UFCW UNIONS AND PARTICIPATING EMPLOYERS HEALTH AND WELFARE FUND

PLAN Z
SUMMARY PLAN DESCRIPTION

September 2006

The Administrative Manager:

- Receives *participating employer*/employee contributions
- Keeps eligibility records
- Processes claims
- Provides information about the Fund

The Administrative Manager is:

Associated Administrators, LLC

911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

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

OR
Toll Free (800) 638-2972

Hours: 8:30 a.m. to 4:30 p.m., Monday through Friday

Automated Attendant

You can check the status of your claims 24 hours a day, 7 days a week by using the automated phone system. Call (800) 638-2972 and press "1" at the prompt. See page 93 for complete instructions.

Plan Z
September 2006

COVERED EMPLOYMENT

- Magruder's Inc. employees who became eligible for benefits **on or after** May 1, 2002
- Farmer's Market employees hired **on or after** July 2, 2003
- Ace Sushi
- Automated Communications
- Union Communications
- Retail Brand Alliance

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Note: Certain terms in this book are defined under the "Definitions" section on page 87. Such terms will appear in *italics* throughout this booklet.

DEAR PARTICIPANT,

The UFCW Unions and Participating Employers Health and Welfare Fund ("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 union and the *participating employer*s. 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 of benefits available. The *Trustees* have the power to interpret, apply and construe the terms of the Plan and make factual determinations regarding the Plan's construction, interpretation and application. Further, the Trustees may amend the rules and benefit levels at any time and may terminate the Plan. 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. Participants and beneficiaries have no vested rights to the benefits described in this booklet. Any decision made by the Trustees is binding upon *participating employers*, employees, participants, beneficiaries and all other persons who may be involved with, or affected by, the Plan. You will be notified of any material modifications (changes) to the 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 as "the *Fund office*" in this booklet) 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 and the Fund pays premiums. Benefits 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 as an explanation of your benefits--and the plan or formal agreements between the Fund and insurance carriers or providers of service, the plan and 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 your 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

FACTS ABOUT THE PLAN

Plan Name
UFCW Unions and Participating Employers Health and Welfare Fund

Plan Sponsor
Board of Trustees of the UFCW Unions and Participating Employers Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-2341, (410) 683-6500. A list of participating employers and employee organizations is on page 111.

Employer Identification Number	**Plan Number**
52-6044428	502

Type of Plan
This is a welfare plan designed to provide health care benefits such as: life, accidental death and dismemberment, hospitalization, medical, surgical, mental health, accident & sickness, prescription drug, dental, and optical benefits.

Type of Administration
Contract Administration - The Board of Trustees has contracted with Associated Administrators, LLC to provide administrative management services.

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, 911 Ridgebrook Road, Sparks, MD 21152-2341

Sources of Contribution
Sources of contributions to the Fund are participating employers pursuant to the terms of their *collective bargaining agreements* and self-payments made by participants and/or dependents.

Funding Medium
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 claim processing and administrative services related to such benefits. A current Summary Annual Report (available from the Plan Administrator) gives details of Plan funding of benefits. The Fund's assets are held by Mercantile Safe Deposit and Trust Company.

Plan Year and Fiscal Plan Year: January 1 -- December 31.

BOARD OF TRUSTEES

Union Trustees

C. James Lowthers, Chairman
UFCW Local 400
4301 Garden City Drive
Landover, MD 20785

Margaret Bohon
UFCW Local 27
21 West Road
Towson, MD 21204

Richard Eventoff
UFCW Local 27
21 West Road
Towson, MD 21204

Michael Earman
UFCW Local 400
4301 Garden City Drive
Landover, MD 20785

Employer Trustees

Steve Wood, Secretary
The Kroger Company
4111 Executive Parkway
Westerville, OH 43081

George Anderson
The Kroger Company
P.O. Box 14002
Roanoke, VA24038

John T. Dougherty
SuperValu, Inc.
10461 Manchester Road
Kirkwood, MO 63122

Julie McWilliams
Shoppers Food Warehouse
4600 Forbes Boulevard
Lanham, MD 20706

Making the Most of Your Medical Benefits
This booklet is more than a basic description of your coverage - 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

NOTICE - No Fund Liability
Use of the services of any *hospital*, clinic, doctor, or other provider rendering health care, whether designated by the Fund or otherwise, is the voluntary act of the participant or dependent. Some benefits may only be obtained from providers designated by the Fund. This is not meant to be a recommendation or instruction to use the provider. 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.

If the Fund pays benefits in error, such as where the Fund pays you more benefits than you are entitled to, or if the Fund advances benefits that you 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. 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 repayment of the benefits advanced by the Fund, you or your dependent or beneficiary shall pay all costs and expenses, including attorney's 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 become obligated to repay the Fund through the date that the Fund is paid the full amount owed.

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.

Right of Recovery
In the event that the Fund pays benefits on your behalf of which you are not entitled, the Fund has the right to collect any excess payment directly from you or from the providers involved, **or by offset against any future payment from the Fund** on your behalf. This right of the offset does not keep the Fund from recovering erroneous payments in any other manner.

SCHEDULE OF BENEFITS – SUMMARY

For Full Time Participants

Group A Benefits

Hospitalization	
Participant and Eligible Dependents	Semi-private room covered in full up to 180 days with no deductible, Coronary Care and Intensive Care Units covered in full up to the semi-private room rate with no deductible; balance covered under Comprehensive at 80%.
All Other Medical Benefits	
Participant and Eligible Dependents	$100 deductible, 80% of usual, customary and reasonable (UCR) fees paid up to an accumulation of $2,500 covered out-of-pocket expenses in a calendar year; 100% after accumulation of $2,500 out-of-pocket expenses in a calendar year; $350,000 lifetime maximum.
Mental Health/Substance Abuse Benefit	
Participant and Eligible Dependents	Comprehensive coverage as described under the "Mental Health/Substance Abuse Benefit" section. See page 82. **Mental health benefits paid are counted towards the $350,000 overall lifetime benefit maximum.**
Life Benefit	
Participant Only	$5,000
Accidental Death and Dismemberment Benefit	
Participant Only	$5,000

Group B Benefits

Weekly Disability Benefit Participant Only	
After 6 months continuous employment	Maximum Benefit - 66 2/3% of gross straight time pay for first 8 weeks plus 50% of gross straight time pay for the next 4 weeks.
After 3 years continuous employment	Maximum Benefit - 66 2/3% of gross straight time pay for first 16 weeks plus 50% of gross straight time pay for the next 8 weeks.
After 5 years continuous employment	Maximum Benefit - 66 2/3% of gross straight time pay for first 24 weeks plus 50% of gross straight time pay for the next 12 weeks.
Benefits begin	1st day of accident or hospitalization; 2nd day of *sickness*
Prescription Drug Benefit Participant and Eligible Dependents	5% *co-payment* if you use the pharmacy of a *participating employer*; 10% *co-payment* if you use any NMHC Rx pharmacy participating in NMHC Rx that is not the pharmacy of a participating Employer. If you live outside the geographic area of a participating pharmacy, the 5% *co-payment* will apply.
Dental Benefit Participant and Eligible Dependents	Comprehensive coverage as described in "Dental Benefit" section. See page 58.
Optical Benefit Participant and Eligible Dependents	Exam, frames, and lenses once every two years.

SCHEDULE OF BENEFITS – SUMMARY

For Part Time Participants

Group A Benefits

Hospitalization	
Participant and Eligible Dependents	Semi-private room covered in full up to 180 days, Coronary Care, and Intensive Care Unit covered in full up to the semi-private allowance; balance covered under Comprehensive at 80%.
All Other Medical Benefits	
Participant and Eligible Dependents	$100 *deductible*, 80% of ***usual, customary and reasonable (UCR)*** fees paid up to an accumulation of $2,500 covered out-of-pocket expenses in a calendar year; 100% after accumulation of $2,500 out-of-pocket expenses in a calendar year; $350,000 lifetime maximum.
Mental Health/Substance Abuse Benefit	
Participant and Eligible Dependents	Comprehensive coverage as described under the "Mental Health/Substance Abuse Benefit" section. See page 82. **Mental health benefits paid are counted towards the overall lifetime benefit maximum.**
Life Benefit	
Participant Only	$2,500
Accidental Death and Dismemberment Benefit	
Participant Only	$2,500

Group B Benefits

Weekly Disability Benefit Participant Only	
After 1 year continuous employment	Maximum Benefit - 60% of average weekly straight time pay for first 8 weeks; 50% for the next 4 weeks.
After 5 years continuous employment	Maximum Benefit - 60% of average weekly straight time pay for first 16 weeks plus 50% for the next 8 weeks. Benefits begin 1st day of accident or hospitalization; 4th day of *sickness*.
Prescription Drug Benefit Participant and Eligible Dependents	5% *co-payment* if you use the pharmacy of a *participating employer*; 10% *co-payment* if you use any NMHC Rx pharmacy that is not the pharmacy of a participating employer.. If you live outside the geographic area of a participating pharmacy, the 5% *co-payment* will apply.
Dental Benefit Participant and Eligible Dependents	Comprehensive coverage as described in "Dental Benefit" section. See page 58.
Optical Benefit Participant and Eligible Dependents	Exam, frames, and lenses once every two years.

EMPLOYEE ELIGIBILITY

Initial Eligibility – Full Timers

If you are a full time employee, your participation begins on the first day of the calendar month in which your *participating employer* is required to make the first contribution to the Fund on your behalf. On this day, you are eligible for Group A benefits. You will become eligible for Group B benefits after you are eligible for Group A benefits for three months.

> Look in your *collective bargaining agreement* for the date your employer is required to begin making contributions on your behalf.

Initial Eligibility – Part Timers

If you are a part time employee, your participation begins on the first day of the calendar month following three months from the date your *participating employer* is required to make the first contribution to the Fund on your behalf. On this day, you are eligible for Group A benefits. You will become eligible for Group B benefits after you are eligible for Group A benefits for six months.

Delay in Eligibility

If you are absent from work on the day your eligibility for any group of benefits would otherwise begin, you will not be eligible for those benefits until the day you actually return to work with a *participating employer*. However, if you are not *actively at work* 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, provided you actually began work covered by the Fund.

Retirees

This Plan does not include Retiree Health and Welfare coverage.

Transfers

Any employee of a *participating employer* who comes into the jurisdiction of a participating *union* because of a geographical transfer or change in job classification will have the initial eligibility requirements waived, provided:

1. the *participating employer* agrees to make contributions to the Fund beginning with the first month following the date of the transfer or change of job classification; and
2. the length of the employee's non-covered employment was sufficient to otherwise satisfy the Plan's initial eligibility requirements.

You are eligible for all benefits on the first day of the calendar month following the date of transfer or reclassification. If you are employed by a *participating employer* within 30 days of termination of coverage under the UFCW Unions and Participating Employers Health and Welfare Fund ("the Fund"), you will be eligible for benefits under this Fund according to your total length of covered employment under both Plans.

If, within the same company, you are transferred from a food to a non-food classification or from a non-food to a food classification, you will be entitled to immediate benefits. The level of benefits is determined by the contribution rate.

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 who are listed on the enrollment card will be 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 17 of this SPD for more information on *QMCSOs*.

Continued Eligibility

Once you are initially eligible, you become and remain a participant as long as you are employed by a *participating employer* making contributions on your behalf and you are in a position covered by a *collective bargaining agreement* with a participating *union*. 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 Accident and Sickness 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 ("*FMLA*") as described on page 26

Loss of Eligibility

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, except as provided under *USERRA* (see page 27)
5. leave of absence
6. unpaid vacation for which no contributions are made to the Fund
7. exhaustion of Weekly Disability benefits provided by this Plan
8. absence because of an accident or *sickness* compensable under Workers' Compensation exceeding your Weekly Disability Benefit entitlement
9. the end of the *participating employer*'s obligation to make contributions pursuant to a *collective bargaining agreement*
10. your *participating employer*'s failure to make the required contributions to the Fund on your behalf
11. death.

If loss of eligibility occurs due to your termination of employment, a reduction in your hours of employment, or death, you and your eligible dependent(s) may be entitled to continue your coverage under *COBRA*, as explained on page 21. In addition, if loss of eligibility occurs due to military service, you may be entitled to continue your coverage under "*USERRA*" as explained on page 27. Further, you may be entitled to continue your eligibility by making self-payments. See the "Self-Payments" section on page 28 for complete details of this provision.

Certificate of Prior Coverage

If you or your covered dependents lose eligibility for any reason, you 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.

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 17). 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 in the Summary Plan Description. 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 enroll 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 break in coverage. Waiting periods do not count as Creditable Coverage, but neither do they count as Creditable 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 illness or disease, supplemental benefits such as *Medicare* Supplemental insurance, and any other benefits as defined under Section 773 (c) or 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 "Claims Filing and Review Section" on page 92. 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.**

Certificate of Coverage

If you lose Fund coverage, including COBRA continuation coverage, for any reason, the Fund will send you and/or your dependents a Certificate of Coverage.

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

Date Benefits Terminate

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

- **Medical** benefits terminate at the end of the calendar month in which you lose eligibility. However, if you or your eligible dependent are in the *hospital* when loss of eligibility occurs, these benefits will continue for the hospitalized person until he or she is discharged or until the benefits are exhausted, whichever occurs first.

- **Life** benefits terminate 31 days following the loss of eligibility, but **Accidental Death and Dismemberment** benefits terminate on the day loss of eligibility occurs. See page 48 for the Life Conversion Privilege.

- **All Other** benefits terminate on the day you lose your eligibility. However, Weekly Disability will be continued to a participant who is disabled and receiving such benefits when loss of eligibility occurs, until the end of the disability or until this benefit is exhausted, whichever occurs first.

Reinstatement of Eligibility

If you lose your eligibility because of layoff, or a leave of absence approved by your *participating employer*, and you return to *active employment*, you will be reinstated to eligibility status on the first day of the month in which your *participating employer* makes a contribution on your behalf. If you lose your eligibility because of military service, you will be reinstated as provided under the provisions of *USERRA* (see page 27). If you lose your eligibility for any other reason, but become *actively employed* again by the same or another *participating employer* within 30 days, your eligibility will automatically be reinstated on the day you return to *active employment* and contributions are made on your behalf. If the separation is 31 days or longer, you must again meet the initial eligibility requirements. The contribution rate paid by the *participating employer* will determine the level of benefits you receive.

Change of Status

A full time participant who met the initial full time eligibility requirements and was reduced to part time status will

be eligible for the part time schedule of benefits beginning the first of the calendar month following the month in which he or she was reduced. However, if the reduction to part time is involuntary, the *participating employer* will continue full time contributions and you will continue to be eligible for full time benefits until the first of the calendar month following the period determined by your *collective bargaining agreement*.

