
**United Food and Commercial Workers
Unions and Employers
Midwest Health Benefits Plan**

**Plan B5
Summary Plan Description**

Message from the Board of Trustees

Dear Participant:

The Board of Trustees is pleased to provide this Summary Plan Description of the benefits available through the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan. This booklet replaces any and all booklets that were previously issued. Please read this booklet and keep it in a safe place for future reference.

Your Health Plan features a cost-effective preferred provider arrangement that allows you to receive health care at lower rates when you use hospitals and physicians that belong to the BlueCross BlueShield of Illinois Network. See page 25 for a complete description of how using the network can help you save money on your out-of-pocket costs for health care.

Although this booklet provides essential information about your Health Plan, it is not a complete description. The Health Plan provisions are contained in the Plan document and related documents. If there is ever a conflict between the wording in this Summary Plan Description and the Plan documents, the applicable Plan documents will govern.

The Benefits Fund Office can answer any questions you may have about your benefits. You may call the Benefits Fund Office from 8:00 a.m. to 4:30 p.m., Monday through Friday, at 847-384-7000, toll free at 800-621-5133, or TDD at 847-384-0199.

The Board of Trustees

United Food and Commercial Workers
Unions and Employers
Midwest Health Benefits Plan
January 1, 2007

1300 Higgins Road, Suite 300
Park Ridge, Illinois 60068-5713
ufewmidwest.org

Important Information

You Must Elect Coverage and Authorize Payroll Deduction

You must elect whether or not to participate in the Health Plan. If you do not elect to participate, you are not covered. See page 8 for full information.

Pre-Certification

Your Health Plan requires pre-certification of certain expenses. If you do not obtain the required pre-certification, the expense may not be covered, benefits may be reduced and an additional \$100 Non-Compliance Deductible may be applied.

For This Treatment	Contact Us at this Time
Scheduled hospital admission	Two weeks before you are admitted to the hospital
Emergency hospital admission	As soon as possible or within 48 hours of the admission
Admission for childbirth (this is considered a scheduled admission) unless the hospital admission is less than 48 hours postpartum for a vaginal delivery or less than 96 hours postpartum for delivery by caesarian section	Any time during pregnancy (must be before admission)
Surgery, inpatient or outpatient	Two weeks before you are scheduled for surgery
Advanced diagnostic testing Skilled nursing facility care Rehabilitation therapy Home health care Hospice care Durable medical equipment	Before care or before purchase or rental of equipment

Contact Health Information Services at the Benefits Fund Office to request pre-certification:

847-384-7000 ♦ 800-621-5133
TDD 847-384-0199 ♦ FAX 847-384-0198

1300 Higgins Road, Suite 300
Park Ridge, Illinois 60068-5713

ufcwmidwest.org

8:00 a.m. to 4:30 p.m., Monday through Friday

When you contact us, you will generally need to supply:

1. Your full name and UFCW ID # or Social Security number.
2. Doctor's name, address and phone number.
3. Diagnosis.
4. Proposed treatment.

Details regarding this important requirement begin on page 23.

Second Opinion

You must obtain a Second Opinion before undergoing certain surgeries. A list of these surgeries is on page 24. Contact Health Information Services at the Benefits Fund Office for information on obtaining a second opinion.

BlueCross BlueShield Participating Provider Option (PPO)

The Health Plan has made arrangements with certain doctors, hospitals, and immediate care centers to provide health care to you at lower rates than they would normally charge. In addition, the Plan pays a greater percentage of your hospital expenses when you use BlueCross BlueShield participating hospitals. This arrangement helps you save money on your out-of-pocket costs for health care and also reduces the Health Plan's costs.

See page 25 for further information and for how to locate a PPO Provider.

Table of Contents

Summary of Benefits	7
Election of Coverage and Authorization of Payroll Deductions	8
If You Do Not Elect Coverage	8
Enrollment Periods	8
Eligibility Provisions	9
Eligibility Based on Rate-Per-Hour Employer Contributions.....	9
Initial Eligibility.....	9
Continuing Eligibility	11
Termination and Reinstatement of Eligibility	11
Reinstatement After You Return to Work.....	11
Table of Effective Date Examples	12
Eligibility Based on Flat-Rate Employer Contributions.....	13
Initial Eligibility.....	13
Continuing Eligibility	14
Termination and Reinstatement of Eligibility	14
Reinstatement After You Return to Work.....	14
Table of Effective Date Examples	15
Special Rules for Continuing Eligibility	16
Military Service.....	16
Extension of Coverage During Disability	17
Family and Medical Leave Act.....	17
Certification of Coverage When Coverage Ends	18
COBRA Continuation Coverage	19
Cost Containment Features of the Health Plan	23
When to Notify Health Information Services	23
How to Notify Health Information Services	24
Penalties for Failure to Notify Health Information Services	25
BlueCross Blue Shield Participating Provider Network	25
Comprehensive Medical Benefits	26
Lifetime Maximum Benefit.....	26
Annual Deductible.....	26
Non-PPO Hospital Deductible.....	26
Non-Compliance Deductible	26
Out-of-Pocket Limit.....	27
PPO Providers—BlueCross BlueShield of Illinois	27
Surgery at Non-PPO Facility.....	27
Pre-Existing Condition Limitation.....	27
Covered Medical Expenses	28
What is Not Covered	32
Prescription Drug Benefit.....	35
Prescription Drug ID Card	35
Participating Pharmacy Program	35
Annual Maximum Benefit	35
Drugs that Require Pre-Approval	35

Generic Equivalents and Brand-Name Drugs.....	35
Preferred and Non-Preferred Drugs	36
Covered Prescription Drugs.....	36
Co-Payments.....	36
What is Not Covered	38
Direct Reimbursement.....	39
Not Creditable Coverage Under Medicare.....	39
General Exclusions and Limitations.....	40
Recovery Incentive Program.....	42
Filing a Claim and Claim Information.....	44
Claim Forms	44
Authorization to Release Personal Health Information	44
Payment or Status of Claims.....	44
Assignment	44
Coordination of Benefits Provisions	45
Determining Which Plan is Primary	45
Primary Plan Procedures Must Be Followed.....	46
Coordination with Medicare	46
Coordination with Automobile and Similar Coverage.....	47
Subrogation and Reimbursement Rights.....	48
Claim Appeal Procedure	50
Statement of Rights Under the Employee Retirement Income Security Act of 1974.....	51
Definitions.....	53
Important Information about the Health Plan.....	56
Participating Local Unions	59
Appendix A: Claim Procedures	60
Filing a Claim.....	60
Pre-Certification of Covered Expenses	60
Notification of Benefit Determinations.....	61
Filing an Appeal of a Benefit Determination	62
Time Requirements for Appeal Response	63
Right to File a Lawsuit	64
Authorized Representative	65
Appendix B: Privacy Policy.....	66
Appendix C: Prescription Drug Not Creditable Coverage— Medicare Part D.....	73
Appendix D: Summary of the Cafeteria Plan for Employees Participating in the Health Benefits Plan	76

Contact the Office for Assistance

**COMUNIQUESE CON LA OFICINA PARA
RECIBIR AYUDA**

ΕΠΙΚΟΙΝΩΝΗΣΤΕ ΜΕ ΤΟ ΓΡΑΦΕΙΟ ΜΑΣ ΕΑΝ ΧΡΕΙΑΖΕΣΤΕ ΒΟΗΘΕΙΑ ΣΕ
ΟΠΟΙΟΔΗΠΟΤΕ ΘΕΜΑ

如果 需要 幫助，請 與 辦公室 聯絡。

助けが必要な際は、事務所にご連絡ください。

**PROSZĘ SKONTAKTOWAC SIĘ Z BIUREM W
CELU OTRZYMANIA POMOCY**

اتصل بالذائرة من أجل المساعدة

PER ASSISTENZA RIVOLGERSI ALL UFFICIO

**FALLS SIE HILFE BENÖTIGEN, SETZEN SIE
SICH MIT DEM BÜRO IN VERBINDUNG**

United Food and Commercial Workers Unions and Employers
Midwest Health Benefits Plan
1300 Higgins Road, Suite 300
Park Ridge, Illinois 60068-5713

847-384-7000 ♦ 800-621-5133 ♦ TDD 847-384-0199

General FAX 847-384-0197
Claims Department FAX 847-384-0196
Health Information Services FAX 847-384-0198
Prescription Drug Program FAX 847-384-0188

ufcwmidwest.org

8:00 a.m. to 4:30 p.m., Monday through Friday

Daniel W. Ryan, Fund Administrator

The Trustees reserve the right to change, modify or discontinue all or part of this Plan or any of its benefits at any time, or to change the method and amount of any self-payments and the eligibility criteria for self-payments under the Plan. You will be notified of any changes. All changes will be subject to the Plan's provisions and applicable laws.

The Board of Trustees has full discretion and authority to interpret the terms of all documents establishing the Plan, including but not limited to, the rules of eligibility, and to decide any factual question related to eligibility for and the type and amount of benefits. The decision of the Trustees shall be final and binding unless determined by a court of law to be arbitrary and capricious. Benefits will only be paid under the Plan if the Trustees, in their discretion, determine that the applicant is entitled to them.

Summary of Benefits

The following chart highlights key features of your Plan.

Comprehensive Medical Benefit

Lifetime Maximum	\$150,000
Annual Deductible	\$250
Non-PPO Hospital Deductible	\$350
Non-Compliance Deductible	\$100
Percentage Paid	
PPO Hospital	Plan pays 85%, you pay 15%
Non-PPO Hospital	Plan pays 65%, you pay 35%
Out-of-Area or Emergency Hospital	Plan pays 80%, you pay 20%
Surgery when required Second Opinion not obtained	Plan pays 50%, you pay 50%
Most other covered expenses	Plan pays 80%, you pay 20%
Annual Out-of-Pocket Maximum	\$2,000 including Annual Deductible

The following benefits are paid at 100% by the Plan and are not subject to the Annual Deductible

Preventive Care	Plan pays first \$50 per calendar year (expenses in excess of \$50, paid at 80% after Annual Deductible)
Screening Mammogram	Up to \$130 per calendar year within age limits (expenses in excess of \$130, paid at 80% after Annual Deductible)

Other Limits

Occupational Therapy	\$2,500 per calendar year
Physical Therapy, Chiropractic Therapy, Prolo Therapy, Acupuncture	Chiropractic Therapy maximum of \$1,500 per calendar year; combined maximum of \$2,500 for all therapy per calendar year
Speech Therapy	\$2,500 per calendar year
Cardiac Rehabilitation	\$1,000 per event
Oxygen, outpatient or portable	\$500 per calendar year plus the one-time cost of an oxygen concentrator, if applicable
Home Health Care	\$10,000 per calendar year plus the cost of durable medical equipment, if applicable
Mental Health: Inpatient Outpatient	Maximum of 10 days per calendar year 20 visits per calendar year payable at 50%
Substance Abuse	\$5,000 lifetime maximum
Transplant	\$100,000 per transplant
Hearing Aid	\$500 in any 5-consecutive year period
Intentionally Destructive Injury	Plan pays 50% up to \$5,000 per event
Pre-Existing Condition	Plan pays 50% up to \$5,000 per condition
Treatment of Varicose Veins	\$2,500 per leg, lifetime maximum
Voice Communication Machine	\$7,500, lifetime maximum

Prescription Drug Benefit

Annual Benefit Maximum	\$1,500
Percentage Paid	Plan pays 100% after you pay the co-payment
Co-payment:	
Generic Drug	\$7
Brand Name Drug	\$15
Preferred Drug	\$0
Non-Preferred Drug	\$25
Dispensing Limitation	30-day supply, 90-day supply for maintenance drugs

Election of Coverage and Eligibility Provisions

This plan provides coverage only for you; family coverage is not provided. You become covered:

- after you elect coverage and authorize payroll deductions; and
- after you satisfy the eligibility provisions.

All of these requirements are described in the following paragraphs.

Election of Coverage and Authorization of Payroll Deductions

The Collective Bargaining Agreement between your employer and your local union requires that you elect whether or not to participate in the Health Plan. If you elect to participate, you must make a weekly contribution via payroll deduction.

Eligible employees may elect:

No Coverage. You may elect not to participate and you will not receive any health coverage or related benefits. There is no weekly payroll deduction if no coverage is elected.

Single Coverage. You may elect Single Coverage to receive health coverage and related benefits for yourself only (no family members) and make a weekly payroll deduction of \$5. Additionally, you must work the minimum hours necessary to maintain coverage.

The weekly payroll deduction of \$5 can be made under an Internal Revenue Code Section 125 Cafeteria Plan that your employer can adopt. Under the Cafeteria Plan, no federal or state tax is withheld from or due on your contribution amount. A summary of the Cafeteria Plan begins on page 76.

The Benefits Fund Office or your employer will provide you with an “Election and Payroll Deduction Authorization Form” at the time you first become eligible for health coverage. A completed, signed form must be returned to the Benefits Fund Office in a timely manner or you will not have health benefits coverage. If you do not receive an “Election and Payroll Deduction Authorization Form,” contact the Benefits Fund Office immediately.

If You Do Not Elect Coverage

You will not be eligible for health benefits if you do not elect coverage and authorize payroll deduction.

Enrollment Periods

New Employee/Initial Enrollment. The enrollment period ends 60 days following the Health Coverage Effective Date (see page 12 and page 14 for Tables of Effective Date Examples for new employees). If you do not make an election within this time, you will not have health coverage. The next opportunity to enroll will be the Open Enrollment Period or the Special Enrollment Period, both explained below.

Open Enrollment Period. In December of each year, you may enroll or cancel your existing enrollment. The change will become effective on January 1 of the following year. Contact the Benefits Fund Office during November or early December and the proper forms will be sent to you.

Special Enrollment Period. If you are declining enrollment because of other health insurance or group health plan coverage, you may be able to enroll in the Health Plan if you lose or gain eligibility for that other coverage (or if the employer stops contributing towards your other coverage). However, you must request enrollment within 30 days after your other coverage changes.

A complete list of events and situations which may allow you to enroll under the Special Enrollment Period provisions begins on page 76.

To request Special Enrollment, contact the Benefits Fund Office.

Eligibility Provisions

You are eligible to participate in the Plan when you work in covered employment for an employer that contributes to this Health Fund on your behalf.

The eligibility provisions that apply to you are based on whether your employer makes a Rate-Per-Hour Contribution or a Flat-Rate Contribution:

- **Rate-Per-Hour Employer Contributions.** Your employer makes a contribution for every covered hour that you work each month. Rate-Per-Hour Eligibility Provisions are described beginning on page 9.
- **Flat-Rate Employer Contributions.** Your employer contributes a flat amount each month. Flat-Rate Eligibility Provisions are described beginning on page 13.

