281.25
Both legs.....	421.89
OBSTETRICAL PROCEDURES	
Delivery of child or children.....	843.75
Caesarean section.....	1125.00
Abdominal operation for extra-uterine pregnancy.....	1125.00
Miscarriage.....	703.14

The Fund office determines payment for any cutting operation not listed. Payment of Basic benefits will be consistent with an operation of comparable difficulty and complexity, but in no event will it exceed the Maximum Surgical Benefit. Eligible balances remaining after the surgical benefit has paid will be paid under Major Medical.

IN-HOSPITAL MEDICAL BENEFITS

Provided through the Fund. These benefits are not insured and claims are processed by Associated Administrators, LLC

In-Hospital Medical Benefits are payable to participants and eligible dependents. Medical treatment must be administered by a physician. The hospital confinement must be one for which daily benefits are payable under the Plan. Confinement must result from:

- 1) a non-occupational accidental bodily injury, or
- 2) disease for which you are not entitled to a benefit under any Workers' Compensation law or act.

Benefits

Coverage is provided for fees charged by a physician other than a surgeon for treatment during the hospital confinement. The amount payable for all treatment received during any one continuous period of disability cannot exceed the amount in your Schedule of Benefits. The maximum payable as a basic benefit under In-Hospital Medical Benefits during any one continuous period of disability is \$1000. No more than one daily physician's visit will be covered. Only one physician will be reimbursed under the Basic In-Hospital Medical benefit unless concurrent care given by more than one physician is determined to be medically necessary.

Eligible balances remaining after the Basic In-Hospital Medical benefit has paid will be paid under the Major Medical benefit.

With respect to Participants, treatments received during successive periods of hospital confinement are considered as having been received during one continuous period of disability unless the successive confinements are separated by 60 days or unless the confinements are due to entirely unrelated causes. With respect to eligible dependents, treatments are considered as being received during one continuous period of disability if 90 days do not elapse between the date of discharge and the date of readmission.

Reimbursement is made for eligible consultation services when you are confined to the hospital as an inpatient, if such services are requested by the attending physician.

Exclusions under In-Hospital Medical

In-Hospital Medical Benefits are not payable for dental work or treatment, x-rays, drugs, dressings, medicine, nor for treatment received in a Marine or Veteran's hospital or elsewhere at federal government expense for a sickness or injury sustained while serving in any branch of the armed forces.

DIAGNOSTIC LABORATORY AND X-RAY BENEFIT

If you have a laboratory or x-ray examination in connection with a diagnosis of (1) a non-occupational accidental bodily injury or (2) a disease for which you are not entitled to a benefit under any Workers' Compensation Law or Act, a Basic Benefit is payable in the amount equal to the fee charged for the examination, up to the *UCR* amount. The benefit paid will not be in excess of the maximum payment in your Schedule of Benefits in connection with any accidental bodily injury. The same maximum applies in connection with all diseases in a calendar year. If you receive two or more examinations at one time or in connection with one accidental bodily injury or disease, the total amount payable will not exceed the maximum in your Schedule of Benefits for any one injury or disease.

Limitations on Lab and X-Ray Expense

No payment will be made for any examination:

1. not recommended, approved and performed by a physician;
2. while confined in a hospital, unless it is an outpatient expense (inpatient lab and x-ray services are covered under the Hospital Miscellaneous and Major Medical benefits);
3. in connection with dental work or treatment;
4. received in a Marine or Veteran's Hospital or any other hospital where exams are provided at government expense, or with respect to an exam for which a charge not requiring payment is made.

PHYSICAL EXAMINATION

You are entitled to a physical examination once every 24 months once you become eligible for Group A benefits. Dependents and retirees are not eligible for the exam. The exam is covered when performed by a licensed physician in an outpatient facility. It may include an initial history (for a new patient) or an interval history (for an established patient) and an examination related to a healthy individual. It may also include related diagnostic tests. The Plan will reimburse you up to the first \$50 charged and the remaining amount will be processed under Major Medical. How the claim is paid depends on whether you have already satisfied your Major Medical deductible and whether you have already used all or part of your Basic benefit for Diagnostic Lab and X-ray.

WELL BABY CARE

Well Baby CARE is covered for up to eight visits at 100%, up to the *Usual, Customary, and Reasonable* (“*UCR*”) amount. These visits are not subject to the annual \$100 deductible. Coverage is provided for the following services:

- Immunizations
- Growth and Development Assessments

- Physical Exams
- Interim history of sickness for newborns up to age six

Other regular visits are covered as described in the Major Medical section of this booklet.

MAJOR MEDICAL BENEFITS

Your Major Medical program gives you and your family additional protection for health care expenses that can result from a serious sickness or injury. It supplements your Basic Benefits to provide you and your eligible dependents, from the first day of sickness or injury, with extra protection against especially serious, lengthy and costly sickness or accidents.

How Major Medical Works

Your Basic Benefits cover many hospital and medical expenses. However, certain expenses may occur after your Basic Benefits are exhausted; others may not be covered by your Basic Benefits at all. Once you have exhausted your Basic program, you are responsible for the next \$100 of covered expenses in a calendar year. After you meet the annual \$100 deductible, Major Medical pays 80% of covered expenses up to a \$250,000 lifetime max. Each covered family member who is eligible for Major Medical has a lifetime maximum of \$250,000.

Covered Medical Expenses

Covered medical expenses include all reasonable and medically necessary charges for the treatment of a non-occupational sickness or injury for the following services performed or prescribed by a physician and not covered by Basic Benefits:

1. services of physicians, including specialists, except for care or treatment of mental health & substance abuse, in the outpatient department of a hospital or outside a hospital in excess of \$20 per visit or in excess of an aggregate maximum of \$1,000 during any one benefit period;
2. surgical services - payments are based on the Health Insurance Association of America schedule, using the 80th percentile;
3. room and board including special diets; except for room and board charges in excess of the hospital's average semi-private room rate. (If less than 25% of the hospital's accommodations are semi-private, a reasonable daily allowance toward the hospital's regular charges for bed, meals and general nursing services in the private room is provided);
4. use of operating or treatment rooms;
5. anesthetics and their administration;
6. x-ray and laboratory procedures; examinations or analysis made for diagnosis or treatment;
7. x-ray, radon, radium and radioactive isotope treatments or therapy;
8. oxygen and its administration;

9. blood transfusions; including cost of blood, blood plasma and plasma expanders;
10. services of a qualified physiotherapist;
11. chemotherapy and radiation therapy
12. services of an actively practicing nurse;
 - a) in a hospital, services of a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.);
 - b) outside a hospital, services of a registered professional nurse (R.N.) except in cases where an R.N. is not available and the physician provides certification that the services of a nurse are essential, the services of a licensed practical nurse (L.P.N.) will be considered covered medical expenses;
13. rental (or at the discretion of the Plan, purchase) of a wheelchair, hospital bed, or other durable equipment necessary for therapeutic use;
14. professional ambulance services used locally to or from the hospital when related to inpatient or outpatient care for accidental bodily injury;
15. prosthetic appliances such as casts, splints, crutches, braces or artificial limbs, except that such appliances are subject to the Plan's pre-existing condition exclusion;
16. services or supplies for mental disorders outside a hospital, in the outpatient department of a hospital, or in a hospital primarily engaged in the treatment of such disorders, provided that the treatment is coordinated through Value Options. Services of a social worker are covered under the Fund's Major Medical program only when under the direct supervision of a licensed psychiatrist or PhD psychologist;
17. Podiatry services for diabetics, such as the removal of corns, the removal of bunions, and nail clippings;
18. Sclerotherapy (treatment for varicose veins) as follows:
 - a. Treatment must be pre-approved by InforMed (see section on InforMed for details on how to call for approval).
 - b. Benefits are provided on a "per treatment session" basis with the number and frequency of sessions and the amount of benefit paid to be determined by InforMed.
 - c. You must send a letter of *medical necessity*, pre-operative photographs, and a patient history indicating the need for testing to InforMed demonstrating the *medical necessity* of treatment (treatment for cosmetic purposes is not covered).
 - d. Pre-operative testing will be approved only for those cases in which justification can be provided. Subsequent review will be required on any case which exceeds 5 treatments per area.
 - e. Consecutive treatments must be separated by 6-8 weeks to evaluate the effectiveness of the treatment.
 - f. Only the initial consultation will be covered as a separate office visit - charges for subsequent office visits during the course of treatment will not be covered.

