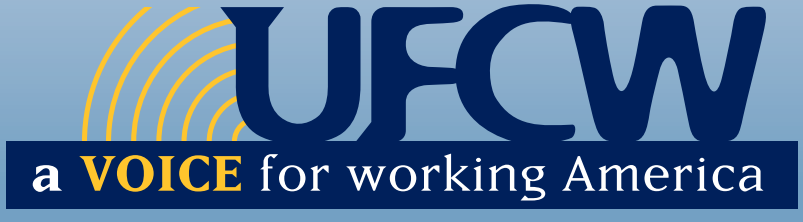
United Food and Commercial Workers
Unions and Employers
Midwest Health Benefits Fund

SUMMARY PLAN DESCRIPTION

December 1, 2020 Edition



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

Summary Plan Description

Effective December 1, 2020

Dear Participant:

The Board of Trustees is pleased to provide this Summary Plan Description booklet, which describes the benefits available through the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund. This booklet replaces any booklets that were previously issued. Please read this booklet in its entirety 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 pages 27 and 28 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 BlueCross BlueShield of Illinois. 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, toll free at 800-621-5133.

The Board of Trustees

United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
2625 Butterfield Rd, Suite 208E
Oak Brook, IL 60523
ufcwmidwest.org

Important Information

You Must Elect Coverage and Authorize Payroll Deduction

You must elect whether or not to participate in the Health Plan under certain Plan Classifications. If a Coverage Election is required for coverage under your Plan Classification and you do not elect to participate, you will not be covered the following year. See pages 1 and 2 for 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 Penalty 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). Pre-certification is required for Hospital stays beyond 48 hours for a vaginal delivery and 96 hours for a caesarian section	Any time during pregnancy (must be before admission)
Inpatient or out-patient surgery	Two weeks before you are scheduled for surgery

Advanced diagnostic testing, Skilled nursing facility care, rehabilitation therapy, home health care, hospice care, and durable medical equipment	Before care or before purchase or rental of equipment

Call ActiveHealth Management to request pre-certification at 855-210-8738.

When you contact ActiveHealth Management, you will generally need to supply:

1. Your full name and UFCW ID number 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 21.

Second Opinion

You must obtain a Second Opinion before undergoing certain surgeries. A list of these surgeries begins on page 24. Contact ActiveHealth Management 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 of Illinois participating Hospitals. This arrangement helps you save money on your out-of-pocket costs for health care and reduces the Health Plan's costs.

See pages 27 and 28 for further information and for how to locate a PPO provider.

Claims Administrator(s)

The Fund Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Zenith American Solutions 2625 Butterfield Rd. Suite 208E Oak Brook, IL 60523 800-621-5133 or 312-649-1200 zenith-american.com	• Medical Pre-Service and Post-Service Claims • Mental Health/Substance Use Disorder Urgent, Concurrent, Pre-Service and Post-Service Claims • Income Protection Benefit Claims • Death Benefit Claims • Accidental Death and Dismemberment Claims • Vision Pre-Service and Post-Service Claims • Dental Pre-Service and Post-Service Claims • Hearing Post-Service Claims
ActiveHealth Management 3200 Highland Avenue Downers Grove, IL 60515 855-210-8738 activehealth.com	• Urgent, Concurrent and Pre-Service Medical Claims
WellDyneRx 500 Eagles Landing Drive Lakeland, FL 33810 888-479-2000 wellview.welldyne.com	• Pre-Service drugs • Post-Service Claims for out–of-network retail drugs

Section 1557 Nondiscrimination Notice

The United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund provides free aids and services to participants so they can communicate effectively with us about their benefits, such as:

- Qualified sign language Interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats) for people with disabilities.
- Free language services to people whose primary language is not English, such as Qualified Interpreters and information written in other languages.

If you need these services, please contact:

Joshua Todd,
Fund Administrator
2625 Butterfield Rd, Suite 208E
Oak Brook, IL 60523
Phone: (630) 974-4515
jotodd@zenith-american.com

If you believe that the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Joshua Todd
Fund Administrator
2625 Butterfield Rd, Suite 208E
Oak Brook, IL 60523
Phone: (630) 974-4515
jotodd@zenith-american.com

You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, the Fund Administrator will be available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019, (800) 537-7697(TDD)

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html

- (English) ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 800-621-5133
- (Spanish) ATENCIÓN: si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-621-5133
- (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-621-5133