Your employer's method of making contributions is specified in your Collective Bargaining Agreement with your local union. Contact your employer, your local union or the Benefits Fund Office if you need more information on which contribution method your employer uses.

Eligibility Based on Rate-Per-Hour Employer Contributions

If your employer makes a contribution for every covered hour that you work each month, these Rate-Per-Hour Eligibility Provisions apply to you. If your employer contributes a flat amount each month, see page 13 for the eligibility provisions that apply to you.

Initial Eligibility

Before your health coverage becomes effective, you must satisfy certain waiting periods as specified in your Collective Bargaining Agreement and other eligibility provisions.

(Rate-Per-Hour Eligibility continues on following page)

Eligibility is based on the average number of hours you work in covered employment during a certain period. Hours of covered employment are the hours that you work for which your employer contributes to the Health Fund on your behalf.

A “Table of Effective Date Examples” begins on page 12. The date your coverage becomes effective depends on the length of time you must work before your employer is required to make contributions on your behalf. The Table gives examples of coverage dates for employees whose employer contributions start after 30 days, three months, six months and one year of employment. Refer to your Collective Bargaining Agreement to determine when your employer is required to begin making contributions on your behalf.

Definition of a Week: A week is a payroll week. For example, if you are paid from Sunday through Saturday, this is what the Plan means when it refers to a week. You should count your hours for each week that ends in the month for which you are determining your eligibility. This means that some of the days for the first week may be contained in the prior month, and some of the days in the month that follow the last week may not be counted.

Example of Initial Eligibility

If your payroll week runs from Sunday through Saturday and you are determining your hours for May 2007, there are four weeks for which you count the hours you worked. Because May 2007 contains four Saturdays, count the covered hours in the weeks running from:

Sunday through Saturday	Covered Hours Worked
April 29 through May 5	14
May 6 through May 12	10
May 13 through May 19	20
May 20 through May 26	8

Use the following formula to determine your average weekly hours worked during the calendar month of May:

$$\frac{\text{Divide the total number of covered hours worked during each payroll week that ends in the calendar month}}{\text{By the number of payroll weeks that end during the month (this will be either 4 or 5 weeks)}} = \text{Average weekly covered hours during the calendar month}$$

The formula works as follows:

$$\frac{14 + 10 + 20 + 8}{4} = \frac{52}{4} = 13$$

(Rate-Per-Hour Eligibility continues on following page)

Even though you worked fewer than 12 hours during some of the payroll weeks that ended in May, your *average* covered hours worked for the four payroll weeks is 12 or greater, so you are able to count May as a month in which you met the hours requirement.

This chart illustrates the hours you need to work to be eligible for benefits.

You Become Eligible for	When You Have Worked these Average Covered Hours	For Each Week Ending During this Period	Your Initial Coverage Begins
Comprehensive Medical and Prescription Drug	12 per week	2 full calendar months in a row	The first day of the month following the 2-month period
Example: If May is the first full month of employment for which your employer made contributions	and you averaged 13 covered hours per week	during May and June	then your initial eligibility date would be August 1, 2007

Continuing Eligibility—You will continue to be eligible if you meet the following requirements:

To Continue to be Eligible for these Benefits	You Must Work these Average Covered Hours	For Each Week Ending During this Period
Comprehensive Medical and Prescription Drug	12 per week	2 full calendar months in a row

Termination and Reinstatement of Eligibility

Your eligibility for all benefits will end when you fail to work an average of at least 12 covered hours per week during weeks that end in 2 full months in a row. Coverage ends on the last day of the first month in which you fail to work the required average covered hours. You will lose all coverage for at least 2 months and will not be reinstated until you again work an average of at least 12 covered hours per week during weeks that end in 2 full months in a row.

You may be eligible to make self-payments to continue coverage under COBRA. See COBRA Continuation Coverage beginning on page 19 for more information.

The following chart shows when coverage ends and when it is reinstated:

Your Coverage for	Ends When You Fail to Work these Average Covered Hours	For Each Week Ending During this Period	Coverage Ends	Reinstatement Occurs
Comprehensive Medical and Prescription Drug	12 per week	1 calendar month	The last day of that month. Coverage is lost for two months.	The first day of the month after you again meet the continuing eligibility requirements

Reinstatement After You Return-to-Work

If you were previously covered under the Plan and are returning to work immediately after:

- a leave of absence for a period of total disability covered under the Plan of a least one calendar month but not more than 12 calendar months; or

(Rate-Per-Hour Eligibility continues on following page)

- a temporary layoff of at least one calendar month but not more than six calendar months; or
- a sanctioned strike,

you will become covered again, to the extent that you were previously covered, on the date you return to work, provided that your employer is required to begin making contributions on your behalf immediately.

Rate-Per-Hour Employer Contributions—Table of Effective Date Examples

The effective dates listed in the following table assume that you are working continuously for an employer participating in the Fund, and that your Collective Bargaining Agreement requires rate-per-hour employer contributions on your behalf beginning with the first weekly pay period after you complete at least 30 continuous days of employment or, as specified in many grocery labor contracts, after three months, six months or one year for "baggers," "utility," "courtesy" and "front-end" clerks. If your Collective Bargaining Agreement contains different requirements, this table does not apply to you.

If you work the required hours each month and your employer fully contributes for those hours:

If Rate-Per-Hour Employer Contributions Begin After 30 Days and		If Rate-Per-Hour Employer Contributions Begin After 3 Months and	
Your first day of employment is between these inclusive dates	Your Health Coverage is effective	Your first day of employment is between these inclusive dates	Your Health Coverage is effective
03/2/07 – 04/1/07	07/1/07	03/2/07 – 04/1/07	09/1/07
04/2/07 – 05/1/07	08/1/07	04/2/07 – 05/1/07	10/1/07
05/2/07 – 06/1/07	09/1/07	05/2/07 – 06/1/07	11/1/07
06/2/07 – 07/1/07	10/1/07	06/2/07 – 07/1/07	12/1/07
07/2/07 – 08/1/07	11/1/07	07/2/07 – 08/1/07	01/1/08
08/2/07 – 09/1/07	12/1/07	08/2/07 – 09/1/07	02/1/08
09/2/07 – 10/1/07	01/1/08	09/2/07 – 10/1/07	03/1/08
10/2/07 – 11/1/07	02/1/08	10/2/07 – 11/1/07	04/1/08
11/2/07 – 12/1/07	03/1/08	11/2/07 – 12/1/07	05/1/08
12/2/07 – 01/1/08	04/1/08	12/2/07 – 01/1/08	06/1/08
01/2/08 – 02/1/08	05/1/08	01/2/08 – 02/1/08	07/1/08
02/2/08 – 03/1/08	06/1/08	02/2/08 – 03/1/08	08/1/08
03/2/08 – 04/1/08	07/1/08	03/2/08 – 04/1/08	09/1/08

(Rate-Per-Hour Eligibility continues on following page)

Rate-Per-Hour Table of Effective Date Examples (Continued)

**If Rate-Per-Hour Employer
Contributions Begin After 6 Months and**

Your first day of employment is between these inclusive dates	Your Health Coverage is effective
03/2/07 – 04/1/07	12/1/07
04/2/07 – 05/1/07	01/1/08
05/2/07 – 06/1/07	02/1/08
06/2/07 – 07/1/07	03/1/08
07/2/07 – 08/1/07	04/1/08
08/2/07 – 09/1/07	05/1/08
09/2/07 – 10/1/07	06/1/08
10/2/07 – 11/1/07	07/1/08
11/2/07 – 12/1/07	08/1/08
12/2/07 – 01/1/08	09/1/08
01/2/08 – 02/1/08	10/1/08
02/2/08 – 03/1/08	11/1/08
03/2/08 – 04/1/08	12/1/08

**If Rate-Per-Hour Employer
Contributions Begin After 1 Year and**

Your first day of employment is between these inclusive dates	Your Health Coverage is effective
03/2/07 – 04/1/07	06/1/08
04/2/07 – 05/1/07	07/1/08
05/2/07 – 06/1/07	08/1/08
06/2/07 – 07/1/07	09/1/08
07/2/07 – 08/1/07	10/1/08
08/2/07 – 09/1/07	11/1/08
09/2/07 – 10/1/07	12/1/08
10/2/07 – 11/1/07	01/1/09
11/2/07 – 12/1/07	02/1/09
12/2/07 – 01/1/08	03/1/09
01/2/08 – 02/1/08	04/1/09
02/2/08 – 03/1/08	05/1/09
03/2/08 – 04/1/08	06/1/09

Eligibility Based on Flat-Rate Employer Contributions

If your employer contributes a flat amount each month, these Flat-Rate Eligibility Provisions apply to you. If your employer makes a contribution for every covered hour that you work each month, see page 9 for the eligibility provisions that apply to you.

Initial Eligibility

Before your health coverage becomes effective, you must satisfy certain waiting periods as specified in your Collective Bargaining Agreement and other eligibility provisions.

Eligibility is based on your employer’s contribution on your behalf:

- If your employer makes a contribution, you eligible.
- If a contribution is not made on your behalf, you not eligible.

(Flat-Rate Eligibility continues on following page)

You first become eligible on the first day of the month after your employer makes the required monthly contribution on your behalf.

A “Table of Effective Date Examples” is shown on page 15. The date your coverage becomes effective depends on the length of time you must work before your employer is required to make contributions on your behalf. The Table gives examples of coverage dates for employees whose employer contributions start after 30 days and after three months of employment. Refer to your Collective Bargaining Agreement to determine when your employer is required to begin making contributions on your behalf.

This chart shows the employer contribution that must be made to be eligible for benefits.

You Become Eligible for	When this Employer Contribution is Made	Your Initial Coverage Begins
Comprehensive Medical and Prescription Drug	1 part-time or full-time contribution	The first day of the month after the month in which the contribution is made

Continuing Eligibility—You will continue to be eligible if you meet the following requirements:

To Continue to be Eligible for these Benefits	This Employer Contribution Must be Made
Comprehensive Medical and Prescription Drug	part-time or full-time contribution

Termination and Reinstatement of Eligibility

Your eligibility for all benefits will end when employer contributions are no longer made on your behalf. Coverage ends on the last day of the month for which a contribution was made. Coverage is reinstated on the first day of the month after you again meet the eligibility requirements.

You may be eligible to make self-payments to continue coverage under COBRA. See COBRA Continuation Coverage beginning on page 19 for more information.

The following chart shows when coverage ends and when it is reinstated:

Your Coverage for	Ends When	Coverage Ends	Reinstatement Occurs
All Benefits	no contribution is made	Last day of the month for which a contribution was made	The first day of the month after you again meet the eligibility requirements

Reinstatement After You Return-to-Work

If you were previously covered under the Plan and are returning to work immediately after:

- a leave of absence for a period of total disability covered under the Plan of a least one calendar month but not more than 12 calendar months; or
- a temporary layoff of at least one calendar month but not more than six calendar months; or
- a sanctioned strike,

(Flat-Rate Eligibility continues on following page)

you will become covered again, to the extent that you were previously covered, on the date you return to work, provided that your employer is required to begin making contributions on your behalf immediately.

Flat-Rate Employer Contributions—Table of Effective Date Examples

The effective dates listed in the following table assume that you are working continuously for an employer participating in the Fund, and that your Collective Bargaining Agreement requires flat-rate employer contributions on your behalf beginning with the month after you complete at least 30 continuous days of employment or, as specified in many labor contracts, after three months. If your Collective Bargaining Agreement contains different requirements, this table does not apply to you.

If Flat-Rate Employer Contributions Begin After 30 Days and		If Flat-Rate Employer Contributions Begin After 3 Months and	
Your first day of employment is between these inclusive dates	Your Health Coverage is effective	Your first day of employment is between these inclusive dates	Your Health Coverage is effective
03/2/07 – 04/1/07	06/1/07	03/2/07 – 04/1/07	08/1/07
04/2/07 – 05/1/07	07/1/07	04/2/07 – 05/1/07	09/1/07
05/2/07 – 06/1/07	08/1/07	05/2/07 – 06/1/07	10/1/07
06/2/07 – 07/1/07	09/1/07	06/2/07 – 07/1/07	11/1/07
07/2/07 – 08/1/07	10/1/07	07/2/07 – 08/1/07	12/1/07
08/2/07 – 09/1/07	11/1/07	08/2/07 – 09/1/07	01/1/08
09/2/07 – 10/1/07	12/1/07	09/2/07 – 10/1/07	02/1/08
10/2/07 – 11/1/07	01/1/08	10/2/07 – 11/1/07	03/1/08
11/2/07 – 12/1/07	02/1/08	11/2/07 – 12/1/07	04/1/08
12/2/07 – 01/1/08	03/1/08	12/2/07 – 01/1/08	05/1/08
01/2/08 – 02/1/08	04/1/08	01/2/08 – 02/1/08	06/1/08
02/2/08 – 03/1/08	05/1/08	02/2/08 – 03/1/08	07/1/08
03/2/08 – 04/1/08	06/1/08	03/2/08 – 04/1/08	08/1/08

Special Rules for Continuing Eligibility

You may remain eligible for benefits under the Plan when your eligibility would otherwise end if you qualify under one of the following conditions.

Military Service. If you are inducted into the armed forces of the United States or if you enlist in military service, your eligibility will end. However, coverage may be continued if you satisfy the eligibility criteria of the Uniformed Service Employment and Reemployment Rights Act of 1994, as amended (USERRA). If you are called into uniformed service for fewer than 31 days, your medical coverage during that leave period will be continued, provided that you pay your share of the premium as established by the Trustees from time to time. Contact the Benefits Fund Office to determine the amount you must contribute to continue your coverage during a leave of fewer than 31 days.

If you are called into uniformed service for 31 or more days, you can continue your coverage for up to 24 months after your coverage under the Plan would otherwise terminate (termination provisions are described beginning on pages 11 and 14). If you fail to provide advance notice of your uniformed service, you will not be eligible to continue coverage unless the failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees determine that your failure to provide advance notice is excused, you may then elect to continue coverage and pay all amounts required to continue coverage in accordance with the COBRA election and payment procedures described beginning on page 19. Your continuation coverage will then be effective retroactive to the date you lost coverage due to your leave of absence to perform uniformed service.

If the Benefits Fund Office has been notified that you are entering the uniformed service, you shall have the option of continuing the same class of coverage under the Plan. Election, payment and termination of this USERRA continuation coverage will be governed by the election, payment and termination rules for COBRA Continuation Coverage, described beginning on page 19, provided the COBRA rules do not conflict with USERRA.

