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

Plan D5

Summary Plan Description

Revised January, 2010

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. Please share this information with your spouse (if you are married).

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 38 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 such as the certificate of insurance issued by Fort Dearborn Life Insurance Company. 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 Fund

1300 Higgins Road, Suite 300
Park Ridge, Illinois 60068-5713
ufcwmidwest.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 11 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. Patient's full name and relationship to you.
3. Doctor's name, address and phone number.
4. Diagnosis.
5. Proposed treatment.

Details regarding this important requirement begin on page 36.

Second Opinion

You must obtain a Second Opinion before undergoing certain surgeries. A list of these surgeries begins on page 36. 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 and your eligible dependents 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 38 for further information and for how to locate a PPO Provider.

Table of Contents

Summary of Benefits 8

Election of Coverage and Authorization of Payroll Deductions 11
- If You Do Not Elect Coverage 11
- Enrollment Periods 12

Eligibility Provisions 12
- Eligibility Based on Rate-Per-Hour Employer Contributions 13
  - Initial Eligibility 13
  - Your Continuing Eligibility 15
  - Your Dependents' Eligibility 16
  - Termination and Reinstatement of Eligibility 16
  - Reinstatement After You Return to Work 17
  - Termination of Your Dependents' Eligibility 17
  - Table of Effective Date Examples 17
- Eligibility Based on Flat-Rate Employer Contributions 19
  - Initial Eligibility 19
  - Your Continuing Eligibility 20
  - Your Dependents' Eligibility 20
  - Termination and Reinstatement of Eligibility 20
  - Reinstatement After You Return to Work 21
  - Termination of Your Dependents' Eligibility 21
  - Table of Effective Date Examples 22
- Eligible Dependents Defined 24
- Qualified Medical Child Support Order 25
- Michelle's Law: Coverage for Disabled College Students 25
- Special Rules for Continuing Eligibility 26
  - Military Service 26
  - Extension of Coverage During Disability 27
  - Family and Medical Leave Act (FMLA) 27
- Certificate of Creditable Coverage 28

COBRA Continuation Coverage 30

Cost Containment Features of the Health Plan 36
- When to Notify Health Information Services 36
- How to Notify Health Information Services 37
- Penalties for Failure to Notify Health Information Services 38
- BlueCross Blue Shield Participating Provider Network 38

Comprehensive Medical Benefits 39
- Lifetime Maximum Benefit 39
- Annual Deductible 39
- Non-PPO Hospital Deductible 39
- Non-Compliance Deductible 39
- Out-of-Pocket Limit 40
- PPO Providers—BlueCross BlueShield of Illinois 40
- Surgery at Non-PPO Facility 40
- Pre-Existing Condition Limitation 41

Covered Medical Expenses 41
What is Not Covered 46
Prescription Drug Benefit 49
Prescription Drug ID Card 49
Participating Pharmacy Program 49
Annual Maximum Benefit 49
Drugs that Require Pre-Approval 49
Generic Equivalents and Brand-Name Drugs 49
Preferred and Non-Preferred Drugs 50
Covered Drugs 50
Co-Payments 50
What is Not Covered 52
Direct Reimbursement 53
Creditable Coverage Under Medicare 53
Vision Benefit 54
Dental Benefit 55
How the Plan Pays Benefits 55
Covered Dental Expenses 55
Orthodontia Benefit 56
Alternate Procedures 56
Pre-Treatment Estimate 56
What is Not Covered 57
Schedule of Dental Benefits 58
Income Protection Benefit 59
Life Insurance Benefit 60
Accidental Death & Dismemberment (AD&D) Benefit 63
General Exclusions and Limitations 64
Recovery Incentive Program 66
Filing a Claim and Claim Information 68
Claim Forms 68
Authorization to Release Personal Health Information 68
Payment or Status of Claims 68
Assignment 69
Coordination of Benefits Provisions 70
Determining Which Plan is Primary 70
Primary Plan Procedures Must Be Followed 72
Working Spouse Rule 72
Coordination with Medicare 72
Coordination with Automobile and Similar Coverage 73
Subrogation and Reimbursement Rights 74
Claim Appeal Procedure 76
Statement of Rights Under the Employee Retirement Income Security Act of 1974 77

Definitions 79
Important Information about the Health Plan 82
Participating Local Unions 85
Appendix A: Claim Procedures 86
Filing a Claim 86
Pre-Certification of Covered Expenses 87
Notification of Benefit Determinations 88
Filing an Appeal of a Benefit Determination 89
Time Requirements for Appeal Response 90
Right to File a Lawsuit 92
Authorized Representative 92
Appendix B: Privacy Policy 93
Appendix C: Prescription Drug Creditable Coverage—Medicare Part D 100
Appendix D: Summary of the Cafeteria Plan for Employees Participating in the Health Benefits Plan 102

Contact the Office for Assistance

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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 بالدائرة من أجل المساعدة

PER ASSISTENZA RIVOLGERSI ALL UFFICIO

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

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Midwest Health Benefits Fund
1300 Higgins Road, Suite 300
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847-384-7000 ♦ 800-621-5133 ♦ TDD 847-384-0199

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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.

Dependent Coverage is provided only to employee-members who elected Family Coverage and who are working enough hours to qualify for full-time coverage.

Income Protection Benefit for You	
Maximum Benefit	55% of weekly earnings, up to $250 per week
Maximum Payment Period	26 weeks
Benefits Begin	1st day of an accident 1st day of hospitalization 1st day of outpatient surgery 8th day of sickness
Life Insurance Benefit for You	$15,000

Life Insurance Benefit for Your Dependents	
Spouse	$2,500
Child 15 days but less than 1 year old 1 year but less than 18 years old	 $100 $2,500
Accidental Death & Dismemberment for You	Up to $7,500 determined by severity of injury

Comprehensive Medical Benefit for You and Your Dependents	
Lifetime Maximum	$1,000,000 per person
Annual Deductible Per Person Maximum Per Family	 $250 $750 (3 persons must each satisfy Annual Deductible)
Non-PPO Hospital Deductible	$350
Non-Compliance Deductible	$100
Percentage Paid PPO Hospital Non-PPO Hospital Out-of-Area or Emergency Hospital Surgery when required Second Opinion not obtained Most other covered expenses	 Plan pays 85%, you pay 15% Plan pays 65%, you pay 35% Plan pays 80%, you pay 20% Plan pays 50%, you pay 50% Plan pays 80%, you pay 20%
Annual Out-of-Pocket Maximum	$2,000 per person, including Annual Deductible

The following benefits are paid at 100% by the Plan and are not subject to the Annual Deductible	
Well-Child Care (to age 2)	Up to $500 per child, lifetime maximum
Preventive Care for you and your spouse	Plan pays first $50 per calendar year (expenses in excess of $50, paid at 80% after Annual Deductible)

Seasonal Flu Shot for you and your spouse	Up to $15 per calendar year
Screening Mammogram	Up to $130 per calendar year within age limits (expenses in excess of $130, paid at 80% after Annual Deductible)
Designated Preferred Laboratory Testing	Plan pays 100%

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 per person in any 5-consecutive year period
Intentionally Destructive Act	Plan pays 50% up to $5,000 per event
Pre-Existing Condition	Plan pays 50% up to $5,000 per condition
Hospital Charges for Dental Surgery	Plan pays 50% up to $5,000 per event
Treatment of Varicose Veins	$2,500 per leg, lifetime maximum
Voice Communication Machine	$7,500 per person, lifetime maximum

Prescription Drug Benefit for You and Your Dependents

Annual Benefit Maximum	$14,000 per person
Percentage Paid	Plan pays 100% after you pay the co-payment
Dispensing Limitation	30-day supply; 90-day supply for maintenance drugs
Co-payment for 30-day supply of:	
Tier Zero—Preferred Drugs	$0
Tier One—most Generic Drugs	$7
Tier Two—most Brand Name Drugs and Non-Preferred Generic Drugs	$15
Tier Three—Non-Preferred Drugs	$25
Co-payment for 90-day supply of maintenance drugs	2 times the co-payment for a 30-day supply

(continued on following page)

Vision Benefit for You and Your Dependents

Annual Benefit Maximum	$135 per person
Annual Deductible	None
Percentage Paid	Plan pays 100%

Dental Benefit for You and Your Dependents

Annual Deductible	
Diagnostic and Preventive Treatment	None
All other covered Dental charges, including Orthodontia	$50
Percentage Paid	Plan pays 100% up to scheduled amount
Orthodontia (including TMJ)	
Percentage Paid	Plan pays 50%, you pay 50%
Maximum Lifetime Benefit	$1,000

Election of Coverage and Eligibility Provisions

You and your eligible dependents become covered:

- after you elect coverage and authorize payroll deductions; and
- after you satisfy the applicable 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 any of the following levels of coverage:

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 Single Coverage. Note that Single Coverage includes the disability Income Protection Benefit if you qualify as a full-time employee.