- (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-621-5133
- (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電800-621-5133
- (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-621-5133
- (Serbo-Croatian) OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-621-5133
- (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-621-5133 번으로 전화해 주십시오.
- (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-621-5133
- (Arabic) 800-621-5133 كل رفاوتت ةيوغلا تادعاسملا نإف ةغلا ركذا ثدحتت تنك اذإ :ةظوحلممقرب لصتا .ناجملاب،
- (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-621-5133
- (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-621-5133
- (Pennsylvania Dutch) Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800-621-5133
- (Hindi) □ान द□: य□द आप □हदी बोलते ह □तो आपके िलए मु□ म□ भाषा सहायता सेवाएं उपल□ ह।□ 800-621-5133 पर कॉल कर□।
- (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-621-5133）まで、お電話にてご連絡ください。
- (Persian) 800-621-5133 امش یارب ناگیار تروصب ینابز تالیهست دینک یم وگتفگ یسراف نابز هب رگا،
- (Urdu) نیہ، نیہ بایتسد نیم تفم تامدخ یک ددم یک نابز وک پآ وت لاک ۔ ےتلوب ودرا پآ رگا :رادربخ 5133-621-800 رک
- (Gujarathi) □ુનો: જો તમે □જરાતી બોલતા હો, તો ન:□ુ ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 800-621-5133

- (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-621-5133
- (Dutch) AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 800-621-5133

Statement of Grandfathered Status

The UFCW Unions and Employers Midwest Health Benefits Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at UFCW Midwest Health Benefits Fund, 2625 Butterfield Rd, Suite 208E, Oak Brook, IL 60523, 800-621-5133. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Table of Contents

Election of Coverage and Eligibility Provisions

You (and your dependents, if eligible under your Plan Classification), become covered:

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

All of these requirements are described in the following paragraphs.

Note: An Eligible Employee covered under Plan Classification D5-Tier B will become eligible for Plan Classification D5-Tier C while working at least 30 hours per week for a Contributing Employer that has 50 or more Employees.

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 under D5 Plan Classifications may elect any of the following levels of coverage:

- **No Coverage.** If you elect not to participate, 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 the weekly payroll deduction. 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 (For all participants, except those in Plan Classification D5-Tier B).** You may elect Family Coverage to receive health coverage and related benefits for yourself and your eligible family members and make the weekly payroll deduction. Additionally, you must work the minimum hours necessary to maintain Family Coverage.

The weekly payroll deduction set forth in your Collective Bargaining Agreement or Participation Agreement, as approved by the Trustees 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 is provided as Appendix D (see page 138).

The Benefits Fund Office or your employer will provide you with an "Election and Payroll Deduction Authorization Form" when you first become eligible for health coverage. A completed, signed form must be returned to the Benefits Fund Office in a timely manner for you and your family to have health benefits coverage. The form should be executed within 60 days of the effective date of your initial eligibility for coverage or on an annual date established by the Trustees. If you do not receive an "Election and Payroll Deduction Authorization Form," contact the Contribution Accounting Department at the Benefits Fund Office immediately.

Enrollment Periods

New Employee/Initial Enrollment. The enrollment period ends 60 days following the Health Coverage Effective Date. If you do not make an election within this time, you will not have health coverage. The next opportunity to enroll is the following 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 Contribution Accounting Department at the Benefits Fund Office during November or early December and ask for the proper forms.

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 dependent loses or gain eligibility for that other coverage (or if the employer stops contributing towards you 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 that may allow you to enroll under the Special Enrollment Period provisions begins on page 9.

To request Special Enrollment, contact the Contribution Accounting Department at the Benefits Fund Office 800-621-5133.

Initial Eligibility Requirements

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.

Eligibility for Plan coverage differs for employees who are subject to **rate-per-hour contributions** or **flat-rate contributions** made by their Contributing Employers pursuant to the applicable Collective Bargaining Agreement. In addition, coverage may differ for employees who are required to make self-contributions.

If your Contributing Employer makes a full-time monthly contribution, you are also eligible to have coverage for your Eligible Dependents and a higher level of some benefits as shown in the Schedule of Benefits. If your Contributing Employer makes a part-time monthly contribution, only you are covered and lower levels of certain benefits apply.