COBRA and USERRA coverage run concurrently. This means that if you are not simultaneously eligible for COBRA and USERRA, then you will be entitled to the more generous benefit provisions under each law for periods in which you remain eligible for both forms of continuation coverage. If you fail to follow the COBRA rules when electing and paying for USERRA coverage, you may lose the right to continue coverage under USERRA. Once lost, the right to USERRA continuation coverage cannot be reinstated. However, if circumstances make it otherwise impossible or unreasonable for you to timely elect and pay for USERRA continuation coverage, the Trustees may, in their sole discretion, reinstate your right to USERRA continuation coverage provided that you pay all amounts required for such continuation coverage.

If you are discharged from the uniformed service under honorable conditions and have USERRA reemployment rights, eligibility may be reinstated on the date you return to work in covered employment or make yourself available for work in covered employment, provided your return to work is within 90 days from the date of your discharge or such shorter or longer period required by law if you serve less than 180 days or are hospitalized when your military service is terminated.

Extension of Coverage During Disability. If you are unable to work because you are totally disabled, your coverage may be automatically continued at no cost to you. If at the time of your total disability you had elected Single Coverage and you were working enough hours to qualify for Single Coverage, then your coverage will be extended for up to two months following your date of disability.

A new two-month extension will apply to a newly-occurring disabling condition unrelated to a previous condition which occurs more than four weeks after you return to work. Only one two-month extension will apply to the same or related condition, even if you have returned to work for four weeks.

Any period of extended coverage provided here at no cost will reduce the period allowed for self-payment of contributions for continuation coverage under the COBRA provisions by a period equal to the extended coverage.

If your employer is required to make contributions under the Family and Medical Leave Act or under a provision of the Collective Bargaining Agreement during a portion of your period of total disability, the automatic extension will be available to you in addition to the period of time covered by your employer's contributions. COBRA Continuation Coverage may become available once you exhaust your entitlement to health coverage under this provision.

Family and Medical Leave Act. Under the Family and Medical Leave Act of 1993, you may qualify to take up to 12 weeks of unpaid leave for a serious illness, to care for your newborn child or newly adopted child, or to care for your seriously ill spouse, parent or child. If the Family and Medical Leave Act applies to your employer (small employers are exempt), it requires your employer to maintain your health coverage for the length of your leave (up to 12 weeks) as if you were actively at work. The Act also states that if you take a Family and Medical Leave, you cannot lose any benefits accrued before the leave.

Your employer will let you know what payment methods are available for continuing coverage during a leave of absence under the Family and Medical Leave Act and may require that the employee portion of the contributions for health coverage during the leave be paid by you upon your return to work or while you are on leave.

The Fund will grant eligibility for a Family and Medical Leave and will maintain your current eligibility status for the duration of the leave, provided your employer properly grants the leave of absence under the Federal law and makes the required contributions to the Health Fund on your behalf.

If you do not return to work after your leave and you are no longer eligible to continue health coverage under the Plan, COBRA Continuation Coverage may become available.

See your employer if you believe you may be entitled to a leave under the Family and Medical Leave Act.

Certification of Coverage When Coverage Ends

When coverage for you ends, you will be provided with a Certificate of Creditable Coverage that indicates the period of time you were covered under this Plan. If you become covered under another health plan, show this Certificate to your next plan administrator. It may decrease or eliminate any pre-existing condition limitation period under that plan.

If you elect COBRA Continuation Coverage (see page 19), an additional Certificate can be provided to you, upon request, after your COBRA coverage stops.

You can request a Certificate of Creditable Coverage at any time within the 24-month period after coverage ends by calling the Benefits Fund Office.

COBRA Continuation Coverage

In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Plan offers you the opportunity to continue health coverage by making self-payments when coverage would otherwise end.

Qualifying for COBRA

To qualify for COBRA coverage, you must experience a qualifying event.

A qualifying event is:

- a reduction in the number of hours worked; or
- a termination of employment for any reason (including retirement) other than gross misconduct.

Proof of good health is not required to obtain COBRA coverage.

Continuation Coverage Period

The COBRA coverage period depends on the type of qualifying event that caused loss of eligibility under the Plan.

Generally, COBRA coverage will remain in effect for a period of 18 months (or up to 29 months for disabled individuals, as described below) if the qualifying event is:

- a reduction in the number of hours you work; or
- termination of your employment (including retirement) for any reason other than gross misconduct.

Coverage for Disabled Individuals

If you are disabled (as determined by Social Security) at the time or within 60 days of the date your employment ends or your hours are reduced, COBRA coverage can be extended an additional 11 months, to a maximum period of 29 months. For coverage to continue, the Benefits Fund Office must be properly notified:

- before the 18 month period ends; and
- within 60 days of the date of disability.

Any period of extended coverage during disability (see page 17) provided at no cost will reduce the period allowed for COBRA coverage by a period equal to the extended coverage.

Proof of disability must be given. The premium payment for this extended coverage may be higher than that for COBRA coverage.

The Benefits Fund Office must also be notified within 30 days of any subsequent determination by Social Security that the disabled individual is no longer disabled.

Termination of COBRA Coverage

Once COBRA coverage is elected, it will stay in effect until the earliest of the following:

- the date you complete the maximum period of COBRA coverage for which you are eligible;
- the date a self-payment is not paid on time;
- the date after your COBRA election date that you become covered under any other group health plan;
- the date after your COBRA election date that you become entitled to Medicare; or
- the date the Plan terminates; or
- the date your employer ceases to provide any group health plan to any employee.

Note: If you become covered under another group health plan that has a pre-existing condition limitation or exclusion of coverage period, COBRA coverage provided under this Plan will remain in effect until the pre-existing condition waiting period is satisfied. However, in no event will COBRA remain in effect longer than the maximum period to which the individual is entitled.

COBRA Premium Payments

After the Benefits Fund Office receives your form electing COBRA coverage, you will be mailed a statement showing the amount due. You will then have 45 days from the date of election to pay the full amount due. COBRA coverage will not be effective until full payment is made.

When you elect COBRA coverage, you must make your COBRA payments on time in order to keep your coverage in effect. If you are late with your payments, your coverage will be terminated. You will receive more information regarding premium amounts and due dates after you experience a qualifying event.

Premium payments must be sent to the Benefits Fund Office at: 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713.

COBRA Notice Procedures

General Notice of Continuation Coverage. An initial general notice describing COBRA rights will be given to you when you become covered under the Plan and will contain the information required by COBRA. The Benefits Fund Office may provide this notice in a summary plan description ("SPD") furnished in accordance with the paragraph below.

The general notice will be provided no later than 90 days after you become covered under the Plan.

Notice of Qualifying Events. If the qualifying event that occurs is the termination of employment or reduction of hours of employment, the employer must notify the Benefits Fund Office of the qualifying event. However, you should notify the Benefits Fund Office if any of these qualifying events occurs to assure that you receive COBRA election materials as soon as possible.

As noted above, you must also notify the Benefits Fund Office of a disability determination before the 18-month period ends and within 60 days of the date of disability. In addition, the Benefits Fund Office must be notified within 30 days of any subsequent determination by Social Security that the disabled individual is no longer disabled.

The notice of a qualifying event or disability determination must be in writing and must include sufficient information to enable the Plan Administrator to determine the following information:

- the Plan,
- the covered participant,
- the type of qualifying event or disability determination, and
- the date on which the qualifying event occurred or the disability determination was made.

A notice that does not contain all of the required information will not be considered notice of a qualifying event. If you do not timely provide all of the information necessary to meet the content requirements, you will lose the right to elect or extend continuation coverage.

Notice of Right to Elect COBRA Coverage. Once notified, the Benefits Fund Office will mail you the necessary forms to enable you to elect the COBRA coverage. When you receive the forms, you will have 60 days from the date of the Benefits Fund Office's notification letter in which to elect or decline COBRA coverage. You will be ineligible for COBRA coverage if you do not timely elect COBRA coverage.

This notice will be written in a manner calculated to be understood by the average Plan participant and shall contain the information required by COBRA. The notice will be provided by first class mail no later than 14 days after the Benefits Fund Office receives notice that a qualifying event has occurred.

Notice of Unavailability of COBRA Coverage. If the Benefits Fund Office receives notice of a qualifying event or of a determination of disability by the Social Security Administration and determines that you are not entitled to continuation coverage under COBRA, the Benefits Fund Office will give you an explanation of why you are not entitled to continuation coverage.

The notice will be provided by first class mail no later than 14 days after the Benefits Fund Office receives notice that a qualifying event has occurred.

Notice of Early Termination of COBRA Coverage. The Benefits Fund Office will provide notice to you if continuation coverage will terminate before the end of the maximum period of continuation coverage.

The notice will be written in a manner calculated to be understood by the average Plan participant and will include the following information:

- the reason that continuation coverage has been terminated,
- the date of termination, and
- any rights under the Plan or applicable law to elect alternate or individual coverage.

The notice will be furnished by the Benefits Fund Office as soon as practicable after its decision that continuation coverage shall terminate.

Address Changes

To protect your rights, you should keep the Benefits Fund Office informed of any changes to your address

More Information

This notice may not contain all information about your rights under the Plan. If you have any questions or need more information, contact the Benefits Fund Office.

Cost Containment Features of the Health Plan

Your Health Plan includes programs designed to manage your costs for health care and ensure that you get the most out of the benefits available to you.

The *Pre-Certification and Utilization Review Program* provides pre-certification review services for hospital admissions, surgeries, advanced testing and home health care. The use of this program lets you be assured that your medical treatment is covered under the Plan and received in an appropriate and cost-effective manner.

The *Second Opinion Program* helps to determine whether a proposed surgery is medically necessary or whether an effective alternative approach exists.

The Plan also offers you further opportunity to save on your out-of-pocket costs for health care through the *BlueCross BlueShield of Illinois Participating Provider Network*. Participants in this network of hospitals and physicians agree to provide medical services at a lower rate than they normally charge. This means that your share of the cost for covered services is automatically reduced.

The ultimate decisions regarding your medical care must be made by you or your doctor. The Pre-Certification and Second Opinion Programs only determine the medical necessity of a service or supply according to the Plan's benefits and provisions.

The Plan and the Board of Trustees do not express opinions regarding the quality of care or services rendered by a Participating Provider.

When to Notify Health Information Services

Inpatient Hospital Admission. You must contact Health Information Services at least two weeks before the start of the hospital stay. If you do not pre-certify your hospitalization, an additional \$100 deductible will be applied. This penalty does not apply to maternity stays that are less than 48 hours postpartum for a vaginal delivery and less than 96 hours postpartum for delivery by caesarian section.

Emergency Care. When emergency care is required that results in you being admitted to the hospital, contact Health Information Services within 48 hours of the admission. If you do not contact Health Information Services, an additional \$100 deductible will be applied.

Surgery. You must contact Health Information Services at least two weeks before a scheduled inpatient or outpatient surgery. If you do not pre-certify your surgery, an additional \$100 deductible will be applied before any benefits are paid.

Second Opinion Surgery. You may be required to obtain a Second Opinion. The types of surgeries that require a Second Opinion are:

- artery and vein surgery
- back surgery
- digestive system surgery
- exploratory surgery
- eye surgery
- foot surgery if it is anticipated that the surgeons' fees will be \$1,000 or more for any one surgery or for a series of surgeries
- genital surgery
- joint surgery
- nose surgery

If you have surgery without obtaining a Second Opinion when required, the Plan will pay 50% of covered expenses related to the surgery. You will be responsible for the remaining charges. The additional amount you pay will not count towards your out-of-pocket maximum.

Advanced Diagnostic Testing. It is required that you contact Health Information Services (*not* BlueCross BlueShield) before undergoing advanced testing such as magnetic resonance imaging (MRI) scans, computerized tomography (CT) scans, positron emission tomography (PET) scans, Thallium stress tests, sleep studies, nerve conduction studies, or echo Doppler tests.

The pre-certification must be done by Health Information Services at the Benefits Fund Office, not by BlueCross BlueShield—you or your doctor should speak directly with Health Information Services. If you do not pre-certify the expense for advanced testing, an additional \$100 deductible will be applied.

Skilled Nursing Facility Care, Rehabilitation Therapy, Home Health Care and Hospice. Before incurring expenses for care in a skilled nursing facility, for rehabilitation therapy, for home health care, or for care in a hospice, you must contact Health Information Services for approval. If the expense is not approved, it will not be considered medically necessary and the Plan will not cover it.

Durable Medical Equipment. Before purchasing or renting durable medical equipment, contact Health Information Services for approval. If the expense is not approved, it will not be considered medically necessary and the Plan will not cover it.

How to Notify Health Information Services

You may contact Health Information Services in person or by telephone during office hours, Monday–Friday from 8:00 a.m.–4:30 p.m., or in writing, by FAX, or by visiting our website.

1300 Higgins Road, Suite 300, Park Ridge, Illinois 60068-5713

Health Information Services FAX 847-384-0198

847-384-7000 ♦ 800-621-5133 ♦ TDD 847-384-0199

ufcwmidwest.org

Penalties for Failure to Notify Health Information Services

Your Health Plan requires pre-certification of certain expenses.

If you do not pre-certify expenses for a hospitalization, for surgery, or for advanced diagnostic testing, an additional \$100 deductible, called a Non-Compliance Deductible, will be applied.

If you have surgery without obtaining a Second Opinion when required, the Plan will pay 50% of covered expenses related to the surgery. You will be responsible for the remaining charges. The additional amount you pay will not count towards your out-of-pocket maximum.

If you do not pre-certify expenses for skilled nursing facility care, for rehabilitation therapy, for home health care, for hospice care, or for the purchase or rental of durable medical equipment, the expense will not be considered medically necessary and the Plan will not cover it.

BlueCross BlueShield of Illinois Participating Provider Network

BlueCross BlueShield has made arrangements with certain hospitals and physicians to provide health care to you at lower rates than normally charged.

Simply by choosing a hospital and physician in the network and showing your Health ID card when you receive medical care, you will receive a discount on your medical bill. The amount of the discount is the difference between the hospital's or physician's regular charge and the negotiated fee contracted by BlueCross BlueShield. Discounts vary and may change from time to time. In addition, the Plan will pay a greater portion of your expenses when you use a PPO hospital.

You save 3 ways when you use the BlueCross BlueShield of Illinois Participating Provider Network:

1. Your percentage is applied to a discounted fee;
2. Your percentage is smaller; and
3. You avoid the extra \$350 deductible charged for using an out-of-network hospital.

You can find a participating provider by using the "Doctor and Hospital Finder" provided on-line by BlueCross BlueShield. Visit our website at ufcwmidwest.org and click on "Links" to find the BlueCross BlueShield link. The Benefits Fund Office will furnish, without charge, a list of the hospitals that belong to the network in Illinois; click on the Forms page of our website or contact the Benefits Fund Office to request a copy.