- g. Surgical supplies over the *UCR* amount approved by InforMed will not be covered.
- h. Billing for laser treatment of varicose veins will be covered at the same level as *sclerotherapy*.

The Deductible

The cash deductible is the first \$100 of covered medical expenses incurred in a benefit period (calendar year) for a sickness or an injury. A separate deductible is required for each participant and each eligible dependent except in the case of a common accident, when only one deductible will be applied to all eligible dependents involved.

After the annual deductible has been met, benefits will be paid at 80% of covered expenses (up to the *UCR* amount) under the Major Medical benefit.

Benefit Period

The benefit period is the length of time Major Medical benefits are provided in or out of the hospital. Your first benefit period begins on the first day of eligibility for Major Medical benefits and ends December 31. Each subsequent benefit period will begin on January 1 and end on December 31.

Maximum Benefit

The lifetime maximum major medical benefit amount payable under the Plan is \$250,000 for each covered family member, excluding room and board charges. However, on each January 1st, each covered family member shall have an amount equal to the lesser of payments made during preceding benefit periods or \$1000 automatically restored to the aggregate maximum available to such family member, up to but not to exceed the maximum of \$250,000.

Claims Procedure

The following filing procedures apply to Major Medical Benefits:

1. Claims must be filed within 180 days from the date of service. If a claim is not filed within that time period, benefits will be denied
2. **A claim is as follows:** An invoice from a provider of medical service (HFCA 1500 Form or UB-92 Form), or an invoice marked paid with a copy of the receipt from a participant or covered dependent. The invoice must contain the participant's name and Social Security Number, the patient's name and date of birth, the date or dates of service, the procedure (CPT) code, the diagnosis (ICD-9) code, the number of units (if applicable), the charge in dollars, the provider's name and federal tax identification number (TIN), and the provider's billing name and address (some providers are in practices or use billing services).

3. If you or your eligible dependent is enrolled in another group health plan, and that plan provides your primary coverage, include the "*Explanation of Benefits*" from your primary coverage along with copies of the itemized bills.
4. Benefit payments will be sent directly to the provider unless they are "unassigned" and evidence of your payment is reflected. In that case, payment will be sent directly to you.
5. *Hospital* bills in excess of \$12,000 are audited and a portion of the charge is withheld pending completion of the audit.
6. An *Explanation of Benefits ("EOB")* will be sent when your claim is processed or with the benefit payment. Please keep the *EOB* and refer to it if you have questions about your claim and how it was processed.
7. Always keep copies of bills for your records--originals will not be returned.
8. **You must use a OneNet PPO participating provider.** Mail your claim for benefits/itemized bills to:

**OneNet PPO, LLC
P.O. Box 936
Frederick, MD 21705-0936**

Write your OneNet PPO control number on your bills: AL0006

9. **If you have other correspondence to send to the *Fund office* concerning medical claims, send to:**

**UFCW Unions & Participating Employers
Health & Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451**

REHABILITATION BENEFITS

Benefits are provided *through InforMed, not insured*

The Rehabilitation Benefit covers up to 30 inpatient visits or up to 60 outpatient visits, per injury or sickness up to a lifetime maximum of \$25,000, which is included in the overall lifetime maximum under Major Medical of \$250,000 for the following:

- Cardiovascular or cerebrovascular accidents
- Closed head *injuries*
- Neurological disorders
- Major joint procedures

All inpatient rehabilitative care must be approved by InforMed.

How Benefits Are Provided

Payments are made by the Fund upon receipt of paid bills and doctors' statements for covered expenses, as long as you are eligible. The Fund will accept an authorized assignment for in-hospital benefits. When forwarding bills or statements, include the participant's name, employer, and date of hire, and the patient's name, if your dependent. Keep copies of receipts or statements; they cannot be returned.

CARDIAC REHABILITATION BENEFIT

To be eligible as a patient for the Cardiac Rehabilitation Program (CRP), you or your eligible dependent must have angina pectoris, or must have previously had a myocardial infarction or undergone coronary surgery. Benefits are based on the number of visits you make. This is because the services and supplies available to each patient will vary with the choice of cardiac rehabilitation provider. The program provides benefits for up to a maximum of 90 visits under any one course of treatment; however, benefits can be renewed for recurring heart problems, such as a hospital stay for a heart attack or heart surgery or as a result of a diagnosis of angina pectoris (chest pain).

The program must include planned exercise under guidelines set by the American Heart Association. Approved programs must also include educational sessions on topics such as diet and personal health behavior, as well as individual, family, and group counseling to aid mental and social adjustment to heart disease. The Cardiac Rehabilitation Program must be conducted under direction of a *physician* in a hospital outpatient setting.

Only those services or supplies provided at the direction of or through the coordination of CRP providers are covered. Your CRP benefits will be

renewed for another 90 visits as a result of another *hospital* admission for a diagnosed myocardial infarction or coronary surgery or, in the case of diagnosed angina pectoris, by satisfying a given set of criteria. Unused visits from one course of CRP treatment may NOT be carried over to a subsequent CRP course of treatment.

Send your treatment plan to the *Fund office* to see if it meets the above requirements.

EXCLUSIONS AND LIMITATIONS

The following are excluded under all benefit categories:

1. Work-related *injuries* or sicknesses which are generally compensable under Workers' Compensation legislation, occupational disease act legislation, employer's liability law or other similar legislation. If *except for* your failure to follow the appropriate procedural requirements for filing a claim or to otherwise similarly act, your claim *would have been covered by Workers' Compensation*, it will be treated as if it were covered by Workers' Compensation and will be excluded for coverage under the Plan.
2. Care which is furnished to you or your eligible dependent under the laws of the United States or any political subdivision.
3. Care provided to you or your eligible dependent(s) to the extent that the cost may be recoverable by, or on behalf of, you or your eligible dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your dependent, or you or your dependent's attorney may receive as a result of the accident or injury no matter how these amounts are characterized or who pays these amounts as provided in the "Subrogation" section on page 43 and in the "Advance Benefits for Workers' Compensation Claims" section on page 47.
4. Disease or *injuries* resulting from any war, declared or undeclared.
5. Dental Care and treatment to the natural teeth and gums except as provided in the Dental Benefit section starting on page 81.
6. Dental surgery or appliances to replace the natural teeth and gums unless charges are necessary because of accidental injury, except as provided in the Dental Benefit section starting on page 81. When covered, these charges are subject to pre-existing condition exclusion.
7. Appliances or treatment related to bite corrections.
8. Eyeglasses (except when necessary as a result of eye surgery) and the exam for prescription or fitting other than as described in the Optical Benefits section on page 75.
9. Any services for cosmetic purposes.
10. Hearing aids and the examination for them.
11. Services or supplies not medically necessary for the treatment of sickness or injury.
12. Travel, whether or not recommended by a physician.
13. Custodial, milieu, or sanitarium care, or rest cures.
14. Convalescent Services for the treatment of infertility or contraception except as specifically provided in the Prescription Drug section on page 77.
15. Surgical implant of Norplant is not covered.
16. Services or supplies related to sterilization reversal.
17. Trans-sexual operations or any care or services associated with this type of operation.
18. Services, supplies, or care of any kind related to the pregnancy of a dependent daughter of a participant.