Family Coverage. You may elect Family Coverage to receive health coverage and related benefits for yourself and your eligible family members and make a weekly payroll deduction of $15. Additionally, you must work the minimum hours necessary to maintain Family Coverage.

The weekly payroll deduction of either $5 or $15 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 102.

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 and your family 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 and your family members 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 17 and page 22 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 change 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 for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Health Plan if you or your dependents lose or gain eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage changes.

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

A complete list of events and situations which may allow you to enroll under the Special Enrollment Period provisions begins on page 102.

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 13.
- **Flat-Rate Employer Contributions.** Your employer contributes a flat amount each month. Flat-Rate Eligibility Provisions are described beginning on page 19.

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 19 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 for you and your dependents 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.

For certain benefits, you must meet the hours requirement and also a waiting period. For instance, to be eligible for Dental Benefits, you must meet the hours requirement as well as a two-month period in which your Health Benefits have been in effect. To be eligible for Income Protection Benefits, you must meet the hours requirement as well as a four-month period during which your Health Benefits have been in effect.

A "Table of Effective Date Examples" is on page 17. 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 three months or after six months 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.

Examples of Initial Eligibility

If a payroll week for John and Sue runs from Sunday through Saturday, and John and Sue are determining their hours for June 2009, there are four weeks for which they count the hours they worked. Because June 2009 contains four Saturdays, they count the covered hours in the weeks running from:

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

Sunday through Saturday	John's Covered Hours Worked	Sue's Covered Hours Worked
May 31 through June 6	14	40
June 7 through June 13	10	20
June 14 through June 20	20	28
June 21 through June 27	8	26

John and Sue use the following formula to determine their average weekly hours worked during the calendar month of June:

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

In John's case, the formula works as follows:

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

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

In Sue's case, the formula works as follows:

$$\frac{40 + 20 + 28 + 26}{4} = \frac{114}{4} = 28.5$$

Even though Sue worked fewer than 28 hours during some of the payroll weeks that ended in June, her average covered hours worked for the four payroll weeks is 28 or greater, so she is able to count June as a month in which she met the hours requirement.

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

This chart illustrates the hours you need to work to be eligible for the different types of benefits offered.

You Become Eligible for this Benefit	When You Have Worked these Average Covered Hours	For Each Week Ending During this Period	Your Initial Coverage Begins
Life Insurance Accidental Death & Dismemberment Comprehensive Medical Prescription Drug Vision	12 per week	2 full calendar months in a row	The first day of the month following the 2-month period
Example: John: If June is the first full month of employment for which his employer made contributions	and he averaged 13 covered hours per week	during June and July	then John's initial eligibility date would be August 1, 2009
Example: Sue: If June is the first full month of employment for which her employer made contributions	and she averaged 28.5 covered hours per week	during June and July	then Sue's initial eligibility date would be August 1, 2009
Dental	12 per week	4 full calendar months in a row	The first day of the month after your medical benefits have been in effect for 2 full calendar months
Example: John	13 per week	June through September	October 1, 2009
Example: Sue	28.5 per week	June through September	October 1, 2009
Income Protection	28 per week	3 of the 4 preceding months in a row	The first day of the month after your medical benefits have been in effect for 4 full calendar months in a row
Example: John	13 per week	June through November	Does not qualify
Example: Sue	28.5 per week	June through November	December 1, 2009

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

To Continue to be Eligible for this Benefit	You Must Work these Average Covered Hours	For Each Week Ending During this Period
Life Insurance Accidental Death & Dismemberment Comprehensive Medical Prescription Drug Vision Dental	12 per week	2 full calendar months in a row
Income Protection	28 per week and Not less than 12 per week	3 of the 4 preceding calendar months in a row 2 preceding full calendar months in a row

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

Your Dependents' Eligibility—Coverage for your eligible dependents is based on the number of hours you work and on certain waiting periods; additionally, you must have elected Family Coverage. See page 24 for the definition of an eligible dependent. Your dependents become eligible as shown below:

Your Dependents Become Eligible for this Benefit	When You Have Worked these Average Covered Hours	For Each Week Ending During this Period	Initial Coverage Begins
Dependent Life Insurance Comprehensive Medical Prescription Drug Vision	28 per week	3 of the 4 preceding calendar months in a row	The first day of the month after your medical benefits have been in effect for 2 full calendar months in a row
Dental	28 per week	3 of the 4 preceding calendar months in a row	The first day of the month after your medical benefits have been in effect for 8 full calendar months
Your Dependents Continue to be Eligible	28 per week (and not less than 12 per week every month)	3 of the 4 preceding 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 30 for more information.

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

Your Coverage for these Benefits	Ends When You Fail to Work these Average Covered Hours	For Each Week Ending During this Period	Coverage Ends	Reinstatement Occurs
Income Protection Dependent Coverage	28 per week	3 of the 4 preceding calendar months in a row	The last day of the 4-month period	The first day of the month after you again meet the 28-hour requirement
All Benefits	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

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

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,

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.

Termination of Your Dependents' Eligibility

Your dependents will lose coverage on the earliest of the following dates:

- the last day of the month in which you become ineligible for coverage; or
- the last day of the month in which you do not work the required hours for dependent coverage; or
- the last day of the month in which your dependent fails to meet the definition of an eligible dependent described on page 24; or
- the date you and your spouse divorce (coverage for your spouse ends on the date of your divorce).

In the event of your death, coverage for your spouse and your dependent children continues until the earliest of:

- the last day of the third month following the date of your death;
- the last day of the month in which your dependent fails to meet the definition of an eligible dependent; or
- the date your dependent becomes eligible for health coverage under another group plan or policy.

If you have elected Family Coverage and were working enough hours to qualify for Family Coverage, dependents' coverage may be continued by making self-payments under COBRA. See COBRA Continuation Coverage beginning on page 30 for more information.

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;
- your Collective Bargaining Agreement requires rate-per-hour employer contributions on your behalf; and
- the contributions begin with the first weekly pay period after you complete at least three continuous months or six continuous months of employment.

If your Collective Bargaining Agreement contains different requirements, this table does not apply to you.

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

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

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

Your first day of employment is between these inclusive dates	Your Health Coverage is effective	Your Dental Coverage and your Dependents' Health Coverage are effective	Your Income Protection Coverage is effective	Your Dependents' Dental Coverage is effective
If Rate-Per-Hour Employer Contributions Begin After 3 Months				
09/2/09 – 10/1/09	03/1/10	05/1/10	07/1/10	11/1/10
10/2/09 – 11/1/09	04/1/10	06/1/10	08/1/10	12/1/10
11/2/09 – 12/1/09	05/1/10	07/1/10	09/1/10	01/1/11
12/2/09 – 01/1/10	06/1/10	08/1/10	10/1/10	02/1/11
01/2/10 – 02/1/10	07/1/10	09/1/10	11/1/10	03/1/11
02/2/10 – 03/1/10	08/1/10	10/1/10	12/1/10	04/1/11
03/2/10 – 04/1/10	09/1/10	11/1/10	01/1/11	05/1/11
04/2/10 – 05/1/10	10/1/10	12/1/10	02/1/11	06/1/11
05/2/10 – 06/1/10	11/1/10	01/1/11	03/1/11	07/1/11
06/2/10 – 07/1/10	12/1/10	02/1/11	04/1/11	08/1/11
07/2/10 – 08/1/10	01/1/11	03/1/11	05/1/11	09/1/11
08/2/10 – 09/1/10	02/1/11	04/1/11	06/1/11	10/1/11
09/2/10 – 10/1/10	03/1/11	05/1/11	07/1/11	11/1/11
If Rate-Per-Hour Employer Contributions Begin After 6 Months				
06/2/09 – 07/1/09	03/1/10	05/1/10	07/1/10	11/1/10
07/2/09 – 08/1/09	04/1/10	06/1/10	08/1/10	12/1/10
08/2/09 – 09/1/09	05/1/10	07/1/10	09/1/10	01/1/11
09/2/09 – 10/1/09	06/1/10	08/1/10	10/1/10	02/1/11
10/2/09 – 11/1/09	07/1/10	09/1/10	11/1/10	03/1/11
11/2/09 – 12/1/09	08/1/10	10/1/10	12/1/10	04/1/11
12/2/09 – 01/1/10	09/1/10	11/1/10	01/1/11	05/1/11
01/2/10 – 02/1/10	10/1/10	12/1/10	02/1/11	06/1/11
02/2/10 – 03/1/10	11/1/10	01/1/11	03/1/11	07/1/11
03/2/10 – 04/1/10	12/1/10	02/1/11	04/1/11	08/1/11
04/2/10 – 05/1/10	01/1/11	03/1/11	05/1/11	09/1/11
05/2/10 – 06/1/10	02/1/11	04/1/11	06/1/11	10/1/11
06/2/10 – 07/1/10	03/1/11	05/1/11	07/1/11	11/1/11

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 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.