Comprehensive Medical Benefits

Your Plan pays a significant portion of your covered medical expenses and protects you from financial hardship in the event of serious illness or injury. The Plan covers non-occupational illnesses and injuries only.

This benefit provides coverage for many common medical needs after you satisfy the Annual Deductible. Certain medical expenses are paid before the Annual Deductible is satisfied. A list of covered medical expenses starts on page 28.

Lifetime Maximum Benefit

Total payment for all covered charges incurred during a covered individual's lifetime is limited to \$150,000. Lifetime refers to a covered individual's duration of coverage under the Plan.

Annual Deductible

You must pay the first \$250 of covered expenses each calendar year before the Plan begins to pay benefits for most covered medical expenses. This is called the Annual Deductible.

Once you have satisfied the \$250 Annual Deductible, the Plan will pay the percentage specified in the Summary of Benefits for the cost of covered medical expenses. You are responsible for the difference.

Certain covered medical expenses are not subject to the Annual Deductible. These expenses are paid at 100%, as described on page 30.

Non-PPO Hospital Deductible

If you are admitted to a non-PPO hospital, and it is not an emergency, you must pay a \$350 deductible. This is in addition to the Annual Deductible.

Non-Compliance Deductible

If you are admitted to a hospital without having that admission pre-certified by Health Information Services, you must satisfy an additional \$100 deductible. The additional \$100 deductible also applies to emergency care that results in hospital admission if Health Information Services is not contacted within 48 hours of the admission.

If you have a scheduled surgery, either inpatient or outpatient, and you do not pre-certify the surgery, an additional \$100 deductible will be applied before any benefits are paid.

If you have advanced diagnostic testing (see page 24) done without having the expenses pre-certified by Health Information Services, you must satisfy an additional \$100 deductible.

Out-of-Pocket Limit

After you pay \$2,000 (including the \$250 Annual Deductible) in covered expenses during a calendar year, the Plan will reimburse covered medical expenses at 100% of allowable charges for the remainder of that calendar year.

Expenses that do not count toward the out-of-pocket limit are:

- charges that exceed the usual and customary charges;
- amounts you are required to pay because you failed to pre-certify your hospital stay or surgery, or otherwise failed to follow the Plan's Utilization Review Program;
- charges that the Plan pays at 50%; and
- any other charges that are not covered by the Plan.

PPO Providers—BlueCross BlueShield of Illinois

You have access to Participating Provider Option (PPO) hospitals and physicians under the Plan. PPO providers offer discounts on services to you. When you use a PPO hospital, the Fund is charged a discounted rate. When you use a PPO physician, you receive treatment at an agreed upon, discounted rate. The Fund shares these savings with you by reducing your out-of-pocket costs. The Fund also pays a higher percentage of your expenses when PPO hospitals are used. See page 25 for further information and how to locate a PPO Provider.

Surgery at Non-PPO Facility

When certain surgeries are performed at a non-PPO facility, benefits will be limited to the Plan-defined Usual and Customary fee (see page 55) or the following allowance, whichever is lower:

• arthroscopy	\$ 3,200
• cataract	\$ 3,000
• colonoscopy	\$ 1,100
• cystourethroscopy	\$ 1,500
• elective abortion	\$ 750
• endoscopy	\$ 1,100
• epidural injections with fluoroscopy	\$ 1,300
• foot—hallux valgus	\$ 3,000
• foot—hammer toe	\$ 2,500
• foot—other	\$ 2,500
• gynecological	\$ 3,200
• joint implant removal	\$ 250
• nasal septum	\$ 3,500
• skin disorder repair	\$ 250
• tonsillitis-related	\$ 2,400

Pre-Existing Condition Limitation

If you had a pre-existing medical condition before you became covered by the Plan, benefits for that condition will be paid at 50%, up to a maximum of \$5,000, until:

-
- 180 days of coverage have elapsed during which no medical care or treatment has been provided for that pre-existing condition; or
 - you have been continuously covered for 12 consecutive months.

A pre-existing condition is a sickness, injury, disease, or other physical condition that was diagnosed or treated by a physician during the 6 months before health coverage became effective.

Pregnancy is not a pre-existing condition for the purposes of this Plan.

This limitation may not apply, or may be shortened, if you show certification that you were covered under another group plan immediately before you were covered under this Plan. If you cannot obtain such certification, the Plan will assist you. If certification is unavailable, the Plan will consider other acceptable evidence.

Covered Medical Expenses

The Plan provides coverage for the following medical expenses, provided you are under the care of a licensed physician and the covered services and supplies are medically necessary.

1. Hospital services and supplies, including:
 - room and board, up to the semi-private room rate.
 - specialty care unit charges.
 - Emergency Room charges.
2. Surgery and related charges.
3. Physician's charges for surgery, radiotherapy procedures or medical services.
4. Outpatient treatment, services and supplies for illness or injury.
5. Ambulatory surgical center services.
6. Diagnostic x-ray and laboratory charges.
7. X-ray, chemotherapy, radium, and radiation therapy.
8. Anesthesia and its administration.
9. Oxygen and its administration. Outpatient or portable oxygen is limited to \$500 per calendar year plus the one-time cost of an oxygen concentrator, if applicable.
10. Professional ambulance transportation to and from a local hospital or between local hospitals. Convenience transfers are limited to \$300. Covered air ambulance expenses are limited to \$15,000 in North America and \$25,000 elsewhere.
11. Pregnancy. Federal law requires that benefits be provided to the mother for hospital confinement of at least 48 hours following a vaginal delivery or at least 96 hours following a cesarean section, unless the mother chooses to leave the hospital sooner. Your doctor or hospital is not required to obtain authorization for a length of stay that does not exceed 48 (or 96) hours.

12. Durable medical equipment for therapeutic treatment. The purchase price for the following equipment is limited to:

- hospital bed\$ 1,500
- custom wheelchair.....\$ 12,000
- limb prosthesis\$ 20,000
- scooter or other non-wheelchair transportation.....\$ 2,600
- stander\$ 3,000
- CPAP machine, complete.....\$ 1,200
- CPAP machine replacement supplies for 6 months....\$ 200

Any expenses must be pre-certified by Health Information Services (see page 24).

13. Orthopedic or prosthetic appliances. The Plan will pay for the initial appliance, and after 5 years, one replacement for each 5 years of consecutive coverage. Covered items include:

- artificial limbs or eyes (limited to purchase price of \$20,000).
- external breast prosthesis.
- internal breast prosthesis (breast implant).
- penile implant, but limited to one per lifetime.
- orthotic appliance.

Cochlear implants are not covered.

14. Medical supplies, trusses, braces or supports, casts, splints, and crutches. The following supplies are limited to a maximum per calendar year:

- 4 pairs of surgical stockings;
- 1 wig, up to a maximum of \$150; and
- 2 bras for a breast prosthesis.

15. Charges made by a registered nurse or licensed practical nurse, other than one who normally lives in your home or is a member of your or your spouse's immediate family. Only Home Health Care expenses that are pre-certified will be covered.

16. Home health care. The Plan pays up to \$10,000 per calendar year for the following services when provided by a Home Health Care Agency:

- skilled nursing care by, or supervised by, a licensed nurse; home aides are not covered.
- administration of IV therapy.

Covered medical expenses are limited to expenses that are pre-certified by Health Information Services (see page 24). Each visit by a member of the home health team will count as one visit.

17. Physical therapy. Benefits are limited to a combined maximum of \$2,500 per calendar year for the following:

- chiropractic treatment of the back, neck, spine or vertebra, for conditions due to subluxations, strains, sprains and nerve root problems (limited to \$1,500 per calendar year); and

- osteopathic manipulation, physiotherapy, prolo therapy, acupuncture and physical medicine services.

- Occupational therapy. Benefits are limited to \$2,500 per calendar year.
- Speech therapy. Benefits are limited to \$2,500 per calendar year.
- Cardiac rehabilitation. Benefits are limited to \$1,000 per event.
- Organ/tissue transplants. Benefits are limited to \$100,000 per transplant, including related charges up to 120 days after a transplant procedure; donor-related expenses are not covered.
- Varicose vein treatment. Benefits are limited to a lifetime maximum of \$2,500 per leg, except for ulcerated conditions.
- Reconstructive treatment because of an accidental injury or congenital disease or anomaly that results in a functional defect or deformity from trauma, infection or other disease of the involved body parts.
- Dental treatment due to accidental injury to sound and natural teeth within one year from the date of the accident.
- Voice communication machines. The Plan pays up to a \$7,500, lifetime maximum.

Other Covered Medical Expenses

The following services are also covered under the Comprehensive Medical Benefit and are subject to the rules and limitations explained under each item.

These coverages are not subject to the Annual Deductible—benefits are payable immediately at 100% up to the specified maximum:

Mammography. Benefits are payable up to \$130 per calendar year for a screening mammogram and its interpretation to detect the presence of breast cancer in women according to the following schedule:

Age 35-39	one baseline mammogram
Age 40 and up	annually

Expenses in excess of \$130 are payable at 80% after the Annual Deductible.

Preventive Care. You are eligible for benefits up to \$50 (expenses in excess of \$50 are payable at 80% after the Annual Deductible) each calendar year for the following:

- A routine physical exam.
- A PAP test.
- Complete blood count, cholesterol test, multi-channel blood test and urinalysis.
- Colon cancer testing if age 50 or older.
- Prostatic Specific Antigen (PSA) blood test.

These coverages are subject to the Annual Deductible:

Bone Density Scan. Benefits are payable once every four calendar years if you are age 45 or older.

Mental Health. Benefits for covered charges incurred for mental health treatment are subject to the following maximums:

<u>Inpatient</u>	<u>Limited to 10 days in any one calendar year</u>
<u>Outpatient</u>	<u>Plan pays 50% for up to 20 visits per calendar year</u>

Substance Abuse. Benefits for covered charges incurred for substance abuse treatment are limited to:

<u>Combined Inpatient and Outpatient Maximum</u>	<u>\$5,000 lifetime maximum</u>
--	---------------------------------

Obesity Surgery. Charges for surgical treatment of obesity must be pre-certified by Health Information Services and the following conditions must be met or the surgery will not be covered:

- The patient must have a Body Mass Index (BMI) of 50 or greater, must have achieved adult height, must be older than age 18, and must have no medical or psychiatric contraindication to undergoing bariatric surgery.
- The patient must have undergone a medically-supervised weight-loss program acceptable to the Board of Trustees. The program must include physician supervision for a period of not less than six months and concurrent evaluation and treatment by a registered dietician (R.D.). The supervising physician must not perform bariatric surgery.
- The patient must have been evaluated by a mental health professional skilled in the evaluation and treatment of persons with morbid obesity, and, if appropriate, must have received treatment for behavioral or psychiatric co-morbid conditions. Documentation of all evaluations and treatment must be available for review by the Benefits Fund Office.

Once the above conditions have been met, the surgery must be provided by a board-certified surgeon experienced in the treatment of bariatric surgical patients and be performed at a facility acceptable to the Board of Trustees and the Fund Administrator.

If the surgery or the surgeon is not approved, the Plan will not cover any expenses incurred.

Intentionally Destructive Injury. Benefits are payable at 50% up to \$5,000 per event for the care and treatment of attempted suicide, self-inflicted injury or other intentionally destructive acts that are not attributable to a known medical condition.

Hearing Aid. Benefits are payable at 80% up to \$500 in a five consecutive year period for covered charges for a hearing examination and hearing aid.

Covered charges include the following hearing expenses:

- The hearing aid (monaural or binaural) prescribed as a result of an examination. This generally includes ear mold(s), the hearing aid instrument, the initial batteries, cords and other necessary ancillary equipment.
- A follow-up consultation within 30 days following the delivery of the hearing aid.

The following expenses are not covered:

- Expenses for more than one hearing examination without a hearing aid being obtained.
- Replacement batteries.
- Charges for repairs, servicing and alterations.

Skilled Nursing Facility Care, Rehabilitation Therapy and Hospice Care. Medically necessary care in a skilled nursing facility, rehabilitation therapy and hospice care are covered if pre-certified by Health Information Services (see page 24). The Plan will not consider these expenses medically necessary and will not cover them if you do not receive pre-certification for them.

Women's Health and Cancer Rights Act of 1998. Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. If you are receiving benefits under the Plan in connection with a mastectomy and elect breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient, for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

What is Not Covered

Expenses that are not covered under the Comprehensive Medical Benefit include but are not limited to the following:

- Custodial care, educational and training care.
- Cosmetic treatment or complications thereof.
- Expenses for hormone therapy, artificial insemination or any other direct attempt to induce or facilitate fertility or conception.
- Genetic testing, except for amniocentesis, government-mandated neonatal testing, and testing for the purpose of determining the medical appropriateness of therapy for newly-diagnosed breast cancer.

-
- Charges related to a surrogate pregnancy.
 - Naturopathic or homeopathic services and substances.
 - Personal hygiene, comfort or convenience items such as air conditioners and humidifiers or physical fitness equipment.
 - Over-the-counter supplies.
 - Foods and nutritional supplements including, but not limited to, home meals, formulas, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided through a feeding tube as sole nutrition.
 - Shoes, for any reason.
 - Wigs or toupees except made necessary due to loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury (limited to one per calendar year up to a maximum benefit of \$150); hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
 - Breast reduction surgery except for reconstruction due to breast cancer (see page 32).
 - Expenses related to sexual reassignment.
 - Skin removal surgery for any reason.
 - Immunizations.
 - Routine screening tests, except as otherwise noted.
 - Routine foot care such as the cutting and trimming of toenails.
 - Routine circumcision of newborns.
 - Marriage counseling or treatment for anti-social behavior which is not the result of a mental or nervous disorder.
 - Services or supplies for weight reduction by diet control or behavior modification, with or without drugs. However physician visits for weight loss for morbid obesity are covered.
 - Transportation other than local ambulance service and covered air ambulance.
 - Expenses for and related to travel for you or a physician.
 - Donation of an organ or tissue.
 - Blood storage charges except for use for an anticipated covered medical condition for a period not to exceed six months.
 - Blood donated by family members or others specifically for another patient's use.

-
- Expenses for home blood pressure monitoring or home uterine monitoring equipment, for any reason.
 - Muscle stimulators in excess of \$500.
 - Cochlear implants.
 - Snoring correction devices, unless sleep apnea has been diagnosed.
 - Repair of or operating supplies for durable medical equipment.
 - Services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes except for tumors or cysts or unless resulting from an accidental injury to sound natural teeth.
 - Eye refractions, eye examinations, frames and lenses (including contact lenses) or their fitting.
 - Procedures for surgical correction of myopia and/or other refractive errors.
 - Vision therapy.
 - Non-prescription (over-the-counter) drugs or medicines.
 - Vitamins, including vitamins requiring a written prescription. However, pre-natal vitamins are covered.
 - Smoking cessation products, including those requiring a prescription.
 - Contraceptives or medications for contraception, including medications or contraceptives requiring a written prescription, regardless of intended use.
 - Charges for infection control and medical waste disposal.
 - Anything excluded under the General Exclusions and Limitations listed beginning on page 40.