19. Services or supplies covered under any federal or state program of health care for the aged, including but not limited to Medicare, except to the extent coverage is required by federal law.
20. Services, supplies, or care of any kind other than those previously defined as covered medical expenses.
21. Services, supplies, or medications rendered in a nursing home or extended care facility.
22. Services, supplies, or medications primarily for dietary control.
23. Rehabilitative therapy not specifically covered herein, including, but not limited to, speech, occupational, recreational, or educational therapy, or non-medical self-care or self-help training; related outpatient diagnostic testing.
24. Air conditioners, humidifiers, dehumidifiers, purifiers, and similar equipment.
25. Care for nervous and mental conditions, including drug addiction and alcoholism except as specified in the "Mental Health Benefit" section.
26. Care for quarantinable diseases in special institutions.
27. Except as provided in the Prescription Drug Benefit section (see page 77), all drugs and medicines other than those provided while inpatient in a hospital.
28. Services or supplies in excess of the usual, customary and reasonable (*UCR*) amount.
29. Any service which is made available without charge, not including Medicaid or services provided only to insured persons.
30. Services rendered by a provider who is a member of the participant's or dependent's immediate family (parent, spouse, children, brother or sister).
31. Telephone consultations with patients, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
32. Routine podiatry services which are not medically necessary. Routine podiatry services (such as nail clippings) are often medically necessary for diabetics due to the risk of performing them at home and are therefore covered.
33. Pre-admission diagnostic testing which relates to an inpatient admission which is not covered under the Plan.
34. Admissions of oral chemotherapeutic agents, except as provided in the Major Medical section.
35. Domestic or housekeeping services other than those specifically provided for under the Homecare program.
36. Treatment of autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation.
37. Meals-on-Wheels and similar food arrangements.
38. Services performed by interns, residents, or physicians who are employees of a hospital and whose fees are charged for, or payable to, a hospital or other institution.

39. Treatment, care, or services through a medical department or clinic or similar services provided or maintained by a *participating employer*.
40. Injections of varicose veins except as provided in the section on sclerotherapy in the Major Medical benefits section.
41. Injections of hemorrhoids or hernias.
42. Injection of cortisone or other preparations, except for trauma or acute suppurative infections.
43. Manipulations of the joints unless under general anesthesia except as provided under the Major Medical benefits section.
44. Care of corns, bunions (except capsular or bone surgery for such), callouses, nails of the feet fallen arches, weak feet, except when major surgery, as defined by the Trustees, is performed.
45. Biopsy of the cervix for other than hospital inpatients.
46. Injections of local anesthetics except as provided under the Major Medical benefit.
47. The cost of a blood donor, blood plasma, or any prosthetic or supportive appliances such as braces, crutches, and trusses except as provided under the Major Medical benefit. See page 53 for details about the Durable Medical Equipment Network.
48. Screening examinations including x-ray examinations made without film.
49. Services, supplies, drugs, devices, medical treatment, procedures or care any kind which is experimental in nature, or which is not accepted practice by the medical community practicing as determined the Fund (see “Experimental” under the Definitions section).
50. Services or care of any kind other than those defined and limited in this Plan.
51. Consultation services are not available with medical or surgical services when they are rendered by the same physician at the same hospital during the same hospital admission, except at the sole discretion of the Plan.
52. Unless otherwise stated, *injuries* resulting from an act of domestic violence or from a medical condition (including a mental health condition), are not excluded solely because the source of injury was an act of domestic violence or a medical condition.
53. Complications resulting from cosmetic *surgery* are not covered.
54. Services incidental to dental *surgery*, including care of the teeth, dental structures, alveolar processes, dental caries, extractions, corrections of impactions, gingivitis, orthodontia, and prostheses, except as provided under the Dental Benefit section.

Extension of Benefits

Major Medical coverage terminates if your basic coverage terminates or if you leave employment at the end of the month for which payment has been made. However, Major Medical Expense Benefits will be payable if you or your eligible dependent are an inpatient in a hospital at any time within 90 days after your coverage has been terminated, provided you or your eligible dependent has

been totally and continuously disabled and under the regular care of a legally qualified physician from the date your coverage terminates to the date the hospital confinement begins.

HMO OPTION

Newly Eligible Participants

When you first become eligible for benefits under the Fund, you may choose whether your medical benefits will be provided under the Fund (as shown in the Schedule of Benefits section of this booklet), or through an HMO (Health Maintenance Organization) option. Prior to your initial eligibility date, the *Fund office* will send you an enrollment packet containing information about these choices. **Before you enroll in one of the HMOs, to check to be sure there are participating providers in your area (some HMOs do not serve all geographic areas).** Participants who elect an HMO will have their Medical Benefits provided by the HMO, using HMO physicians and facilities. However, your Optical, Dental, and Prescription Drug benefits will be provided by United Optical, Group Dental Service, and NMHC, as further described in this booklet.

If you want your Medical benefits to be provided through one of the HMOs, you must complete and return the election form from the HMO packet within 30 days from the date you first become eligible for benefits. **If you do not return an HMO enrollment form within 30 days from the date of your initial eligibility, you will automatically be enrolled for Fund coverage for your medical benefits.** You may not change your election until the next open enrollment, unless permitted under HIPAA.

All Participants

The Fund has entered into contracts with one or more Health Maintenance Organizations (HMOs). If you enroll in an HMO option, the benefits are guaranteed and paid through the HMO contract and the HMO provides claims processing and all administrative services related to the benefits provided by the HMO. You should review the HMO materials for a detailed description of the benefits and administrative procedures.

Open Enrollment

Each year, during the “Open Enrollment” period, the Fund may offer one or more HMOs (Health Maintenance Organizations) as an option to specified participants. During open enrollment, participants and their dependents may choose an HMO in lieu of the Fund medical benefits processed by the *Fund office*. You will keep all your other existing Fund benefits, including Optical, Dental, and Prescription Drug. **This election must be for a full twelve months.** Participants may keep the HMO, change HMOs, or return to medical

benefits administered by the Fund (those described in this booklet) at Open Enrollment each year.

Please note that upon retirement, you will no longer have the ability to elect the HMO option during the open enrollment period. However, upon becoming Medicare eligible, you must enroll in a Medicare HMO, if one is available in your area, to continue coverage under the Fund.

Under an HMO, participants must use HMO centers and physicians, and hospital admissions are arranged by the HMO. With the HMO, there are usually no deductibles and minimal “per visit” payments required for each office visit. You are covered for hospital, preventive, and routine office visits.

Cost

There may be a monthly co-payment for coverage through an HMO. You will be billed each month. Missed co-payments will result in a loss of coverage. **Once coverage through the HMO is lost, coverage through the Fund may only be reinstated at the next enrollment period. If you have lost coverage due to lack of payment, you will automatically be enrolled for Fund medical coverage at the next open enrollment unless you actively choose otherwise (to re-enroll in the HMO).**

Participants will be sent an open enrollment letter from the *Fund office* as well as a Benefit Summary and application from the HMOs being offered, explaining the options in greater detail. **Note: If you do not live within the service area of one of the HMOs, you will not receive information/enrollment materials from that HMO.**

At the time this book was printed, Kaiser Permanente is the only HMO offered by the Fund. This is subject to change as determined by the Board of Trustees.

MEDICARE SUPPLEMENTAL BENEFIT

Medicare Eligible Retirees

Medicare eligible retirees and their eligible dependents who are covered by Medicare must enroll in a Medicare HMO reviewed by the Fund if one is available in their area. In some cases, the Medicare HMO will provide the prescription drug benefit through a drug provider. This prescription drug benefit will be up to the limits of the benefit formerly provided through NMHC. If a Medicare HMO is not available, the Fund will provide the following Supplemental Benefit:

Hospitalization

1. The amount of inpatient hospital coverage which is subject to a deductible by Medicare
2. The required per day hospital care expenses from the 61st day to the 70th day.
3. Emergency outpatient care in the hospital within 72 hours of an accident, up to a maximum of \$200.
4. Hospital charges for surgery in the hospital outpatient department, up to a maximum of \$200.
5. Diagnostic outpatient coverage supplementary to Medicare payments.

Surgery

20% of reasonable charges as defined by Medicare for surgery in or out of the hospital, but in no event more than the amounts payable under the surgical schedule applicable to your current Plan of benefits.

Claims Filing

Medicare Supplemental Claims should be submitted directly to the *Fund office* (not to OneNet PPO) after Medicare has paid its portion. Send the claim or itemized bill to:

Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451

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DEFINITIONS

Accidental Injury. Bodily injury arising out of an accident. All *injuries* sustained in connection with one accident will be considered one injury. *Accidental injury* does not include ptomaine poisoning, disease or infection (except pyogenic infection occurring through an accidental cut or wound).

Active Work or Actively at Work. Your attendance in person at your usual and customary place of business (outside your residence), acting in the regular performance of the duties of your occupation for wages or profit.