You first become eligible on the first day of the month after your employer makes the required monthly contribution on your behalf. To be eligible for Dental Benefits, your Health Benefits must have been in effect for two months.

Eligibility for you and your dependents is based on your employer's contribution on your behalf:

- If your employer makes a full-time contribution, you and your dependents are eligible for benefits, including the Income Protection Benefit for you.
- If your employer makes a part-time contribution, your dependents are not eligible and you are not eligible for the Income Protection Benefit.
- If a contribution is not made on your behalf, you and your dependents are not eligible.

A "Table of Effective Date Examples" begins on page 22. 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 three months or after six months of employment. Refer to your Collective Bargaining Agreement to determine when your employer is required to begin making contributions on your behalf.

The following chart shows the employer contribution that must be made to be eligible for the different types of benefits offered.

You Become Eligible for this Benefit	When this Employer Contribution is Made	Your Initial Coverage Begins
Life Insurance Accidental Death & Dismemberment Comprehensive Medical Prescription Drug Vision	1 part-time or full-time contribution	The first day of the month after the month in which the contribution is made
Dental	part-time or full-time contributions	The first day of the month after your medical benefits have been in effect for 2 full calendar months
Income Protection	1 full-time contribution	The first day of the month after the month in which the contribution is made

(Flat-Rate Eligibility continues on following page)

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

To Continue to be Eligible for this Benefit	This Employer Contribution Must be Made
Life Insurance Accidental Death & Dismemberment Comprehensive Medical Prescription Drug Vision Dental	part-time or full-time contribution
Income Protection	full-time contribution

Your Dependents' Eligibility—Coverage for your eligible dependents is based on full-time employer contributions being made and on certain waiting periods; additionally, you must have elected Family Coverage. See page 24 for the definition of an eligible dependent. Your dependents become eligible as shown below:

Your Dependents Become Eligible for this Benefit	When this Employer Contribution is Made	Initial Coverage Begins
Dependent Life Insurance Comprehensive Medical Prescription Drug Vision	1 full-time contribution	The first day of the month after the month in which the contribution is made
Dental	full-time contribution	The first day of the month after your medical benefits have been in effect for 8 full calendar months
Your Dependents Continue to be Eligible	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. You will lose coverage for the Income Protection Benefit and for Dependent Coverage if a full-time contribution is not made on your behalf. 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 30 for more information.

(Flat-Rate Eligibility continues on following page)

Termination and Reinstatement of Eligibility *(Continued)*

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

Your Coverage for these Benefits	Ends When	Coverage Ends	Reinstatement Occurs
Income Protection Dependent Coverage	a full-time contribution is not made	Last day of the month for which a full-time contribution was made	The first day of the month after you again meet the eligibility requirements
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,

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.

Termination of Your Dependents' Eligibility

Your dependents will lose coverage on the earliest of the following dates:

- the last day of the month in which you become ineligible for coverage; or
- the first day of the month for which a full-time employer contribution is not made on your behalf; or
- the last day of the month in which your dependent fails to meet the definition of an eligible dependent described on page 24; or
- the date you and your spouse divorce (coverage for your spouse ends on the date of your divorce)

In the event of your death, coverage for your spouse and your dependent children continues until the earliest of:

- the last day of the third month following the date of your death;
- the last day of the month in which your dependent fails to meet the definition of an eligible dependent; or
- the date your dependent becomes eligible for health coverage under another group plan or policy.

If you have elected Family Coverage and your employer has made full-time contributions on your behalf, dependents' coverage may be continued by making self-payments under COBRA. See COBRA Continuation Coverage (page 30) for more information.

(Flat-Rate Eligibility continues on following page)

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;
- your Collective Bargaining Agreement requires monthly flat-rate employer contributions on your behalf; and
- the contributions begin with the month after you complete at least three continuous months or six continuous months of employment.

If your Collective Bargaining Agreement contains different requirements, this table does not apply to you.

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

(Flat-Rate Eligibility continues on following page)

Flat-Rate Table of Effective Date Examples *(Continued)*

If your first day of employment is between these inclusive dates	Your and your Dependents' Health Coverage is effective	Your Dental Coverage is effective	Your Dependents' Dental Coverage is effective
If Flat-Rate Employer Contributions Begin After 6 Months			
07/2/09 – 08/1/09	03/1/10	05/1/10	11/1/10
08/2/09 – 09/1/09	04/1/10	06/1/10	12/1/10
09/2/09 – 10/1/09	05/1/10	07/1/10	01/1/11
10/2/09 – 11/1/09	06/1/10	08/1/10	02/1/11
11/2/09 – 12/1/09	07/1/10	09/1/10	03/1/11
12/2/09 – 01/1/10	08/1/10	10/1/10	04/1/11
01/2/10 – 02/1/10	09/1/10	11/1/10	05/1/11
02/2/10 – 03/1/10	10/1/10	12/1/10	06/1/11
03/2/10 – 04/1/10	11/1/10	01/1/11	07/1/11
04/2/10 – 05/1/10	12/1/10	02/1/11	08/1/11
05/2/10 – 06/1/10	01/1/11	03/1/11	09/1/11
06/2/10 – 07/1/10	02/1/11	04/1/11	10/1/11
07/2/10 – 08/1/10	03/1/11	05/1/11	11/1/11

Eligible Dependents

If you have elected Family Coverage, your eligible dependents are:

- your lawful spouse of the opposite sex; and
- your unmarried children who are under 19 years of age, dependent on you for more than one-half of their support and who reside with you in a regular parent-child relationship for more than one-half of each year or who are otherwise specified in a Qualified Medical Child Support Order (QMCSO). If you are a non-custodial parent due to divorce or legal separation, your child must reside with either you or the other parent for more than one-half of each year.

Your unmarried children include:

- your natural children;
- your legally-adopted children or those for whom adoption proceedings have been started and who have been placed in your home by a licensed placement agency for the purpose of adoption;
- your step-children if both the child and the child's natural parent live with you; and
- children for whom you have legal responsibility as the result of a court order if the child is your first degree relative.

If your dependent is a full-time student attending an accredited school and is financially dependent on you for more than one-half of their support, he or she will be eligible to age 23. He or she must reside with you for more than one-half of each year. A temporary absence to attend school is permissible if the child returns home when school is not in session. Proof of full-time student status for each school semester is required for children age 19 and older. For example, each semester obtain proof of attendance and number of enrolled credit hours for that semester by requesting written verification from the school registrar's office; forward this proof to the Benefits Fund Office each semester. Unless a student continues to be enrolled, coverage usually ends January 31 for the fall semester and September 30 for the spring semester. If the student either cannot continue full-time or must take a leave of absence for medical reasons, coverage may be extended for up to one year. For details, see "Michelle's Law" beginning on page 25.

If a dependent was covered up to the date coverage would otherwise end because of reaching age 19, and if on that date the dependent:

- is incapable of self-support due to mental retardation or physical handicap which began before the child attained age 19,
- is dependent upon you for more than one-half of his or her financial support and maintenance, and
- resides with you permanently and regularly for more than one-half of each year or lives in a treatment center,

then that dependent will be covered for so long as the incapacity and dependency continue, but not beyond the date on which your coverage ends.