A part time participant who met the initial part time eligibility requirements and is later reclassified to full time status will be eligible for the full time schedule of benefits only after satisfying the initial full time eligibility requirements. During the period before you satisfy those full time requirements, you will remain eligible for the part time schedule. However, if you had previously satisfied the full time eligibility requirements and are reclassified to full time status, you will be eligible for the full time schedule of benefits on the first of the calendar month following the month you are reclassified.

An eligible courtesy clerk promoted to either a full time or part time clerk will have his or her total length of employment counted toward the initial eligibility requirements of a full time or part time clerk.

DEPENDENT ELIGIBILITY

Eligible dependents include your spouse and children only. The children covered are your biological children, stepchildren, legally adopted children, or children placed with you for adoption. In order for children to be eligible for coverage, they must be:

- under the age of 19
- not married
- not employed on a regular full time basis, and
- dependent on you for support.

Stepchildren must reside with the eligible participant. The Plan requires you to submit evidence of the dependent(s) eligibility status--a birth certificate for your child, adoption papers or other proof of adoption or placement for adoption acceptable to the *Trustees*, 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 *Qualified Medical Child Support Order* ("*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.

Order/Notice to Withhold Income for Child Support

An Order/Notice to Withhold Income for Child Support 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 QMSCO, 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 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 which would otherwise be excluded from coverage will not apply to a child who is adopted or placed for adoption with the participant.

Legal Custody

If you are a full timer and have legal custody of a child, you can enroll the child for dependent coverage under the Fund. To request coverage, you must write to the Board of *Trustees* and get approval. The child must have been under court-awarded legal custody for a minimum of six months before coverage can begin. You must also submit a notarized letter every six months that the custody remains in force. Pre-existing medical conditions are subject to the pre-existing condition exclusion on page 13.

Full Timers: Waiting Period for Dependent Eligibility

Dependents of full time participants are eligible for benefits on the same date as the participant. Dependents of full time Non-Food Clerks and Service Clerks hired on or after January 1, 1987 have a 24 month waiting period, with

coverage beginning the first of the month following completion of the waiting period, provided the dependent is properly enrolled.

Part Timers: Waiting Period for Dependent Eligibility
Dependents of part time participants are eligible for benefits on the first day of the calendar month following the participant's completion of 24 months of continuous active employment with a *participating employer*. Any breaks in active employment will not count toward the 24 month requirement.

Part Timer Dependent Coverage--Cost
Part timers pay part of the cost for dependent coverage. Your employer pays 80% of the cost and the participant pays 20% (via payroll deduction with your employer). Contact your employer to see how much the payroll deduction will be. Your employer will set up payroll deductions to begin with the first month you are eligible for dependent coverage. Dependent coverage will not begin until the month in which your first payroll deductions are made. Note that this payroll deduction for dependent coverage is **not the same** as any monthly co-payment you may be making for choosing an HMO to provide your medical coverage. The payroll deduction for dependent coverage applies in addition to any HMO monthly co-payment which may apply.

Part Timers: If you fail to enroll your dependents upon initial eligibility, you can only enroll them during the months of January and July, each year.

Enrolling New Dependents – FULL TIMERS AND PART TIMERS

In order for your eligible dependents to be covered on the first date they are eligible (their "initial *eligibility* date"), you must enroll prior to their initial *eligibility date*. To do this, notify the *Fund office* that you want dependent coverage between your 21st - 23rd months of employment (which is one to three months before the dependent would become eligible for the coverage). The *Fund office* will set up payroll deductions via your employer (see "Cost" next section). Your dependent coverage will begin in the month in which your firs payroll deduction is made. **If you fail to enroll your dependents upon initial eligibility, you can do so only during the enrollment periods, which are from January 1 -31 and July 1 – 31 each year. See the section entitled, "Open Enrollment for Dependent Coverage" below.**

Once you have satisfied the waiting period for dependent coverage, a **new** eligible dependent can be included for benefit coverage by notifying the *Fund office* and completing a new enrollment card. You must apply for dependent coverage **within 30 days** of the date your family member becomes your dependent. When you apply for dependent coverage within 30 days, your eligible spouse may be included for benefit coverage on the first day of the calendar month following the date of marriage.

When you apply within 30 days of the date of birth, biological children and/or newborn children adopted or placed for adoption with a participant may be added at the date of birth. When you apply within 30 days, stepchildren may be added on the first of the month following your date of marriage.

Full Timers: If you do not enroll for dependent coverage within 30 days of the date your family member becomes your dependent, your dependent's coverage will begin on the first of the month following the date you enroll him or her as your dependent. There will be no retroactivity.

Part Timers: If you do not enroll your dependent within 30 days of the date he or she became your dependent, you must wait until Open Enrollment for Dependent Coverage (January and July each year) to add him or her. Coverage would be effective on March 1st if the dependent is added during the January enrollment period, and effective September 1st if the dependent is added during the July enrollment period. See the section on Open Enrollment for Dependent Coverage for Part Timers, following.

Proof of Eligibility for Dependents – All Participants
The participant must submit evidence acceptable to the *Fund office* to certify the eligibility status for 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 or your dependents, even if you turned it down when you firs 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 ended.** 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 provision if the other coverage was lost because you stopped paying premiums.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

Open Enrollment for Dependent Coverage: PART TIMERS ONLY!
If you did not enroll for dependent coverage when you were first eligible, you may do so during the months of January and July each year. If you submit a request to the *Fund office* during January, your payroll deductions and your dependent coverage will begin March 1st. If you submit a request in July, the deductions and coverage will begin September 1st. You can cancel your coverage at any time by notifying the *Fund office* in writing. However, once you have cancelled your dependent coverage, **you cannot re-apply for it until the open enrollment period following 12 full months from the date you cancelled the coverage**. Call the *Fund office* if you have questions concerning the monthly rate for dependent coverage.

Do You Already HAVE Coverage on A Dependent?
See "Coordination of Benefits" on pages 30-31 for the rules governing availability of dependent coverage under the Plan when more than one group plan is available.

Newborn Children
Benefits begin at birth for any eligible newborn children or newborn children adopted or placed for adoption with a participant, provided the participant is eligible for dependent coverage and has added the child(ren) by submitting a new enrollment card within thirty days of birth or adoption.

A baby born to a female participant or a newborn baby adopted or placed for adoption with a female participant who is not entitled to dependent coverage will be eligible for medical benefits only from the date of birth until the end of the month following the date of birth. For example, if a baby is born on April 15th, he/she will be covered through May 31st.

This extension of coverage only applies if the female participant is not entitled to dependent coverage. If a participant is eligible for dependent coverage, the newborn, the newly born child placed for adoption, or newly born adopted child must be enrolled in order to be covered under the Plan.

Loss of Dependent Eligibility
Your dependents cease to be eligible for benefits when:

1. You lose your own eligibility.

2. The dependent becomes eligible as an employee of a *participating employer*.
3. The dependent is a spouse and is divorced or legally separated from you. If you and your spouse are physically separated, but not legally separated, your spouse may remain a dependent until the earlier of 3 years from the date of physical separation or the date of divorce or legal separation.
4. The dependent is a child and it is the earlier of:
   a) the calendar year in which the child has his or her 19th birthday
   b) the month in which the child begins regular full time employment
   c) the calendar year in which the child ceases to be dependent on you for support
   d) the month in which the child is married.
5. In the case of a child placed with you for adoption, when you no longer have a legal obligation to support the child.

Dependents of an eligible participant who will lose eligibility under the Plan may be entitled to continue coverage under the provisions of *COBRA* as described on page 21.

Student Coverage

Student coverage includes medical and optical benefits only.

If an otherwise eligible dependent child will lose eligibility due to age, and the child is not eligible for COBRA rights or, if eligible, elects to waive *COBRA* rights, **medical** and **optical** benefits may continue without cost to him or her, provided that he or she is enrolled as a full time student in an accredited school; is unmarried; is financially dependent on you for support; and if eligible, rejects his/her option to elect *COBRA* coverage under the *Fund*. You must complete a student certification form and return it to the *Fund office* before the child's 20th birthday and annually thereafter in order for coverage to be continued. Students are eligible for coverage only through the calendar year in which they become 23.

If you do not complete a student certification form or the child is not enrolled in school at the time he/she loses eligibility for benefits under the Plan, the child's coverage under this Plan will cease. However, you may submit a subsequent student certification form and obtain coverage from the Plan after the applicable waiting period. Contact the *Fund office* for details concerning student coverage.

Important: In order to receive student coverage for a dependent who is over age 19, he/she must have been a covered dependent under the Plan BEFORE he/she turned age 19.

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 for Disabled Dependents

Any unmarried child who is age 19 or over who is incapable of self support because of a physical or mental disability which began before age 19 may continue to be covered as an eligible dependent for all dependent benefits offered by the Plan, provided that the child elects to waive *COBRA* rights. The child must be dependent upon the participant for support. You must complete a disability certificate annually and return it to the *Fund office*. See also "*Medicare*--Coordination of Benefits for Participants Who Are *Actively Working*," on page 30.

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

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 may 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. However, if a participant obtains coverage, including Medicare, after he or she has elected COBRA under the Fund, such COBRA coverage may be terminated.

Spousal Rights

The dependent spouse of an eligible participant may continue coverage for himself or herself if he or she loses covered under the Plan 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 an eligible participant may continue coverage for himself or herself if he or she loses coverage under the Plan 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 that 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, 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 the *participating employer* 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. If the participant or eligible dependent fails to notify the *Fund office* within 60 days of such an event, the right to elect *COBRA* continuation coverage will be forfeited.

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 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, the participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund. However, these events are second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. 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 or 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 is terminated due to the participant's:
   a) termination of employment, other than for gross misconduct; or
   b) reduced work 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 CHAMPUS (as an employee or otherwise) that 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 re-marry 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* stops participating in the Plan, 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*.
8. The date the applicable period of continuation coverage is exhausted; or
9. The first month that begins more than 30 days after the Social Security Administration's determination that you or your eligible dependent are 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 mailed or hand delivered to the Fund office, Attention: COBRA Department, at UFCW Unions and Participating Employers Health and Welfare Fund, 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* or 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 and Dismemberment Benefit, or the Accident and Sickness 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 continued 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.

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 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 will be 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 required premiums.

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*)

The Family and Medical Leave Act of 1993 *("FMLA"*) requires *participating employer*s 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 USERRA

As required by the Uniformed Services Employment and Re-Employment Rights Act of 1994 ("*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 begins from employment due to military service, including Reserve and National Guard Duty, as described on 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 the 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 the *USERRA* by the same method that the Fund uses to determine the cost of COBRA continuation coverage. See page 24.

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 after 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 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 remit payments to the *Fund office*. Late payments can result in termination of coverage.** You are responsible for the payment of 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

A participant who is granted a leave of absence in writing by a *participating employer* may elect to continue coverage 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 your eligibility status by making self-payments directly to the Fund.

If you choose to self-pay, you may continue:
1. Medical benefits **ONLY**;
2. Life and Accidental Death and Dismemberment benefits **ONLY**;
3. Drug, Optical and Dental benefits **ONLY**; or
4. Any combination of these three groups.

You may make self-payments only for those benefits for which you were eligible as of the last 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.

   You have 30 days in which to elect to make self-payments.

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* at 911 Ridgebrook Road, Sparks, MD 21152-9451, Attn: Eligibility.

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 18 months following your loss of eligibility.

5. Self-payments will no longer be necessary when you return to work and your *participating employer* resumes contributions on your behalf.

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 CHAMPUS 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.

COST CONTAINMENT

The following cost containment measures have been instituted by the Board of *Trustees* to help you receive quality *medical care* at the most reasonable cost. You'll find an explanation of each in this booklet on the page indicated.

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COORDINATION OF BENEFITS

Coordination of Benefits applies when a participant or dependent is entitled to benefits under any other kind of group health coverage in addition to the Fund. When duplicate coverage exists, the primary plan normally pays benefits according to its Schedule of Benefits, and the secondary plan pays a reduced amount. **The Plan will never pay, either as the 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 another plan. The Fund is authorized to obtain information about benefits and services available from *Medicare* or other plans to implement this rule.

The following rules apply:
If one plan does not have a coordination of benefits rule, it will be primary. Otherwise, the plan which covers the person as an employee is the primary plan. The plan which covers the person as a dependent is the secondary plan.

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:
1. If a court determines financial responsibility for a child's health care expenses, the plan of the parent having that responsibility pays first.
2. If a court determination has not been made or divides the responsibility equally, the plan of the parent with custody pays before the plan of the other parent. The plan of the step-parent married to the parent with custody of the child pays before the plan of the parent who does not have custody.

Important Notice – Read Below!
When an eligible dependent under the Plan is offered a program of health, dental, drug, and/or vision benefits by another employer as a result of his or her employment, and the dependent has the option of selecting the other employer's health coverage or receiving cash or other financial incentive, this Plan coordinates its benefits as if the other employer's health coverage were applicable. It does so even when the dependent does not elect the coverage under another employer-sponsored plan.

Before the Fund will pay benefits to an employed dependent, he or she must provide the *Fund office* with information explaining the other employer's health coverage, if any.

Medicare - Coordination of Benefits For Participants Who Are "*Actively Working*"

If you work for an employer with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or proceeding calendar year, and the Fund has obtained an exception from the Health Care Financing Administration ("HCFA") for your Employer, then Medicare is primary for you and your dependents. Otherwise, the following rules apply.

All active participants over age 65 and spouses over age 65 of active participants of any age will be entitled to receive coverage under this Plan under the same conditions as a participant or participant's spouse under age 65.

Absent an election (described below), the Plan will be the primary payor of medical costs for active participants, and spouses over age 65 of active participants of any age, with *Medicare* providing secondary coverage. This means you

will be reimbursed first under this Plan (except in the case of End Stage Renal Disease "ESRD," as set forth below). If there are covered expenses not paid by the Plan, *Medicare* may reimburse you--if the expenses are covered by *Medicare*. To get reimbursement from *Medicare*, you must enroll for *Medicare*. In addition, to get coverage under Part B of *Medicare*, you must enroll and pay a monthly premium.

1) Election of Medicare
If you are age 65 or older you are still entitled to elect *Medicare* as your primary coverage in lieu of the Plan. However, an active participant over age 65 or an active participant's spouse over age 65 will automatically continue to be covered by this Plan as the primary plan unless you a) notify the *Fund office*, in writing, that you do not want coverage under this Plan or b) you cease to be eligible for coverage under this Plan. If you elect your coverage under *Medicare* to be primary, the Plan cannot, under law, pay benefits secondary to *Medicare*. If you have any questions about the coordination of benefits under this Plan with *Medicare* benefits, contact the *Fund office*.

2) Disability
If you are actively employed and you or your eligible dependent(s) are under age 65 and are entitled to *Medicare* due to disability (other than ESRD), the Plan will pay benefits as primary.