Administrative Manager. The company responsible for receiving employer contributions, keeping eligibility records, paying claims, and providing information to you about the Plan. The company is Associated Administrators, LLC, and is referred to in this booklet as "the *Fund office*."

Benefit Period. A calendar year from January 1st – December 31st.

Board of Trustees. An equal number of people appointed by the *unions* and *participating employers* who administer the Fund by making rules regarding eligibility for benefits and level of benefits. They serve the Fund without compensation.

Cardiac Rehabilitation. Health care specializing in the rehabilitation of persons suffering from angina pectoris or persons who have recently undergone cardiac surgery or who have suffered a heart attack.

COBRA. Consolidated Omnibus Budget Reconciliation Act. This Act provides for continuation of benefits under certain circumstances when benefits are lost. See page 29.

Collective Bargaining Agreement. The agreement or agreements between a *participating employer* and the *United Food and Commercial Workers Unions* which require contributions to the UFCW Unions & Participating Employers Health and Welfare Fund.

Concurrent Care Claim. A pre-service claim related to an ongoing course of treatment or a number of treatments over time.

Co-Payment. The amount a participant or dependent is responsible for paying when receiving benefits.

Coordination of Benefits. Coordination of Benefits or COB applies when a participant has coverage under two or more group plans. COB is intended to

prevent duplicate payments or overpayments for the same service by different insurers.

Deductible. The cash deductible is the first \$100.00 of Covered Major Medical Expenses incurred in a calendar year--January 1 through December 31--for an sickness or injury. In cases of a common accident in which two or more family members are involved, only one cash deductible must be satisfied. After the deductible is met, the Plan covers 80% of your covered medical expenses. There is no deductible for room and board charges under this Plan.

Dental Emergency. An unforeseen situation requiring dental treatment to relieve a condition necessitating immediate care. Includes accidental injuries requiring immediate treatment.

Diagnostic (Procedure, Test, Service, Study). A medical procedure test, service or study for determining a sickness or condition. Must be ordered by and performed by (or under the direction of) a physician and may not be experimental in nature.

Durable Medical Equipment. Equipment which (1) can withstand use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a person in the absence of a sickness or injury and (4) is appropriate for use in the home.

Effective/Eligibility Date. According to the Eligibility Rules, the date on which coverage for a participant or dependent begins.

ERISA. The Employee Retirement Income Security Act of 1974, and regulations thereunder, as amended from time to time.

Experimental. A drug, device, medical treatment, or procedure is considered to be experimental or investigative unless:

1. It has been approved by the U.S. Food and Drug Administration and approval for marketing the drug or device has been given at the time the drug or device is furnished;
2. The drug, device, medical treatment, or procedure, or the patient informed consent document used with the drug, device, medical treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other such body serving a similar function, if federal law requires such review or approval;
3. Reliable evidence shows that the drug, device, medical treatment or procedure is not the subject of on-going Phase I or Phase II clinical trials or the research, experimental study, or investigational arm of ongoing Phase III clinical trials, or is not otherwise under study to determine its maximum

tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable medical evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Explanation of Benefits. Abbreviated "EOB," it is a comprehensive statement how a claim was processed.

FMLA. The Family Medical Leave Act of 1993, and any regulations, as amended from time to time.

Fund office. The Administrative Manager of the Fund (defined above) is also referred to as "the *Fund office*." Associated Administrators, LLC is the Administrative Manager of the Plan and acts as the *Fund office*.

Health Maintenance Organization. (HMO) A company which contracts a panel of physicians, hospitals, and other providers to perform medical services for its members. If you are enrolled in an HMO, you must use a participating HMO provider in order to receive the medical benefits the HMO provides.

Hospice Care. Care designed for meeting the specific spiritual, physical, psychological, and social needs of dying individuals and their families.

Hospital. A legally constituted general hospital which provides diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and Care of injured and sick persons, and which is not, other than incidentally, a nursing home or a place for: rest, the aged, drug addicts, or alcoholics. The definition specifically includes institutions which provide treatment for pulmonary tuberculosis or for mental disorders.

Hospital Confinement. Confinement for which a daily hospital room and board charge is made, except that a daily hospital room and board charge is not required if a surgical procedure is performed or if emergency treatment is rendered within 48 hours after an accidental injury.

One period of hospital confinement includes successive periods of hospital confinement resulting from the same or related causes **unless** they are (a) with respect to a participant, two or more unrelated conditions which are separated by your return to active work on your regular schedule for one full day (or fully scheduled day) or for related conditions, separated by your return to active work on a regularly scheduled basis for at least 60 days; (b) with respect to eligible dependents, the confinements must be separated by at least 90 days.

Incurred. A charge will be considered “incurred” on the date a participant receives the supply or service for which the charge is made.

Injury. Bodily injury caused by an accident and resulting, directly and independently of all other causes, in loss which is covered by the Plan. All injuries sustained in one accident will be considered one injury.

In-patient. A participant or eligible dependent who receives treatment while a registered bed patient in a hospital or facility, and for whom an overnight room and board charge is made.

Medical Emergency. A situation which arises suddenly and which poses a serious threat to your life or health. Medical emergencies include, but are not limited to heart attack, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and other acute conditions. The diagnosis or the symptoms, and the degree of severity, must be such that immediate medical care would normally be required.

Medically Necessary Services or Supplies. Those services or supplies provided by a hospital, physician, or other provider of health care to identify or treat the sickness or injury which has been diagnosed or is reasonably suspected which are 1) consistent with the diagnosis and treatment of your condition, 2) in accordance with standards of good medical practice, 3) required for reasons other than convenience to you, your physician, the hospital or another provider, and, 4) the most appropriate supply or level of service which can safely be provided to you. When applied to inpatient care, medically necessary means that your symptoms or condition require that those services or supplies cannot be safely provided to you on an outpatient basis. The fact that a service or supply is prescribed by a physician or another provider does not necessarily mean it is medically necessary.

As applied to Mental Health benefits, “medical necessity” also means that a service or supply is provided at the lowest appropriate level of care for that patient’s diagnosed condition in accordance with generally accepted psychiatric and mental health practices and the professional and technical standards adopted by Value Options.

Mental Sickness. Any emotional or mental disorder which, according to generally accepted medical professional standards, is amenable to significant improvement through short-term therapy and as further specified (or limited) under the Schedule of Benefits and the benefits described in the Mental Health section of this booklet.

Nurse Midwife. A licensed regular nurse, certified by the American College of Midwives as qualified to render non-surgical obstetrical care.

Optometrist. Doctors of optometry who are registered and licensed in the respective states in which they practice and who are graduates of accredited schools of optometry.

Outpatient. Services or treatment in a hospital or medical facility that have been determined to allow the patients immediate release following the procedure.

Participating Dentist. A dentist who is duly licensed to practice as a dentist in the locality in which he or she performs a dental service and who has contracted with Group Dental Service to provide dental services to participants and their eligible dependents.

Participating Employer. An employer who is a party to a Collective Bargaining Agreement or other similar arrangement with the United Food and Commercial Workers *Unions* Locals 27 or 400, which requires contributions to the UFCW *Unions & Participating Employers* Health and Welfare Fund.

Pedodontia. Dental treatment of children under age four.

Periodontia. Dental treatment for gum disease.

Physician. Any person, other than a close relative, who is licensed by the law of the state in which treatment is received as qualified to treat the type of sickness or injury causing the expenses, or loss, for which claim is made. A close relative is a spouse, brother, sister, parent, or child of a participant or eligible dependent.

Post-Service Claim. A claim for which the treatment or service has already been rendered.

Pre-Service Claim. A claim which requires pre-authorization, such as a hospital stay or a transplant procedure.

Prosthetics. Devices, such as artificial limbs, used to help compensate for a physical deficiency.

Qualified Medical Child Support Order (QMCSO). A medical child support order which creates or recognizes the existence of an alternate payee's right to receive benefits from the Plan and which complies with the requirements for a QMCSO under ERISA.

Sclerotherapy. Treatment of varicose veins in which a solution is injected directly into a blood vessel, causing it to shut down and disappear.