- An Employee subject to **rate-per-hour contributions** will be eligible for all benefit coverages (except for the Income Protection Benefit and coverage for his/her Eligible Dependents) if:
  - he/she has worked an average of at least 12 covered hours per calendar week during the calendar weeks that end in each of two full consecutive calendar months; and
  - his/her Contributing Employer has made contributions for the aforementioned two full consecutive calendar months.
- An Employee will be eligible for the **Income Protection Benefit** and coverage for his/her Eligible Dependents if:
  - he/she has worked an average of at least 12 Covered Hours per calendar week during each calendar month and an average of at least 28 Covered Hours per calendar week during the calendar weeks that end in the two of the three preceding calendar months; and
  - his/her Contributing Employer has made contributions for two of the aforementioned full consecutive calendar months.
- An Employee subject to **flat-rate contributions** will be eligible for coverage if:
  - he/she works the minimum number of covered hours within the period of time required by the applicable Collective Bargaining Agreement for either a full-time or part-time Employee; and
  - his/her Contributing Employer has made contributions for the number of covered hours within a period of time required by the Collective Bargaining Agreement.

Effective Date of Coverage for Initial Employee Eligibility

Your coverage will become effective on the first day of the calendar month following your completion of the initial eligibility requirements.

Your coverage will become effective no later than 90 days following your completion of the initial eligibility requirements. Any waiting period (i.e., the period of time between when you satisfy the initial eligibility requirements and the effective date of your coverage) set forth in a Collective Bargaining Agreement will not have the effect of delaying coverage beyond legal limits.

Your Continuing Eligibility

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

If Available Through Your Plan Classification	You Must Work these Average Covered Hours	For Each Week During this Period (not subject to 90-day waiting period rule)
Life Insurance, Accidental Death & Dismemberment, Comprehensive Medical, Prescription Drug, Vision and Dental	12 per week	2 full consecutive calendar months in a row
Income Protection	28 per week And Not less than 12 per week	2 of the 3 preceding calendar months in a row 2 preceding full calendar months in a row

Termination of Eligibility

Your eligibility will terminate upon the earliest of the following dates:

- the last day of the month in which you cease to be actively employed or cease to work the covered hours required to qualify for coverage under the Plan;
- the first day of the month for which any self-payment is due and unpaid;
- the last day of the month in which you are no longer disabled, if an extension of coverage due to disability is provided; or
- the date the Plan terminates or the Contributing Employer ceases to participate in the Plan.

You may be eligible to make self-payments to continue coverage under COBRA. See COBRA continuation coverage beginning on page 14 for more information.

Reinstatement of Eligibility

If your eligibility has been terminated and you return 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;
- a sanctioned strike;

you will become covered again on the date you return to work, provided you were previously covered and previously satisfied the initial eligibility requirements, and your employer immediately begins making contributions on your behalf.

If your eligibility was terminated due to your failure to work required hours, you will become reinstated by again meeting the initial eligibility requirements.

Your Dependents' Eligibility

Coverage for your Eligible Dependents, if applicable, is based on the number of hours you work and on certain waiting periods; additionally, you must have elected Family Coverage.

If you elect coverage under a Plan Classification that offers family coverage, and you elect Family Coverage, generally, your Eligible Dependents are:

- your lawful Spouse; and
- your children, through the last day of the month in which they turn age 26.

Refer to the Definitions section on page 87 for details regarding who is considered an Eligible Dependent under the Plan.

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. Photocopies and digital records are accepted.

If you and your Spouse, if applicable, are both eligible as full-time Employees, your dependent children are covered as dependents under both of you.

Initial Eligibility of a Dependent

Your dependents become eligible on the later of the following dates:

- the first day of the month during which you work the hours required to qualify for the Contributing Employer's full-time contribution for dependent coverage, as set forth in the Collective Bargaining Agreement; or
- the date your dependent becomes an Eligible Dependent, as defined beginning on page 87.

Notwithstanding the foregoing, your dependents will become eligible only if your Plan Classification provides Family Coverage and you elect such coverage and authorize the weekly payroll deduction.

Termination of Dependent Eligibility

Your dependents' eligibility will terminate upon the earliest of the following dates:

- the last day of the month in which the dependent ceases to be an Eligible Dependent as defined beginning on page 87;
- the last day of the month in which you fail to work the hours required to qualify for the Contributing Employer's full-time contribution;
- the last day of the month in which the date of divorce or legal separation occurs for a covered spouse; or
- the last day of the month in which you are ineligible for coverage.

You may be eligible to make self-payments to continue coverage under COBRA. See COBRA continuation coverage beginning on page 14 for more information.

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 14 for more information.