3) End Stage Renal Disease (ESRD)
If you or your eligible dependent(s) 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
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 by the Fund as secondary payer**. If you go outside of your HMO for services (or otherwise fail to follow the rules of the HMO), and then submit the bill to the Fund for secondary payment, it will be denied.

For purposes of coordinating benefits, an HMO is treated the same as any other plan. **If you fail to follow the rules of any plan, including an HMO, the Fund will not pay benefits as either primary or secondary.**

The Fund also has the right to collect any 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 notify 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.

Important: To ensure that the Fund coordinates and pays your benefits properly, you must keep the Fund informed of any and all coverage for you and your eligible dependent.

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

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 rust, 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 our 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 to 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 covered 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 to you, your dependent or your attorney may receive as 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 choose 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 choose 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. 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 waive 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.

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.

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.

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 Accident and Sickness 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 denied because is not compensable, meaning that it is not work-related. 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 determines that your claim is 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 attorney's 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 generically. To help keep prescription costs down, only generic drugs will be covered as long as a generic equivalent is available.

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 – any 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 Optum/CARE Programs.

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.

Using 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 consult your OneNet Directory or look online at www.onenetppo.com when choosing a provider of medical service and verify with the provider that it participates with OneNet.

ONE NET 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. You must use a OneNet PPO provider to have coverage for hospital, medical, or surgical benefits under the Fund.

OneNet PPO, LLC discounts claims when you use a participating provider, but **OneNet PPO is not your insurance carrier.** Your coverage is provided through the Fund.

Provider directories are furnished automatically, without charge, as a separate document. Select a provider from the directory, or online at www.onenetppo.com or call the OneNet Member Services Department at (802) 342-3289. OneNet Member Services will assist you in locating a provider and can also verify that the health care provider you selected participates with OneNet PPO. Also, verify that the health care provider you selected participates with OneNet when you make your appointment since information in the directory is subject to change. At your appointment, show your Fund ID card and tell the *physician or facility* that you participate with OneNet PPO. **Write "AL0006" on your itemized bill.** This number tells OneNet exactly 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

OneNet PPO will discount the claim and forward it to the *Fund office* for processing. **If you do NOT use a OneNet PPO provider**, send your claim directly to the *Fund office* at:

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

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 PPO provider. Check with the *physician* before having the procedure.

You still must:

- continue to get Optum/CARE pre-certification and second opinions
- use ValueOptions for mental health and substance abuse problems
- use dentists within Group Dental Service
- use opticians within United Optical

A OneNet PPO provider should **not** require payment 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 at the time of your visit for covered services, remind the provider that payment will be made by the Fund after OneNet discounts 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.

Important

For laboratory services, you must use Quest or LabCorp. Quest and LabCorp are contracted with OneNet PPO.

OPTUM/CARE PROGRAMS, INC.
(CERTIFIED ADMISSION REVIEW AND EVALUATION)
If You Have Chosen an HMO Option for Providing Your Medical Benefits, Optum/CARE Programs Does Not Apply to You

Optum/CARE Programs is a cost containment program designed to control *inpatient hospital* costs by reducing unnecessary admissions. Optum/CARE 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 Optum/CARE Programs 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.

Optum/CARE certification is required to determine the *medical necessity* of procedures. Optum/CARE 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*. Optum/CARE provides advisory opinions using medically recognized standards. At no time will Optum/CARE interfere with the delivery of high quality care to you. You should contact Optum/CARE when you need to be admitted or require services for:

1. Elective (Non-Emergency) Admission (Requires Certification Prior to Admission)
   - Call Optum/CARE Programs -- **(800) 638-6265** (From Baltimore Area: **(410) 265-7182**)
   - 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 Optum/CARE program and that Optum/CARE 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 Optum/CARE.** Follow the steps for elective (Non-Emergency) Admissions above.

Concurrent Care

Optum/CARE Programs will monitor your stay while in the *hospital* to assure an appropriate length of confinement. Optum/CARE 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, Optum/CARE 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 a peer-to-peer telephone discussion between your *physician* and an Optum/CARE Medical Director regarding the *medical necessity* of the treatment or services being rendered.

2. Expedited Appeals

Your *physician* may appeal Optum/CARE's decisions on an expedited basis by calling Optum/CARE's Utilization Review Department or 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 disagree with the outcome of an expedited appeal, he/she may initiate a standard appeal within 30 days from the date of Optum/CARE's non-certification notification.

3. Standard Reviews

All appeals to Optum/CARE must be made within 180 days from the date you are notified of Optum/CARE's decision. A written or verbal request for a standard appeal 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 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 Optum/CARE's decision will be sent to you, your *physician*, the facility and the Fund within 30 days following the receipt of your appeal and all the necessary documentation. The clinical rationale, clinical criteria, and copies of any other documents relevant to the 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 Optum/CARE'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 received Optum/CARE's decision on review to uphold its non-certification.

If you do not wish to go through Optum/CARE'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 you received Optum/CARE's original decision to deny your certification. See "Review of A Denied Claim," page 96, for more information.

DURABLE MEDICAL EQUIPMENT NETWORK ("DME")
If You Have Chosen One of The HMO Options for Providing Your Medical Benefits, the DME Network Does Not Apply to You

Durable Medical Equipment (DME) is covered by the Fund through the DME network administered by Optum/CARE Programs, Inc. Use *the Durable Medical Equipment* network 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

Optum/CARE's network of DME suppliers includes (but is not limited to):

- Kirson
- Homedco
- Home Health Equipment Company
- United Health Care Services
- Morsch Medical Equipment

Because Optum/CARE 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 Optum/CARE at 800-638-6265 as soon as you know you will need *durable medical equipment*. Optum/CARE 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 Optum/CARE. Optum/CARE 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 Optum/CARE Programs.

MANDATORY SECOND SURGICAL OPINION PROGRAM

If You Have Chosen an HMO Option for Providing Your Medical Benefits, the Mandatory Second Surgical Opinion Does Not Apply to You

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, Diskectomy, 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 usual, customary and reasonable (***UCR***) 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 will 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 Optum/CARE Programs:

Baltimore Area........(410) 265-7182
Toll free......(800) 638-6265

Optum/CARE provides *physician* referrals and can answer any questions you have about the program. Tell the Optum/CARE representative you would like to arrange a second opinion. Optum/CARE will recommend that you seek a *physician* in the appropriate specialty. If you need the name of a *physician*, Optum/CARE 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 Optum/CARE.

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*.

HOMECARE PROGRAM

HomeCare benefits are provided through the Fund, not insured.
Benefit claims are *administered* by Optum/CARE Programs.

If You Have Chosen One Of The HMO Options For Providing Your Medical Benefits, the HomeCare Program Does Not Apply To You--Contact Your HMO To Determine Your Coverage

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 Optum/CARE Programs. 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 Optum/CARE Programs**.

If you believe you need HomeCare, have your *physician* contact Optum/CARE Programs. Optum/CARE will discuss your treatment with the *physician* and determine whether the services are *medically necessary*. Optum/CARE'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*). Optum/CARE 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 Optum/CARE Programs at (800) 638-6265 or (410) 265-7182.

HOSPICE CARE SERVICES

Hospice Care benefits are provided through the Fund, not insured.
Benefit claims are *administered* by Optum/CARE Programs.

If an HMO Provides Your Medical Benefits, These *Hospice Care* Services Do Not Apply to You--Contact Your HMO to Determine Your Coverage

Up to 30 days of *Hospice Care* Services are covered at 100% of the *UCR*. These 30 days are included in the 180-day Hospitalization maximum. (You do not have 180 days of Hospitalization benefits plus 30 days of *Hospice Care*. You have a maximum of 180 days Hospitalization benefits, of which 30 may be used for *Hospice Care*.) Should the Hospice stay extend beyond 30 days, additional days will be covered under Comprehensive 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 Optum/CARE Programs.

For more information about HospiceCare, contact Optum/CARE Programs at (800) 638-6265 or (410) 265-7182.

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.

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*. You will be mailed 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.

LIFE BENEFIT

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

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.

There are different benefit amounts in the schedule of benefits, depending on your status (full time or part time). A part time participant who has satisfied the initial eligibility requirement and is later promoted to full time will continue to be eligible for the part time life benefit until eligible for full time benefits. A participant is never eligible for both a part time and a full time life benefit.

Beneficiary Designation
You may name any person you choose to be your beneficiary. You may change the named beneficiary at any time.

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 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*.

Waiver of Rights
A beneficiary may waive his or her rights as beneficiary under the Plan in an entered court order, provided that such order contains a clear waiver of rights. The waiver will become effective only when it is received by the Fund and will be effective only if the Fund has not made payment or taken other action before the waiver was entered. A waiver in a court order meeting the above requirements will supersede any prior conflicting beneficiary designation that has been filed with the *Fund office*. If a court order contains a waiver of rights by the beneficiary on file with the *Fund office*, and you subsequently die without naming a new beneficiary, then the Fund may pay the death benefit to the first survivor in the following order:

1. Your surviving spouse
2. Your surviving children
3. Your surviving parents
4. Your surviving brothers and sisters
5. The executor of administrator of your estate

* These same beneficiary designation procedures apply to the Accidental Death and Dismemberment benefits payable on your behalf under the Plan.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

ING/ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, MN 55440
(Participant Only)

This benefit is payable if you suffer any of the losses below as a result of and within 180 days from the date of an accident occurring while you are covered under the Plan .

For Loss of:	Benefit Amount is as stated in the "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 for the insured during all periods of coverage under the policy will be paid for more than one loss for which the full amount is payable, nor for more than two losses for which half the amount is payable.

The benefit for accidental death is in addition to the life insurance benefit.

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 illness
- 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

Beneficiary Designation
Your beneficiary for Life Insurance and 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, 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 this occurs, 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 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 pursuant to the order listed above.

Group Policy Information – Life AD&D

The group policy has been issued to the UFCW Unions and Participating Employers Health and Welfare Fund. The group policy is on file and may be examined at the *Fund office*. **The policy number is GL-13228-4.**

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 COVERAGE

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, by applying to ING/ReliaStar at this address:

ING/ReliaStar Life Insurance Company
Post Office Box 20
Minneapolis, MN 55440

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 your insurance is terminated due to discontinuance of the Plan, you have the same conversion privilege if insured under this Plan for five years or longer, except that the amount of life insurance will be reduced by the amount of any life insurance you are eligible for under any new plan within 31 days of termination or $10,000, 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

Life and AD&D
Notice of a Life and/or Accidental Death and Dismemberment Claim 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 92.

WEEKLY DISABILITY (ACCIDENT & SICKNESS) BENEFITS

Benefits are provided through the Fund, not insured.
Benefit claims are processed by Associated Administrators, LLC

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 to the extent that he/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 received by the *Fund office* within 180 days from the date your disability began. Continuation forms are sent to you every six weeks (or as needed) and must be returned within four weeks of the date sent by the *Fund office*. If your continuation form is not returned on time, you will not receive any additional 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 ValueOptions. 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).

   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.

3. Your *participating employer* must complete its section of the form.

4. 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.

5. 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. This rule will be waived if your physician provides documentation that he/she has been treating you on a regular basis for that same disability. The usual waiting periods for when benefits begin will apply.

6. No disability will be considered as beginning until after your last day worked.

7. Requests for additional information from the Fund must be returned within two weeks from the date mailed by the Fund.

8. 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).

9. 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 and Limitations" on page 79),
   b. caused by an act 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.

   If the felony or willful misconduct is the use of illegal substances, claims will be denied except when you are already in a treatment program approved by ValueOptions at the time of the *injury* or *sickness*, or, if your mental health 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.

10. 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 accident and sickness benefits.

11. Benefits will not be payable for days used as vacation days or other time paid by the *participating employer*.

12. 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*.

13. 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.

14. 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.

15. Lack of knowledge of coverage does not excuse these requirements.

16. No benefits will be paid to any participant who owes money to the Fund.

17. 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.

18. If the Fund receives an Order/Notice to Withhold Income for Child Support directing that Weekly Disability benefits be paid to satisfy a participant's child support obligations, and benefits are currently payable or become payable while the order/notice is in effect, the Fund will make payment to either the state agency or alternate payee listed in the order/notice.

19. You must actively be receiving treatment from a physician to improve the condition which is causing your disability.

Benefit Amount -- Full Time Participants

The weekly benefit amount will be determined by the length of continuous employment with a *participating employer* based on the following schedule.

After 6 months continuous employment*	Maximum Benefit - 66 2/3% of gross straight time pay for first 8 weeks plus 50% of gross straight time pay for the next 4 weeks.
After 3 years continuous employment*	Maximum Benefit - 66 2/3% of gross straight time pay for first 16 weeks plus 50% of gross straight time pay for the next 8 weeks.
After 5 years continuous employment*	Maximum Benefit - 66 2/3% of gross straight time pay for first 24 weeks plus 50% of gross straight time pay for the next 12 weeks.

* Note that the length of time worked is used only to determine the percentage of pay and the duration of the benefit. You must first be eligible for Weekly Disability benefits as explained in the Eligibility Section starting on page 12.

Benefits begin on the first day of disability if the disability is due to an accident. Benefits begin immediately upon hospitalization if it occurs any time during your waiting period.

Hospitalization after your waiting period will not cause your waiting period to be waived. However, there are approximately 65 *outpatient* medical procedures for which the Fund will pay benefits beginning on the first day of the disability if the procedure is performed on the first day of disability. Contact the Accident and Sickness Department to see if your planned *surgery* is on this list.

Benefits begin on the second day of disability if it is because of *sickness*. The daily benefit amount will be 1/5 of the weekly benefit amount. However, in the case of a work-related disability, where the Fund is providing a Supplemental benefit, the daily benefit amount will be 1/7 of the weekly benefit amount to conform with Workers' Compensation payments. Sundays or other premium days will not be counted in determining the benefit amount, but shift premiums will be counted. Benefits will not be paid for your regular day off.

Example of benefit amount computation (Full Timers):
1st 8 weeks:

Hourly rate	= $10.00
$10.00 x 40	= $400.00 gross straight time pay
$400.00 x .666666 (66 2/3%)	= $266.67 weekly benefit amount
$266.67 ÷ 5	= $53.33 daily benefit amount

Next 4 weeks:

$10.00 x 40	= $400.00 gross straight time pay
$400.00 x .5 (50%)	= $200.00 weekly benefit amount
$200.00 ÷ 5	= $40.00 daily benefit amount

Benefit Amount -- Part Time Participants
The weekly benefit amount will be determined by the length of continuous employment with a *participating employer* based on the following schedule.