Sickness. Any physical sickness or mental sickness.

Surgery. The performance of generally accepted operative and cutting procedures including endoscopic examinations and other invasive procedures for the correction of fractures/dislocations, the usual and related pre-operative and post-operative care, and other procedures approved by the Plan.

Trustees. Members of the Board of Trustees of the UFCW Unions & Participating Employers Health and Welfare Fund.

Total Disability. Unless otherwise defined with respect to a particular benefit, means (a) your complete inability, because of sickness or accidental injury, to perform the duties of your regular employment within the first two years of the disability, and (b) after the first two years of the disability, your complete inability, because of sickness or accidental injury, to do work for which you may, by your education and training (including rehabilitative training) be qualified. With respect to your dependent, "total disability" means the complete inability of the dependent, because of sickness or accidental injury, to engage in the normal activities of a person in good health and of the same age and sex.

Union. The United Food and Commercial Workers International *Union* or any successor by combination, consolidation, or merger, or any other local *union* affiliated with the United Food and Commercial Workers International that (a) has a Collective Bargaining or other Agreement with an employer requiring contributions to the trust establishing the UFCW *Unions* and *Participating Employers* Health and Welfare Fund ("Trust"); (b) has agreed in writing to participate in the Trust or has signed the Trust Agreement; and (c) is accepted for participation in the Plan by the Trustees.

Urgent claim. A pre-service claim for treatment of illness or injury which involves imminent danger to life, health, or function or which causes the patient to be in extreme pain that, in the opinion of the patient's doctor, cannot be managed without the treatment requested in the claim.

Urgent concurrent care claim. An urgent pre-service claim related to an ongoing course of treatment or a number of treatments over time.

USERRA. The Uniformed Services Employment and Re-employment Rights Act of 1994 (“USERRA”), which provides for the continuation of participants and their eligible dependent(s) who are absent from work due to military service. See page 37.

Usual, Customary, and Reasonable or “UCR.” The fee, as determined by the Fund, which is regularly charged and received for a given service by a health care provider which does not exceed the general level of charges being made by providers of similar training and experience when furnishing treatment for a similar sickness, conditions, or injury. The locality of where the charge is incurred is also considered.

PARTICIPANT SERVICES HOTLINE

The Fund has toll free telephone lines directly to Participant Services so you can:

1. ask about your eligibility for benefits and your coverage,
2. find out how your claims were processed;
3. get medical benefit counseling.

Participant Services representatives can locate your claims history in the computer using your Social Security number. When you call, have the participant's Social Security number ready. Also be ready to give you Local *union* number and company name.

Toll Free --1-800-638-2972

Automated Attendant

If you call 1-800-638-2972, you will be given an option to access our system using the buttons on your touch tone phone to check the status of your claim 24 hours a day, 7 days a week (have the specifics about your claim ready, such as date of service, amount of the claim, etc.). See page 126 for more information about using the Automated Attendant system.

CLAIMS FILING AND REVIEW

For information regarding how to file a claim for benefits, first look at the Claims Procedure subsection at the end of the SPD Section describing the particular benefit. Below are the general rules which apply to ALL claims for benefits under this Plan as well as the addresses and claims procedures for filing any Hospital/Major Medical claim.

Filing A Claim:

1. You must submit hospital, medical, or surgical claims within 180 days from the date of treatment or service. If your provider agrees to file the claim on your behalf but fails to submit the claim to the appropriate entity within the 180 day deadline, causing the claim to be denied, the Fund will defend you against any attempts by the provider to collect payment from you. However, in order for the Fund to do so, you must notify the *Fund office* within two weeks if you receive a bill from the provider for those services or if the provider takes any other action against you. Further, in order for the Fund to defend you, you must notify the Fund when your first have action taken against you by the provider. If you do not notify the Fund, you can be held responsible by the provider for and the Fund will not defend you.
2. You must submit Weekly Disability claims within 90 days from the first date your disability began.
3. You must submit Life and Accidental Death and Dismemberment claims within 20 days from the date of loss upon which the claim is based, or as soon thereafter as reasonably possible.
4. Present your UFCW Unions & Participating Employers Health and Welfare Fund identification card when seeking service from a *provider*. The *provider* may submit a bill directly to the Fund when you sign the "Assignment to Pay Benefits to a Provider" section on your claim form. This allows the Fund to pay the fee for covered services directly to the *provider*.
5. You or your provider must either submit an itemized bill or file a claim in order to be eligible for benefits.
6. Continuation forms or requests for additional information by the *Fund office* must be returned within two weeks from the date mailed by the *Fund office*.
7. If your provider has not billed the Fund directly, you must submit an itemized bill to or file a claim for benefits (using a claim form) with the *Fund office*. Bills must be fully itemized and on the letterhead stationery of the provider of service. Bills must show the participant's name and social security number, patient's name, type of service, diagnosis, date(s) of service and the charge per service. Cancelled checks, cash register receipts, and personal itemizations are not acceptable.

8. If the Fund is paying as the secondary payer, we must receive an Explanation of Benefits (EOB) from the primary carrier in order to process your claim as secondary.
9. The fact that a claim for benefits from a source other than the Fund has been filed or is pending does not excuse these claim filing requirements. Lack of knowledge of coverage also does not excuse these requirements.
10. No assignment of benefits under this program is valid except for hospital, surgical, x-ray, laboratory, and medical benefits.
11. If you receive hospital care in a veterans, marine, or other federal hospital or elsewhere at government expense, no benefits are provided under the Plan. However, to the extent required by law, the Fund will reimburse the VA hospital for care of a non-service related disability if the Fund would normally cover charges for such care and if the claim is properly filed within the appropriate Fund time periods.
12. If bills are submitted for more than one family member at a time, a separate itemized bill must be submitted for each individual.
13. The Fund reserves the right and opportunity to examine the person whose injury or sickness is the basis of a claim as often as it may reasonably require during pendency of the claim.
14. You will receive an *EOB* from the Fund when your claim is processed. Please keep the EOB and refer to it when you have questions about your claim and it was processed.
15. Keep copies of all submitted bills for your records. Original bills will not be returned.
16. Benefit payments will be sent directly to the provider unless they are unassigned and there is evidence of your payment on the bill.

Advance Benefits for Workers' Compensation Claims

If you apply for Workers' Compensation and your claim is denied by either your *participating employer* or your *participating employer's* insurance carrier, you may apply to this Plan for Weekly Disability or Medical Benefits. See "Advance Benefits for Workers' Compensation Claims" (page 47) for the conditions of payment.

WHERE TO SUBMIT A CLAIM

Life and AD&D Benefits

Submit to the *Fund office*: UFCW Unions & Participating Employers Health & Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451. Include proof of loss and send within 90 days after date of loss.

Prescription Drug, Dental, and Optical Benefits

See the claims procedure in that section of the booklet.

Medical, Major Medical Benefits

If you did NOT use an OneNet Provider, send your medical claims directly to the *Fund office* at:

UFCW Unions Participating Employers Health & Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

If you DID use an OneNet Preferred Provider, send your medical claims directly to OneNet—after discounting, they will forward it to the *Fund office* for processing. (Most OneNet providers will mail the claim for you.)

Mail it to: OneNet PPO, LLC
P.O. Box 936
Frederick, MD 21705-0936

The *Fund office* does not require claim forms for routine claims.

Weekly Disability Benefits

Send to the *Fund office*:

UFCW Unions & Participating Employers H&W Fund
P.O. Box 1064
Sparks, MD 21152-1064

Payment of a Claim

You will know your claim has been paid in one of several ways. For example, you will receive your weekly disability check in the mail, or, in the case of a medical claim, you'll receive an Explanation of Benefits. If we don't pay promptly and an extension is required, you will be notified. This extension notice will tell you why the *Fund office* requires extra time and the approximate date that a decision on your claim is expected.

Use the Automated Attendant System to Check Your Claim 24 Hours a Day, 7 Days a Week

You can check on a claim at YOUR convenience by using the *Fund office*'s "automated attendant" system. To use the system, call **1-800-638-2972**. At the prompt, press "one." Follow the prompts to select the option for checking on the type of claim you had (medical, weekly disability, etc.). You'll need to have some information ready in order to access your claim.