Prescription Drug Benefit

The Prescription Drug Benefit provides coverage for most drugs that require a doctor's prescription, for certain over-the-counter medications when prescribed by a doctor and for some diabetic supplies.

Prescription Drug ID Card

You will receive an ID card when you become eligible for benefits. When you use your ID card at a participating pharmacy to fill prescriptions, you pay only the applicable co-payment. You do not have to complete any claim forms.

If you need a replacement card or an additional card, contact NMHC/Rx Customer Service at 888-354-0090.

Participating Pharmacy Program

The Prescription Drug Benefit is managed by NMHC/Rx, a prescription benefit manager with a large network of pharmacies, called "participating pharmacies." You receive the highest level of benefits when you fill your prescription at a participating pharmacy.

Most pharmacies are participating pharmacies. However, should you have any problem locating a participating pharmacy, please contact the NMHC/Rx Customer Service at 888-354-0090.

Annual Maximum Benefit

Total payment for covered prescription drug expenses is limited to \$1,500 each calendar year.

Drugs that Require Pre-Approval

Some drugs require pre-approval before your prescription can be filled under the Prescription Drug Benefit. For example, drugs which may require pre-approval include narcotics, amphetamines, anabolic steroids and protein pump inhibitors (stomach drugs) when more than one tablet per day is taken.

The Fund Administrator, in consultation with the Fund's Medical Consultant and with the approval by the Trustees, periodically makes changes regarding which drugs require pre-approval. Contact NMHC/Rx Customer Service at 888-354-0090 for information on which drugs currently require pre-approval and how to obtain the pre-approval.

Generic Equivalent and Brand-Name Drugs

If you request a brand-name drug when a generic equivalent is available (and medically appropriate), you will be responsible for paying the difference in cost between the generic and the brand-name drug, in addition to the brand-name co-payment amount.

In general, using generic drugs usually helps to control the cost of health care while providing quality drugs—and can be a significant source of savings for you and the Fund. Your doctor or pharmacist can assist you in substituting generic drugs when appropriate.

Preferred and Non-Preferred Drugs

For the purpose of controlling costs (both yours and the Fund's), certain drugs are designated as either preferred or non-preferred. Preferred drugs have no co-payment—you pay nothing. Non-preferred drugs have a \$25 co-payment.

Contact NMHC/Rx Customer Service at 888-354-0090 for updated information on which drugs are preferred drugs.

Covered Prescription Drugs

The Plan covers the following:

- Most drugs that require the written or oral prescription of a licensed physician or dentist under federal or state law, up to a 30-day supply maximum per prescription or refill
- Exceptions to the 30-day supply maximum are maintenance drugs that are used on a long-term or on-going basis to treat chronic conditions. You can receive up to a 90-day supply of these drugs. Contact NMHC/Rx Customer Service at 888-354-0090 for specific information on maintenance drugs.
- Certain over-the-counter (OTC) drugs when prescribed by a doctor. These drugs are OTC Prilosec and OTC Loratadine (Claritin).
- Insulin, blood glucose testing strips, needles and syringes, up to a maximum of 150-unit supplies each 30 days.
- Needles and syringes up to a 30-day supply.

Co-Payments

Co-payments are based on tiers established by the Trustees to encourage cost-effective use of the Prescription Drug Benefit.

You'll pay the following:

30-Day Supply	Co-Payment
Tier Zero	
Lovestatin	\$0
OTC Prilosec	\$0
OTC Loratadine (Claritin)	\$0
other preferred drugs	\$0
Tier One	
most generic drugs	\$7
Tier Two	
most brand-name drugs	\$15
high-cost generic drugs	\$15

(chart continues on following page)

30-Day Supply (<i>Continued</i>)	Co-Payment
Tier Three	
Januvia	\$25
Zocor and the generic equivalent	\$25
prescription allergy drug (such as Allegra and Zyrtec)	\$25
prescription ulcer and acid-reflux drug (such as Nexium and Prevacid)	\$25
sleep medication, anti-dementia drug, influenza drug, erectile dysfunction drug, Mobic, Accutane	\$25
other non-preferred drugs	\$25
Maintenance Drug (90-Day Supply)	
Tier Zero	
Lovestatin	\$0
OTC Prilosec	\$0
OTC Loratadine (Claritin)	\$0
other preferred drugs	\$0
Tier One	
most generic drugs	\$14
Tier Two	
most brand-name drugs	\$30
high-cost generic drugs	\$30
Tier Three	
Januvia	\$50
Zocor and the generic equivalent	\$50
prescription allergy drug (such as Allegra and Zyrtec)	\$50
prescription ulcer and acid-reflux drug (such as Nexium and Prevacid)	\$50
sleep medication, anti-dementia drug, influenza drug, erectile dysfunction drug, Mobic, Accutane	\$50
other non-preferred drugs	\$50

You will also be responsible for paying the difference in cost between the generic and the brand-name drug if you request a brand-name drug when a generic drug is available and medically appropriate.

Contact NMHC/Rx Customer Service at 888-354-0090 for updated information on which drugs are preferred drugs.

What is Not Covered

Expenses for the following are not covered:

- Drugs or medications that are payable under any other benefit provided by the Plan.
- Drugs or medications that require pre-approval when you did not obtain approval before they were dispensed to you.
- Medicines that do not require a prescription (over-the-counter) except as otherwise specifically noted.
- The difference in cost if you request a brand-name drug when a generic drug is available and medically appropriate.
- Drugs dispensed for use while medically confined.
- Drugs (except Lupron) consumed at the time and place of prescription.
- Drugs that are considered experimental or not approved by the U.S. Food and Drug Administration for the condition, dose, rate or frequency prescribed.
- Appliances and devices.
- Blood and blood plasma, immunization agents and biological sera.
- Oral contraceptives or implanted drugs or devices, regardless of intended use.
- Fertility drugs.
- Drugs used for cosmetic purposes.
- Drugs to promote hair growth.
- Drugs used as an aid to weight loss.
- Lancets.
- Lifestyle drugs.
- Non-drug items including nutritional supplements, regardless of intended use.
- Smoking deterrents, including Nicorette and nicotine transdermal patches.
- Vitamins, except prescription pre-natal vitamins.
- Aciphex.
- Ambien CR.
- Axid and its generic, Nizatidine.
- Cipro CR.
- Clarinex.
- Daytrana.
- Exubera.
- Fluoxetine tablets.
- Ketek.

-
- Lamisil.
 - Omeprazole.
 - Paxil CR.
 - Prescription Prilosec.
 - Ranitidine capsules.
 - Serafam.
 - Singular, unless used solely for the treatment of asthma.
 - Wellbutrin XL.
 - Xanax XR.
 - Zegerid.
 - Zmax.

Other drugs, as determined by the Trustees from time to time, may be excluded from coverage.

Direct Reimbursement

You receive the highest level of benefits when you fill your prescription using your ID card at a participating pharmacy. If for some reason you cannot use a participating pharmacy or your ID card, you may submit a “Direct Reimbursement” claim form to request reimbursement. Contact the Benefits Fund Office to obtain a Direct Reimbursement claim form.

Not Creditable Coverage Under Medicare

The prescription drug benefit provided by the Health Plan has been determined NOT to be “creditable coverage” under Medicare. For more detailed information, refer to Appendix C: Prescription Drug Not Creditable Coverage—Medicare Part D beginning on page 73.

Plan Pays Limited Benefits

This Plan B5 pays limited benefits for prescription drugs. The annual maximum is \$1,500. You are encouraged to work with your doctor to ensure that the most cost-effective drugs are prescribed.

General Exclusions and Limitations

This Plan contains some general exclusions and limitations that apply to all benefits provided by the Plan. No benefits are payable under the Plan for the following:

- Accidental injury or illness arising out of or in the course of employment, or which is compensable under any Workers' Compensation or Occupational Disease Act or Law.
- Services, supplies or treatments that are not medically necessary.
- Services or supplies that are experimental or investigative or do not meet accepted standards of medical practice.
- Expenses incurred while coverage is not in force.
- Accidental injury or illness caused by war or any act of war, declared or undeclared, or by participating in a riot, or as the result of the commission of a felony.
- Examinations or treatment ordered by a court in connection with legal proceeding or obtained for the purpose of receiving favorable consideration by a court or similar body, unless such examinations or treatment would otherwise qualify as a covered expense.
- Any charges that exceed the usual and customary charges.
- Any expenses over the maximum benefit amounts.
- Expenses that you would not have been charged had there been no coverage.
- Expenses for which there is no legal obligation or financial liability to pay.
- Physical examinations or medical certificates required for employment.
- Any hospital confinement, operation or other service that meets one of the following criteria:
 - ✓ is provided in a U.S. government hospital or in any other hospital operated by a government unit, except for those provided by the Veterans Administration when services are provided to a veteran for a disability which is not service-connected, or unless you are legally required to pay;
 - ✓ is not recommended and approved by a legally-qualified physician or surgeon;
 - ✓ is not medically necessary (see page 54)
 - ✓ is experimental or investigational in nature;
 - ✓ exceeds the usual and customary charge (see page 55);
 - ✓ is received outside the United States or Canada, except for emergency care.

-
- Diagnosis, testing or treatment of infertility.
 - Diagnosis, testing or non-surgical treatment of obesity, except that other appropriate treatment will be covered when acceptably certified by a qualified physician as morbid obesity due to body weight in excess of 100 pounds over ideal body weight (or 100% over ideal body weight if body weight is less than 100 pounds), as determined by the Trustees. Generally, morbid obesity occurs when the Body Mass Index (BMI) calculation is 40 or higher. The criteria for surgical treatment of obesity are described on page 31.
 - Reversal of a surgical procedure.
 - Services provided by a person who normally resides in your household or who is a parent, spouse, child, brother or sister of the eligible employee-member or his or her dependent.
 - Educational services, supplies or equipment, including but not limited to, computers, software, printers, books, tutoring and visual aids even if they are required because of an injury or illness.
 - Dental treatment, except for removal of tumors, treatment of fractures, direct surgery on the temporomandibular joint itself or surgery to correct a malocclusion of the jaw due to a skeletal deformity.
 - Expenses for which the Fund has not received complete documentation of the claim, including medical reports and records if needed.
 - If you are employed by more than one employer participating in this Fund, the benefits provided to you will be no greater than if you were employed by only one employer.
 - If you are covered under more than one plan classification, the benefits provided will be payable under the plan classification providing the largest benefit.
 - Expenses payable by another group medical plan under the Plan's Coordination of Benefits provision.
 - Charges for failure to keep a scheduled visit, completion of a claim form or routine supplemental report, phone calls, handling fees and personal items.
 - Charges from a doctor for more than one office visit on the same day.
 - Anything excluded under any other provision of the Plan.

Recovery Incentive Program

The Recovery Incentive Program provides you with a cash incentive to discover and arrange for the recovery of overcharges made on your inpatient hospital bills. The program pays 25% of the actual amount of the overcharge that the hospital agrees is valid. Reimbursement is subject to a maximum of \$500 per calendar year. Payment for typographical errors is limited to \$250.

Following is a detailed description of the Recovery Incentive Program including guidelines to assist you in reviewing the services received at a hospital. Remember, always request an itemized bill in order to review the services rendered.

Recovery Incentive Program Guidelines

For purposes of the cash incentive, only hospital expenses that the Plan covers, not telephone bills, television rental, newspapers, etc., shall be considered in determining the amount payable to you under this program. Claims involving coordination of benefits will be eligible only if this Plan is primary (that is, this Plan is required to pay benefits first for you).

Proof of eligibility for a cash incentive must be submitted in the form of a copy of the initial itemized bill with the overcharges circled, and a copy of the adjusted bill showing that the hospital dropped these charges. Such proof must be submitted to the Benefits Fund Office within 45 days following the date of discharge from the hospital. Within 30 days after receipt of proof and verification that the overcharge has been recovered, the Fund will issue a check to you for 25% of the amount of the overcharge.

The Trustees and administrative staff of the Fund will not get involved in any differences between you and the hospital with respect to disputed charges. You are solely responsible.

The Trustees have the sole right at any time to amend or modify these guidelines or terminate the Recovery Incentive Program entirely.

Suggestions for Reviewing Your Itemized Bills

- Before leaving the hospital, make sure the hospital provides or arranges to send an itemized bill.
- Either during your hospital stay or immediately after discharge, list the events of your stay. Match this list against your actual hospital bills to detect any overcharges.
- Check your bill carefully for charges that represent any treatments, services, or supplies that were not received. Follow this or a similar checklist.
- Determine if you were billed for the correct number of days; and for the correct type of room occupied (private, semi-private, ward).

-
- If intensive care was required, determine if you were billed for the correct number of days.
 - Determine if you were charged for the day that you were discharged even though you left before the day's charges began.
 - Determine if you were charged for only the tests or x-rays that you actually received.
 - Determine if you were charged for medication, injections, dressings, supplies, etc., that you did not receive or for quantities in excess of what you remember.
 - Determine if medication ordered by your physician for a specified period was billed to you for your entire hospital stay.
 - Determine if you were billed for purchases that you were not allowed to take home—for example, humidifiers, bedpans, admission kits, etc.
 - If you received physical, radiation, inhalation, and/or occupational therapy, determine if you were charged for the correct type of treatment and for the correct number of hours.
 - If you received a blood transfusion, determine if you were charged for blood that a donor, blood bank or a Red Cross family or community assurance program replaced.
 - If admitted to the maternity wing, determine if you were billed for a labor room that may not have been used due to swift delivery.
 - Ask for an explanation of specific terms used in your bill—for example, miscellaneous charges.

When an Overcharge is Discovered

- Circle any overcharges on your bill.
- Report the overcharges to the hospital's billing department and request a corrected bill. If errors are properly identified in the hospital bill, the hospital must drop these charges, unless there is evidence in the medical file to the contrary.
- A copy of the adjusted bill is considered proof that the hospital acknowledged and dropped the charges.

A Recovery Incentive Program payment is considered income to you and should be reported to the Internal Revenue Service.

Filing a Claim and Claim Information

For prompt processing of your claims, please follow the detailed information in Appendix A: Health Benefits Plan Claim Procedures beginning on page 60.

Please submit your claims to the Benefits Fund Office as soon as possible. If you do not file a claim for benefits within 24 months of the date the service is received, the claim will not be processed and no benefits will be paid.