After 1 year continuous employment*	Maximum Benefit - 60% of average weekly straight time pay for first 8 weeks plus 50% of average weekly straight time pay for the next 4 weeks.
After 5 years continuous employment*	Maximum Benefit - 60% of average weekly straight time pay for first 16 weeks plus 50% of average weekly straight time pay for the next 8 weeks.

* Note that the length of time worked is used only to determine the percentage of pay and the duration of the benefit. You must first be eligible for Weekly Disability benefits as explained in the Eligibility Section starting on page 12.

Your average weekly straight time pay is based on the average straight time hours worked in the five full pay weeks preceding the disability, as reported to the Fund by your *participating employer*. Sundays or other premium days are not counted in determining the benefit amount, but shift premiums will be counted.

Benefits begin as of the first day of disability if it is due to an accident which immediately disables you from working. Benefits begin immediately upon hospitalization if it occurs at any time during your waiting period.

Hospitalization after your waiting period will not cause your waiting period to be waived. However, there are 65 *outpatient* medical procedures for which the Fund will pay disability beginning on the first day. Contact the Accident & Sickness Department/Weekly Disability department to see if your planned *surgery* is on this list.

Benefits begin on the fourth day of disability if it is due to *sickness*. The daily benefit amount will be 1/7 of the weekly benefit amount.

Benefits will not be paid for your regular day off.

Example of benefit amount computation (Part Timers):
1st 8 weeks:

Hourly rate	= $10.00
Average hours worked	= 25
$10.00 x 25	= $250.00 gross straight time pay
$250.00 x .60 (60%)	= $150.00 weekly benefit amount
$150.00 ÷ 7	= $21.43 daily benefit amount

Next 4 weeks:

$10.00 x 25	= $250.00 gross straight time pay
$250.00 x .50 (50%)	= $125.00 weekly benefit amount
$125.00 ÷ 7	= $17.86 daily benefit amount

Nervous and Mental Claims
Disabilities arising from a nervous condition or ***mental illness*** must be verified by a board eligible or board certified psychiatrist, a licensed or certified PhD psychologist, a Master's Level Social Worker or a Certified Alcohol Counselor. Contact ValueOptions at 800-454-8329 for referral to an appropriate provider. The Fund will reimburse you for any uncovered balance you may owe for your initial visit upon receipt of an actual paid-in-full receipt from the psychiatrist or psychologist. Note: If ValueOptions refers you to another provider (such as a Master's Level social worker or a Certified Alcohol Counselor) or, if you have chosen one of the HMOs to provide your medical benefits and your HMO refers you to another type of provider, the *Fund office* will accept such provider's signature on the claim form).

If an initial claim for a disability arising from a nervous condition or *mental illness* was certified by a medical *physician* who is not a board eligible or board certified psychiatrist, only the first six days after the appropriate waiting period will be paid. Should you be 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 a licensed or certified PhD psychologist or another type of provider approved by ValueOptions (such as a Master's Level social worker, for example) and/or your HMO provider.

Benefit Exhaustion
Your eligibility status for other benefits will be maintained while you are receiving Weekly Disability benefits. But if you exhaust your Weekly Disability benefits, you will lose eligibility and all benefits will terminate as described on page 15. If you secure a leave of absence from your *participating employer*, benefits may be continued under the provisions of *COBRA* as described on page 21. If you waive your *COBRA* election rights, you can continue benefits by making self-payments as discussed on page 28.

Claims Procedure
To claim a benefit from the Fund, you must:

You have 90 days from the first date of disability to file a Weekly Disability claim.

1. Get a "Weekly Disability Claim Form" from your *participating employer* or the *Fund office*.
2. Complete the participant section of the form and sign it.
3. Have your *physician* complete the *physician* section of the form. A certified

Nurse Midwife may certify a disability for delivery only. If you are disabled prior to delivery, a *physician* must complete the form and state the pregnancy-related disability. If the return to work date is unknown, your *physician* should estimate a date. ONLY the treating *physician*, Master's Level social worker, or certified alcohol counselor can complete this section. All questions must be answered completely.

4. Have your store manager or other authorized employer representative complete the employer section of the form. ONLY an authorized employer representative can complete it. All questions must be answered completely.
5. Corrections to the form **must be initialed** by the person making the change or the form will be returned.
6. Mail the completed form to:
   UFCW Unions and Participating Employers Health & Welfare Fund
   P.O. Box 1064
   Sparks, MD 21152-1064.
   Claims must be received in the *Fund office* within 90 days from the beginning of the disability.
7. If you remain disabled you may be required to submit a "Notice of Continuation for Group Weekly Disability/Accident and Sickness" form periodically for the duration of your disability. Continuation forms must be returned within four weeks and requests for other information must be returned within two weeks. If a Continuation Form is required, the *Fund office* will send you one.
8. If you fail to return your Continuation Form on time, all future benefits related to that disability will terminate.

The claims filing and review procedures are further explained on page 92.

How to Pick Up Your Check

Disability claims are paid weekly and are not issued at any other time. Your check will be mailed to you each Friday unless you decide to pick it up yourself at the *Fund office*. Checks may be picked up at any *Fund office* location between 12:30 and 2:30 p.m. on Friday.

If you want to pick up your check at the Sparks or Landover offices, you must notify Participant Services by 4:30 p.m. on Wednesday. Call toll free (800) 638-2972. **Only the participant may pick up a check.** For your protection, photo identification is required. Your check will **not** be released if you do not have proof of identity. Holidays may cause a change in the check pick-up schedule.

Withholding Income Taxes

A form reporting the total benefits paid in a calendar year will be provided to you each year by the Fund or your *participating employer*. A copy will 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 for federal or an Annuitant's Request for State Income Tax Withholding to the *Fund office*; **and**
2. The amount to be withheld is not less than $4.00 per day or $20.00 per week.

Withholding will not take place if the amount you wish to have withheld will reduce the weekly benefit amount to $10.00 or less. Withholding on partial weeks will be pro-rated.

Social Security

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

Federal Unemployment Taxes

Federal law requires that federal unemployment taxes (FUTA) be withheld from your Weekly Disability benefits and forwarded to the federal government. Your *participating employer* pays FUTA on your Weekly Disability benefit payments. There are no forms necessary for you to fill out for FUTA withholding.

Workers' Compensation – Supplemental Benefit
If you become disabled as a result of an accident or illness related to your employment with a *participating employer,* the Fund may supplement the benefits you receive under your *participating employer*'s Workers' Compensation insurance. There are two types of additional benefits:

- **Waiting Periods**. Time lost without pay because of waiting periods imposed by State Workers' Compensation laws will be supplemented by the Fund.

  Example: Workers' Compensation in Maryland begins on the fourth day of disability. If the disability lasts for more than 14 days, the Workers' Compensation benefit then pays the first three days. If the disability is 14 days or less, the Fund will pay for the first three days.

- **Supplemental Benefit**. If you are a **full-time** participant, the Fund will pay you the difference between the weekly benefit amount you receive from Workers' Compensation and the amount you would have received from the Fund if the disability had **not** been work related.

  Example: If the Plan's Weekly Disability benefit is $266.66 per week and the Workers Compensation Benefit is $250.00 per week, the Fund Supplemental Benefit would be $16.66 per week. If the Workers' Compensation payment exceeds your Weekly Disability Benefit amount, the Fund will make no supplemental payment. **Remember, this Supplemental Benefit is only available for full-time participants (not part-time).**

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 to this Fund for Weekly Disability benefits. See the "Advance Benefits for Workers' Compensation Claims" section (page 34) 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.

PRESCRIPTION DRUG BENEFIT

Benefits are provided through the Fund, not insured.
Closed Panel Services provided through NMHC Rx.

The Fund will pay for *medically necessary* prescription drugs which require compounding, legend drugs, insulin, and oral contraceptives. The prescriptions must be written by a *physician*. You pay a 5% *co-payment* for each prescription filled at a pharmacy of a *participating employer* of the Fund, such as Giant, Safeway, Kroger, or Shoppers Food Warehouse. You pay a 10% *co-payment* for each prescription filled at other participating NMHC Rx pharmacies. If you live outside the geographic area in which *participating employers* operate pharmacies, the 5% *co-payment* will apply. The Fund will pay the balance, provided the following conditions are met:

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 $950.00 is approved by NMHC Rx.
5. The prescription **is not** for over-the-counter drugs, appliances, devices, immunological agents, or for legend drugs whose usage has not been pre-approved by the Food and Drug Administration.
6. The prescription is *medically necessary* to treat *medically necessary* conditions..
7. Syringes and needles may be covered under your prescription benefits **for diabetics only,** and only if you obtain prior approval from the *Fund office*.
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 Optum/CARE Programs.
9. Refills must be authorized by your *physician*.
10. Prescriptions for cosmetic purposes will not be covered.
11. Injectables are covered with the regular co-payment applying. Office visits associated with an injectable are covered under your Comprehensive Medical benefit.

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 Rx 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, a participant will receive a Fund ID card which shows his or her medical and prescription Plans. You should keep this card in your wallet or purse so you have it with you at all times.
2. Take your *physician's* prescription to a participating pharmacy.
3. Identify yourself by presenting your ID card.
4. Pay the pharmacist the 5% or 10% *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 of 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*.

Generic Drugs
Generic drugs will be dispensed whenever available unless your doctor has indicated a brand name is medically necessary on your prescription. If you get a brand name drug when there is a generic available (and it is not medically necessary for you to have he brand name drug), you must pay the difference in cost between the brand name and the generic drug ***in addition to*** the regular co-payment.

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

NMHC Rx
P.O. Box 1170
Port Washington, NY 11050

Specific Drug Restrictions
- **Imitrex**, an injectable drug for the treatment of migraines, is covered up to two pre-filled syringes (one kit) per week. The first kit will include an injector gun. In its tablet form, there is a maximum allowed dosage of 900 milligrams per month for Imitrex. If you are prescribed over 900 milligrams per month for three consecutive months, the *Fund office* must receive verification from your *physician* before it will pay for any further prescriptions.
- The cost of the contraceptive drug **Norplant** is covered for the participant or the participant's spouse under the Prescription Drug Benefit; however, the cost of surgical implantation is not covered under the Fund.
- Prescriptions for drugs such as **Retin-A and Renova** are prescribed primarily for cosmetic reasons and are usually not *medically necessary*. They must be accompanied by a written diagnosis from your *physician* of acne vulgaris or another medical condition in order to be covered.
- 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 @ (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 Rx. Your <u>first</u> office visit (including the charge for administration of the shot) is covered under Major Medical. Subsequent <u>office visit</u> 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-injectible medications (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.

Diabetic Benefit

If you or a covered dependent have Diabetes Mellitus, you may be reimbursed up to $100 every five years for the cost of blood sugar monitors (like Glucometer and Accu-Check) and other supplies, such as Chemstrips. Send your **paid, itemized** receipts to the ***Fund office***, along with a note from your *physician* verifying that you (or your eligible dependent) have Diabetes Mellitus, and that the supplies are related to the treatment of your illness.

The first $100 of expenses in a five year period will be reimbursed in full (the *deductible* does not apply); thereafter, diabetic supplies will be covered at 80% after the $100 annual *deductible* under your Major Medical coverage, or through your HMO if an HMO provides your medical benefits.

DENTAL BENEFIT

Benefits are provided through Group Dental Service (GDS) and are insured.

The Plan provides benefits for the following dental services as described in this section only when performed by a participating dentist. Any services rendered by a pedodontist (a dentist specializing in children's teeth) or a non-participating dentist, oral surgeon, periodontist, endodontist, or orthodontist will NOT be covered by this Plan. Children under four are not eligible for dental benefits. An eligible dependent covered by another dental plan is **not** eligible for dental benefits under this Plan with the exception of *periodontia* or orthodontia benefits in cases where the other dental plan does not cover them.

Claims Procedure

To request a provider in the Plan, 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, please be ready to take down the name, address, and phone number of the dentist. Be ready to give the participant's social security number. 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 scheduled appointment time for any broken appointment unless you notified the dentist with whom you had the appointment at least 24 hours **prior** to the scheduled appointment. 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 or specialist 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.

Schedule of Dental Benefits

Procedure Code	Description	Member Co-payment
Diagnostic & Preventive		
00110	Initial Oral Exam	No Charge
00120	Periodic Oral Exam	No Charge
00130	Emergency Oral Exam	No Charge
00210	Intraoral FMS and Bitewings	No Charge
00220	Intraoral-Periapical-First Film	No Charge
00230	Intraoral-Periapical-Each Addl Film	No Charge
00270	Bitewings - Single Film	No Charge
00272	Bitewings - Two Films	No Charge
00274	Bitewings - Four Films	No Charge
00275	Bitewings - Each Additional	No Charge
00330	Panoramic Film	No Charge
00460	Pulp Vitality Tests	No Charge
01110	Prophylaxis - Adult (6 months)	No Charge
01120	Prophylaxis - Child (6 months)	No Charge
01201	Top Appl. Fluoride (Incl. Prophy), Child	No Charge
01203	Top Appl. Fluoride (Excl. Prophy), Child	No Charge
01510	Space Maint. - Fixed - Unilateral	$ 10
01515	Space Maint. - Fixed - Bilateral	$ 20
01520	Space Maint. - Remove Unilateral	$ 10
01525	Space Maint. - Remove Bilateral	$ 20
01550	Re-cementation of Space Maintainer	No Charge
02110	Amalgam, One Surface Deciduous	No Charge
02120	Amalgam, Two Surfaces Deciduous	No Charge
02130	Amalgam, Three Surfaces Deciduous	No Charge
02131	Amalgam, Four Surfaces Deciduous	No Charge
02140	Amalgam, One Surface Permanent	No Charge
02150	Amalgam, Two Surfaces Permanent	No Charge
02160	Amalgam, Three Surfaces Permanent	No Charge
02161	Amalgam, Four or More Surfaces Permanent	No Charge
02210	Silicate Cement per Restoration	No Charge
02330	Resin One Surface Anterior	No Charge
02331	Resin Two Surfaces Anterior	No Charge
02332	Resin Three Surfaces Anterior	No Charge
02335	Resin Four or More Surfaces or Incisal Angle	No Charge
02380	Resin One Surface, Post-primary	* (See End)
02381	Resin Two Surfaces, Post-primary	* (See End)