You should complete and return a "Dependent Registration Form" as soon as you receive it from the Benefits Fund Office. This will help to ensure that your dependents can be considered for all health benefits for which they are eligible.

Legal documentation of your dependent's status, such as by an original registered marriage certificate, certified government-issued birth certificate or divorce decree, may be required by the Benefits Fund Office.

If both husband and wife are eligible as full-time employees, their dependent children are covered as dependents under both the wife and husband.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order that requires a participant to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation, or a paternity dispute. Coverage will be provided to a child even if that child does not reside with the employee or was not covered under the Plan due to custody-related issues, if that child is identified as an alternate recipient under a QMCSO.

The Benefits Fund Office will notify affected participants and alternate recipients if a QMCSO is received. If you, your child or the child's custodial parent or legal guardian would like a copy at no charge of the Plan's written procedure for QMCSOs, or have any questions, please contact the Benefits Fund Office.

Michelle's Law: Coverage for Disabled College Students

Michelle's Law (Public Law 110-381) became effective December 1, 2009 and provides that health coverage for an eligible dependent who is a full-time college student will not be terminated if the student becomes disabled and therefore cannot maintain full-time student status.

A full-time student (see the definition of eligible dependent on page 24 to determine whether your child meets the full-time student requirement) who

- takes a medically-necessary leave of absence from school, or
- changes to part-time status for medical reasons

may have health coverage extended for up to one year at no cost. The student will be entitled to the same benefits as if he or she had not taken a leave or changed to part-time.

The Benefits Fund Office must receive written certification from the student's treating physician stating the student is suffering from a serious illness or injury and the leave or change in enrollment status is therefore medically necessary.

Extended coverage will begin on the first day of the month for which the student would lose coverage because of the disabling condition. The extended coverage will terminate on the earlier of:

- one year from the date extended coverage began;
- the date coverage would otherwise terminate under the Plan, such as reaching age 23; or
- the date the student is no longer disabled.

If the student does not return to full-time student status, regardless of the reason, the student may exercise his or her right to continue

coverage under the COBRA provisions of the Health Plan (described beginning on page 30). However, to the extent permitted by law, the extended coverage period will run concurrently with COBRA. This means that, for example, if the student receives one year of extended coverage and, after the end of the one-year period the student is not eligible for Plan coverage for any reason, he or she can only elect to continue coverage under COBRA for up to 24 months instead of 36 months.

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 and your dependents' eligibility will end. However, coverage for you and your dependents 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 and dental 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 16 and 20). 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 30. 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 30, 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 for you and your eligible dependents 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, except for the Income Protection Benefit, 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. If you work enough hours to qualify as a full-time employee, your coverage will be extended for up to six months following your date of disability.

- Family Coverage and you were working enough hours to qualify for Family Coverage, then your and your dependents' coverage will be extended for up to six months following your date of disability.

Either a new two-month or six-month extension, whichever you are eligible for above, 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 or six-month extension will apply to the same or related condition, even if you have returned to work for any period of time.

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 (FMLA). 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, to care for your seriously ill spouse, parent or

child, or for a spouse, parent or child who is notified of an impending call to active duty. You may qualify to take up to 26 weeks of unpaid leave to care for a spouse, parent, child or nearest blood relative who is recovering from an injury or illness sustained while on active duty.

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.

Certificate of Creditable Coverage

When coverage for you or any of your dependents ends, you and/or your dependents 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 the Certificate to your next plan administrator. It may decrease or eliminate any pre-existing condition limitation period under that plan.

The procedures described below are followed by the Plan in providing you with a Certificate.

Automatic Issuance of a Certificate of Creditable Coverage. The Plan will issue a Certificate of Creditable Coverage automatically as required by federal law as follows:

- **Exhaustion of Lifetime Limit.** Individuals who lose coverage due to the operation of a lifetime limit on all benefits will receive the Certificate as soon as possible after a claim is denied due to the operation of the lifetime limit.

- **COBRA Events.** Individuals who lose coverage due to a COBRA qualifying event will receive the Certificate together with the required COBRA notices.

Individuals who lose coverage due to a COBRA qualifying event and elect COBRA coverage will receive two Certificates—one upon the occurrence of the qualifying event and one upon the termination of COBRA coverage.

- **Other Terminations of Coverage.** Individuals who lose coverage but do not experience a COBRA qualifying event will receive the Certificate within a reasonable time after coverage ceases or after the expiration of any grace period for nonpayment of premiums. For example, an individual may lose coverage if coverage is suspended because of employer delinquency, even if the employee continues employment. Additionally, an individual who loses coverage upon the termination of COBRA coverage will receive the Certificate within a reasonable time after the termination of COBRA.

Requests for a Certificate of Creditable Coverage. Individuals may request a Certificate, even if the Plan previously provided one, at any time while the individual is covered under the Plan and up to 24 months after the loss of coverage. To request a Certificate, an individual may call the Benefits Fund Office at 847-384-7000, 800-621-5133 or TDD 847-384-0199. The individual may also send a written request for a Certificate to the Benefits Fund Office at United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund, 1300 Higgins Road, # 300, Park Ridge, IL 60068-0197.

Delivery of a Certificate of Creditable Coverage. The Plan will send the Certificate by first class mail. If the Certificate is addressed and mailed to the participant and the participant's spouse at the participant's last known address, then the notice requirement will be satisfied with regard to all individuals residing at that address. If a dependent's last known address is different from the participant's last known address, a separate certificate will be provided to the dependent at the dependent's last known address.

COBRA Continuation Coverage

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

You may elect to continue coverage for Medical Benefits only or for Medical, Dental and Vision Benefits. Life Insurance, Accidental Death and Dismemberment, and Income Protection Benefits cannot be continued.

Qualifying for COBRA

To qualify for COBRA coverage, you or your eligible dependent must experience a qualifying event.

A qualifying event for you is:

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

For an eligible dependent, a qualifying event may be:

- your death;
- a reduction in the number of hours you work;
- termination of your employment (including retirement) for any reason other than gross misconduct;
- your divorce or legal separation;
- your entitlement to Medicare; or
- the loss of dependent status as explained on page 24.

If you or your eligible dependent have a qualifying event, you need to notify the Benefits Fund Office in writing within 60 days. Notice procedures are found beginning on page 33.

If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA coverage is in effect, you may add this child to your coverage if you were eligible for Dependent Coverage when you elected COBRA coverage. You must submit an original, certified birth certificate issued by the appropriate governmental agency. In the case of adoption, you must submit legal documentation indicating the initiation and/or finalization of the adoption process.

If you get married while your COBRA coverage is in effect, you may add your spouse to your coverage if you were eligible for Dependent Coverage when you elected COBRA coverage. A copy of your marriage license may be required by the Benefits Fund Office.

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.

COBRA coverage will continue for a maximum period of 36 months if the qualifying event is:

- your death;
- divorce or legal separation;
- your entitlement to Medicare; or
- the loss of dependent status.

Extension of Coverage Period for a Second Qualifying Event

If your family experiences a second qualifying event while receiving 18 months of COBRA coverage because of a reduction in the number of hours you work or termination of employment, your eligible dependents can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Benefits Fund Office.

This extension is available to your eligible dependents if one of the following events occurs and would have caused the eligible dependent to lose coverage under the Plan if the first qualifying event had not occurred:

- your death;
- divorce or legal separation;
- your entitlement to Medicare; or
- the loss of dependent status.

Coverage for Disabled Individuals

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

Note: If you or your eligible dependent 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.

The Benefits Fund Office has the capability to collect your monthly COBRA payment directly from your bank account through electronic transfer. You may wish to consider this option. Don't let a late or lost COBRA check jeopardize your coverage.

Contact the Billing Department at the Benefits Fund Office to request the "Authorization Agreement for Electronic Transfer of Payments for COBRA." Or, you can download and print the form from our website at ufcwmidwest.org on the "Forms" page.

COBRA Notice Procedures

General Notice of Continuation Coverage. An initial general notice describing COBRA rights will be given to you (and your spouse if you are married) 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. If, on the basis of the most recent information available to the Benefits Fund Office, you and your spouse reside at the same location, and your spouse becomes covered under the Plan on or after the date you become covered (but not later than the date on which the notice required by this section is required to be provided to the participant), the Benefits Fund Office may mail you and your spouse a single notice or SPD.