Special Enrollment Periods

If you or your Eligible Dependent loses eligibility under another group health plan (or if an Employer stops contributing toward your or your Eligible Dependent's other coverage), you or your Eligible Dependent may be eligible for a special enrollment period. However, you or your Eligible Dependent must request enrollment within 30 days after your other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your Eligible Dependent(s). However, you must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption. If you fail to enroll a newly Eligible Dependent or provide evidence of your dependent's eligibility on time, coverage begins on the first of the month following the day you sufficiently complete the enrollment (coverage is not retroactive to the date of birth, marriage, adoption or placement for adoption). In addition, the Plan is not responsible for any bills or charges incurred prior to the coverage effective date.

Two additional circumstances allow for a special enrollment period:

- you or your Eligible Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your Eligible Dependent becomes eligible for a subsidy under Medicaid or CHIP.

Federal and state laws require an Eligible Employee to enroll any dependents who are receiving health insurance coverage through Medicaid. If an Eligible Employee does not enroll his or her Eligible Dependents who are receiving health insurance through Medicaid, the Eligible Employee will be responsible for any penalties assessed on the Plan by Medicaid due to the Eligible Employee's failure to follow these rules.

Qualified Medical Child Support Orders

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.

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 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 page 6). 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 14. 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 will 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 14, 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 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 were eligible for and elected Single Coverage, as a part-time employee, 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.
- You were eligible for and elected 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 at no cost will reduce the period allowed for self-payment of contributions for continuation coverage under 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 FMLA 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 FMLA 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 FMLA.

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 and Prescription Drug Benefits only, or for Medical, Prescription Drug, Dental, and Vision Benefits, if they are available under your Plan Classification. Life Insurance, Accidental Death and Dismemberment, and Income Protection Benefits cannot be continued, even if they are covered under your Plan Classification.

Note: When referring to "Eligible Dependents" in this section, they apply only to the Plan Classifications that offer dependent coverage.

Qualifying for COBRA

To qualify for COBRA coverage, you (or your dependents, if eligible under your Plan Classification), must experience a qualifying event that causes a loss of coverage.

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 8.

If you or your Eligible Dependent(s) have a qualifying event, you need to notify the Benefits Fund Office in writing within 60 days of the loss of coverage. Notice procedures are found beginning on page 18. Even though a notice is required from your employer, the Plan recommends you contact the Benefits Fund Office as soon as possible if you (or a dependent) experience a qualifying event.

If you have a newborn child, adopt a child, or have a child placed with you for adoption 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 months 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.

Note: 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.

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:

UFCW Midwest Health Benefits Fund
Attn: Contribution Accounting Department
2625 Butterfield Rd, Suite 208E
Oak Brook, IL 60523

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. Do not let a late or lost COBRA check jeopardize your coverage.

Contact the Contribution Accounting Department at the Benefits Fund Office to request the "Authorization Agreement for Electronic Transfer of Payments for COBRA," or download and print the form at ufcwmidwest.org on the "Forms & Publications" Health 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, 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.

You must promptly notify the Benefits Fund Office if you and your Spouse divorce or legally separate. 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 previously noted, 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 provide all of the information necessary to meet the content requirements in a timely manner, 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 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 elect COBRA coverage within 60 days.

This notice will be written in a manner calculated to be understood by the average Plan participant and will 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 will terminate.

Address Changes

Please make sure the Benefits Fund Office has you and your family members' correct addresses on file.

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 Review Program provides pre-certification review services for Hospital admissions, surgeries, advanced testing and home health care as well as other services described below. 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.

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 Penalty may be applied.

Treatment Type	**When to Contact ActiveHealth Management**
Scheduled Hospital admission	Two weeks before you are admitted to the Hospital (Non-Compliance Penalty applies)
Emergency Hospital admission	As soon as possible or within 48 hours of the admission (Non-Compliance Penalty applies)
Admission for childbirth (this is considered a scheduled admission). Pre-certification is required for Hospital stays beyond 48 hours for a vaginal delivery or 96 hours for delivery by caesarian section	Any time during pregnancy (must be before admission) (Non-Compliance Penalty applies without pre-certification after 48 hours for vaginal delivery and 96 hours for caesarian delivery)
Inpatient or outpatient surgery	Two weeks before you are scheduled for surgery (Non-Compliance Penalty applies)
Skilled nursing facility care Rehabilitation therapy Home health care Hospice care Durable medical equipment	Before care or before purchase or rental of equipment

Advanced diagnostic tests such as MRI, CT scans, or Thallium stress tests	Before care (Non-Compliance Penalty applies)
Ultrasound guidance for outpatient arthrocentesis for therapeutic joint injections	Before care (Non-Compliance Penalty applies)
IV sedation utilized in conjunction with outpatient epidural or other pain management interventional injections or procedures	Before care (Non-Compliance Penalty applies)

When to Notify the Funds UR/UM Vendor

Pre-certification must be done by the Fund's UR/UM Vendor, not by BlueCross BlueShield—you or your Doctor should speak directly with ActiveHealth Management.