Diagnostic & Preventive		**Member Co-Payment**
02382	Resin Three Surfaces, Post-Primary	* (See End)
02385	Resin One Surface, Post-Permanent	* (See End)
02386	Resin Two Surfaces, Post-Permanent	* (See End)
02387	Resin Three Surfaces, Post-Permanent	* (See End)
02510	Inlay Metallic One Surface	$ 40
02520	Inlay Metallic Two Surfaces	$ 40
02530	Inlay Metallic Three Surfaces	$ 40
02540	Onlay per Tooth in Addition to Above	$ 40
02710	Crown-Resin (Laboratory)	$ 80
02720	Crowns, Plastic with High Noble Metal	$ 80
02721	Plastic with Predom Base Metal	$ 80
02722	Plastic with Noble Metal	$ 80
02740	Porcelain Crown	$ 80
02750	Crowns, Porcelain Fused to High Noble Metal	$ 125
02751	Porcelain Fused to Predom BS Metal	$ 125
02752	Porcelain Fused to Noble Metal	$ 125
02790	Crown - Full Cast High Noble Metal	$ 80
02791	Crown - Full Cast Predom Base Metal	$ 80
02792	Crown - Full Noble Metal	$ 80
02810	Crown - 3/4 Cast Metallic	$ 80
02930	Prefab Stainless Steel Crown, Primary Tooth	$ 30
02931	Prefab Stainless Steel Crown, Permanent Tooth	$ 30
02932	Prefabricated Resin Crown	$ 30
02940	Sedative Fillings	No Charge
02950	Crown Buildup, Including Pins	No Charge
02951	Pin Retention - per Tooth, in Addition to Rest	No Charge
02952	Cast Post & Core in Addition to Crown	No Charge
02953	Cast Post As Part of Crown	No Charge
02954	Prefab Post & Core in Addition to Crown	No Charge
02980	Crown Repair, by Report	No Charge
03110	Pulp Cap Direct Extraction Fin Rest	No Charge
03120	Pulp Cap Indirect Extraction Fin Rest	No Charge

Removable Prosthetics, Diagnostic and Preventive		**<u>MemberCo-payment</u>**
05110	Complete Upper Denture (Incl. Adjustments)	$ 30
05120	Complete Lower Denture (Incl. Adjustments)	$ 30
05130	Immediate Upper Denture (Incl. Adjustments)	$ 30
05140	Immediate Lower Denture (Incl. Adjustments)	$ 30
05211	Upper Partial Resin Base (Incl. Adjustments)	$ 30
05212	Lower Partial Resin Base (Incl. Adjustments)	$ 30
05213	Upper Partial-Cst Met BS with Res Sadd	$ 30
05214	Lower Partial-Cst Met BS with Res Sadd	$ 30
05215	Upper Partial-Hi Noble cust BS-Acr Sdls & C	$ 30
05216	Lower Partial-Hi Noble cust BS-Acr Sdls-C&R	$ 30
05280	Rm Uni Par D-1PC-Hi Noble-Clsp-Per Un	$ 30
05281	Rm Uni Par D-1PC-BS CST-Clsp-Per Un	$ 30
05410	Adjust Complete Denture - Upper	No Charge
05411	Adjust Complete Denture - Lower	No Charge
05421	Adjust Partial Denture - Upper	No Charge
05422	Adjust Partial Denture - Lower	No Charge
05510	Repair Broken Complete Denture Base	No Charge
05520	Replace Missing/Broken Tooth, Compl. Denture, Each Tooth	No Charge
05610	Partial Denture Repair Resin Sole/Base	No Charge
05620	Partial Denture Repair Cast Framework Repair/Replace	No Charge
05630	Repair or Replace Broken Clasp	No Charge
05640	Partial - Replace Broken Tooth, per Tooth	No Charge
05650	Add Tooth to Existing Partial Denture	No Charge
05660	Add Clasp to Existing Partial Denture	No Charge
05710	Rebase Complete Upper Denture	No Charge
05711	Rebase Complete Lower Denture	No Charge
05720	Rebase Partial Upper Denture	No Charge
05721	Rebase Partial Lower Denture	No Charge
05730	Reline Comp. Upper Denture (Chairside)	No Charge
05731	Reline Comp. Lower Denture (Chairside)	No Charge
05740	Reline Upper Partial (Chairside)	No Charge
05741	Reline Lower Partial (Chairside)	No Charge
05750	Reline Complete Upper Denture (Lab)	No Charge
05751	Reline Complete Lower Denture (Lab)	No Charge
05760	Reline Upper Partial Denture (Lab)	No Charge
05761	Reline Lower Partial Denture (Lab)	No Charge
05890	Tissue Conditioning per Denture Unit	No Charge

Fixed Prosthetics		**MemberCo-payment**
06210	Pontic - Cast High Noble Metal	$ 80
06211	Pontic - Cast Predom Base Metal	$ 80
06212	Pontic - Cast Noble Metal	$ 80
06240	Pontic - Porcelain to High Noble Metal	$ 125
06241	Pontic - Porcelain to Predom Base Metal	$ 125
06242	Pontic - Porcelain Fused to Noble Metal	$ 125
06250	Pontic - Resin to High Noble Metal	$ 80
06251	Pontic - Resin to Predom Base Metal	$ 80
06252	Pontic - Resin to Noble Metal	$ 80
06520	Inlay Metallic, Two Surfaces	$ 40
06530	Inlay Metallic, Three or More Surfaces	$ 40
06540	Inlay Metallic - Onlay Cusps	$ 40
06720	Crown - Resin with High Noble Metal	$ 80
06721	Crown - Resin with Predom Base Metal	$ 80
06722	Crown - Resin with Noble Metal	$ 80
06750	Bridge Crown - Porc. to High Noble Metal	$ 125
06751	Bridge Crown - Porc. to High Base Metal	$ 125
06752	Bridge Crown - Porc. Fused to Noble Metal	$ 125
06780	Bridge Crown - 3/4 Cast, High Noble Metal	$ 80
06790	Bridge Crown - Full Cast High Noble Metal	$ 80
06791	Bridge Crown - Full Cast Predom BS Metal	$ 80
06792	Bridge Crown - Full Cast Noble Metal	$ 80
06930	Re-cement Bridge	No Charge
06970	Cast Post & Core in Addition to Bridge Ret.	No Charge
06972	Refab. Post & Core in Addition to Bridge Ret.	No Charge

Oral Surgery

07110	Extraction, Single Tooth	No Charge
07120	Extraction, Each Additional Tooth	No Charge
07130	Root Removal - Exposed Roots	No Charge
07210	Surgical Extraction - Erupted Tooth	No Charge
07220	Remove Impacted Tooth - Soft Tissue	No Charge
07230	Remove Impacted Tooth - Part Bony	No Charge
07240	Remove Impacted Tooth - Complete Bony	No Charge
07241	Remove Impacted Tooth - Complete Bony, Unusual Surgical Complications	No Charge
07250	Surgical Removal of Residual Roots	No Charge
07310	Alveoplasty in Conj. w/ Extraction, per Quad	No Charge
07510	I & D of Abscess, Intraoral	No Charge
07560	Max Sinusotomy - Remove Tooth Fragment	No Charge

Orthodontics		**MemberCo-payment**
08440	Orthodontic, Fully Banded	$ 425/year
	Upon Completion, Additional	$ 75

Miscellaneous

09110	Palliative Treatment Den. Pain - Minor Proc.	No Charge
09210	Anesthesia - Local, Non-Surg. Operation	No Charge
09211	Regional Block Anesthesia	No Charge
09215	Local Anesthesia	No Charge
09220	Gen. Anesthesia, First 30 Min. (Extr. Only)	** (See End)
09221	Gen. Anes., Each Addl. 15 Min. (Extr. Only)	** (See End)
09230	Analgesia-Nitrous Oxide/per Hr. (Extr. Only)	** (See End)
09240	I.V. Sedation (Extraction Only)	** (See End)
09310	Consultation per Session	No Charge
09430	Office Visit During Scheduled Hrs., No Svc.	No Charge
09440	Office Visit After Scheduled Hrs., No Svc.	No Charge
09999	Broken Appointment Chg. (per 1/2 Hr. Appt.)	$ 10

Periodontal Plan

04110	Initial Oral Exam	$ 30
00210	Radiographs, Full Mouth	$ 30
00220	Radiographs, Single	$ 4
00470	Diagnostic Cast (per Set)	$ 20
03920	Hemisection	$ 110
04210	Gingivectomy (per Quadrant)	$ 200
04211	Gingivectomy (per Tooth)	$ 55
04220	Gingival Curettage (per Quadrant)	$ 75
04230	Distal or Proximal Wedge	$ 90
04240	Gingival Flap Procedure w/ Root Plane, (per Quadrant)	$ 200
04250	Mucogingival Surgery (per Quadrant)	$ 210
04260	Osseous Surgery (per Quadrant) ***	$ 325
04271	Free Gingival Graft	$ 200
04341	Scaling and Root Planing (per Quadrant)	$ 70
04910	Periodontal Maintenance (per Visit)	$ 35

*** Anesthesia and/or general anesthesia is covered only when administered in an oral surgeon's office for extractions and other related *services*.**

- N/C = No Charge
- *Procedures* not shown above are not covered by Dental Plan.
- Pedodontists are coved for Local 27 Enrollees only.
- When gold is used, a gold surcharge will be charged. Patient will be advised of the surcharge prior to performance of procedure.
- If a condition can be treated by more than one *procedure*, GDS will only cover the least costly professionally adequate service.

Surcharges

If gold is used in any of the procedures listed, surcharges will depend on the market price. 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 (cleaning), including scaling and polishing, is limited to once every six months.
2. Dentures are limited to one partial or complete denture 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 36 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(s) not more than once within a five year period.
   h. Patients must be age 11 or older.
4. Covered services are limited to services provided by a participating dentist except under the following circumstances:
   a. when authorized by GDS;
   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:
   a. alteration or extraction and replacement of sound teeth;
   b. any treatment of the teeth to remove or lessen discoloration except in connection with endodontic treatment.
6. Examination, evaluation, and treatment of temporomandibular joint (TMJ) pain dysfunction are excluded. Evaluation of TMJ is covered when it is incidental to another appointment.
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(s) received such appliance more than five years prior to the date of loss or theft.
8. Any service or treatment begun while the participant or eligible dependent(s) was not covered by GDS will be treated 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 through GDS.
11. Dental implants are excluded.
12. Appliances or treatment related to bite correction are not covered.
13. Services rendered by prosthodontic specialists and which are necessary for complete oral rehabilitation or reconstruction are excluded.
14. Services for injuries or conditions which are covered under Workers' Compensation or employer's liability laws are not covered; services which are provided by any municipality, county, or other political subdivision without cost to the participant or eligible dependent(s) are not covered.

Grievance Procedure

Grievances or complaints may be directed orally or in writing to the GDS Administrative Office at 111 Rockville Pike, Suite 950, Rockville, MD 20850, telephone number (800) 242-0450 within 180 days of the date of the denied claim, grievance or complaint. A Member Services 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 of 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.**

OPTICAL BENEFITS
For Local 400 Participants

Benefits are provided and guaranteed pursuant to an insurance contract with Spectera/United Optical
2811 Lord Baltimore Drive
Baltimore, MD 21244-2644

The Fund will provide optical benefits once every two years. There will be no charge to you when the services are rendered by Spectera/United Optical or an *optometrist* participating in the Spectera/United Optical network. The following optical benefits are covered:

1. A complete eye examination by a licensed *optometrist* (dilation of the eyes is not considered to be part of a routine eye exam).
2. A pair of eyeglasses, if prescribed, including:
   a. a choice from a selection of frames; and
   b. clear glass or plastic lenses, either:
      single vision,
      bifocal: TK, FT22, FT25, FT28, or executive, or
      trifocal: 7x25, 7x28.
3. Minor repairs and adjustments to eyeglasses.

Exclusions and Limitations
Unless they are *medically necessary*, cosmetic items are not covered by the program. Such items include, but are not limited to:

1. Gradient tints
2. Photosensitive lenses
3. Oversized and specialty lenses
4. Cataract lenses
5. Contact lenses

Non-covered frames are available at the wholesale cost of the frame less $7.00.

Claims Procedure If You Use A United Optical Facility
Call the Spectera/United Optical facility most convenient to you and make your appointment (see list of United Optical phone numbers on pages 67 and 69). If you live outside the United Optical service area, a voucher may be required--you must call Spectera/United Optical to make sure. Your Fund ID card is not necessary to make an appointment; the United Optical facility will ask you for the participant's name and social security number, and the patient's date of birth. The facility will then verify eligibility for benefits with the *Fund office*.

If You Need To Find A United Optical Provider
If you need to locate a participating provider, you may call Spectera/United Optical's Customer Service Department at (800) 638-3120 and a representative will assist you.

You may also call United Optical's IVR (Integrated Voice Response) system at (800) 839-3242. The system will answer as "Spectera," which is United Optical's corporate name. Follow the voice prompts. After you enter your social security number and zip code, the system will give you the names of three participating providers in your area. Call one of the providers directly to schedule an appointment. Make sure to tell the provider that your vision care Plan is with "Spectera" so he or she can verify your eligibility before your appointment. If you have other questions, stay on the line and you will be connected to a service representative.

If You Live Outside the Spectera/United Optical Service Area
If you live outside the Spectera/United Optical Service Area (you MUST call United Optical to be sure), you will need to pay for your services and request reimbursement. Remember, you will be reimbursed only up to the limits of the Plan. For reimbursement, send your paid itemized receipts to:

Spectera
2811 Lord Baltimore Drive
Baltimore, MD 21244-2644

Important: include your name and social security number with the receipt so Spectera/United Optical can identify your correct coverage. If you live within the service area of Spectera/United Optical, you must use a participating *optometrist* or you will not be eligible for reimbursement.

For more information, see the "Claims Filing and Review" section on page 92.

Important!
Any services you receive from an *optometrist* in the Spectera/United Optical service area who does NOT participate with Spectera/United Optical will NOT be covered under the Plan.

OPTICAL BENEFITS
For Local 27 Participants

Benefits are provided and guaranteed pursuant to an insurance contract with Spectera/United Optical
2811 Lord Baltimore Drive
Baltimore, MD 21244-2644

The Fund will provide optical benefits once every two years. There will be no charge to you when the services are rendered by a Spectera/United Optical Center or an *optometrist* participating in the Spectera/United Optical network. The following optical benefits are covered:

1. A complete eye examination by a licensed *optometrist* (dilation of the eyes is not considered to be part of a routine eye exam).
2. A pair of eyeglasses, if prescribed, including:
   a. a choice from a selection of frames; and
   b. clear glass or plastic lenses, either:
      single vision,
      bifocal: TK, FT22, FT25, FT28, or executive, or
      trifocal: 7x25, 7x28.
3. Minor repairs and adjustments to eyeglasses.

Exclusions and Limitations
Unless they are *medically necessary*, cosmetic items are not covered by the program, but they are available for purchase at a discount. Such items include, but are not limited to:

1. Solid and gradient tints
2. Photosensitive lenses
3. Oversized and specialty lenses
4. Cataract lenses
5. Contact lenses

For non-covered frames, you will receive a credit of $20.00 off the retail price of the frame. You will be responsible for any remaining balance for the cost of a non-covered frame.