Notice of Qualifying Events. If the qualifying event that occurs is the termination of employment or reduction of hours of employment, your death or entitlement to Medicare benefits, the employer must notify the Benefits Fund Office of the qualifying event. However, you or another family member 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.

If you or your eligible dependent have a qualifying event or second qualifying event that is a divorce or legal separation or a dependent child's loss of eligibility for coverage as a dependent, you need to notify the Benefits Fund Office in writing within 60 days. You may be asked to provide verification in the form of a copy of your divorce decree, certified copy of your marriage certificate, etc. You or your eligible dependent will be ineligible for COBRA coverage or extended COBRA coverage (in the case of a second qualifying event) if you or your dependent fail to timely notify the Benefits Fund Office.

You must promptly notify the Benefits Fund Office if you and your spouse become divorced. If you fail to do so and your former spouse continues to claim or receive benefits under the Plan, you and your spouse can be subject to loss of benefits, lawsuits and criminal charges. In addition, it is your responsibility to understand your marital status and to inform the Benefits Fund Office when a qualifying event has occurred.

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 and qualified beneficiaries,
- 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 or your eligible dependent 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.

If, on the basis of the most recent information available to the Benefits Fund Office, you and your spouse reside at the same location, the Benefits Fund Office may provide a single notice addressed to both you and your spouse.

The Benefits Fund Office may provide notice to a dependent child by furnishing a single notice to you or your spouse if, on the basis of the most recent information available, the dependent child resides at the same location as the parent to whom the notice is provided.

Notice of Unavailability of COBRA Coverage. If the Benefits Fund Office receives notice of a qualifying event, determination of disability by the Social Security Administration or second qualifying event and determines that the individual is not entitled to continuation coverage under COBRA, the Benefits Fund Office will give the individual an explanation of why he or she is 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 each qualified beneficiary 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 family's rights, you should keep the Benefits Fund Office informed of any changes to the addresses of family members.

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 and your family.

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 or an eligible dependent 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. If you do not pre-certify expenses for obesity surgery, the Plan will not cover the expenses.

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.

Obesity Surgery. Before incurring expenses for surgical treatment of obesity, contact Health Information Services for approval. If certain conditions are not met (see page 45) and if the expense is not approved, it will not be considered medically necessary and the Plan will not cover it.

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 (or within 48 hours of an emergency admission), 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 obesity surgery, 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 and your eligible dependents 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 and physician.

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 and your family 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 41.

Lifetime Maximum Benefit

Total payment for all covered expenses incurred during a covered individual's lifetime is limited to $1,000,000. Lifetime refers to a covered individual's duration of coverage under the Plan.

Annual Deductible

For most covered medical expenses, you must pay the first $250 of covered expenses per person each calendar year before the Plan begins to pay benefits. This is called the Annual Deductible.

The family Annual Deductible is $750. When three family members have satisfied their own $250 Annual Deductible, no further Annual Deductible will be required from your family for the remainder of the calendar year.

Once you have satisfied the $250 Annual Deductible or the $750 family 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 44.

Non-PPO Hospital Deductible

If you or your dependents 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 or your dependents 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 or your dependents 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 or your dependents have advanced diagnostic testing (see page 37) 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 for each covered person 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 fee (see page 81);
- 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 and your dependents. 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 38 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 81) 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

A pre-existing condition is a sickness, injury, disease, or other condition (except pregnancy) that was diagnosed or treated by a physician during the 180 days immediately preceding the enrollment date. The enrollment date is the earlier of the date coverage starts or a waiting period starts (generally, a waiting period starts on an employee-member's date of hire).

If you or an eligible dependent have a pre-existing condition, benefits for that condition will be paid at 50%, up to a maximum of $5,000, until the earlier of:

- 180 days have elapsed during which no care or treatment has been provided for that pre-existing condition; or
- 12 consecutive months have passed since the enrollment date.

This limitation does not apply to a newborn or newly-adopted child who becomes covered under the Plan within 30 days of birth or adoption.

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 other health coverage, without experiencing a break in coverage of 63 consecutive days, 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. For any assistance, contact the Benefits Fund Office at 800-621-5133, TDD 847-384-0199. You may also send a written request for assistance to the Fund Administrator at United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund, 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-0197.

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 and/or newborn child 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. Benefits for rental of durable medical equipment cannot exceed the purchase price, as determined by the Trustees.

    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 36).

13. Orthopedic or prosthetic appliances. The Plan will pay for the initial appliance, and after 5 years, one replacement for each 5 years of continuous use. 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 36). 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 person 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.

18. Occupational therapy. Benefits are limited to $2,500 per calendar year.

19. Speech therapy. Benefits are limited to $2,500 per calendar year.

20. Cardiac rehabilitation. Benefits are limited to $1,000 per event.

21. 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.

22. Varicose vein treatment. Benefits are limited to a lifetime maximum of $2,500 per leg, except for ulcerated conditions.

23. 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.

24. Dental treatment due to accidental injury to sound and natural teeth within one year from the date of the accident.

25. Voice communication machines. The Plan pays up to a $7,500 per person, lifetime maximum.

Other Covered Medical Expenses

The following services are also covered 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.

Well-Child Care. Your dependent children under age two are eligible for benefits up to a lifetime maximum of $500 per child for the following:

- Outpatient newborn and well-child physician office visits.
- Routine childhood immunizations.

Preventive Care for You and Your Spouse. You and your dependent spouse are eligible for benefits up to $50 each calendar year for the following:

- A routine physical exam.
- A PAP test (every three calendar years, an HPV 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.

Expenses in excess of $50 are payable at 80% after the Annual Deductible.

Seasonal Flu Shot for You and Your Spouse. You and your dependent spouse are each eligible for benefits up to $15 per calendar year for a seasonal flu shot.

These coverages are subject to the Annual Deductible:

Bone Density Scan. Benefits are payable for you and your dependent spouse once every four calendar years if the patient is age 45 or older.

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

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

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

Combined Inpatient and Outpatient Maximum	$5,000 lifetime maximum per person

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 Act. Benefits are payable at 50% up to $5,000 per event for the care and treatment of a self-inflicted injury (except for suicide or attempted suicide) or other intentionally destructive acts that are not attributable to a medical condition (including both physical and mental health conditions) or to an act of domestic violence.

Hospital Charges for Dental Surgery. Benefits are payable at 50% up to $5,000 per event for hospital charges for covered dental surgery. To be covered, the charges must be pre-certified by Health Information Services. Other charges, including professional fees of any kind for dental care, anesthesia, diagnosis, treatment or supplies, are not covered under the Comprehensive Medical Expense Benefit. Such charges may be covered under the Dental Benefit.

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

Covered charges include the following hearing expenses:

- An otologic examination performed by a physician.
- An audiologic examination performed by a physician or a licensed audiologist.
- 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 36). 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 or a dependent 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 when 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 46).
- Skin removal surgery for any reason.
- Immunizations, except as specified under Well-Child Care.
- 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, a covered family member 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, eyeglasses 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 64.

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 informedRx Customer Service at 888-354-0090.

Participating Pharmacy Program

The Prescription Drug Benefit is managed by informedRx, 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 informedRx Customer Service at 888-354-0090.

Annual Maximum Benefit

Total payment for covered prescription drug expenses is limited to $14,000 per person 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 informedRx Customer Service at 888-354-0090 for information on which drugs currently require pre-approval and how to obtain the pre-approval.

Generic Equivalents and Brand-Name Drugs

If you or your eligible dependent 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 informedRx Customer Service at 888-354-0090 for updated information on which drugs are preferred drugs.

Covered 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 informedRx 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
non-preferred generic drugs	$15

(chart continues on following page)

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)	Co-Payment
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
non-preferred 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 informedRx 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.
- Erectile dysfunction drugs in excess of six tablets per 30 days.
- 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.

Creditable Coverage Under Medicare

The prescription drug benefit provided by the Health Plan has been determined to be "creditable coverage" under Medicare. This means that if you are eligible for Medicare, you may defer electing Medicare Part D Prescription Drug Coverage while you remain covered under the Plan and you will not be penalized if you then elect it at a later date. For more detailed information, refer to Appendix C: Prescription Drug Creditable Coverage—Medicare Part D beginning on page 100.

Vision Benefit

Vision Benefits help you pay for the cost of medically necessary eye examinations, frames and lenses for you and your eligible dependents. You must use a licensed ophthalmologist, optometrist or optician to receive benefits under the Plan.