Inpatient Hospital Admission. You must contact ActiveHealth Management at least two weeks before the start of the Hospital stay. If you do not pre-certify your hospitalization, an additional $100 Non-Compliance Penalty will apply. 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 ActiveHealth Management within 48 hours of the admission. If you do not contact ActiveHealth Management, an additional $100 Non-Compliance Penalty will be applied.

Surgery. You must contact ActiveHealth Management at least two weeks before a scheduled inpatient or outpatient surgery. If you do not pre-certify the surgery, an additional $100 Non-Compliance Penalty will be applied before any benefits are paid. If you do not pre-certify expenses for bariatric surgery, it will not be considered Medically Necessary and the Plan will not cover the expenses.

The Second Opinion Surgery Program helps to determine whether a proposed surgery is Medically Necessary or whether an effective alternative approach exists.

You may be required to obtain a Second Opinion. The types of surgeries that require a Second Opinion include but are not limited to:

- artery and vein surgery
- back surgery
- breast surgery
- coronary artery bypass
- exploratory surgery
- eye surgery
- foot surgery if it is anticipated that the surgeons' fees will be $2,000 or more for any one surgery or for a series of surgeries
- genital surgery
- hysterectomy (removal of the uterus)
- intestinal surgery
- joint surgery/joint replacement
- nose surgery
- penile implant
- prostatectomy or transurethral resection

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 expenses. The additional amount you pay will not count towards your out-of-pocket maximum.

If the Second Opinion does not agree with the recommended procedure or surgery, then a third medical examination and opinion is also necessary.

If the majority of Doctors do not agree that the procedure or surgery is Medically Necessary or if a required third examination is not performed, no benefits will be payable.

Advanced Diagnostic Testing. It is required that you contact the Fund's UR/UM Vendor (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. If you do not pre-certify the expense for advanced testing, an additional $100 Non-Compliance Penalty will be applied.

Durable Medical Equipment. Get pre-certified approval before purchasing or renting durable medical equipment. If the expense is not approved, it will not be considered Medically Necessary and the Plan will not cover it.

Weight Loss Treatment. Get pre-certified approval before incurring expenses for weight loss treatment, including surgery. If certain conditions are not met and if the expense is not approved, it will not be considered Medically Necessary and the Plan will not cover it. Exception: Obesity screening and counseling obtained in-network is covered.

Nutritional Counseling. Expenses for nutritional counseling sessions are covered if the sessions are ordered by your Doctor as part of a comprehensive treatment plan and if approved by the Fund's UR/UM vendor. If the expense is not approved, it will not be considered Medically Necessary and the Plan will not cover it. Exception: If nutritional counseling is considered a preventive service by your Health Care Provider, it will be covered.

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 the Fund's UR/UM vendor for approval. If the expense is not approved, it will not be considered Medically Necessary and the Plan will not cover it.

Physical Therapy. Physical therapy is limited to 25 sessions per Illness or Injury. Additional benefits may be payable for treatment of certain conditions. These additional benefits must be pre-certified or payment will be limited to 50% of covered expenses.

Occupational Therapy. Occupational therapy is limited to 25 sessions per Illness or Injury. Additional benefits may be payable for treatment of certain conditions. These additional benefits must be pre-certified or payment will be limited to 50% of covered expenses.
Note: The Non-Compliance Penalty does not apply to Durable Medical Equipment (DME) and Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, occupational therapy, and physical medicine services ordered by a qualified Doctor in excess of 25 sessions per Acute Occurrence.

If Durable Medical Equipment (DME) is not pre-certified, it will not be covered. If Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, occupational therapy, and physical medicine services ordered by a qualified Doctor in excess of 25 sessions per Acute Occurrence are not pre-certified, 50% of the Usual and Customary Charges for the Covered Expense are payable.

How to Notify the Fund's UR/UM Vendor

You may contact them directly at:
ActiveHealth Management
3200 Highland Avenue
Downers Grove, IL 60515
855-210-8738
activehealth.com

See your Insurance Card instructions for additional details.

BlueCross BlueShield of Illinois Participating Provider Network

The Plan also offers you the 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.

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 in three ways when you use the BlueCross BlueShield of Illinois Participating Provider Network:

- your percentage is applied to a discounted fee;
- your percentage is smaller; and
- you avoid the higher deductible charged for using an out-of- network Hospital.