Claims Procedure -- Using A United Optical Center
Call the Spectera/United Optical facility most convenient to you and make your appointment (see list of United Optical phone numbers at the end of this section). Your Fund ID card is not necessary to make an appointment; the Spectera/United Optical facility will ask you for the participant's name and social security number, and the patient's date of birth. The facility will then verify eligibility for benefits with the *Fund office*.
For information on other Spectera/United Optical facilities (other than those listed below), call (410) 265-6084. You may call collect if necessary. The Spectera/United Optical Service Representative will help you find a Spectera/United Optical center that is convenient to you. If you have questions or concerns about your Optical benefit, you should first contact the *Fund office*, but if you need to contact Spectera/United Optical, the address is:

Spectera/United Optical Centers
2811 Lord Baltimore Drive
Baltimore, MD 21244-2644

If You Live Outside the Spectera/United Optical Service Area
If you live outside the Spectera/United Optical Service Area (you MUST call Spectera/United Optical to be sure), you will need to pay for your services and request reimbursement. Remember, you will be reimbursed only up to the limits of the Plan. For reimbursement, send your paid itemized receipts to:

Spectera
2811 Lord Baltimore Drive
Baltimore, MD 21244-2644

Important: Include your name and social security numb4er with the receipt so Spectera/United Optical can identify your correct coverage. If you live within the service area of Spectera/United Optical, you must use a participating *optometrist* or you will not be eligible for reimbursement.

Important!
Any services you receive from an *optometrist* in the Spectera/United Optical service area who does NOT participate with Spectera/United Optical will NOT be covered under the Plan.

For more information, see the "Claims Filing and Review" section.

Optical Appointments and Provider Locations
Local 27 (call collect if necessary) ………………… (410) 265-6084
Washington, DC Metropolitan area………………… (301) 621-4694
Virginia area………………………………………… (800) 638-3120
Cumberland area…………………………………… (301) 729-2243
Hagerstown………………………………………… (301) 790-3877
Salisbury…………………………………………… (410) 742-6148

IVR Phone System (United Optical/Spectera)….. (800) 839-3242

COMPREHENSIVE MEDICAL BENEFITS

Benefits are provided through the Fund – they are not insured.

Benefit claims are processed by Associated Administrators, LLC

ID Card

Each participant will receive a Fund identification card showing his/her name, membership number, and information on the medical and prescription benefits. If you have dependent coverage, you will receive two cards. Separate cards are not sent for each covered dependent child. **Always show the *physician*, *hospital*, or pharmacy your Fund ID card.**

If you choose an HMO option for your medical benefits, you will keep your Fund ID card to use for prescriptions, but you will use your **HMO ID card** and go to an HMO doctor or facility for medical benefits.

Benefit Amount

The following pages describe the services payable under the Comprehensive Medical Benefit. Covered services include *hospital* services, medical-surgical services, and medical services. Unless specified otherwise, these expenses are paid at 80% after you have satisfied the annual ***deductible*.**

The Deductible

The cash *deductible* is the first $100 of covered medical expenses *incurred* in a calendar year for an illness or *injury*. In cases of a common accident in which two or more of your family members are involved, only one *deductible* must be satisfied. After the *deductible* is met, the Comprehensive Medical benefit covers 80% (up to the *UCR* amount) of your eligible medical expenses.

When a participant or dependent has *incurred* covered medical expenses which result in $2,500 being paid out-of-pocket in a calendar year, reimbursement will be increased to 100% of covered charges for the remainder of that *calendar year*.

Room and Board

Room and Board in the *hospital* or in a special care unit is payable at 100% of the semi-private room rate**. The annual *deductible* does not apply to Room and Board**.

Hospital Services

Optum/CARE pre-authorization is required for all *hospital* admissions. Contact Optum/CARE at (410) 265-7182 or (800) 638-6265. See page 37 for additional information about Optum/CARE.

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.

You are eligible for benefits for these *Hospital* Services for up to 180 days for each hospitalization. Re-admissions to a *hospital* for the same or related condition (as determined by the *Trustees*) within 60 days after your previous hospitalization will be considered part of the first hospitalization.

If you request a private room, you are eligible for all the benefits above, but you must pay the *hospital* the difference between its actual charge for the private room and its average charge for semi-private rooms.

Pre-Admission Testing
Benefits are available to you and eligible dependents for pre-operative laboratory tests and x-ray examinations performed in the *outpatient* department of a ***hospital*** prior to your scheduled admission for an *inpatient* stay, provided the tests would have been available under this program to a *hospital inpatient* and are *medically necessary* for the treatment of your condition.

Benefits will not be payable if those tests are not *medically necessary* at the time of the subsequent *hospital* admission or if the admission is cancelled for non-medical conditions.

Admission for Diagnostic Study
Inpatient admissions for *diagnostic* study are covered when the study is directed toward the diagnosis of a definite condition of disease or *injury*. Benefits are not provided for *inpatient* admissions for:
1. audiometric testing;
2. eye refractions;
3. examinations for the fitting of eye glasses or hearing aids;
4. psychiatric examinations;
5. psychological testing;
6. dental examinations;
7. pre-marital examinations;
8. research studies;
9. allergy testing;
10. screening;
11. routine physical examinations or checkups; or
12. fluoroscopy without films.

Outpatient Treatment
Outpatient hospital treatment will be covered when the treatment is for:
1. the performance by a *physician* of minor surgical procedures required for treatment and not solely for diagnosis,
2. care rendered within 72 hours after a non-occupational *accidental injury*, or
3. care received as the result of a *medical emergency*.

Benefits for coverage of *outpatient* radiation and radioactive isotope therapy will be provided when performed in the *outpatient* department of a *hospital* and billed as a *hospital* service.

Rehabilitation Benefit
Rehabilitation benefits are available for participants and eligible dependents who have had cardiovascular or cerebrovascular accidents, closed head injuries, spinal cord injuries, neurological disorders, and major joint procedures. **All rehabilitative care must be approved by Optum/CARE Programs.** Coverage includes 30 days of *inpatient* rehabilitation or 60 *outpatient* visits when the visits are determined (by Optum/CARE) to be in lieu of

inpatient treatment. Speech and occupational therapy services are covered when provided as part of the approved rehabilitation program. The benefit has a $25,000 lifetime maximum which includes both *inpatient* and *outpatient* care. Benefits for *outpatient* care are counted towards the total $250,000 lifetime maximum for Comprehensive Medical benefits.

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 expenses 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 also must 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 the 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 are renewed for another 90 visits by 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 CRP course of 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.

Medical-Surgical Benefit -- Payment of Benefits
When the professional services described below are rendered by a *physician*, the Plan will provide benefit payment at 80%, up to the *UCR* fee. Payment by the Fund will constitute full and final payment, except as may otherwise be provided or limited here. Charges made by a *physician* in excess of these amounts are the responsibility of the patient.

Surgical Services
Benefits for surgical services are available to you or your eligible dependent wherever performed by a *physician* for operative and cutting procedures, the reduction of fractures and dislocations, as well as major endoscopic and other surgical-*diagnostic* procedures.

When two or more surgeries are performed at the same time and in the same operative field, benefits are payable for the most expensive operation. Multiple unrelated surgical procedures performed during the same operative session will be as follows:
1. The *UCR* charge of the most expensive procedure,
2. 75% of the *UCR* charge for the procedure with the next highest cost, and
3. 50% of the *UCR* charges of each additional procedure.

Inpatient Medical Services
Benefits for medical services are available to you when you or your eligible dependent is admitted to a *hospital* as an *inpatient* during the first 180 days of each *hospital confinement*. Successive *hospital confinements* will be considered continuous and constitute a single confinement if discharge from and readmission to a *hospital* for the same or related conditions, as determined by the Fund, occurs within a 60 day period.

Maternity Benefits
A female participant or spouse entitled to dependent coverage is eligible to receive the *Hospital* Services described

above beginning on the date she is eligible for benefits. There is no **additional** waiting period for maternity benefits. Benefits are available for services rendered in a maternity center or by a registered *Nurse Midwife* certified by the American College of Nurse Midwives. Midwives must meet the criteria required by law to be covered. Maternity benefits include nursery care of the newborn child or children while the mother is receiving benefits. **Dependent daughters of participants are not eligible for maternity benefits.**

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).

Obstetrical Benefits

Benefits for obstetrical services are available to all female participants and spouses of participants entitled to dependent coverage. These benefits include prenatal and postnatal care. Care is 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. There is no waiting period for obstetrical benefits. **Dependent daughters of participants are not eligible for obstetrical benefits.**

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.

Pediatric Services

Benefits for pediatric services are available for any properly enrolled newborn child or children born to a participant or eligible dependent spouse or for any newborn child or children adopted or placed for adoption with a participant or eligible dependent spouse if the participant or eligible spouse is otherwise eligible for obstetrical benefits. These benefits will be provided only for the first *inpatient* visit by a *physician* for routine history and necessary examination, however, they will not be provided if the pediatric service is rendered by the same *physician* who rendered obstetrical services. **Dependent daughters of participants are not eligible for pediatric benefits for their newborn child(ren) or for any newborn child(ren) adopted or placed for adoption with them.**

Human Organ Transplants

Benefits are available for *Hospital* Services and supplies and practitioner services for kidney, cornea, and bone marrow transplants. If you or your eligible dependent are the recipient of the transplant, benefits cover both you and the donor. If you are the donor, only you are covered, and only to the extent that the recipient does not cover you.

In addition, specified coverages are available for human heart, heart-lung, liver, and pancreas transplants. Charges for evaluation, room and board, *Hospital* Services and supplies, and practitioner services are covered up to the limits of the Plan and are subject to a combined Basic and Major Medical benefit of $1 million for each different organ transplanted. There are other conditions and exclusions under this benefit, including a specific "*benefit period*." If you are a candidate for a transplant, you must contact the *Fund office* at least 30 days prior to the proposed transplant for approval. **Pre-certification is required and services must be approved by Optum/CARE Programs.**

Replacement transplants are not covered, and services related to a second transplant (including for complications from the second transplant) are not covered.

Anesthesia Services
Benefits for anesthesia services are available to you or your eligible dependent when rendered by a *physician* anesthetist (other than the operating surgeon or his or her assistant) in conjunction with surgical or obstetrical services, provided you are otherwise eligible for surgical or obstetrical benefits.

Consultation Services
Benefits for consultation services, except staff consultation required by *hospital* rules or regulations, are available to you or your eligible dependent when you are admitted to a *hospital* as an *inpatient* in conjunction with surgical or medical services and when the consultation is requested by the attending *physician*. Benefits will be provided for one consultation per consultant during any *hospital confinement*.

Surgical Assistant Services
Benefits are available to you or your eligible dependents for the services of a *physician* who actively assists the operating surgeon in the performance of surgical services when the condition of the patient and type of surgical performance require assistance and when interns, residents, or house staff are not available.

Outpatient Emergency Care
Benefits are available to you or your eligible dependents for care received within 72 hours of an *accidental injury* wherever rendered by a *physician* or for care received within 72 hours as the result of a *medical emergency* when performed in the *outpatient* department of a *hospital* by a *physician*.

Medical Conditions of the Mouth, Jaw, and Proximate Areas
Benefits are available to you for oral surgical services consisting of the reduction or manipulation of fractures or bones; excision of the mandible joints and lesions of the mandible, mouth, lip, or tongue; incision of the accessory sinuses, mouth, salivary glands, or ducts; manipulations of dislocations of the jaw; removal of impacted teeth only when *hospital confinement* is required or when rendered in the *outpatient* department of a *hospital*; plastic reconstruction or repair of the mouth or lips necessary to correct *accidental injury*. Charges *incurred* for the treatment of the teeth, dental structures, alveolar processes, dental caries, extractions, corrections of impactions, gingivitis, orthodontia, or prostheses, or the professional fee for extraction of teeth <u>will not</u> be covered under the medical benefit; but they may be covered under your Dental Benefits through Group Dental Service - see page 58 of this booklet.

In general, services related to the mouth, jaw, and proximate areas are covered under the medical benefit when the clinical diagnosis and symptoms are medical in nature, not dental. (See the exclusion for dental services under "Exclusions and Limitations" on page 79.) Eligible services may be covered when there is a diagnosis of medical disease, skeletal deformity with actual or potential for degeneration or skeletal discrepancy. The Fund may require radiological exams and a medical history and physical exam in order to determine whether the services are medical in nature. Please submit a treatment plan to the *Fund office* so it may make this determination before claims are *incurred*.

Temporomandibular Joint Disorder (TMJ)
The Fund will pay for the cost of *surgery* for TMJ disorder, but not for related services such as occlusal equilibration and physical therapy. <u>Not</u> covered, for example, are: isometric therapy, capping/crowning of teeth, subperiosteal implants, endosseus implants, mandibular staple implants, photographic records, intra-oral dental slides, dental x-rays, and dental tracings. Because TMJ treatment usually involves both covered and non-covered services, you should contact the *Fund office* prior to treatment so that planned procedures may be reviewed and you may be advised of what will be covered.

Ambulance Service
Benefits are provided for emergency *ambulance service* up to $25 per trip. The patient's condition must be such that use of any other method of transportation is not medically advisable.

Radiation Therapy
Benefits shall be provided to you or your eligible dependent(s) for the reasonable cost for the following services wherever administered by a *physician*. See below.

1. Deep or superficial x-rays for the treatment of neoplasms, lymphoid hyperplasia of the nose and pharynx, and disorders of the female genital system and breasts. The maximum basic benefit payable in any one calendar year shall be 25 treatments for any and all such conditions.
2. The application or implantation of radium or radon.

Benefits are not provided for the cost of radiation therapy materials used.

Chemotherapy
Benefits for chemotherapy services are available to you or your eligible dependent(s) for the reasonable cost for administration of anti-cancer chemotherapeutic agents when provided in the *physician's* office. Benefits include the cost of chemotherapy materials used. Chemotherapy and radiation are each covered for 25 treatments as a basic benefit (meaning at 100% up to the UCR, with no deductible). Treatments beyond 25 will be covered at 80% up to the UCR, and are subject to the annual deductible.

Ambulatory Center Benefit
In place of a *hospital*, you may use an ambulatory surgical facility which has permanent facilities and equipment for performing surgical procedures on an *outpatient* basis. This facility must provide treatment by or under the supervision of *physicians* and nursing services whenever the patient is in the facility, but it cannot provide *inpatient* accommodations. It must not, other than incidentally, be used as an office or clinic for the private practice of a *physician* or another provider. The facility must be approved by the Plan.

Tonograms
Tonograms are covered whether rendered on an *inpatient* or *outpatient* basis provided they are performed by a *physician* and directly related to a *sickness*.

Flu Shots, Immunizations and Medically Necessary Injectables
A flu shot will be covered once every 12 months. The shot itself is covered in-full, up to the UCR (with no deductible), while the office visit charge (if there is one) is covered at 80% after satisfying the annual deductible.