You will need:

- the participant's social security number
- the 4 digit PIN number. The default PIN is the participant's month and date of birth (for example, someone born on June first would enter "0601" as his/her PIN). However, you may change your PIN at any time by following the prompts in the system.
- the date of birth--month, day and year--of the patient.
- the date of service for the claim you are questioning. If you don't know the exact date, you can use the month and year in which the claim was *incurred*.
- the dollar amount of the claim.

Follow the prompts, entering the information the system requests. If your claim has been entered, the system will tell you its current status. If it has been processed, the system will tell you when, for how much, and to whom the payment (if any) was made. It takes about three weeks from the date of service for a claim to be entered into our system (this allows time for the provider to bill us and for the claims adjusters to enter the claim). If there is "no record" of your claim, that means it has not yet been entered in our system. If your claim is not in the system and you think it should be, or if you need more information about a claim, simply call the same 800 number (1-800-638-2972) and press option 2 to speak with a Participant Services representative. He or she will be happy to answer any questions you may have. Remember, because of the new Privacy Rules, the information you can receive on someone else's claim (a spouse or a non-minor child) may be limited. See the Fund's Notice of Privacy Practices on page 139 for a full explanation of these rules.

How Long the Fund Has to Respond/Process Your Claim

The Department of Labor has issued regulations regarding how long the Fund has to respond to your claim, make a decision, or process your claim. These time frames are described below. *Urgent Claims, Urgent Concurrent Care Claims, Pre-Service Claims, and Post-Service Claims* are all defined in the Definitions section of this booklet on page 116.

General Information Regarding Benefit Claims

Claims for hospital, medical, prescription, mental health and substance abuse benefits are provided directly by the Fund. The following procedures regarding claims and appeals apply to these benefits.

Claims for dental and vision benefits, as well as claims for benefits provided under an HMO, are provided under insurance agreements between the Fund and specific insurers. Please consult the booklet provided to you by the relevant insurer for a description of the applicable claims and appeals procedures for those benefits. However, because the Fund is still responsible for determining your eligibility for these benefits, you may follow the appeal procedures

provided below for vision, dental or HMO benefit appeals for eligibility denials. Further, if you appeal a denial of dental benefits pursuant to the procedures provided by Group Dental Services, and that appeal is denied, please refer to the Appeal Procedure Section below for additional appeal rights relating to dental benefit claims.

You may name a representative to act on your behalf during the claims procedure. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number and authorize the Fund to release information (which may include medical information) to your representative. Please contact the *Fund office* for a form to designate a representative. In the case of an Urgent Care claim, defined below, a health care professional with knowledge of your medical condition will be permitted to act as your representative. The Fund does not impose any charges or costs to review a claim or appeal; however, regardless of the outcome of an appeal, neither the Board of Trustees nor the Fund will be responsible for paying any expenses that you might incur during the course of an appeal.

The Fund and Board of Trustees, in making decisions on claims and on appeal, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similarly situated claimants. Additionally, the Fund and Trustees will take into account all information you submit in making decisions on claims and on appeal.

If your claim is denied in whole or in part, you are not required to appeal the decision. However, you must exhaust your administrative remedies by appealing the denial before you have a right to bring an action in federal or state court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your SPD.

The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

Medical Benefit Claim Review

1. Pre-Service Claim. You are required to obtain pre-certification from InforMed before an elective or non-emergency hospitalization. If your pre-service claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within five days of the date you filed the claim. The Fund will notify you of its decision on your pre-service claim (whether approved or denied) within a reasonable period of time

appropriate to the medical circumstances, but not later than 15 days after the claim is received by the Fund. InforMed has the same 15 day period to make its pre-authorization decision on behalf of the Fund. The Fund may extend the period for a decision for up to 15 additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial fifteen day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly re-file the claim, the Fund will decide the claim based on the information it has available, and your claim may be denied.

2. Urgent Care Claim. It is important to note that the rules for an Urgent Care claim apply only when the Plan requires approval of the benefit *before* you receive the services; these rules do not apply if approval is not required before health care is provided, for example in the case of an emergency.

If your Urgent Care claim is filed improperly or is incomplete, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within 24 hours of the date you filed the claim. The Fund will notify you of the decision on your Urgent Care claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the claim is received by the Fund, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If the Fund needs more information, the Fund will notify you of the specific information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim by the Fund. You will be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the requested information. The Fund will notify you of its decision as soon as possible, but not later than 48 hours after the earlier of: (1) the Fund's receipt of the specified information or (2) the end of the period given to you to provide the specified information. Due to the nature of an Urgent Care claim, you may be notified of a decision by telephone, which will be followed by a written notice of the same information within three days of the oral notice.

If you do not provide the information requested, or do not properly re-file the claim, the Fund will have to decide the claim based on the information it has available, and your claim may be denied.

3. Concurrent Care Claim. If you have been approved by the Fund for Concurrent Care treatment, any reduction or termination of such treatment (other than by Plan amendment or termination of the Plan) before the end of the period of time or number of treatments will be considered denial of a claim. The Fund will notify you of the denial of the claim at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on review of the denial of the claim before the benefit is reduced or terminated.

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care claims (see above), except the Fund will notify you of the decision (whether approved or denied) within 24 hours after the Fund's receipt of the claim, provided that the claim is made to the Fund at least 24 hours before the end of the previously approved period of time or number of treatments.

4. Post-Service Claim. If the Fund denies your post-service claim, in whole or in part, the Fund will send you a notice of the claim denial within a reasonable period of time, but not later than 30 days after the claim is received by the Fund. The Fund may extend the period for a decision for up to 15 additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial 30 day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If your post-service claim is incomplete, the Fund will deny the claim within the 30 day period mentioned above. You may resubmit the claim, with the necessary additional information, at any time within 180 days from the date of service.

Denial of a Claim

With respect to any claim relating to medical, hospital, mental health and substance abuse benefits, if the Fund denies the claim, in whole or in part, the Fund will send you a written notice of the denial, unless, as noted above, your claim is for Urgent Care, then this notice may be oral, followed in writing. The notice will provide (1) the specific reason or reasons for denial; (2) reference to specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary to perfect the claim as an explanation of why such material or information is necessary; (4) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures, including the expedited review process applicable to Urgent Care claims; (5) a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal; (6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol,

or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (7) if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

With respect to any claim relating to prescription benefits, if the NHMC denies a reimbursement claim, in whole or in part, NMHC will send you a written notice of the denial. The written notice of denial from NMHC will provide (1) the specific reason or reasons for denial; (2) reference to specific Plan provisions on which the denial is based; (3) a description of any additional material or information necessary to perfect the claim, as well as an explanation of why such material or information is necessary; (4) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures; (5) a statement of your right to bring a civil action under Section 502(a) of ERISA if you choose to appeal and your appeal is denied; (6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion determination of medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

Review of a Denied Claim - Appeal Process

You have the right to appeal a denial of your benefit claim to the Fund's Board of Trustees. Your appeal must be in writing and must be sent to the Board of Trustees at the following address:

UFCW Unions and Participating Employers
Health & Welfare Fund
4301 Garden City Drive, Suite 201
Landover, MD 20785

An appeal of an Urgent Care claim (see above) may also be made by telephone by calling (800) 638-2977 or by faxing a letter to (877) 227-3536.

If your claim is denied, you (or your authorized representative) may, within 180 days from receipt of the denial, request a review by writing to the Board of Trustees. Pursuant to your right to appeal, you will have the right (1) to submit written comments, documents, records, and other information relating to your claim for benefits; and (2) upon request, to have reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits. In making a decision on review, the Board of

Trustees or a committee of the Board of Trustees will review and consider all comments, documents, records, and all other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing your claim, the Board of Trustees will not automatically presume that the Fund's initial decision was correct, but will independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Board of Trustees will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the Fund on the initial claim.

In the case of an appeal of a claim involving Urgent Care as defined above, the Board of Trustees will notify you of the decision on your appeal as soon as possible, taking into account the applicable medical exigencies, but not later than 72 hours after the Fund's receipt of your appeal. In the case of an appeal of a pre-service claim, the Board of Trustees will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Fund's receipt of your appeal. The Fund may also request that you voluntarily extend the period of time for the Board of Trustees to make a decision on your appeal.