You can find a participating provider by using the "Doctor and Hospital Finder" provided online 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.

The ultimate decisions regarding your medical care must be made by you and 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 Health Care Provider.

Comprehensive Medical Benefits (All Participants)

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.

The Comprehensive Medical Benefit provides coverage for many common medical needs after you satisfy the Annual Deductible.

Certain medical expenses are paid with no deductible required if you use a PPO provider. A list of covered medical expenses starts on page 31.

You should refer to the Summary of Benefits for your Plan Classification for additional details about what the Plan covers and what costs, if any, are your responsibility.

Calendar Year Deductible

The Calendar Year Deductible is the amount of covered medical charges that you and your family pay each Calendar Year before the Plan's medical benefits begin to pay for any covered charges.

Your Plan Classification may have a specific *individual* and *family* Calendar Year Deductible requirement. If you have covered dependents, each family member must meet their own individual deductible until the overall family deductible is met.

Once you meet your individual deductible, no further deductible will be required from you for the remainder of that Calendar Year. The Plan will pay the percentage specified in the Summary of Benefits for the cost for any covered medical expenses you incur. You will be responsible for any difference.

Separate deductibles apply when you receive Hospital services from a non-PPO network Hospital and when you do not have certain services pre-certified, as explained later in this section. Refer to the Cost Containment section for more details.

Non-PPO Hospital Deductible

If you or your dependent is admitted to a non-PPO Hospital and it is not an emergency, you must pay a $450 Non-PPO Hospital Deductible. This is in addition to the Calendar Year Deductible.

Non-Compliance Penalty

If you or your dependent(s) are admitted to a Hospital, have a scheduled surgery (either inpatient or outpatient), or have advanced diagnostic testing done without pre-certification by the Fund's UR/UM vendor for the expenses for admission, surgery, or testing, you will be required to pay an additional $100 Non-Compliance Penalty. The additional $100 Non-Compliance Penalty also applies to emergency care that results in Hospital admission if a request for pre-certification is not made within 48 hours of the admission.

Out-of-Pocket Maximum

The Plan has imposed an out-of-pocket maximum in order to minimize the amount of money you will pay out-of-pocket for the expenses you will incur during a Calendar Year.

After you have paid the annual out-of-pocket maximum toward covered expenses, the Plan will pay 100% of those covered expenses for the remainder of that Calendar Year.

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

- charges that exceed the Usual and Customary Charge;
- 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 Cost Containment Program;
- amounts you pay to satisfy the Non-PPO Hospital Deductible;
- the balance of charges that the Plan pays at 50%; and
- any other charges that are not covered by the Plan.

The annual medical out-of-pocket maximum is detailed in the Schedule of Benefits. This amount includes the Calendar Year Deductible.

PPO Providers—BlueCross Blue Shield of Illinois

You have access to a Preferred Provider Organization (PPO) network that consists of Hospitals, Doctors and ancillary providers. 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 Doctor, 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.

Please note that charges by a non-PPO facility may be substantially in excess of the Plan's Usual and Customary Charges. These excess charges are not covered under the Plan. Additionally, certain surgeries have limited benefits payable if performed at a non-PPO facility—see the next section.

Refer to page 94 for a definition of "Usual and Customary Charge."

To locate a provider, visit www.bcbs.com or call 800-810-2583.

Surgery at Non-PPO Facilities

When certain surgeries are performed at a non-PPO facility, benefits will be limited to the Plan's defined Usual and Customary Charge (see page 94).

Covered Medical Expenses

The Plan provides coverage for the following medical expenses, provided you are under the care of a licensed Doctor and the covered services and supplies are Medically Necessary. Refer to the General Exclusions and Limitations beginning on page 61 to see what is not covered by the Plan.

Covered Medical Expenses include the actual usual and reasonable charges incurred for the services and supplies listed below:

1. hospital services and supplies, including:
    - room and board, up to the standard daily rate for a semi-private room;
    - specialty care unit charges (e.g. intensive care unit, cardiac care unit);
    - other services and supplies furnished by a Hospital; and
    - emergency room charges.
2. doctor's professional, medical, and surgical services, including:
    - hospital, office, and home visits;
    - emergency services with respect to an Emergency Medical Condition, which means a medical screening examination within the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.
    - services for surgical procedures;

3. surgery and related charges.

4. doctor's charges for surgery, radiotherapy procedures, or medical services.

5. outpatient treatment, services, and supplies for Illness or Injury.