Covered Vision Expenses

Your Vision Benefit covers examinations, lenses and frames, or contact lenses, and is simple to use. The Plan pays 100% of the covered charges, up to a maximum benefit of $135 per person per calendar year.

What is Not Covered

The following expenses are not covered:

- Lenses which do not require a prescription.
- Vision therapy.
- Procedures for surgical correction of myopia and/or other refractive errors.
- Anything excluded under the General Exclusions and Limitations listed beginning on page 64.

Dental Benefit

Your dental coverage pays a portion of the cost of covered dental services for you and your eligible dependents. The Plan pays only for services that are provided by a licensed dentist or dental hygienist, including any required supplies. Payment for covered dental expenses is limited to the scheduled amount.

How the Plan Pays Benefits

You pay a $50 deductible per calendar year. The deductible does not apply to diagnostic and preventive services, which are described below.

The Plan pays 100% of the remaining expense for covered dental expenses, but only up to the maximum amount shown in the Schedule of Dental Procedures.

Covered Dental Expenses

The following services and supplies are covered under the Dental Benefit.

Diagnostic and Preventive Services

- Oral examination, if performed by a dentist
- Prophylaxis (teeth cleaning), if performed by a dentist or dental hygienist; limited to twice per calendar year
- Necessary x-rays—complete series, including bitewings, limited to once per calendar year; panoramic limited to once every 2 calendar years
- Fluoride treatments
- Sealants

Other Services

- Tooth extractions
- Amalgam and resin-based composite filling restorations for decaying or broken teeth
- Onlays and crowns
- Space maintainers
- Oral surgery, including extractions and surgical procedures
- Periodontal treatment (treatment of the gums and bones), including, but not limited to, periodontal scaling and periodontal maintenance procedures
- Endodontic treatment, including root canal therapy
- Initial fitting and replacement of complete and partial dentures and bridges; replacements will be payable once every five years

Orthodontic Benefit

Covered orthodontic expenses are payable at 50% up to the lifetime maximum benefit of $1,000.

Temporomandibular Joint Disorders (TMJ). The following services and supplies for treatment of TMJ are covered expenses payable under the Orthodontic Benefit:

- occlusal splints
- orthopedic repositioners
- panoramic radiographs
- tomogram x-rays
- cephalometric x-rays
- occlusal equilibration
- Magnetic Resonance Imaging
- temporomandibular joint x-rays
- injection of Xylocaine, alcohol, Benadryl, saline solutions or Cortisone
- hydrostatic appliance
- occlusal guards
- diagnostic casts
- facebow transfer
- arthrocentesis
- hinge axis mounting
- CT scans

Alternate Procedures

In some cases, there is more than one way to treat a dental problem. Your Plan will pay benefits based on the procedure that will provide a professionally acceptable result as determined by national standards of dental care, in a cost-effective manner.

Pre-Treatment Estimate

Whenever you expect that your dental expenses for a course of treatment will be more than $500, you may use the pre-treatment estimate procedure. You and your dentist should complete the regular dental claim form, available from the Benefits Fund Office, indicating the type of work to be performed with the estimated cost. Once it is received, the form will be reviewed and you and your dentist will be sent a statement showing what the Plan will pay. This procedure lets you know how much you will have to pay before you begin treatment.

What is Not Covered

Expenses not covered under the Dental Benefit include the following:

- Services or supplies provided or paid for by any other employer's medical or dental coverage, mutual benefits association, labor union or similar organization under provisions governing the coordination of benefits.
- Cosmetic treatment.
- Replacement of a lost or stolen appliance.
- Customization of a dental prosthesis, including personalized, elaborate, or precision attachment dentures or bridges or specialized techniques, unless the prosthesis cannot be made to function without the specialized technique.
- Periodontal scaling procedures on patients not manifesting Case Type II, III or IV periodontal disease.
- Complete series (including bitewings) of x-rays more often than once each calendar year.
- Panoramic x-rays taken in the same calendar year when complete series x-rays are taken.
- Panoramic x-rays more often than once every two calendar years unless made necessary by a change in dentists.
- Prophylaxis treatments are limited to a maximum of four per calendar year, as follows: up to two can be dental prophylaxis (ADA codes 1110/1120); up to four can be periodontal prophylaxis (ADA code 4910) provided that they are performed as adjunctive periodontal treatment rendered with respect to active periodontal treatment.
- Temporary bridgework and temporary crowns except when a temporary crown is needed due to a fractured tooth.
- Anything excluded under the General Exclusions and Limitations listed beginning on page 64.

Schedule of Dental Benefits

Dental benefits are paid according to a Schedule of Benefits. The table below lists some of the procedures performed most often, including the American Dental Association (ADA) Code and the benefit payment. If a procedure is not listed, you or your dentist may contact the Benefits Fund Office to find out the most the Plan will pay for that procedure.

ADA Code	Description	Maximum Payment
0120	Periodic oral exam	$ 34
0210	Intraoral—complete series (including bitewings)	$ 88
0272	Bitewings—two films	$ 30
0274	Bitewings—four films	$ 45
1110	Prophylaxis—adult (twice each year)	$ 65
1120	Prophylaxis—child (twice each year)	$ 51
1203	Topical fluoride application	$ 26
2140	Amalgam—1 surface, permanent	$ 45
2150	Amalgam—2 surfaces, permanent	$ 57
2160	Amalgam—3 surfaces, permanent	$ 67
2161	Amalgam—4 or more surfaces, permanent	$ 78
2330	Resin—1 surface	$ 55
2331	Resin—2 surfaces	$ 67
2332	Resin—3 surfaces	$ 81
2335	Resin—4 or more surfaces or incisal angle	$ 90
3320	Bicuspid root canal (excludes final restoration)	$316
3330	Molar root canal (excludes final restoration)	$429
4341	Periodontal scaling/root planning—per quadrant	$ 90
4910	Periodontal maintenance prophylaxis	$ 56
5110	Complete upper denture	$367
5120	Complete lower denture	$367
5211	Upper partial—resin base	$367
5212	Lower partial—resin base	$367
5213	Upper partial—cast framework, resin base	$424
5214	Lower partial—cast framework, resin base	$424

Income Protection Benefit

This benefit provides you with a basic level of income if you become disabled and cannot work at any occupation because of a non-occupational injury or illness. Disability benefits are payable only to active, eligible employee-members.

Benefit Amount

The Plan pays 55% of your weekly earnings, up to $250 per week for up to a maximum period of 26 weeks for each period of non-occupational illness or injury. Benefits start on the:

- 1st day of an accident
- 1st day of hospitalization
- 1st day of outpatient surgery
- 8th consecutive day of sickness

While you are disabled, your coverage may be continued under an automatic extension of coverage; see page 27 for details.

When your coverage otherwise ends, you may elect to continue coverage by making self-payments under COBRA; a description of COBRA Continuation Coverage begins on page 30.

Successive Periods of Disability

Successive periods of disability due to the same or related causes are considered one period of disability, unless separated by a return to active, full-time work for four consecutive weeks. Successive periods of disability due to entirely different and unrelated causes are considered one period of disability, unless separated by at least one day of active, full-time work.

What is Not Covered

Benefits are limited to one 26-week period for disability due to any one injury and two 26-week periods for disability due to a single or related illness/injury.

Benefits are not payable for:

- Any period of disability during which you are not under the regular care of a physician; telephone consultations are not considered regular care of a physician.
- Any disability resulting from a loss, problem, complaint, pain or ailment which did not arise from an objectively determined and documented medical impairment.
- Any period of disability for which you receive pay from your employer.
- Anything excluded under the General Exclusions and Limitations listed beginning on page 64.

Life Insurance Benefit

Your Life Insurance Benefit helps to protect your family from a sudden loss of income in the event of your death. If you die from any cause while you are an eligible active employee, the Life Insurance Benefit will be paid in a lump sum to your beneficiary.

Certificate and Description

This is an explanation of the Health Plan's life insurance policy and is your certificate while you are insured. The policy is issued by Fort Dearborn Life Insurance Company and is on file at the Benefits Fund Office. All provisions described are determined pursuant to the provisions, definitions, exceptions and reductions of the insurance policy. In the event of a discrepancy between this description and the policy, the terms of the policy shall control.