Claim Forms

Claim forms are available on-line at ufcwmidwest.org or by contacting the Benefits Fund Office. You may order forms 24 hours a day:

847-384-7000, 800-621-5133, TDD 847-384-0199, FAX 847-384-0196

Send completed forms and all bills, receipts or other documentation to:

United Food and Commercial Workers Unions and
Employers Midwest Health Benefits Fund
1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713

Authorization to Release Personal Health Information

Help us communicate benefits to you and your family. Federal law now requires that every adult covered person must give a written authorization before we may disclose personal health information to another person, such as a spouse, about the individual's treatment or coverage. If an authorization is not on file, we can disclose information only to the covered person.

You should complete and return the "Authorization for Release of Personal Health Information" form as soon as you receive it from the Benefits Fund Office. We will then know to whom we are authorized to disclose information regarding health benefits coverage and medical treatment.

Payment or Status of Claims

To obtain the status of your claim, call the Benefits Fund Office. The person who calls must be you or someone you have authorized and should be able to provide the following information:

1. Your name and UFCW ID # or Social Security number.
2. Your current address and phone number.
3. The nature and date of the accident or illness.
4. The name and location of the hospital or doctor.

All benefits under the Plan will be paid shortly after receipt of your proof of loss.

Assignment

You may file a written assignment to have payment made directly to a provider of medical services and supplies. However, the Fund Administrator may reject or override an assignment and refuse to accept future assignments from a medical provider on your behalf pursuant to criteria established by the Trustees.

Coordination of Benefits Provisions

Your Plan contains a coordination of benefits (COB) provision. This provision ensures that if you are covered by another group medical plan, benefits from all plans combined will not exceed 100% of covered charges.

Group Medical Plan

A group medical plan is one that covers medical expenses provided by:

- Group insurance.
- Group BlueCross, group BlueShield, group practice and other prepayment coverage on a group basis.
- Coverage under labor-management trustee plans, union welfare plans, employer organization plans or employee benefit organization plans.
- Coverage under governmental programs or coverage required or provided by any statute.
- School or association excess plans.
- Other arrangements of covered or self-covered group coverage.
- Plans for which any employer directly or indirectly has made contributions or payroll-deductions.

If you have a claim that is covered by two or more group medical plans, one plan—the primary plan—pays its benefits first, regardless of the amounts payable under any other plan. The other plans—the secondary plans—will adjust their benefit payments so that the total benefits paid to you do not exceed 100% of the charge for covered expenses.

Determining Which Plan is Primary

A plan without a COB provision is always the primary plan.

If a plan has COB provisions that conflict with the COB provisions of this Plan, the Trustees may in their discretion resolve the dispute by having each plan pay 50% of the allowable charges.

Generally, if the other plans have COB provisions, the following rules apply:

- The plan that covers the person as a non-dependent, such as an employee, member, subscriber or retiree, pays before a plan that covers a person as a dependent.
- The plan that covers a person as an active employee shall pay its benefits before a plan which covers the person as a laid-off or retired employee.
- If this Plan covers the person under the COBRA provisions, it pays second.
- If a person is covered by two plans as a non-dependent, the plan under which the person works the greater number of hours pays first.

-
- If none of the above rules apply in determining which plan pays first, then the plan covering the person for the longer continuous period of time shall be primary.
 - If any plan has a provision which results in lower benefits being paid because of the existence of this Plan, this Plan shall pay as if the other plan had paid its regular benefits which would apply to a covered person based upon the customary coordination of benefits rules.

Primary Plan Procedures Must Be Followed

If you are covered under another plan that has primary responsibility for expenses, you must follow all required procedures to obtain treatment and to qualify for all benefits available under your other plan. If, for any reason, you do not follow your primary plan's procedures, this Plan limits coverage to expenses, if any, which would have been payable had the necessary procedures been followed.

Expenses incurred because of a primary plan's refusal for any reason to refer any covered person to any doctor or type of doctor or institution, will not be covered under this Plan.

Additionally, if you are covered under an HMO or clinic which provides necessary treatment without charge, you must obtain the treatment from the HMO or clinic. No benefits will be payable under this Plan for the expense of any treatment which would have been provided by an HMO or clinic without charge.

Coordination of Benefits with Medicare

Benefits from this Plan are coordinated with Medicare. Medicare is a government program that provides health insurance and prescription drug coverage to individuals age 65 and older and to permanently disabled individuals.

Generally, if you work for an employer that has 20 or more employees, this Plan is primary and will pay benefits before Medicare in the following circumstances:

- you are age 65 or older and are covered by this Plan due to your current employment status;
- you are under age 65 and entitled to Medicare due to Social Security disability and covered by this Plan due to your current employment status; or
- you are entitled to Medicare because of End Stage Renal Disease during the coordination period described by the Medicare regulations (currently, the first 30 months).

At all other times, this Plan is secondary to Medicare when allowed by law.

Coordination of Benefits with Automobile and Similar Coverage

Benefits from this Plan will not be paid for the cost of care, treatment, services or supplies which are furnished by or are payable under any motor vehicle or automobile insurance policy or plan or any plan or policy covering loss, liability or damage caused by a third party, including but not limited to, "no fault" or uninsured or underinsured motorist coverage.

Subrogation and Reimbursement Rights

If you receive benefits or are entitled to receive benefits under the Plan as the result of an incident such as an injury or illness that may be caused by another party, the Plan has the right to seek repayment of those benefits. For purposes of this section, “you,” “your” or “claimant” means Plan participants, their parents and dependents (including minor dependents) or their representatives, guardians or trustees. The Plan’s right to seek repayment is often called the right of subrogation or reimbursement. You may be required to sign a subrogation agreement with the Plan if a third party may be responsible for your injury or illness.

The Plan has the right to recover from any source of recovery, including but not limited to, any third party or its insurer, any claim covered by workers’ compensation or occupational disease laws, and any insurance policy which covers a claimant, or against which the claimant has or may have a claim, including, but not limited to, “med-pay,” “personal injury protection,” “financial responsibility,” “no fault,” “uninsured” or “underinsured” motorist coverage, school insurance, and homeowner policies.

If you bring a lawsuit to pursue your claim, benefits payable under the Plan must be included in your claim for relief. The Plan has the right to intervene in the lawsuit or to initiate its own lawsuit. If you hire an attorney, you need to provide the Plan with the attorney’s name, address and telephone number as soon as possible. The Plan will not be liable for any expenses related to the lawsuit unless approved in advance by the Plan. The Plan has the right to be reimbursed immediately from proceeds obtained by settlement of a lawsuit, by judgement, or from any other recovery from any source. The Plan’s rights apply to partial and full recoveries, regardless whether the recovery is designated for medical claims or whether the claimant is made whole. You must hold that portion of any recovery from any source that is equal to the amount of benefits paid or to be paid by the Plan until the Plan’s subrogation and reimbursement rights are satisfied. You will reimburse the Plan immediately upon recovery. You must not do anything to impair, release, discharge or prejudice the Plan’s rights to subrogation and/or reimbursement. You will assist and cooperate with the representatives designated by the Plan. You will do everything necessary to enable the Plan to enforce its subrogation and reimbursement rights. The Plan’s subrogation and reimbursement claim is equal to the benefits it has paid or may be obligated to pay for an injury or illness for which a third party may be responsible. A claimant may retain amounts exceeding the aggregate of: (a) the benefit amounts the Plan paid or may be obligated to pay, and (b) the costs, expenses and fees the Plan incurs enforcing its rights.

When a claim is settled or a judgement is obtained by you from any source, you must first reimburse the Plan for all benefits paid by the Plan to you or on your behalf (or that the Plan is obligated to pay) on a first dollar basis. You are obligated to refrain from doing anything that would prejudice the Plan’s right of recovery. You may be required to sign and execute documents to secure the Plan’s rights. Benefit payments for new claims may be withheld by the Plan until

full compliance with the Plan's subrogation provision is achieved and any reimbursement owed to the Plan is made. If you have received benefits or recovery from other sources, the Plan may demand reimbursement for the benefits paid by the Plan or may credit the benefits or recovery received from other sources against benefits that the Plan may be required to pay in the future. The Plan may also pursue legal and equitable claims (e.g., imposing constructive trust, filing a claim for equitable lien by agreement) to enforce its rights. Once the Plan makes or is obligated to make payments on your behalf, the Plan is granted, and you consent to, an equitable lien by agreement or constructive trust on the proceeds of any payment, settlement or judgement received by you from any source.

Other Recoveries

Whenever benefit payments in excess of the maximum amount of payment required under the Plan have been made, the Plan has the right to recover such excess payments from any person for whom such payments were made, any insurance company or any other organization.

In the event payment is made to or for an individual who is not entitled to payment, the Plan has the right to suspend or withhold future payments to such person. The reduced amount will equal the amount of the erroneous payment and any amount incurred by the Plan in recovering the overpayment. The Plan may take other actions, including filing a lawsuit. These recovery rights also apply to the Plan's subrogation and reimbursement rights.

Submission of Falsified or Fraudulent Claims

All claims, enrollment forms, and any other information submitted or provided to the Plan must be accurate and complete. If the Board of Trustees finds that false or inaccurate information in support of a claim has been provided to the Plan, whether directly or indirectly, the claim will be denied. Further, the Plan shall offset any amount improperly paid and/or terminate future coverage.

Claim Appeal Procedure

If you believe you have been improperly denied benefits provided for under the Plan, you are entitled to a full and fair review of your claim.

The procedure to follow to file an appeal is summarized here. For more detailed information, refer to Appendix A: Health Benefits Plan Claim Procedures beginning on page 60.

If your initial claim is denied, you will be given a written explanation within the period of time allowed by law. The explanation will provide:

- the specific reason(s) for the denial, including a reference to the specific Plan provision on which the denial is based;
- a description of any additional material or information required for you to show you are entitled to benefits; and
- an explanation of the procedure to be followed if you do not agree with the denial, including a statement of your right to file suit under ERISA if you file an appeal and it is denied;
- any internal rule, guideline, protocol or other similar criterion that was used in making the denial decision, or a statement that this information will be provided upon request;
- an explanation of any scientific or clinical judgement for the denial decision if it was based on a medical necessity, experimental treatment or other exclusion or limit, or a statement that this information will be provided upon request; and
- if your claim is an urgent claim, a description of the expedited review process available to you (in the case of an urgent care claim, we may provide this explanation orally and give you a written explanation later).

If you do not agree with the claim denial decision, you may file an appeal within one year of the date of the denial. To file an appeal, send a written statement that includes your reasons for appealing the denial decision and any supporting documents not previously furnished. If you need a description of any additional information to assist you in filing an appeal, contact the Benefits Fund Office. Send your appeal to:

Daniel W. Ryan, Fund Administrator
Claim Appeal
UFCW Unions and Employers
Midwest Health Benefits Fund
1300 Higgins Road, Suite 300
Park Ridge, Illinois 60068-5713

The Plan will make its decision within the period of time allowed by law. You will be advised in writing of the decision. The decision(s) that you receive from the Fund Administrator or from the Appeal Committee of the Board of Trustees will be written in a clear and understandable manner and will include a specific reason for the decision.

You have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) following a denial of a claim on appeal.

Statement of Rights Under the Employee Retirement Income Security Act of 1974

As a participant in the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information about your Plan and Benefits

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as union halls and worksites, 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, collective bargaining agreements, a copy of the latest annual report (Form 5500 Series) and a copy of an updated Summary Plan Description. The Plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report free of charge.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with 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 or 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 new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one,

including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misused 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 field office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

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 Employee Benefits Security Administration or visit their website at dol.gov/ebsa.

Definitions

The following are definitions of specific terms and words used in this booklet.

Authorized Representative. An individual or entity who has been named in writing by a Plan participant to act on the participant's behalf to submit a claim or file an appeal. Once established, an Authorized Representative may only be dismissed in writing by the participant.

Benefits. Payments made to you pursuant to the Plan.

Calendar Year. The twelve-month period beginning January 1 and ending the following December 31.

Collective Bargaining Agreements. The written agreement between participating employers and the union covering wages, hours and other terms and conditions of employment for employee-members in the bargaining unit represented by the union and requiring the participating employer to make contributions to the Health Fund on behalf of bargaining unit employee-members.

Contributions. Payments made by the participating employer to the Health Fund pursuant to a collective bargaining agreement or other written agreement between the participating employer and the union.

Covered Employment. Services performed as an employee of a participating employer for which contributions are made to the Health Fund.

Disability/Total Disability. The inability of an employee to perform all the duties of his or her occupation or any occupation as a result of an illness or injury. To be considered Totally Disabled, you must also be continuously, during the entire period of disability, under the care of a physician for treatment consistent with the disability.

Durable Medical Equipment. Equipment that is intended for repeated use and is not a consumable or disposable item and that is used primarily for a medical purpose.

Employee/Employee-Member. An individual who works for a participating employer that pays contributions to the Health Fund for the individual's work in accordance with a written agreement providing for such contributions.

Fund Administrator. A person employed by the Trustees, charged with any administrative duties of the Fund, such as recordkeeping, reporting and disclosure, processing of applications for benefits, and related functions attendant to the administration of the Plan.

Fund/Health Fund/Trust Fund. The term "Fund" or "Trust Fund" means all cash and other property held by the Trustees under the terms of the Agreement and Declaration of Trust.

Hospital. An institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and meets all of the following criteria:

-
- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
 - Medicare recognizes it as a hospital.
 - It meets all of the following tests:
 - ✓ maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians;
 - ✓ provides continuous 24-hour-a-day nursing service on the premises by or under the supervision of registered graduate nurses; and
 - ✓ is operated continuously with organized facilities on the premises for operative surgery.

Medically Necessary. Services, supplies, treatments and confinements that are:

- generally recognized by physicians as effective and essential for treatment of the injury or sickness for which it is ordered;
- provided at the appropriate level of care and in the most appropriate setting based on the diagnosis;
- based on generally recognized and accepted standards of medical practice in the U.S. and is the type of care that could not be omitted without adversely affecting the patient's condition or the quality of medical care; and
- when hospital-confined, a service or supply is a medical necessity only if the diagnosis and treatment cannot be safely provided on an outpatient basis.

Services, supplies, treatments and confinements are not considered medically necessary if they are:

- Experimental.
- Investigative or primarily limited to research in their application to the injury or sickness.
- Primarily for scholastic, educational, vocational or developmental training.
- Primarily for the comfort, convenience or administrative ease of the provider or the patient or the patient's family or caretaker.

The fact that a physician or other health care provider orders or recommends services, supplies, treatment or procedures does not in itself make them medically necessary.