In the case of an appeal of a post-service claim, the Board of Trustees or a committee of the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the Fund within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within five days of the decision.

If the Board of Trustees has denied your appeal, the notice will provide (1) the specific reason or reasons for the denial; (2) references to specific Plan provisions on which the denial is based; (3) 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 for benefits; and (4) a statement of your right to bring an action under Section 502(a) of ERISA. In addition, the notice will state that: (1) if an internal rule,

guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (2) if the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees is final and binding.

For certain benefits, before filing an appeal with the Board of Trustees as described above, you may wish to contact the appropriate Fund provider identified below with any questions or concerns that you have regarding the claim denial. If you choose to do so, please contact the provider directly for important information regarding the appropriate procedures, including any time limits.

- For denied mental health and substance abuse claims, you may contact Value Options, c/o Utilization Review Manager, P.O. Box 1347, Latham, NY 12110
- For denied prescription benefit claims, you may contact NMHC Rx, P.O. Box 1179, Port Washington, NY 11050
- For certification denials made by InforMed, you may contact InforMed at 1596 Whitehall Road, Annapolis, MD 21409, (866) 290-8147.

Whether or not you choose to address your concerns to the provider, you have the right to appeal a benefit denial to the Board of Trustees as described above. However, if you choose to address your concerns to the provider, you must do so before you appeal to the Board of Trustees and, if you are not satisfied with the results through the provider and wish to file an appeal to the Board of Trustees, you must do so within 180 days from the day you received the claim denial from the *Fund office* or other Fund provider. If you do not choose to address your concerns to the provider and wish to appeal directly to the Board of Trustees, you must do so within 180 days from the day you received the claim denial from the *Fund office*. Please remember that if you are not able to resolve your concerns by contacting the appropriate provider named below, you must appeal to the Board of Trustees before filing a suit against the Fund.

Special Rule Regarding Appeals of Dental Benefit Claims. If you appeal your dental claim denial to GDS-MD and GDS-MD denies your appeal, the

Fund offers an additional level of appeal by the Board of Trustees that is entirely voluntary. Please note the following about the Fund's voluntary level of appeal for dental claims:

- Upon request and free of charge, the Fund will provide you with sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a dental benefit dispute to the voluntary level of appeal, including a statement that your decision as to whether to submit your dental benefit dispute to the voluntary level of appeal will have not effect on your right to any other benefits under the Plan information about the applicable rule, your right to representation, the process for selecting the decision maker, and the circumstances, if any that may affect the impartiality of the decision, such as financial or personal interests in the result or any past or present relationship to any party to the review process.
- You may elect to file a voluntary appeal to the Board of Trustees only after a denial of your appeal by GDS-MD.
- During this voluntary appeal process, the time that it takes to decide your appeal will not be counted against you in determining whether any lawsuit that you file afterward is brought in a timely manner.

Your voluntary appeal must be submitted in writing to the Board of Trustees within forty-five days of the date you receive your appeal denial from GDS-MD. The Board of Trustees or a committee of the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the Fund within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within 5 days of the decision.

If Your Weekly Disability Claim Is Denied

If your Weekly Disability claim is denied in whole or in part, you will be notified in writing within 45 days after your claim has been received by the *Fund office*. The Fund may require an additional 30 days, and occasionally another 30 days beyond that, if extra time is needed for reasons beyond the control of the Fund (including if you fail to properly file the claim or do not submit sufficient information for the Fund to process it). If extra time is required, you will be notified in writing explaining the reasons for the delay, the standards for entitlement to a benefit, any unresolved issues and additional information

required, and the date the Fund expects to issue a final decision. If the Fund requests additional information, you will have 45 days to respond. The Fund will not decide your claim until you respond or the 45 days expires, whichever comes first. If you do not submit the requested information, the Fund will deny your claim.

If your claim is denied, you will be advised of the specific reason for the denial, the specific Plan provision on which the denial is based, any additional information needed to reconsider the claim, a description of the Plan's appeal procedures and time limits, and your right to bring suit against the Plan under ERISA if your appeal is denied. If the Fund relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, etc., or a statement that it was relied upon and is available upon request and free of charge. If the Fund based its decision on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the judgment related to your condition or a statement that such an explanation is available upon request and free of charge. If the Fund received the advice of any medical or vocational expert with respect to your claim, the Fund will identify the expert upon your request.

Appeal Procedures – Weekly Disability Claims

You (or your authorized representative) may appeal the claim denial directly to the Board of Trustees. If you decide to appeal, you must make a written request for review within 180 days after you receive written notice that your claim has been denied. You must include in your written appeal all the facts relating to your claim as well as the reasons you feel the denial was incorrect. You (or your authorized representative) may receive, upon request and free of charge, reasonable access to and copies of any documents relevant to your claim. You may submit issues and comments in writing, and documents, relating to your claim.

You may name a representative to act on your behalf. To do so, you must notify the Fund in writing of the representative's name, address and telephone number. You may, at your own expense, have legal representation at any stage of these review procedures. Regardless of the outcome of your appeal, neither the Board of Trustees nor the Fund will be responsible for paying any legal expenses that you incur during the course of your appeal.

The Board of Trustees, in making its decisions on claims and appeals, will apply the terms of the Plan document and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, are applied consistently with respect to similarly situated claimants.

Who Decides Appeals

You must send your request for review (appeal) to:

Board of Trustees
UFCW Unions and Participating Employers
Health & Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

How Long the Review Takes

The Board of Trustees will make its decision at the next regularly scheduled meeting following receipt of your appeal, unless there are special circumstances, such as the need to hold a hearing, in which case the Board of Trustees will decide the appeal at its next regularly scheduled meeting. If you submit your appeal within 30 days of the next scheduled Board of Trustees meeting, the Board of Trustees will decide the appeal at the second scheduled meeting, or, if there are special circumstances, the third meeting after it receives your appeal. If the Board of Trustees requires a postponement of its decision to the next meeting, you will receive a notice describing the reason for the delay and an expected date of the decision.

The Board of Trustees will also take into account all information you submit. If the initial decision was based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination (or a subordinate of such person). The Board of Trustees did not initially review our claim, and will not give deference to the internal decision.

The Board of Trustees will send you a notice of its decision within 5 days of the date the decision is made. If the Board of Trustees denies your appeal, the notice will contain the specific reason for the decision, the specific Plan provision on which the decision is based, notice of your right to receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to your claim and a statement of your right to bring suit against the Plan under ERISA. If the Fund relied on an internal rule, guideline or protocol in making the decision, you will receive a statement that it was relied upon and is available upon request and free of charge. If the Fund based its decision on medical necessity, experimental treatment or a similar exclusion or limit, you will receive a statement that such an explanation is available upon request and free of charge. If the Fund received the advice of any medical or vocational expert with respect to your claim, the Fund will identify the expert upon your request.

The decision of the Board of Trustees is final and binding.

Life Benefit and Accidental Death & Dismemberment Benefit Claims Procedures

Denial of a Claim

If your claim for benefits results in an adverse benefit determination, in whole or in part, you will receive a written explanation of the reason(s) it was denied usually within 90 days after your claim has been received by the *Fund office*. If additional time of up to 90 days is required because of special circumstances, you will be notified in writing of the reason for the delay, and the date that the Fund expects to issue a final decision. A decision will be made with respect to your claim no more than 180 days from the date your claim is first filed with the *Fund office*.

If your claim is denied, you will receive a written explanation that contains the following information:

1. the specific reason for the denial;
2. reference to the specific provision of the plan document or rule on which your denial is based;
3. a description of additional materials you would need to perfect your claim and an explanation of why we need this material;
4. the steps you must take if you want to have your denied claim reviewed, including the amount of time you have to do this; and
5. your right to bring an action under ERISA if you decide to appeal and that appeal is denied.