Benefit Amount

For you, the employee-member	$15,000

For dependents of employee-member with Family Coverage	
spouse	$2,500
child, age 1 year to 18 years	$2,500
child, age 15 days to 1 year	$100

Naming a Beneficiary and Payment of Benefit

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time. To name a beneficiary or to change your beneficiary, complete a "Designation of Beneficiary for Life Insurance Benefit" form (available from the Benefits Fund Office) and return it to the Benefits Fund Office. The designation or change will be effective when the completed form is received at the Benefits Fund Office

If you do not designate a beneficiary, or if your designated beneficiary is not living at the time of your death, the Life Insurance Benefit will be paid to your estate, or at the option of the insurance company, to your surviving spouse or if not surviving, in equal shares to your surviving children, or if none survive, to your parents equally or the survivor, or if neither survives, in equal shares to your brothers and sisters who survive you.

The Trustees have the right to pay benefits to any organization or person as needed to properly carry out the provisions of the Plan. Those payments that are made in good faith are considered benefits paid under the Plan.

Filing a Claim

Upon notification that your death has occurred, the Benefits Fund Office will send the proper forms to your beneficiary, estate administrator or survivor. Benefits cannot be paid until a completed claim form has been received by the Benefits Fund Office.

Coverage During Disability

If you become totally and permanently disabled before age 65, your life insurance coverage will continue at no cost to you, provided you remain totally and permanently disabled until your death. Coverage extended during your disability is reduced to $2,000 when you reach age 65.

For the purpose of this benefit, totally and permanently disabled means that, due solely to an illness or injury you are prevented from engaging in any business, occupation or employment for wages or profit.

To apply for continued life insurance coverage due to a total and permanent disability, contact the Benefits Fund Office after you have been disabled for a period of nine consecutive months, but not later than one year from the date your disability started. You will be required to complete the appropriate forms and provide proof of your disability. You may also be required to take a physical exam at the insurance company's request. You will be contacted yearly for updated medical information verifying your disability.

Conversion to an Individual Policy

When you are no longer eligible for the Life Insurance Benefit, you may change part or all of your life insurance coverage under the Plan to a personal life insurance policy. You do not need to pass a medical examination to qualify.

If you have been insured under the Life Insurance Benefit for at least 5 years when it ends, you may change your Life Insurance Benefit amount to the smaller of:

- the amount of your insurance under the Plan when it ended less any amount for which you become eligible under any other group life policy within 31 days; or
- $5,000.

To receive your individual policy you must:

- apply for it in writing; and
- make your first premium payment within 31 days after the date your Plan Life Insurance Benefit ends.

You do not need to provide evidence of insurability or evidence of your good health. You may contact the Benefits Fund Office for conversion application forms.

The individual policy that is issued may be of any type customarily being offered by the insurance company, except term insurance. The policy will not include disability or other supplementary benefits. The premium is based on the current rate used by the insurance company according to the type and amount of the policy and your age on the date the policy is issued. The individual policy will be effective on the 32nd day following the date your group insurance ended.

Written notice of your conversion privilege will be given to you or mailed to your last known address. If you are not given written notice of your conversion privilege at least 15 days before the end of the 31-day conversion period, you will have:

- 15 days after the date notice is given to you; or
- 91 days after your life insurance coverage ends

to make your application.

If you die within 31 days after your Life Insurance Benefit coverage ends, we will pay the amount that could have been converted.

Accidental Death & Dismemberment (AD&D) Benefit

AD&D benefits are payable if you sustain an accidental injury resulting in the loss of your life, a limb, or your eyesight within 90 days after the accident.

Benefit Amount

If you suffer more than one of the losses listed below in any one accident, payment will be made only for the loss for which the largest amount is payable. Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint, respectively. Loss of sight means the total and irrecoverable loss of sight.

Type of Loss	Benefit Amount
Life	$7,500
Both hands or both feet or sight of both eyes	$7,500
One hand and one foot	$7,500
One hand and the sight of one eye	$7,500
One foot and the sight of one eye	$7,500
One hand or one foot	$3,750
Sight of one eye	$3,750

Who Receives Benefits

Benefits for loss of your life are payable to your Life Insurance Benefit beneficiary (see page 60). Benefits for any other loss are payable to you.

Filing a Claim

Upon notification that your death or dismemberment has occurred, the Benefits Fund Office will send the proper forms for completion. Benefits cannot be paid until a completed claim form has been received by the Benefits Fund Office.

What is Not Covered

No benefit is payable under the AD&D benefit if death or any loss is caused directly or indirectly by:

- Bodily or mental illness, infirmity or disease of any kind.
- Ptomaine or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound) or hernia.
- Suicide or intentional self-destruction or self-inflicted injury.
- Participation in the commission of a felony.
- War or an act of war.
- Operating or riding in any aircraft, except:
  - ✓ as a passenger in a commercial aircraft that is on a regularly scheduled passenger flight;
  - ✓ as a passenger or pilot of a chartered flight;
  - ✓ as a passenger or pilot of a licensed aircraft operated by a licensed pilot, including student licensees.

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, except in the case of Life and AD&D benefits.
- 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 a 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 fee (see page 81).
- 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 or your eligible dependent are legally required to pay;
  - ✓ is not recommended and approved by a legally-qualified physician or surgeon;
  - ✓ is not medically necessary (see page 80)
  - ✓ is experimental or investigational in nature;
  - ✓ exceeds the Usual and Customary fee (see page 81);
  - ✓ 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 45.
- 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 as provided under the Dental Benefit, and 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 or your eligible dependent 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 or your dependents).

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 86.

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 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 and any adult dependents 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. Benefits for loss of life are payable to your beneficiary if surviving you, otherwise to your estate. All other benefits are payable to you.

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 behalf of you and your eligible dependents 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 or an eligible dependent is 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 trusteed 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.

- When the person is a dependent of parents who are not separated or divorced and both parents have medical coverage for their eligible dependent children, the plan of the parent whose birthday comes earlier in the calendar year will be considered the primary plan. If both parents' birthdays are on the same day, the plan covering the parent for the longer period of time will be primary. If one plan uses the male/female rule and the other plan uses the birthday rule, the plan using the male/female rule pays first.

- If the parents are separated or divorced, their plans will pay medical benefits for eligible dependents as follows:

  ✓ if no court decree exists and the parent with custody has not remarried, the plan of the parent with custody is primary.

  ✓ if the parents have joint custody and the divorce decree does not specify that one parent has responsibility for coverage, the birthday rule applies.

  ✓ if no court decree exists and the parent with custody remarries, the plan of the parent with custody pays first, the plan of the spouse of the custodial parent pays second, and the plan of the parent without custody pays last.

  ✓ if a court order states that one of the parents is responsible for the child's health care expenses, the health plan covering that parent is primary, provided the plan has knowledge of the court decree.

- 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 a person is covered by a plan as a non-dependent and that other plan provides that the customary coordination of benefits rules for health insurance are inapplicable or a reduced level of coverage is applicable because the person in question is covered as a dependent under this Plan, then this Plan shall coordinate benefits as if the other plan had paid based upon the customary coordination of benefits rules for health insurance and the other plan's regular plan of benefits that would have applied to the individual but for the reduction in benefits due to coverage under this Plan. If the Plan cannot disregard the other plan's rule that seeks to avoid the result under customary coordination of benefits rules for health insurance and/or that seeks to apply a reduced level of benefits because of the individual's coverage as a dependent under this Plan, then this Plan will limit such individual's coverage under this Plan to a maximum benefit for claims incurred in a calendar year to $1,000 per calendar year.

- 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 or your eligible dependent 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 or your eligible dependent are covered under an HMO or clinic which provides necessary treatment without charge, you or your eligible dependent 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.

Working Spouse Rule

Your working spouse must elect employer-sponsored health coverage if available. Effective January 1, 2007, the Plan limits coverage for your spouse to expenses which would have been payable had your spouse elected employer-sponsored health coverage. This means that if your spouse does not elect employer-sponsored health coverage, you could be responsible for a large portion of any expenses incurred by your spouse.

If your spouse does not elect employer-sponsored health coverage, the Plan cannot accurately identify what the spouse's coverage would have paid. The Plan will therefore pay 50% of covered expenses.

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 or your eligible dependent are age 65 or older and covered by this Plan due to your current employment status;
- you or your eligible dependent 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 or your eligible dependent 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 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 a Plan participant as well as his or her parent(s) and dependent(s), including minor dependents, or their legal representatives, guardians or trustees. The Plan's right to seek repayment is often called the right of subrogation. You may be required to sign a subrogation agreement with the Plan if a third party may be responsible for your injury, illness, etc.