6. ambulatory surgical center services.

7. diagnostic X-ray and laboratory charges.

8. X-ray, chemotherapy, radium, and radiation therapy.

9. anesthetics and their administration.

10. blood and blood plasma and its administration

11. oxygen and its administration and the rental of equipment for the administration of oxygen, including the one-time purchase of an oxygen concentrator for portable oxygen tanks.

12. professional ambulance transportation to and from a local Hospital or between local Hospitals. Covered air ambulance expenses are limited to $15,000 per incident in North America and $25,000 per incident elsewhere.

13. 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.

14. 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 Doctor 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.

15. reconstructive treatment because of an 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, or in relation to a mastectomy.

16. durable medical equipment for therapeutic treatment. Benefits for the rental of durable medical equipment cannot exceed the allowable purchase price, as determined by the Trustees.

17. orthotic appliances. Benefits are payable for the initial appliance and, after five years, for one replacement for each five years of continuous use.

18. prosthetic appliances. Benefits are payable for the initial appliance and, after five years, for one replacement for each five years of continuous use. Covered items include:

    - artificial limbs or eyes
    - external breast prosthesis;
    - internal breast prosthesis (implant);
    - cataract or corneal transplant basic lenses; and
    - penile implant, limited to one per lifetime.
    - Cochlear implants are not covered.

19. medical supplies, trusses, braces or supports, casts, splints and crutches. The following supplies are limited to a maximum per Calendar Year of:

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

20. charges made by a registered nurse or licensed practical nurse. Only home health care expenses that are pre-certified will be covered.

21. home health care. Benefits are payable 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); and
    - administration of IV therapy.

    Covered medical expenses are limited to expenses that are pre-certified. Each visit by a member of the home health team will count as one visit.

22. skilled nursing facility care, rehabilitation therapy and hospice care. Expenses for Medically Necessary care in a skilled nursing facility, rehabilitation therapy, and hospice care are covered if pre-certified. The Plan will not consider these expenses Medically Necessary and will not cover them if you do not receive pre-certification for them.

23. chiropractic care. Benefits are payable for up $1,500 per Calendar Year for charges by a chiropractor for treatment of the back, neck, spine or vertebra for conditions due to non-work-related subluxations, strains, sprains, and nerve root problems.

24. physical therapy, acupuncture, and prolo therapy. Benefits are payable for up to 25 sessions per acute occurrence. A session includes an evaluation and no more than three medically appropriate modalities or other services for up to one hour per day.

Additional benefits may be payable for treatment of more than one musculoskeletal, neurological, digestive, genitourinary, or skin systems or for loss of any special senses function. These additional benefits must be pre-certified or payment will be limited to 50% of covered expenses.

25. occupational therapy. Benefits are limited to 25 sessions per Illness or Injury. A session includes an evaluation and no more than three medically appropriate modalities or other services for up to one hour per day.

    Additional benefits may be payable, but must be pre-certified by ActiveHealth Management, or payment will be limited to 50% of covered expenses.

26. speech therapy. Benefits are limited to 25 sessions per Illness or Injury. A session includes an evaluation and treatment provided on a single day not to exceed one hour.

27. cardiac and pulmonary rehabilitation. Benefits are limited to 30 sessions per event. A session is a supervised rehabilitation service of no more than one hour per day and may further include one low level stress test per event.

28. pain management treatment for chronic pain. Benefits are payable for treatment provided by a practitioner in the Pain Management Provider Network established by the Fund.

29. transplant expenses, except that no benefits are payable for donor-related expenses.

30. varicose vein treatment. Except for ulcerated conditions, benefits are limited to a lifetime maximum of $2,500 per leg.

31. nutritional counseling. Expenses for up to four nutritional counseling sessions per Calendar Year will be covered if the following conditions are met:

    - the patient must have a known history of diabetes, renal failure, hepatic insufficiency, morbid obesity, or a genetic metabolic disorder requiring diet modification;

- the counseling must be ordered by a Doctor as part of a comprehensive treatment plan and the expense must be pre-certified; and
- the counseling must be provided by a Registered Dietician or a comparably credentialed professional.