Review of a Denied Claim

If you decide to appeal, you must make written request for a review within 60 days after you receive written notice your claim has been denied. You should include in your written appeal all the facts regarding your claim as well as the reason(s) you feel the denial was incorrect. You will receive, if you request it, reasonable access to and free copies of documents relevant to your claim. You may submit issues and comments in writing, and documents, relating to your claim. The Board of Trustees will determine all requests for review for claims that were denied on the basis of the Plan's eligibility rules. Submit your appeal to the *Fund office* address below. Life Benefit and Accidental Death and Dismemberment claims that are denied on the basis of the insurance contract are reviewed by ING/ReliaStar Life Insurance Company.

You may name a representative to act on your behalf. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number. You may, at your own expense, have legal representation at any stage of these review procedures. Regardless of the outcome of your appeal, neither the Board of Trustees nor the Fund will be responsible for paying any legal expenses which you incur during the course of your appeal.

The Board of Trustees, in making its decisions on claims and on appeal, will apply the terms of the plan document and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similarly situated claimants.

Where to Send Your Appeal

You must send your request for review (appeal) to:

UFCW Unions and Participating Employers
Health & Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

How Long the Review Takes

If ING/ReliaStar reviews your claim, you will receive a written decision of the review of your claim denial within 60 days of the date they first receive your request for review. If special circumstances require a delay, you will receive a notice of the reason for the delay within those 60 days. The notice will describe the reason for the delay and the approximate date a decision will be made. The final decision on your claim will be issued no later than 120 days from the date they first receive your request for review. The review will take into account all information you submit relating to your claim. In the event your appeal is denied, you have the right to bring a civil action against ING/ReliaStar under section 502(a) of ERISA.

If the Board of Trustees reviews your claim, it will take into account all information you submit in making its decision. The Board of Trustees will make its decision at the next regular meeting following receipt of your appeal, unless there are special circumstances, such as the need to hold a hearing, in which case the Board of Trustees will decide the case at its next regular meeting. If you submit your appeal less than 30 days before the next scheduled Board of Trustees meeting, the Board of Trustees will decide the case at the second scheduled meeting, or, if there are special circumstances, the third meeting after it receives your appeal. If the Board of Trustees requires a postponement of the decision to the next meeting, you will receive a notice describing the reason for the delay and an expected date of the decision.

The Board of Trustees will send you a notice of its decision within 5 days of the decision. If the Board of Trustees denies your appeal, the notice will contain the reasons for the decision, specific references to the Plan provisions on which the decision was based, notice that you may receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to the claim, and a statement of your right to bring a lawsuit under ERISA.

NOTICE OF PRIVACY PRACTICES

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

THE PLAN'S COMMITMENT TO PRIVACY

The UFCW *Unions and Participating Employers Health and Welfare Fund* (the "Plan") is committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Plan's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refers to participants and dependents who are eligible for benefits under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

The Plan provides not only health care benefits but other non-health care benefits, such as life insurance, accidental death & dismemberment benefits and weekly disability benefits. It is the intent of the Plan, as permitted by the privacy regulations issued under HIPAA, to limit the application of those regulations to the health care components of the Plan. Thus, the components under the Plan subject to the HIPAA privacy regulations shall include all the health care components of the Plan, including the major medical benefits, hospitalization, pharmacy drug program, vision benefits, dental benefits, and mental health and substance abuse benefits but shall not include the non-health care components.

The Plan collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Notice. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information.

SUMMARY OF THE PLAN'S PRIVACY PRACTICES

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Plan discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan may also disclose your health information to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Plan will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- File a complaint with the *Fund office* or the Secretary of the Department of Health and Human Services if you believe that your that privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Practices

The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or if you wish to obtain additional information about the Plan's privacy practices, please contact:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

**DETAILED NOTICE OF THE PLAN'S PRIVACY POLICIES
THE PLAN'S USES AND DISCLOSURES**

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and the processing of your health claims.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** While the Plan does not anticipate making disclosures "for treatment," if necessary, the Plan may make such disclosures without your authorization. For example, the Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.
2. **For Payment.** The Plan may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information with its third party administrator Associated Administrators LLC ("Associated") so that it may process your claims. The Plan may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered under the Plan. Associated also may disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, Associated may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.

3. **For Health Care Operations.** The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Plan, may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan.

Uses and Disclosures to Business Associates

The Plan shares health information about you with its “business associates,” which are third parties that assist the Plan in its operations. The Plan discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Plan shares your health information with Associated so that it may process your claims. The Plan may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Plan may disclose your health information to a translator; and Associated may provide names and address information to mailing services.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected. Similarly, Associated contracts with the subcontractors it uses to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information to the Plan Sponsor, which is the Plan’s Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Plan, without your authorization. The Plan also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Plan that it will protect your health information and that it has amended the Plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Plan, may make without your authorization.

1. **Required by Law.** Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:
 - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
 - To report information related to victims of abuse, neglect, or domestic violence.

- To assist law enforcement officials in their law enforcement duties.
2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.
 3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.
 4. **Active Members of the Military and Veterans.** Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.
 5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.
 6. **Emergency Situations.** Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.
 7. **Others Involved In Your Care.** Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Plan). Also, upon request, Associated may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.
 8. **Personal Representatives.** Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal

representatives are parents for un-emancipated minors and those who have Power of Attorney for adults.

9. **Treatment and Health-Related Benefits Information.** The Plan and its business associates, including Associated, may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.
10. **Research.** Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.
11. **Organ, Eye and Tissue Donation.** If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.
12. **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan and its business associates, including Associated, do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information *other than* those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Plan will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Plan will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, then the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a two year period, state that in your written request, and that request will be accommodated. If you request a copy of your underlying health record or a portion of your health record, the Plan will charge you a fee of \$.25 per page for the cost of copying and mailing the response to your request.

In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your

request. The Plan may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for the Plan, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan, including disclosures by Associated, to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request, except, in accordance with applicable law, the accounting will not include disclosures made before April 14, 2003. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, you will be charged for the cost of providing the accounting, but Associated will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that Associated discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Plan and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy of this Notice at Associated's website, www.Associated-Admin.com.

CHANGES IN THE PLAN'S PRIVACY POLICIES

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in

the future. If the Plan materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be posted for review near the front lobby of Associated's offices in Sparks, Maryland and Landover, Maryland. Any revised notice will also be available at Associated's website, www.Associated-Admin.com.

EFFECTIVE DATE

This Notice is effective as of April 14, 2003, and will remain in effect unless and until the Plan publishes a revised Notice.

YOUR RIGHTS UNDER ERISA

As a participant of the UFCW Unions and Participating Employers Health & Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Board of Trustees complies fully with this law and encourages you to first seek assistance from the *Fund office* when you have questions or problems that involve the plan.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

This Plan is maintained pursuant to Collective Bargaining Agreements. A copy of these documents may be obtained by participants and beneficiaries upon written request to the Fund office. The documents are also available for examination by participants and dependents.

Examine, without charge, at the plan administrator's 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 Benefits Security Administration.

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 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 summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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.

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 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.

Enforce Your Rights

If your claim for a 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 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 medical child support order, you may file suit in federal court. However, if you have a denied claim or disagree with the Plan’s decision regarding an order, you must appeal these decisions within the plan’s time limits before you can bring suit. 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 the 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 Your Questions

If you have any questions about your plan, you should contact the Fund 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 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, Room N-1513, Washington, DC 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.

TELEPHONE NUMBERS AND ADDRESSES

Participant Services (800) 638-2972

Fund Offices

Sparks, MD..... 410) 683-6500

Landover (301) 459-3020

InforMed (Certification of Care)

Toll Free..... (866) 290-8147

Toll Free..... (800) 638-6265

Value Options..... (800) 454-8329

Group Dental Service of MD..... (800) 242-0450

Spectera/United Optical..... (800) 638-3120

Fund Office

UFCW Unions & Participating Employers

Health and Welfare Fund

911 Ridgebrook Road

Sparks, MD 21152-9451

Special Post Office Boxes

Mail your **Disability claims** to our special post office box:

Fund Office

P.O. Box 1064

Sparks, MD 21152-1064

Attn: Weekly Disability

OneNet Medical/Hospital Claims:

OneNet PPO

P.O. Box 936

Frederick, MD 21705-0936

Send your non-OneNet **Medical/Hospital** claims to:

Fund Office

911 Ridgebrook Road

Sparks, MD 21152-9451