Immunizations are covered for eligible dependent children ***through age 5 only.*** A maximum of eight (8) visits will be covered. Both the injection and the office visit will be covered in-full, up to the UCR, with no deductible applying.

Medically necessary injectables are covered at 80%, up to the UCR, after satisfying the annual deductible. If you get the injectable drug from a pharmacy and bring it to the doctor's office to be administered, the drug is covered under your Prescription Benefit (see page 55) while the office visit is covered under the Comprehensive Medical benefit.

Cleft Lip or Palate Conditions
Benefits are available to cover medical expenses for the treatment of cleft lip and cleft palate conditions. The various covered services include: expenses arising from orthodontics; oral *surgery*; otologic, audiological, and speech/language treatment.

Diagnostic X-Ray and Lab Services
Benefits for *diagnostic* x-ray and laboratory services (including pathological examination of tissue, electrocardiograms, electroencephalograms, routine PAP smears, annual mammograms for eligible participants over age 39, and basal metabolism tests) are available to you and your eligible dependent when treated in the *outpatient* department of a *hospital* or a *physician's* office and such examinations are required for the diagnosis or treatment of *sickness* or *injury*.

Benefits do not include services for any examinations in connection with care of teeth, research studies, pre-marital examinations, fluoroscopy without films, or an examination not incidental to or necessary for the diagnosis of a disease or *injury*. Payment will not be made to both a *hospital* and *physician* for the same service.

Other Medical Services

Covered medical expenses include charges for the services shown below which are *incurred* during the treatment of a *sickness* or *injury* and which are performed or prescribed by a duly licensed *physician*:

1. Services of *physicians* (including specialists) provided in a *hospital*, in the home, and in the *physician's* office;
2. Room and board including special diets; general nursing services in a *hospital* except for room and board charges in excess of the *hospital*'s average semi-private room rate;
3. Use of operating or treatment rooms;
4. Anesthesia and its administration;
5. X-ray laboratory procedures, examination, or analysis made for *diagnostic* or treatment purposes;
6. X-ray, radon, radium, and radioactive isotope treatments or therapy;
7. Oxygen and its administration;
8. Blood transfusions, including the cost of blood and blood plasma (except when donated or replaced);
9. All drugs, medicines, and dressings used in the *hospital*;
10. Services of a licensed physical therapist when indicated for medical reasons but not as part of rehabilitative care (except when included in the rehabilitation benefit programs described on page 71);
11. Services of an actively practicing private duty nurse when *medically necessary* as follows:
    a. In or out of the *hospital*, the services of a registered professional nurse (R.N.) or licensed practical nurse (L.P.N.);
    b. The technical proficiency and scientific skills of an R.N. or L.P.N. are required and skilled services are actually rendered;
    c. Services cannot be rendered by the *hospital's* general nursing staff.
12. Rental or--at the discretion of the Plan--purchase of a wheelchair, *hospital*-type bed, or other *Durable Medical Equipment* (DME) which is necessary for therapeutic use (see section on DME Network, page 39. Replacement batteries for electric wheelchairs will be covered once every two years.
13. Professional *ambulance services* for *outpatient hospital* care for *accidental injury* and for *inpatient* admissions (donations for the services of a volunteer ambulance are ineligible for coverage);
14. Services for cosmetic purposes for the correction of congenital defects or conditions resulting from traumatic injuries are subject to the pre-existing condition exclusion on page 13
15. Prosthetic appliances such as casts, splints, crutches, braces, or artificial limbs when prescribed by a *physician* are subject to the pre-existing condition exclusion on page 13.
16. Services or appliances for dental care resulting from an accidental bodily *injury* occurring are subject to the pre-existing condition exclusion on page 13 (services for the replacement or correction of false teeth as a result of *accidental injury* are ineligible for coverage;
17. Covered expenses arising out of pregnancy for enrolled female participants or spouses of participants entitled to dependent coverage;
18. Allergy shots and allergy testing, when *medically necessary* and administered by a *physician*;
19. Any services rendered by a chiropractor up to an annual limit of $1,000 for you and $1,000 for each eligible dependent.
20. One annual routine mammogram for each female participant and eligible dependent who is age 40 and over.
21. One annual PAP smear for each participant and eligible dependent.
22. *Sclerotherapy* (treatment of varicose veins) as follows:
    a. Treatment must be pre-approved by Optum/CARE (see section on Optum/CARE 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 Optum/CARE.

c. Your *physician* must send a letter of *medical necessity*, pre-operative photographs, and a patient history indicating the need for testing to Optum/CARE 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 five treatments per area.
e. Consecutive treatments must be separated by six to eight 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 Optum/CARE will not be covered.
h. Billing for laser treatment of varicose veins will be covered at the same level as *sclerotherapy*.

If You Reach the Benefit Maximum

In any case where the maximum lifetime benefits (shown in the Schedule of Benefits Summary on page 8) have been paid to you or your eligible dependent(s), additional benefits shall be granted to you for a *sickness* (other than substance abuse) at 80% (up to the *UCR*) of the excess eligible medical expenses *incurred*, paid to a maximum of $1,000 per calendar year. The $100 *deductible* applies.

CLAIMS PROCEDURES

The following filing procedures apply to Comprehensive 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.** 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 you first have action taken against you by the provider. If you do not notify the Fund, you can be held responsible by the provider and the Fund will not defend you.

2. Make sure you bills are fully itemized and on the letterhead stationery of the provider of service. Bills must show: ***Participant's name and Social Security Number (important)***, patient's name, type of service, diagnosis, date(s) of service, and charge per service. Cancelled checks, cash register receipts, and personal itemizations are not acceptable.

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. **If you used a OneNet PPO participating provider**, mail your claim for benefits/itemized bills to:
   OneNet PPO, LLC
   P.O. Box 936
   Frederick, MD 21705
   Write your OneNet control number on your bills. Your control number is AL0007.

9. If you did not use an OneNet PPO participating provider, mail your claim for benefits/itemized bill(s) to the Fund office. If bills are submitted for more than one family member at a time, a separate itemized bill must be submitted for each family member.

Mail claims/itemized bills to the Sparks, MD *Fund office* at:

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

For a more detailed explanation, see "Claims Filing and Review Procedure" on page 92

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to **all benefits** payable under the Plan, except as specifically required otherwise under the Plan or by applicable law.

1. Work-related injuries or *sicknesses* that 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 compensable by Workers' Compensation*, the Fund will treat your claim as compensable by *Workers' Compensation* and excluded from 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 thereof.
3. Care provided to you or your eligible dependent(s) to the extent that the cost of the professional care or hospitalization 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 32, and in the "Advance Benefits for Workers' Compensation Claims" section on page 34.
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 58
6. Dental *surgery* or dental appliances to replace the natural teeth and gums unless such charges are made necessary by *accidental injury* to physical organs or parts. When covered, these charges are subject to the pre-existing condition exclusion, except as provided in the section entitled, “Medical Conditions of the Mouth, Jaw, and Proximate Areas” on page 74.
7. Appliances or treatment related to bite corrections.
8. 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 on page 58.
9. Hearing aids and the examination for them.
10. Eyeglasses and the examination for prescription or fitting other than as provided in the Optical Benefits section on pages 66 and 68, except when necessary as a result of eye *surgery*; operations performed to correct vision when it is possible to correct vision by using lenses covered under the Optical Benefit of this Plan.
11. Services for cosmetic purposes except those previously specified as covered, unless necessary to correct conditions resulting from traumatic injuries. When covered, these charges are subject to the pre-existing condition exclusion.
12. Complications resulting from cosmetic *surgery* are not covered.
13. Services or supplies not medically necessary for the treatment of *sickness* or *injury* (e.g. routine immunizations, screening examinations including x-ray examinations made without film, routine or periodic physical examinations except where previously defined as covered).
14. Services or supplies for treatment of infertility or contraception except as specifically provided for in the Prescription Drug Benefit section on page 55. Surgical implantation of Norplant is not covered.
15. Services or supplies related to sterilization reversal.
16. Trans-sexual operations or any care or services associated with this type of operation.
17. Services, supplies, or care of any kind related to the pregnancy or complications of pregnancy for a dependent daughter of a participant.
18. Travel, whether or not recommended by a *physician*.
19. Convalescent, milieu, custodial care, sanitaria care, or rest cures.
20. 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 required by federal law.

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 forms of non-medical self-care or self-help training; and any related *diagnostic* testing provided on an *outpatient* basis;
24. Air conditioners, humidifiers, dehumidifiers, purifiers, and all similar equipment.
25. Care for nervous and mental conditions, including drug addiction and alcoholism except as specified in the "Mental Health/Substance Abuse Benefit" section (see page 82).
26. Care for quarantinable diseases in special institutions.
27. Except as provided in the Prescription Drug Benefit section on page 55, all drugs and medicines other than those provided in the *hospital*.
28. Services or supplies which are in excess of the *UCR* amount.
29. Organ transplant expenses in excess of $1 million for each different organ transplanted.
30. Any service which is made available without charges, not including Medicaid or services provided only to insured persons.
31. Services rendered by a provider who is a member of the participant's or dependent's immediate family (parent, spouse, brother, sister, children).
32. Telephone consultations with patients, charges for failure to keep a scheduled visit, or charges for completion of forms.
33. Pre-admission *diagnostic* testing relating to an *inpatient* admission which is not covered under the Plan.
34. Administration of oral chemotherapeutic agents, except as provided in the Chemotherapy section on page 75.
35. Well Baby Care and immunizations. Newborn Care is covered as described previously.
36. Domestic or housekeeping services other than those specifically provided under the HomeCare program.
37. Treatment of autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or mental retardation.
38. Meals-on-wheels and similar food arrangements.
39. Services performed by interns, residents, or *physicians* who are employees of a *hospital* and whose fees are charged for, by, or payable to, a *hospital* or other institution;
40. Treatment, care, or services through a medical department or clinic, or similar services provided or maintained by a *participating employer*;
41. Injections of varicose veins, except as provided in the section on *sclerotherapy*.
42. Injections for treatment of hemorrhoids or hernias.
43. Injection of cortisone or other preparations, except for trauma or acute suppurative infections, except as provided under the Comprehensive Medical section.
44. Care of corns, bunions (except capsular or bone *surgery* therefor), callouses, nails of the feet, fallen arches, weak feet, chronic foot strain, routine care for or symptomatic complaints of the feet, except when major *surgery*, as defined by the *Trustees*, is performed, or in conjunction with the treatment of diabetes.
45. Routine or periodic physical examinations and screening examinations including x-ray examinations made without film except for PAP smears and mammograms, as previously described.
46. Services, supplies, drugs, devices, medical treatment, procedures or care of any kind which is *experimental* in nature, or which is not accepted practice by the medical community practicing as determined by the Fund (see "Experimental" under "Definitions" section).
47. Services or care of any kind other than those defined and limited in this Plan.
48. Consultation services are not available with medical or surgical services when they are rendered by the same *physician* during the same *hospital* admission, except in the sole discretion of the Board of Trustees.
49. 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.

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 by an HMO (Health Maintenance Organization) option. There will be at least one, HMO option offered. Prior to your initial *eligibility date*, the *Fund office* will send you an enrollment packet containing information about these choices. **Before you enroll in an HMO, be sure to confirm there are participating providers in your area (some HMOs do not service 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 Rx, as further described in this booklet.

If you want your Medical benefits provided through an HMO, you must complete and return the election form from the 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.

Each year, the Fund may offer one or more HMOs (Health Maintenance Organizations) as an option to specified participants during the "open enrollment" period. During open enrollment, participants and their dependents may choose an HMO in lieu of the Fund Medical Benefits processed by Associated Administrators, LLC. You will keep all your other existing Fund benefits, including Optical, Dental, and Prescription Drug. **This election must be for a full twelve months.** Thereafter, participants may keep the HMO or return to benefits administered by 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 or no *co-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 which you must submit directly to the HMO (not the *Fund office*). You will receive a letter each year explaining the Open Enrollment options and the monthly cost, if any, for each choice. Missed *co-payment*s 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. It is up to you to contact the *Fund office* during that open enrollment to let us know which option you are choosing for the next year.**

Participants should receive a newsletter from the Fund and a brochure and application from each HMO 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 an information brochure/enrollment application from that HMO.**

The HMO listed below is offered as an alternative to the Fund Medical Coverage as described in this booklet. The selection of HMOs offered is subject to change each year.

Kaiser Permanente
2101 E. Jefferson Street
Rockville, MD 20849-6611

MENTAL HEALTH/SUBSTANCE ABUSE BENEFIT
Benefits are provided through the Fund, not insured.
Closed Panel Services provided through ValueOptions

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 encouraged to use a therapist or facility from the ValueOptions panel for your mental health care or substance abuse care. The psychiatrists, psychologists, licensed social workers, and facilities affiliated with ValueOptions have been selected and credentialed to participate in the program. The program is designed to provide you with a high level of benefits, minimum out-of-pocket costs, and no claims paperwork when you use one of the ValueOptions providers. Panel providers are aware of Fund benefits and how to work with Optum/CARE Programs to certify both *inpatient* and *outpatient* care.

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 a 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. Do NOT use the OneNet PPO for mental health claims.**

When You Use a Panel Therapist
Call the **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 $350,000, which is part of the total lifetime maximum for Comprehensive Medical Benefits of $350,000. **All care must be pre-certified, which means ValueOptions has reviewed and certified the *inpatient* care prior to admission.**

Outpatient mental health care, visits to a psychiatrist, certified psychologist, or independently licensed social worker

who is part of the ValueOptions panel are covered at **100% of the ValueOptions rate** for the first six visits. This is a lifetime benefit. Thereafter, outpatient care is covered at 50% **of the ValueOptions rate**. All care must be certified. The lifetime benefit maximum for outpatient care is $350,000, which is part of the total lifetime Comprehensive Medical Benefit maximum of $350,000.

Inpatient Coverage		**In-Panel**
Mental health:	30 days room and board	100%
	Miscellaneous charges	80%
Substance Abuse:	7 days detox room and board	100%
	Miscellaneous charges	80% up to 1,000
	30 days rehab room and board	100%
	Miscellaneous charges	80% up to 1,000

Combined annual limit of $1,000 for inpatient substance abuse miscellaneous charges.

Outpatient Coverage	**In-Panel**	
Mental Health:	First Six Visits (lifetime)	100%
	Unlimited visits (thereafter)	50%
Substance Abuse:	30 visits	100%

Combined annual limit of $1,000 for outpatient substance abuse visits.
The participant is responsible for the balance after ValueOptions pays. The lifetime benefit maximum for substance abuse rehabilitation is 120 days and/or visits.