The Plan has the right to recover from any source of recovery, including but not limited to any third party or its insurer, and the right to recover for any claim covered by workers' compensation or occupational disease laws. The Plan has the right to recover from any insurance policy or plan 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. The Plan has the right to be reimbursed immediately from proceeds obtained by settlement of a lawsuit, by judgement, or from any other recovery. 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. Any recovery must be held in trust by you until the Plan's subrogation and reimbursement rights are satisfied. The Plan's subrogation and reimbursement claim is equal to the benefits it has paid or may be obligated to pay for an injury, accident, etc. 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, 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 for you and your dependents by the Plan until full compliance with the Plan's subrogation provision is achieved and any reimbursement owed to the Plan is made. The Plan may also pursue legal and equitable claims (e.g., imposing constructive trust) to enforce its rights.

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 and/or his or her family members participating in the Plan. 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 for the Participant and covered family members.

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 86.

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;
- 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, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan 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 and your eligible dependents 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, or the inability of an eligible dependent to perform the normal activities or duties of a person of the same age and sex. To be considered totally disabled, a person 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.

Eligible Dependent. See page 24.

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.
- 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.

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 Chiropody 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 Plan.

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 Fund" 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 Fee. For treatment in the geographic area served by the PPO, the negotiated discounted fee amounts are the usual and customary fees. For treatment outside the area served by the PPO, the usual and customary fee is determined based on the average charge made by the majority of providers located within the geographic area. For durable medical equipment and for home health care, the usual and customary fee is the charge negotiated between the Plan and providers who have agreed in writing to provide the equipment or services. For certain surgeries when performed at a non-PPO facility and for the purchase price for certain medical equipment, the usual and customary fee is a Plan-limited allowance.

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.

Identification of Insurance Companies. Life Insurance and Accidental Death and Dismemberment benefits are provided under group insurance policies issued by Fort Dearborn Life Insurance Company.

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 life, disability, medical, prescription drug, vision and dental benefits in the event of death, accident or illness. The Plan benefits are summarized in the Summary of Benefits beginning on page 8.

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 11.

Claim Procedure. The procedure to follow for filing a claim for benefits is summarized beginning on page 68. If all or any part of your claim is denied, you may appeal that decision within one year (see page 76). See Appendix A beginning on page 86 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 medical, dental, prescription drug and income protection benefits provided under the Plan. The life and accidental death and dismemberment benefits are currently insured by Fort Dearborn Life Insurance Company, 1020 31st Street, Downers Grove, Illinois 60515-5591.

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, Dental, Vision, Prescription Drug, Income Protection, Life Insurance, and Accidental Death & Dismemberment Claims

This document provides covered persons and their 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 claimant for each type of coverage as follows:

- Health Claim—a new claim form is required at least once per year and when a claimant is advised that additional information is needed to process the claim.
- Dental Claim—a UFCW claim form or standard American Dental Association claim form is required for each claim.
- Vision Claim—a UFCW claim form or an optician's form providing the same information is required for each claim. If routine vision care is provided by a BlueCross BlueShield Participating Provider Option (PPO) ophthalmologist, the claim may be submitted electronically through the BlueCross BlueShield system.
- Income Protection Claim (weekly disability)—a UFCW claim form is required initially and periodically during the disability, in most cases every three weeks.
- Life Insurance Claim—death claims are generally reported by telephone and then a UFCW claim form is sent out for completion.
- Accidental Death and Dismemberment Claim—same as above for a Life Insurance claim.
- Prescription Drug Benefit Direct Reimbursement Claim—no claim form is required when a valid prescription drug ID card is used at an informedRx participating pharmacy (see page 49). If a prescription drug is obtained from any other pharmacy, a Direct Reimbursement Claim Form should be submitted.

A claimant may appoint an Authorized Representative to act on his or her behalf (see pages 79 and 92).

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. Claims for Dental, Vision, Income Protection, Life Insurance, AD&D, and 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 informedRx 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 patient's name and relationship to the participant, 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 the patient 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.

Income Protection Claim (Weekly Disability). A claim for Income Protection will be adjudicated within 45 days. This time limit may be extended for up to two 30-day periods if the Fund Administrator determines that an extension is needed due to matters beyond the Fund's control. 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. If additional information is requested, the claimant has 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.

If your claim is denied, you will be given a written explanation, as described on page 76.

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 or spouse
- the covered dependent (correspondence will be directed to the 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.

Income Protection Claim Appeals (Weekly Disability). All Income Protection Claim 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 Appeals 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.

Reviews will include examination of the claim material by qualified medical experts, when appropriate.

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 non-claimant 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 Plan (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 Creditable Coverage—Medicare Part D

The options you have under Medicare Prescription Drug Coverage Part D are explained here. If you defer enrollment in Part D, you will need this notice in order to avoid paying a higher premium.

Medicare Prescription Drug Coverage

Medicare Prescription Drug Coverage is available to anyone entitled to Medicare. 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 Plan (like an HMO or PPO) or Medicare Prescription Drug Plans. Most people must pay a monthly premium for Medicare Prescription Drug Coverage. For people with limited income and resources, extra help paying for Medicare Prescription Drug Coverage is available.

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

If you are entitled to Medicare Part A or enrolled in Medicare Part B, you can enroll in Medicare Prescription Drug Coverage when you first become eligible for Medicare and each year from November 15 through December 31. If you lose or drop prescription drug coverage under the UFCW Health Benefits Plan, you may be eligible for a Special Enrollment Period to sign up for Medicare Prescription Drug Coverage. You can find out more detailed information about Special Enrollment Periods in the "Medicare & You" booklet.

Existing Coverage is as Good as Standard Medicare Prescription Drug Coverage

The Health Benefits Plan has determined that your existing, active Plan prescription drug benefits are "creditable coverage." This means the Health Benefits Plan's coverage is expected to pay, on average, as much in claims for all eligible participants (or more in some cases) as standard Medicare Prescription Drug Coverage.

Because your current prescription drug benefits with the Health Benefits Plan are "creditable prescription drug coverage" under Medicare, you can stay covered under the Health Benefits Plan and join a Medicare plan later and not be subject to the higher premium penalty. You will need a copy of this notice if you defer enrollment in Medicare Prescription Drug Coverage; this notice verifies that you have creditable prescription drug coverage and that you are not required to pay the higher premium.

Your Choices and the Consequences

If you are eligible for Medicare, you should compare your current 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 Benefits Plan, as long as you are otherwise eligible to continue Plan coverage. Remember that the Health Benefits 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, your coverage under the Health Benefits Plan will be coordinated with your Medicare Prescription Drug Coverage. Remember that for most people, there is a monthly premium for Medicare Prescription Drug Coverage.

If you are entitled to Medicare and drop or lose your coverage with the Health Benefits Plan and do not enroll for Medicare Prescription Drug Coverage after your current coverage ends, you may pay more for Medicare Prescription Drug Coverage later. 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 at least 1% per month for every month that you were eligible but did not have coverage. You will have to pay this higher premium as long as you have Medicare Prescription Drug Coverage. For example, if you go 19 months without coverage, your monthly premium will always be at least 19% higher than what most other people pay. In addition, you may have to wait until the next open enrollment period (November 15–December 31 each year) to enroll.

For More Information about Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer Prescription Drug Coverage is available in the "Medicare & You" handbook. You may also receive information directly from Medicare Prescription Drug Plans.

To get more information, you can:

- Visit medicare.gov.
- 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, extra 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.
- 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 single or family coverage under the Health Benefits Plan.

- **Change in Number of Dependents.** You gain or lose dependents due to marriage, divorce, legal separation, annulment, death, birth, adoption and placement for adoption.

- **Change in a Dependent's Status.** Your dependent newly satisfies or ceases to satisfy eligibility requirements (for example, attaining age 19 or gaining or losing full-time student status).

- **Court-Ordered Coverage.** This refers to a judgement, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order, which requires you to enroll your dependent child in the Health Benefits Plan. You may not drop coverage unless coverage is actually provided under another individual's plan.

- **Entitlement to Medicare or Medicaid or Loss of Entitlement.** You or a dependent 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 or a dependent's 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 or your dependent have a plan with different enrollment periods.

- **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 a new dependent or 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.