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

Mental or Nervous Disorder. A mental illness or organic functional nervous disorder that is identified as a mental or nervous disorder in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Conditions included in the DSM for which mental health treatment is received will be considered a mental illness, regardless of the etiology of the patient's symptoms; i.e., if the symptoms are due to an organic (physical) cause or are considered functional (non-physical) in origin.

Participating Employer. Any one or more individuals, partnerships, associations, legal representatives, and corporations of every nature that:

- has or will enter into a collective bargaining agreement with the union covering employees represented by the union; and
- adopts and agrees in writing to be bound by the Health Fund's Agreement and Declaration of Trust and any amendments thereto; and
- other employers that are approved by the Trustees for participation.

Physician. A person who is:

- duly licensed by the appropriate state agency of the state in which the services are performed; and
- practicing within the scope of his or her license as a Doctor of Medicine, a Doctor of Osteopathy, a Doctor of Dentistry, a Doctor of Podiatry, a Doctor of Chiropractic or a Doctor of Chiropractic.

Plan. The program of benefits established by the Trustees, the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund.

Trustees. The Trustees signatory to the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund Agreement and Declaration of Trust and their successors who are duly appointed in accordance with the terms of such Trust Agreement as Plan Sponsors and fiduciaries. The Trustees in their collective capacity will be known as the "Board of Trustees of the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan" and may conduct the business of the Trust and execute all instruments in that name.

Unions. Any local union affiliated with United Food and Commercial Workers International Union which has or will become a party to the Agreement and Declaration of Trust.

Usual and Customary. For treatment in the geographic area served by the PPO, the negotiated discounted fee amounts are the usual and customary charges. For treatment outside the area served by the PPO, the usual and customary amount is determined based on the average charge made by the majority of providers located within the geographic area.

Important Information about the Health Plan

The Employee Retirement Income Security Act of 1974 (ERISA) requires certain information be furnished to you when you participate in an employee benefit plan. This is your Summary Plan Description. This Plan is maintained pursuant to a collective bargaining agreement.

The following information is provided to help you identify this Plan and the people who are involved in its operation:

The Board of Trustees

United Food and Commercial Workers Unions and Employers
Midwest Health Benefits Fund
1300 Higgins Road, Suite 300
Park Ridge, IL 60068-5713

Telephone: 847-384-7000
Toll-Free: 800-621-5133
TDD: 847-384-0199
FAX: 847-384-0197
Website: ufcwmidwest.org

The Trustees of the Plan* are:

Employer Trustees	Union Trustees
John Dougherty	Kenneth R. Boyd
Brian Jordan	Terry Kramer
James V. Morgan	Steven M. Powell

The Alternate Trustees of the Plan* are:

Employer Trustees	Union Trustees
Kristen A. Heiden	Jeff Jayko
Dean Konick	Maynard Jerome
	Kenneth Swanson
	Kenneth Urzedowski

**as of this printing*

Name of Plan. This Plan is known as the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan.

Board of Trustees. A Board of Trustees is responsible for the operation of this Plan. Except as otherwise stated, the Board of Trustees has discretionary authority to determine eligibility for benefits and to construe the terms of the Plan. A decision by the Board of Trustees shall be final and binding, unless determined by a court of law to be arbitrary and capricious. Benefits will only be paid under the Plan if the Trustees, in their discretion, determine that the applicant is entitled to them. The Board of Trustees also has the right to amend or terminate the Plan or any of its benefits, in whole or in part, at any time. The Board of Trustees consists of an equal number of employer and union representatives selected by the employers and local unions that have entered into collective bargaining agreements that relate to this Plan.

Plan Sponsor and Administrator. The Board of Trustees is both the Plan Sponsor and the Plan Administrator.

Identification Numbers. The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 36-6598490.

Agent for Service of Legal Process. The Plan's agent for service of legal process is the Board of Trustees. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Administrative Manager or upon any individual Trustee at the address of the Benefits Fund Office.

Source of Contributions. The benefits described in this booklet are provided through employer contributions and, in some instances, by direct employer payments. The amount of employer contributions, the amount of required payroll deductions from employees, and the employees on whose behalf contributions are made, are determined by the provisions of the collective bargaining agreements. The Benefits Fund Office will provide, upon written request, information as to whether a particular employer is contributing to the Fund on behalf of employees working under the collective bargaining agreement.

Trust Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

Plan Year. The records of the Plan are kept separately for each Plan Year. The Plan Year begins December 1 and ends November 30.

Type of Plan. This Plan is maintained for the purpose of providing medical and prescription drug benefits in the event of accident or illness. The Plan benefits are summarized in the Summary of Benefits on page 7.

Eligibility. The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described in the Plan document, and are summarized beginning on page 9.

Claim Procedure. The procedure to follow for filing a claim for benefits is summarized beginning on page 44. If all or any part of your claim is denied, you may appeal that decision within one year (see page 50). See Appendix A beginning on page 60 for detailed information on how to file a claim or how to appeal a claim denial.

Type of Administration. The Health Fund currently self-insures the benefits provided under the Plan.

Continuation of Plan. The Board of Trustees intends to continue the Plan indefinitely. To protect against any unforeseen situations,

however, the Trustees reserve the right to change the Plan. In the event the obligations of all employers to make contributions to the Fund shall terminate or the Plan otherwise terminates, the Trustees shall determine the disposition of any assets in the Trust remaining after all expenses of the Fund have been paid, provided that any such distribution shall be made only for the benefit of former participants and for the purposes set forth in the Trust Agreement.

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan document. The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgement, conditions so warrant.

Unless otherwise indicated, the benefits described in the Plan document and in this Summary Plan Description are self-funded by the Plan. The benefits payable are limited to Plan assets available for such purposes.

Participating Local Unions

UFCW Local 2

1305 E 27 St
Kansas City MO 64108

2926 Junge Blvd
Joplin MO 64801

2200 E Sunshine Ste 322
Springfield MO 65804

417 E English St #203
Wichita KS 67202

UFCW Local 88

5730 Elizabeth Ave
St Louis MO 63110

UFCW Local 271

2502 Leavenworth St
Omaha NE 68105

UFCW Local 304A

101 S Fairfax Ave Rm 212
Sioux Falls SD 57103

UFCW Local 431

1401 W 3rd St
Davenport IA 52802

8612 Arenzville Rd
Beardstown IL 62618

1695 Burton Ave
Waterloo IA 50703

UFCW Local 536

2200 E War Memorial Dr
Peoria IL 61614

UFCW Local 700

5638 Professional Cir
Indianapolis IN 46241

UFCW Local 789

266 Hardman Ave N
S St Paul MN 55075

UFCW Local 881

10400 Higgins Rd
Rosemont IL 60018

1 Sunset Hills Executive Dr #102
Edwardsville IL 62025

1616 W Main St
Marion IL 62959

5 Lawrence Sq Ste 110
Springfield IL 62704

UFCW Local 1116

2002 London Rd
Duluth MN 55812

UFCW Local 1281P

257 E Country Ct
Bourbonnais IL 60914

UFCW Local 1473

2001 N Mayfair Rd
Milwaukee WI 53226

3030 - 39th Ave
Kenosha WI 53144

6414 Copps Ave Ste 213B
Madison WI 53716

2211 Oregon St Ste A4
Oshkosh WI 54902

UFCW Local 1546

1649 W Adams St
Chicago IL 60612

2246 Palmer Dr Ste 101
Schaumburg IL 60173

501 W 1st Ave
Colona IL 61241

315 Cherry Ave
Rochelle IL 61068

Appendix A: Claim Procedures for Medical and Prescription Drug Claims

This document provides you and your representatives with information regarding filing a claim and appealing a claim decision and is effective January 1, 2002.

Filing a Claim

Inquiries and requests for claim forms may be made by contacting the Benefits Fund Office at 847-384-7000; 800-621-5133; FAX 847-384-0196; TDD 847-384-0199; ufcwmidwest.org; or 1300 Higgins Road, Suite 300, Park Ridge, IL 60068.

Claim forms are required for each type of coverage as follows:

- **Health Claim**—a new claim form is required at least once per year and when you are advised that additional information is needed to process the claim.
- **Prescription Drug Benefit Direct Reimbursement Claim**—no claim form is required when a valid prescription drug ID card is used at an NMHC/Rx participating pharmacy (see page 35). If a prescription drug is obtained from any other pharmacy, a Direct Reimbursement Claim Form should be submitted.

You may appoint an Authorized Representative to act on his or her behalf (see page 53 and 65).

At times, additional information may be required after a claim is filed, such as accidental injury details, information on third-party liability, information on other group health coverage or any other information necessary to ensure that expenses are covered under the Plan.

Claims should be filed within 90 days. No claim that is more than two years old will be considered for payment.

Claims for services provided by BlueCross BlueShield PPO providers should be submitted by the provider directly to BlueCross BlueShield. Medical claims from non-PPO or home health care providers should be sent to:

United Food and Commercial Workers
Unions and Employers Midwest Health Benefits Fund
1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713

The Prescription Drug Benefit is administered for the Fund by NMHC/Rx at 888-354-0090. Claims are filed by the pharmacy at the time a prescription is dispensed. Claims for reimbursement when the drug ID card is not used should be mailed to 1300 Higgins Road, Park Ridge, IL 60068.

Pre-Certification of Covered Expenses

Some treatments and supplies require pre-certification of expenses. To verify whether pre-certification is required, contact Health Information Services at the Benefits Fund Office.

To protect patient privacy and rights, all requests for pre-certification must be submitted in writing by mail, fax or website. The request must include the participant's name and UFCW ID # or social security number, the diagnosis, the proposed treatment, and the name and telephone number of the treating physician. For foot surgery, the request should also include the amount of the surgeon's fee.

Expenses that require pre-certification include any non-emergency treatment or supply, as follows:

- inpatient hospitalization
- surgery (both inpatient and outpatient except for minor procedures in the doctor's office)
- advanced technology testing such as MRI, CT, PET, Doppler and stress tests
- care in a skilled nursing facility
- rehabilitation therapy
- home health care, including oxygen therapy
- hospice care
- durable medical equipment, excluding minor devices such as canes and crutches

When emergency care results in you being admitted to the hospital, the Benefits Fund Office must be contacted within 48 hours of the admission.

Pre-certification may be waived if another insurer or health plan is primarily and substantially responsible for the expense or treatment. If the primary carrier, for whatever reason, decides not to cover the expense, the Fund's pre-certification requirements apply.

Pre-certification may also be waived if, under the circumstances, obtaining prior approval is not possible. Pre-certification is not required if the patient's condition, if left untreated, would seriously jeopardize the life or health of the patient or the ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Medical offices will often request pre-certification from the Benefits Fund Office for equipment, tests or procedures that are not included on the list of expenses which require pre-certification. When such requests are received, the Benefits Fund Office will make every effort to accommodate the request and review the proposed treatment for pre-certification. However, if pre-certification is not required (i.e., the Fund will not deny benefits because pre-certification was not obtained) or the request was not properly submitted, such requests are not considered claims and are not subject to the processing time and appeal time guidelines set forth in this Appendix A.

Notification of Benefit Determinations

Pre-Service Claim. If pre-certification has been appropriately requested, a determination will be made and the Fund will issue a decision within 15 days, although every effort will be made to respond

within a shorter period of time. If additional information is required resulting in a delay in determining benefits or if more time is needed due to matters beyond the Fund's control, then the response may be delayed no more than an additional 15 days. The claimant will be notified if an extension is needed and will be advised of the reason for the extension and the estimated date that a decision will be made. When additional information is requested, the claimant has up to 45 days to provide the information to the Benefits Fund Office. When a request for additional information is made, the measurement of the time elapsed while processing the claim is frozen.

The time limits noted above may be reduced if the treating physician advises the Fund that the need for medical treatment constitutes an "urgent" claim under Federal Department of Labor guidelines and provides an explanation as to why the claim should be considered an urgent claim.

Verbal requests for pre-certification of treatment expenses will be responded to, but such requests do not constitute a claim and will not necessarily be responded to within the time limits noted above (unless the claim is an urgent claim).

Post-Service Claim. Post-service expenses will be adjudicated within 30 days after receipt of the claim at the Benefits Fund Office. If additional time or information is required to determine benefits, the participant will be notified that the determination of benefits will be delayed by no more than 15 days. If additional information is requested, the claimant has up to 45 days to provide the information to the Benefits Fund Office. When a request for additional information is made, the measurement of the time elapsed while processing the claim is frozen.

Concurrent Care Claim. If your ongoing course of treatment or number of treatments was approved and is later reduced or terminated, you will be notified of the reduction or termination in enough time for you to appeal and receive a decision on your appeal before your treatment is reduced or terminated. If you request to extend your treatment and your request is an urgent claim, a decision on your request will be made as soon as possible, taking into account your medical circumstances. You will be notified whether your request has been approved or not within 24 hours after the Fund receives your request as long as you made your request at least 24 hours before your treatment is scheduled to end.

If your claim is denied, you will be given a written explanation, as described on page 50.

Filing an Appeal of a Benefit Determination

You have the right to a full and fair review if your claim is denied in whole or in part by the Plan. The review will be conducted by a fiduciary of the Fund who was not involved in the initial decision (and is not a subordinate of the person who made the decision) and will not give deference to the initial decision. If the denial was based on a medical judgement, the fiduciary will consult with a medical professional who has training and experience in the appropriate medical field and who

was not involved in the initial decision (and is not a subordinate of the person involved). The fiduciary will identify any medical or vocational experts who were consulted regarding the appeal.

How to File an Appeal. You or your Authorized Representative must file your appeal in writing to the Fund Administrator within one year of the denial of the claim. To be considered an appeal, the claimant must file a written request for a review of a specific claim and state the reason for disagreement with the benefit determination. The Fund will review all information submitted with the appeal, whether or not it was considered in the initial decision.

An appeal (as well as a claim) may be submitted by:

- the plan participant
- the provider of services if benefits are assigned to them by the patient (correspondence will be directed to the participant with copies to the provider)
- an Authorized Representative (see the last section of this Appendix A “Authorized Representative”).

What is Not an Appeal. A communication will not be considered an appeal if any of the following apply (unless it is an appeal of an urgent claim): (1) it is a telephone inquiry or other verbal request for review of a claim; (2) it involves a dispute between a BlueCross PPO provider and BlueCross BlueShield regarding contractual allowances agreed to in the contract between the parties; or (3) it is the submission of information originally requested by the Fund that was not previously sent to the Fund.

Time Requirements for Appeal Response

Pre-Service Appeals. Pre-Service Appeals are defined as appeals concerning the denial, in whole or in part, of expenses for services or supplies that have not yet been received by the claimant or billed to the Fund.