When You Do Not Use a Panel Therapist
Non-panel therapists must pre-certify your treatment in order for ValueOptions to reimburse services. If you do not contact the Clinical Referral Line and seek treatment from a panel therapist, you will be responsible for the following:

1. In emergencies, you must have your non-panel therapist call ValueOptions at the time of admission or within 24 hours of hospitalization to begin the certification process.

2. For outpatient care with an eligible therapist, he/she must complete an Outpatient Treatment Report (OTR) and send it to ValueOptions by the 5th visit if the therapist determines that more than ten visits will be needed. You or your therapist can get OTRs by calling ValueOptions and requesting one.

***Inpatient* mental health and substance abuse care is covered at 50% of the ValueOptions fee schedule for your *hospital* stay up to the limits of the Plan, based on certification. The lifetime maximum is $350,000, which is part of your total Comprehensive Medical Benefit lifetime maximum of $350,000.**

Outpatient mental health visits are covered at 25% of the ValueOptions rate up to the limits of the Plan. You must see a psychiatrist, certified psychologist, or independently licensed social worker, and all care must be certified in order for ValueOptions to reimburse services. The lifetime maximum for outpatient care is $350,000, which is part of the total Comprehensive Medical Benefit lifetime maximum of $350,000.

Inpatient Coverage		**Out of Panel**
Mental health:	30 days room and board	50%
	Miscellaneous charges	40%
Substance Abuse:	7 days detox room and board	50%
	Miscellaneous charges	40% up to 1,000
	30 days rehab room and board	40%
	Miscellaneous charges	40% up to 1,000

Combined annual limit of $1,000 for inpatient substance abuse miscellaneous charges.

Outpatient Coverage		**Out of Panel**
Mental Health:	Unlimited visits	25%
Substance Abuse:	30 visits	50%

Combined annual limit of $1,000 for outpatient substance abuse visits.
The participant is responsible for the balance after ValueOptions pays. **The lifetime maximum for substance abuse rehabilitation is 120 days and/or visits.**

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 ValueOptions, Inc.

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

ValueOptions 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 ValueOptions determines that treatment is not medically necessary, it will mail the Participant an written claim denial in the form set forth in Section III. You or your treating provider, acting on the your behalf, may request a Level I review of that determination by a ValueOptions 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 ValueOptions. When contacting ValueOptions 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. ValueOptions will notify you and your treating provider in writing of the outcome of the Level I review. While you are not obligated to follow ValueOptions' Level I or Level II review procedure prior to appealing the denial to the Board of Trustees, if you do choose to appeal to ValueOptions, you must doe 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 ValueOptions, you may request a review of the determination within two weeks from the date of the Level I review notification from ValueOptions. Call ValueOptions immediately after you receive a denial for details regarding further review procedures.

If you are dissatisfied with a ValueOptions 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*, follow the procedures set forth in Section IV below.

II. ValueOptions Review Procedures as to Claims for Services Provided- Post Service Claims

ValueOptions 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 ValueOptions preliminary assessment as to the proper amount to be paid for treatment already provided, the preliminary assessment by ValueOptions that no payment should be made to you or your provider for services rendered in cases where ValueOptions 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 ValueOptions believes to be excluded under the Plan, or that treatment was provided for a service despite the belief by ValueOptions that your benefits were exhausted prior to receiving such service.

After you receive the notice from ValueOptions 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 ValueOptions 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 ValueOptions, you must do so **before** appealing to the Board of Trustees.

You may ask ValueOptions for a review of the preliminary assessment regarding your claim for services provided by either calling the ValueOptions Service Operations Department at 800-454-8329 or by writing to ValueOptions at: **ValueOptions**, 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 ValueOptions, 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 ValueOptions determines after its review that services are not covered, ValueOptions 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 ValueOptions 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 ValueOptions require an extension of time for rendering a final decision on your claim. If such an extension of time is needed, ValueOptions 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 ValueOptions 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. ValueOptions--Denial of Claims

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

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 ValueOptions Denial of Claims

When your claim has been denied by ValueOptions, you can appeal the denial directly to the Board of *Trustees*.. If you decide to appeal the ValueOptions 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 ValueOptions. See the "Review of A Denied Claim" section on page 96 for specific instructions.

EMPLOYEE ASSISTANCE PROGRAM

Benefits are provided through the Fund, not insured.
Benefit claims are processed by **ValueOptions**

If You Have Chosen One Of The HMO Options For Providing Your Medical Benefits, The Employee Assistance Program Does Not Apply To You--Contact Your HMO To Determine Your Coverage

ValueOptions, which administers your Mental Health Benefit, also administers the Fund's Employee Assistance Program (EAP). EAP helps employees in areas not covered by their medical or mental health benefits. It provides early detection and intervention for problems before your health, family, or job is seriously affected. You will be eligible to receive up to six EAP sessions **per lifetime**. **Only ValueOptions therapists can provide EAP services.**

The EAP provides counseling for the problems outlined below:

- Short Term Mental Problems — Up to 6 evaluation visits * see note
- Marriage Problems -- Up to 2 evaluation visits
- Gambling Problems -- Up to 2 evaluation visits
- Obesity -- Up to 2 evaluation visits
- Retirement Planning -- Up to 2 evaluation visits
- Financial Planning -- 1 evaluation visit
- Sexual Dysfunction -- Up to 2 evaluation visits
- Stress Management -- Up to 2 evaluation visits
- Smoking Cessation -- Up to 2 evaluation visits
- Child Care Referrals -- Up to 2 evaluation visits

* Except for short term mental problems, after the evaluation visits, ValueOptions will make a referral to a healthcare provider, community resource, or self-pay program, if necessary. For mental problems, if you continue to need treatment after the evaluation visits, the ValueOptions-affiliated counselor may direct you to a ValueOptions-affiliated therapist for additional visits under your Mental Health benefit at 50% coverage.

EAP benefits are available to you and your eligible dependent(s) at no cost. Access the EAP services through ValueOptions by calling (800) 454-8329, 24 hours a day, 7 days a week.

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/ACTIVELY WORKING/ACTIVE 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.

AMBULANCE SERVICE. A licensed private professional *ambulance service* providing local ground/surface transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

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

CALENDAR YEAR. A calendar year from January 1st through December 31st.

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 of 1985. Provides for continuation of benefits under certain circumstances for participants and their eligible dependent(s) when benefits are lost. Refer to page 21

COLLECTIVE BARGAINING AGREEMENT. The agreement or agreements between a *participating employer* and the United Food and Commercial Workers Unions, Local 27 or Local 400, which require contributions to the UFCW Unions and 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 out-of-pocket amount a participant or dependent is responsible for paying when receiving benefits.

DEDUCTIBLE. The out-of-pocket amount a participant or dependent must pay prior to receiving benefits from the Fund. The *deductible* is the first $100 of covered medical expenses *incurred* in a *calendar year* for *sickness* or *injury*.

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. generally is 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 *experimental* or investigative unless:

1. The approval of 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 utilized 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 Evidence shall mean only published reports and articles in 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 (EOB). A comprehensive statement of how a claim was processed.

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

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

HOSPICE CARE. Care designed for meeting the special physical, spiritual, 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, substance abusers, 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: 1) with respect to a participant, two or more unrelated conditions which are separated by your return to *active work* on a full time basis for one full day, or for related conditions, separated by your return to *active work* on a full time basis for 60 full days; 2) with respect to eligible dependents, the confinements must be separated by at least three months.

INCURRED. A charge will be considered "*incurred*" on the date a participant receives the service or supply for which the charge is made.

INJURY. Bodily *injury* caused by an accident occurring while coverage is in effect and resulting, directly and independently of all other causes, in loss which is covered by the Plan. All injuries sustained in connection with one accident will be considered one *injury*.

INPATIENT. 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 CARE. Professional non-surgical services rendered by a *physician* for the treatment of a *sickness* or *injury*.

MEDICAL EMERGENCY. A situation which arises suddenly and which poses a serious threat to life or health. Medical emergencies include 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 OR MEDICAL NECESSITY. 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 and 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*, your *hospital*, or another provider and 4) the most appropriate supply or level of service which can safely be provided to you. When referring 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 alone mean it is medically necessary.

As applied to the Mental Health Benefit program, "*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 ValueOptions.

MEDICARE. Benefits under Title XVIII of the Social Security Act of 1965, as amended from time to time.

MENTAL ILLNESS. 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) in the Schedule of Benefits.

NURSE MIDWIFE. A licensed registered nurse, certified by the American College of Midwives as qualified to render non-surgical obstetrical care.

OPTOMETRIST. *Physicians* 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. A participant or eligible dependent who receives covered services in a *hospital*, but for whom an overnight room and board charge is not made.

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 of Maryland to provide dental services to participants and their eligible dependent(s).

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, Local 27 or Local 400, which requires contributions to the UFCW Unions and Participating Employers Health and Welfare Fund.

PEDODONTIA. Dental treatment of children under the age of 4.

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 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*, *mental illness*, or pregnancy. Pregnancy is not automatically considered to be a sickness. There must be a medical reason for the pregnancy to be considered a sickness.

SURGERY. The performance of generally accepted operative and cutting procedures including endoscopic examinations and other invasive procedures, 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 and Participating Employers Health and Welfare Fund.

UNION. The United Food and Commercial Workers International Union, Locals 400 and 27 or any successor by combination, consolidation, or merger, or any other local *union* affiliated with the United Food and Commercial Workers International that: 1) 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"); 2) 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 benefits for participants and their eligible dependent(s) who are absent from work due to military service. See page 27.

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*, condition, or *injury*. The locality 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 and coverage,
2. find out how your claims were processed, and
3. get medical benefit counseling.

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

Toll Free......... 800-638-2972

You will be given an option to either 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, or to speak with a representative directly (during office hours).

For more information about the "automated attendant" and how to use it to check the status of a claim, see page 93.

CLAIMS FILING AND REVIEW PROCEDURE

If you want to file a claim for benefits, go to the Claims Procedure at the end of the section describing the particular benefit. For example, if you want to file for Weekly Disability payments, see page 52 in the Weekly Disability Benefit section. Filing procedures for medical claims are listed on page 78. The section below summarizes the general rules which apply to **ALL** claims for benefits under the Plan.

When You File a Claim

1. Present your UFCW Unions and Participating Employers Health and Welfare Fund identification card when seeking service from a *hospital* or *physician*.
2. The *hospital* or *physician* will submit a bill directly to the UFCW Unions and Participating Employers Health and Welfare 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 *hospital* or *physician*.
3. You must either submit an itemized bill or file a claim (using a claim form) in order to be eligible for benefits.
4. If your *physician* or *hospital* has not billed the Fund directly, you must submit an itemized bill 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 charge per service. Cancelled checks, cash register receipts, and personal itemizations are not acceptable.
5. If bills are submitted for more than one family member at a time, a separate itemized bill must be submitted for each individual.
6. Medical or Weekly Disability claims or itemized bills must be filed within 180 days of the date of service or within 180 days from the first date of disability. 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 he provider takes any other action against you. Further, in order for the Fund to defend you, you must notify the Fund when you first have action taken against you by the provider. If you do not notify the Fund, you can be held responsible by the provider and the Fund will not defend you.
7. Requests for additional information from the *Fund office* must be returned within two weeks from the date mailed to you.
8. The fact that a claim for benefits from a source other than the Fund has been filed or is pending does not excuse these claims filing requirements. Further, lack of knowledge of coverage does not excuse these requirements.
9. If you receive *hospital* care in a Veterans', Marine, or other federal *hospital* or elsewhere at government (federal, state, or municipal) expense, no benefits are provided under this 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.
10. 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.
11. 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 regarding your claim and how it was processed.
13. Keep copies of all submitted bills for your records. Original bills will not be returned.
14. 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 34) for the conditions of payment.

Payment of a Claim
When you submit itemized bills or file a claim using a claim form, the *Fund office* begins to process it as soon as possible after receiving it. If your claim is valid, you have prepared the claim so we have all the information necessary to process it, and it is covered under the Plan, it will be paid. 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.

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 will receive an *Explanation of Benefits*.

Use the Automated Attendant System to Check on Your Claim 24 Hours/Day, 7 Days/Week
You can check on your claims at YOUR convenience by using the *Fund office*'s "automated attendant" system. To use the system, call **800-638-2972**. At the prompt for the automated attendant, press "one." Follow the prompts to select the option for checking on the type of claim you had (Medical, Accident & Sickness/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 asks for. 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, the dollar amount, 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 adjustors 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 and select "two" at the beginning of the call. You will be given options for connecting to 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 101 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 87.

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 Optum/CARE 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 fifteen days after the claim is received by the Fund. Optum/CARE has the same fifteen 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 fifteen 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 refile 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, prescription, 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 he 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 coy 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.

Review of a Denied Claim

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 ValueOptions, 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 Optum/CARE Programs, Inc., you may contact Optum/CARE at 2811 Lord Baltimore Drive, Baltimore, Maryland, 21244, (800) 638-6265.

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 the Employee Income Security Act.

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 Trustee 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 accident & sickness benefits. It is 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, birthdate, 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, Maryland 21152-2341
(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 Inc. ("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, Maryland 21152-2341
(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 and 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 participants are 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 of 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 preexisting 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 your and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, 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 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 plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PARTICIPATING EMPLOYERS AND UNIONS

Associated Administrators, LLC

Magruder's Inc.

Scan Furniture

UFCW Locals 27 and 400

Participants and beneficiaries may obtain a complete list of the *participating employers* and *unions* sponsoring the Fund by making a written request to the *Fund office*, and such list is available for examination by participants and beneficiaries.

TELEPHONE NUMBERS

Participant Services……………………… (800) 638-2972

Eligibility - Sparks……………………… (410) 683-6500

Optum/CARE Programs………………… (410) 265-7182
(800) 638-6265

Dental Information and Provider Search
All Areas ………………………………… (800) 242-0450

NMHC Rx……………………………… (888) 354-0090
Ascend Program………………………… (800) 850-9122

Optical Appointments
Local 27………………………………… (410) 265-6084
Local 400………………………………… (301) 621-4694
Cumberland……………………………… (301) 729-2243
Hagerstown……………………………… (301) 790-3877
Salisbury………………………………… (301) 742-6148
Out of State/Long Distance……………… (800) 638-3120

ValueOptions…………………………… (800) 454-8329

ADDRESSES

Local 27 Participants--Write:

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

Local 400 Participants--Write:

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

Special P.O. Box for Claims--Both Locals
Send Weekly Disability claims to:

UFCW Unions and Participating Employers
Health and Welfare Fund
P.O. Box 1064
Sparks, MD 21152-1064

If you did NOT use a OneNet PPO Provider and your medical benefits are provided through the Fund, not an HMO, send your medical claims to:

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

If you DID use a OneNet Provider, send your medical claims to:

OneNet PPO, LLC
P.O. Box 936
Frederick, Maryland 21705