Within 15 days of receipt of the appeal, the Fund Administrative Manager will review all information submitted with the letter of appeal, as well as any additional information that may be reasonably obtained. If the Fund Administrative Manager’s decision is favorable to the claimant, a letter will be sent to the claimant advising of the decision. If the Fund Administrative Manager’s decision is to continue to deny the expenses for the services or supplies, in whole or in part, the appeal will be referred to the Appeal Committee of the Board of Trustees. The claimant will receive a written notice of the Appeal Committee’s decision within 30 days of receipt of the pre-service appeal. The Appeal Committee’s decision will be the final administrative remedy.

For urgent claims, the review may be expedited. Under an expedited review, you may submit a request for review orally or in writing and all necessary information will be transmitted by telephone, facsimile or another expeditious method. You will be notified as soon as possible of the decision, but not later than 72 hours after your appeal is received.

Post-Service Claim Appeals. Post-Service Appeals are defined as appeals concerning expenses already processed and denied in whole or in part by the Fund.

All Post-Service Appeals are reviewed by the Appeal Committee of the Board of Trustees at its quarterly meeting. Prior to the quarterly meeting, the Fund Administrative Manager will issue an advisory notice to the claimant which will provide an analysis of the additional information that has been submitted with the appeal. Following the receipt of the advisory notice, the claimant may provide additional information or justification to the Fund in support of the claim. The Appeal Committee and the Fund Administrative Manager will review the information that was submitted with the letter of appeal as well as any additional information that is provided by the claimant in response to the advisory notice and any other information that may be reasonably obtained, and issue a written decision to the claimant within five days after the decision is made. The Appeal Committee's decision is the final administrative remedy.

Note that if, prior to the quarterly meeting, the Fund Administrative Manager determines that benefits should be paid on behalf of the claimant based on the additional information submitted with the appeal, a favorable decision for the claimant will be made. This favorable decision will be reported in writing to both the claimant and the Appeal Committee.

Notification of Appeal Response. You will be given written notification of the decision on your appeal. If your appeal is denied, the notification will include the following information:

- the specific reason for the denial, including a reference to the specific Plan provision on which the denial is based;
- a statement that you are entitled, upon request and free of charge, to copies of all documents, records and other information relevant to your claim;
- a statement of your right to file suit under ERISA if your appeal is denied;
- any internal rule, guideline, protocol or other similar criterion that was used in denying your appeal, or a statement that this information is available upon request;
- an explanation of any scientific or clinical judgement for the denial decision if it was based on a medical necessity, experimental treatment or other exclusion or limit, or a statement that this information will be provided on request.

Right to File a Lawsuit

A claimant has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) following the denial of a claim on appeal by the Appeal Committee.

Authorized Representative

A participant or legal guardian may authorize another individual or entity to act on his or her behalf to submit a claim and/or an appeal. To establish that a person is an Authorized Representative, written notification must be sent to the Benefits Fund Office on a form provided by the Fund and available on request. Once established, an Authorized Representative may only be dismissed in writing by the participant.

An Authorized Representative does not need to be appointed to receive occasional verbal assistance from the Fund on matters that are not considered a claim or an appeal. An example of this is the use of a translator or a family member to assist a participant in obtaining or understanding information. The Fund will not divulge personal employment or health information when dealing with an informal representative.

Appendix B: Privacy Policy

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information.

The United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures. Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations. The Plan and its business associates will use PHI without your authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your x-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations). For example, the

Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and Disclosures that Require Your Written

Authorization. The Plan will obtain your authorization before releasing your PHI in those circumstances where the law or the Plan's privacy practices do not otherwise permit disclosure. For example, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you prepared by your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Uses and Disclosures that Require that You be Given an Opportunity to Agree or Disagree Prior to the Use or Release.

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

1. the information is directly relevant to the family member or friend's involvement with your care or payment for that care; and
2. you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Additional rules and exceptions apply with family members. You may request additional information from the Plan.

Uses and Disclosures for Which Your Consent, Authorization or Opportunity to Object is Not Required. The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or

domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgement.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI.

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official at 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713, 800-621-5133.

Right to Request Confidential Communications. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official at: 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713, 800-621-5133.

Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

PHI includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official at: 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713, 800-621-5133.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI. You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official at: 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713, 800-621-5133.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (including to business associates pursuant to a business associate agreement and to the Trustees as authorized by the Plan or the HIPAA privacy regulations); (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

Such requests should be made to the Plan's Privacy Official at: 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713, 800-621-5133.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Right to Receive a Paper Copy of This Notice Upon Request. You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official at: 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713, 800-621-5133.

A Note About Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes, notarized by a notary public;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective April 14, 2003, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard. When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information. This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information. The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Your Right to File a Complaint with the Plan or with the US Department of Health and Human Services Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official at: 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713, 800-621-5133.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy official. Such questions should be directed to the Plan's Privacy Official at: 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713, 800-621-5133.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

Appendix C: Prescription Drug Not Creditable Coverage—Medicare Part D

Your prescription drug benefits provided under this Plan B5 of the Health Fund are **not** “creditable prescription drug coverage” under Medicare. This means that if you do not enroll for Medicare Prescription Drug Coverage when you are first eligible, you will have to pay more for coverage if you enroll at a later date (unless you have other coverage that is creditable coverage).

Medicare Prescription Drug Coverage

Beginning January 1, 2006, prescription drug coverage became available through Medicare to anyone entitled to Medicare Part A. Most people have to pay a monthly premium for Medicare Prescription Drug Coverage. Medicare Prescription Drug Coverage is insurance provided by private companies that have been approved by Medicare. If eligible, you can get Medicare Prescription Drug Coverage through Medicare Advantage or Medicare Prescription Drug Plans. For people with limited income and resources, extra help paying for Medicare Prescription Drug Coverage is available.

All Medicare plans will provide at least a standard level of coverage as set by Medicare. Some Medicare plans might offer better coverage for a higher monthly premium.

When you become entitled to Medicare Part A, you can enroll in Medicare Prescription Drug Coverage. You can also enroll each year from November 15th through December 31st. If you have creditable coverage elsewhere (not under this Plan B5) and you lose or drop that coverage, you may be eligible for a Special Enrollment Period to enroll in Medicare Prescription Drug Coverage.

Existing Coverage is Not as Good as Standard Medicare Prescription Drug Coverage

The Health Plan has determined that, as of January 1, 2007, your existing, active Plan B prescription drug benefits are, on average, **not** expected to pay as much as standard Medicare Prescription Drug Coverage. This means that the Health Plan’s coverage is **not** “creditable coverage” under Medicare. This is important for two reasons:

- (1) Enrolling in Medicare Prescription Drug Coverage when you become eligible means that, for most people, there will be more assistance with prescription drug costs than what is available only under the Health Plan’s prescription drug benefit.
- (2) If you do not enroll for Medicare Prescription Drug Coverage when you first become eligible, you will have to pay a penalty (unless you have other creditable coverage such as through your spouse’s coverage) in the form of a higher Medicare premium if you decide to enroll at a later time.

Your Choices and the Consequences

If you are eligible for Medicare, you should compare your options under Medicare Prescription Drug Coverage, including which

medications are covered, with the coverage and cost of the Medicare plans in your area.

If you are eligible and do not enroll for Medicare Prescription Drug Coverage, you will continue to receive prescription drug benefits under the Health Plan, as long as you are otherwise eligible to continue Plan coverage. Remember that the Health Plan also covers medical benefits, in addition to prescription drug benefits. You will continue to be eligible to receive all current benefits.

If you are eligible and enroll for Medicare Prescription Drug Coverage, the Health Plan reserves the right to coordinate with your Medicare Prescription Drug Coverage. Remember that for most people, there is a monthly premium for Medicare Prescription Drug Coverage.

Keep in mind:

If you do not enroll for Medicare Prescription Drug Coverage and you do not have other creditable coverage (such as through your spouse's coverage), you will pay more for Medicare Prescription Drug Coverage if you enroll at a later date.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare Prescription Drug Coverage, your monthly premium for Medicare Prescription Drug Coverage will increase. The increase will be 1% per month for every month that you were eligible but did not have coverage. For example, if you go 19 months without coverage, your monthly premium will always be 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare Prescription Drug Coverage. In addition, you may have to wait until the next open enrollment period (November 15–December 31 each year) to enroll.

If you do not enroll for Medicare Prescription Drug Coverage when you are first eligible, you may have to wait to enroll. Generally, you can enroll only between November 15 and December 31 of each year. This may mean the number of months you have to wait for coverage will be longer, which could make your premium higher.

Issues to consider when you evaluate your Medicare Prescription Drug Coverage options:

Premiums. There are monthly premiums that must be paid for Medicare Prescription Drug Coverage. For many plans, the premium is the amount approved by Medicare. However, companies that offer better benefits than standard Medicare coverage usually require higher monthly premiums. The premium amount depends on the type of coverage that you choose. Medicare premiums can be deducted automatically from monthly Social Security benefits or the company can bill you. For people with limited income and assets, help paying for Medicare Prescription Drug Coverage is available.

Covered Medications. Each Medicare plan has a government-approved list of medications it covers (called a formulary or

preferred drug list). Not all prescription drugs are covered by all plans. If the medications you are taking are not included on the list, you could be paying more for these medications.

Participating Pharmacies. Each Medicare plan has a list of pharmacies that participate in its plan (called participating pharmacies). When you go to a participating pharmacy to have your prescription filled, you receive your prescription at a discounted price. Your current retail pharmacy may not be included under every plan.

Cost-Sharing. Each Medicare plan specifies the deductible, co-payment or co-insurance, and other costs (such as premiums) that you will be responsible for paying. Your costs under each plan may be different.

For More Information about Medicare Prescription Drug Coverage

If you are eligible for Medicare, you will receive a Medicare & You handbook in the mail from Medicare. More detailed information about Medicare Prescription Drug Coverage is included in this handbook. You will also receive information directly from Medicare plans.

To get more information, you can:

- Visit [medicare.gov](https://www.medicare.gov) for personalized help.
- Call your State Health Insurance Assistance Program (the telephone number will be included in the Medicare & You handbook).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited resources, help in paying for Medicare Prescription Drug Coverage is available. To get more information about this help, contact the Social Security Administration:

- Visit [socialsecurity.gov/prescriptionhelp](https://www.socialsecurity.gov/prescriptionhelp)
- Call 1-800-772-1213 (TTY users should call 1-800-325-0778).

Appendix D: Summary of the Cafeteria Plan for Employees Participating in the Health Benefits Plan

Your employer (the “Employer”) may have adopted the “Cafeteria Plan for Employees Participating in the UFCW Unions & Employers Midwest Health Benefits Plan” (the “Cafeteria Plan”) to allow tax savings for certain employees. You should confirm whether or not your Employer has adopted the Cafeteria Plan.

Eligibility

Employees who are eligible to participate for health coverage under the UFCW Unions and Employers Midwest Health Benefits Plan (the “Health Benefits Plan”) are also eligible under this Cafeteria Plan to pay employee contributions for the Health Benefits Plan coverage on a pre-tax basis.

Cafeteria Plan Benefit

The Cafeteria Plan enables you to pay your required employee contributions to the Health Benefits Plan on a pre-tax basis. This allows you to reduce your taxable income and to direct your Employer to use that amount to pay the required health coverage contribution under the Health Benefits Plan. You will pay lower federal income, state income and FICA taxes due to the reduction in your taxable income.

Enrollment and Wage Reduction Contributions

By completing and timely filing the enrollment form to participate in the Health Benefits Plan, you automatically agree to reduce your wages in an amount equal to your required contributions for health coverage benefits and direct your Employer to use that amount to pay the employee contribution.

When You May Change Your Enrollment Form

You must complete and file an enrollment form within 30 days of receiving the enrollment form in order to participate in the Health Benefits Plan. Your enrollment form will be binding for the Plan Year (January 1 through December 31). If you begin participation after the first day of a Plan Year, your enrollment form will be binding from the day you begin participating in the Cafeteria Plan until the end of the Plan Year. Your election remains in place unless you file a change during the annual enrollment period (generally in November and December) or due to a “Change in Election Event” as described below.

You may only file a new enrollment form during the Plan Year to change your coverage and contributions on account of and consistent with a “Change in Election Event” as follows:

- **Change in Employment Status.** A change in employment status means your hours worked increase or decrease to a point that it changes your eligibility for coverage under the Health Benefits Plan.

-
- **Entitlement to Medicare or Medicaid or Loss of Entitlement.** You become entitled to or lose entitlement to Medicare or Medicaid.
 - **Change in Cost.** If there is a significant increase or decrease in the cost of a plan, a change in election may be permitted.
 - **Change in Coverage.** If your coverage is significantly reduced or increased, a change in election may be permitted.
 - **Family and Medical Leave Act.** If you take a leave under the Family and Medical Leave Act, you may revoke or change your election.
 - **Different Enrollment Period.** Your spouse has a plan with a different enrollment period.
 - **Special Enrollment Rights Under HIPAA.** Special enrollment rights are required by the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA allows individuals to enroll in a health plan in special circumstances when an individual has gained or lost eligibility for coverage under another plan.

Changes in elections during the Plan Year must be filed within 30 days of the event.

Unpaid Leaves

If you are eligible for an unpaid leave, your employer may require that your weekly contribution for health coverage during your leave be paid by you upon your return. Catch-up contributions will be taken on a pre-tax basis to the extent allowed under rules from the Internal Revenue Service. If you return from your leave in the same Plan Year in which your unpaid leave began, you will be reinstated in the Cafeteria Plan on the same terms as when the leave began.

If you are on a military leave, you can continue to contribute for health coverage. The Health Benefits Plan will provide appropriate information on USERRA coverage.

COBRA Continuation Coverage

The Health Benefits Plan will provide information about COBRA Continuation Coverage and any other health continuation requirements if you lose coverage under the Health Benefits Plan.

Payments for COBRA Continuation Coverage must be paid on an after-tax basis.

Termination of Participation

Your Cafeteria Plan coverage will automatically terminate the date that you are no longer eligible for health coverage under the Health Benefits Plan, or when the Cafeteria Plan is terminated.

Plan Document Controls

This summary explains the principal provisions of the Cafeteria Plan so that you may understand the Cafeteria Plan's operation and its benefit to you. This summary cannot change, add to, or subtract from, the formal Cafeteria Plan document. In the event of inconsistencies between this summary and the Cafeteria Plan document, the formal Cafeteria Plan document will control.

Your Employer and the Board of Trustees of the Health Benefits Plan reserve the right to amend or terminate the Cafeteria Plan. You may inspect a copy of the Cafeteria Plan document at your employer's office.

Please refer to the Health Benefits Plan's summary plan description for information regarding the Health Benefits Plan's benefits.

If you have any questions after reading this summary, please contact the plan administration office at 1300 Higgins Road, Park Ridge IL 60068 or call 800-621-5133 during normal business hours.