32. weight loss treatment. Benefits are payable for the following services for persons with a known history of morbid obesity:

    - nutritional counseling—Up to four counseling sessions per Calendar Year with a Registered Dietician (or a comparably-credentialed professional) when ordered by your Doctor as part of a comprehensive treatment plan and the expenses are pre-certified;
    - bariatric treatment and management—Up to six visits per Calendar Year with a Doctor (MD or DO) when part of a comprehensive treatment plan and the expenses are pre-certified; and
    - bariatric surgery—The patient must be enrolled in a Fund-approved multi-discipline, Doctor-supervised nutrition and exercise program of at least six months in duration. Any recommended surgery must be pre-certified and must be performed at a Fund-approved Bariatric Surgery Center of Excellence. For more information about the Plan's bariatric surgery policy, refer to Appendix F of the Plan Document.

    Contact the Funds UR/UM vendor for additional details and for referrals to a Fund-approved program.

33. mental health or substance use disorder treatment expenses except when provided as an inpatient in a residential care facility that does not meet the Plan's definition of a Hospital (see page 90). Eligibility for all inpatient and outpatient therapy will be subject to all Plan Provisions, including, but not limited to, a determination that the therapy is Medically Necessary and Appropriate. Expenses for treatment by a residential care center must be pre-certified in writing by the Benefits Fund Office.

34. preventive care expenses for Eligible Employees and Eligible Dependent spouses. Payment will be made as specified in the Schedule of Benefits for the following:

    - Physician's charges for a routine annual physical exam;
    - laboratory and other medical tests commensurate with the patient's gender, age, and family or social history, as approved by the Fund Administrator in consultation with the Fund's medical consultant;
    - bone density scanning for patients age 45 or older once every four Calendar Years;
    - annual seasonal flu vaccination; amount payable set by the Trustees, from time to time.

35. Well child care expenses including outpatient newborn and well-child visits and routine childhood immunizations are treated as Preventive Services and paid at 100% when services are received from an in-network provider. Certain age limitations may apply.

36. laboratory testing. Payment will be made as specified in the Schedule of Benefits for:

    - Preferred laboratory testing for covered tests performed at a stand-alone outpatient laboratory or by an In-Network Physician who processes the tests in his or her office.
    - Outpatient laboratory testing performed at a Hospital or outpatient facility affiliated with a Hospital.

37. mammogram expenses. Payment will be made as specified in the Schedule of Benefits for one test performed between age 35 and 39, and annually beginning at age 40.

38. The residential care center must:

    - be accredited by the Joint Commission or other similar credentialing entity acceptable to the Plan;
    - comply with all federal, state, and local requirements, including required licensing; and

- be a PPO provider unless a PPO facility is unavailable, in which case, the alternative facility must be pre-certified in writing by the Benefits Fund Office.

39. Injury to oral/facial structures, including, but not limited to, jaw and facial bone fractures and Injury to sound and natural teeth.

40. Hospital expenses for dental surgery. Benefits are payable for Hospital expenses for covered dental surgery. To be covered, the expenses must be pre-certified.

    Other expenses, including professional fees of any kind, for dental care, anesthesia, diagnosis, treatment or supplies, are not covered under the Comprehensive Medical Expense Benefit. Such expenses may be covered under the Dental Benefit.

41. voice communication machines. The Plan pays up to $7,500 per person, per lifetime.

42. hearing aids. Benefits are payable up to $500 per person in a five-consecutive-year period for covered expenses for a hearing examination and hearing aid.

    Covered expenses include the following:

    - an otologic examination performed by a Doctor;
    - an audiologic examination performed by a Doctor 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; and
    - 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; and
- charges for repairs, servicing and alterations.

43. Applied Behavior Analysis (ABA) therapy for treatment of autism/autism spectrum disorders is a covered service if approved for Medical Necessity and all of the following conditions are met:

    - when prescribed and monitored by a pediatric neurologist, neurologist, developmental pediatrician, psychologist, or psychiatrist experienced in the diagnosis and monitoring of patients with autism spectrum disorders and when used in the treatment of autism/autism spectrum disorders as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Credentialed Provider). Coverage requires utilization of an in network provider (where available) and pre-certification through the Trust's current Behavior Health Utilization Management program. Eligibility for coverage will require the following:

        (i) there must be a diagnosis of a condition on the Autism Spectrum (ICD-10: F84 through F84.9);

        (ii) there are identifiable target behaviors that impact development, communication, appropriate interaction with peers or others in the child's environment, or adjustment to the settings in which the child typically functions precluding participation in developmentally appropriate essential community activities;

        (iii) there is an individualized treatment plan developed that is child specific, family-focused, community-based, and multi-system, where specific target behaviors are clearly defined. A comprehensive evaluation must have been performed and include identification of targeted behaviors

and deficits with appropriate baseline benchmarking, including the frequency, rate, symptom intensity, and duration of targeted behaviors. A comprehensive treatment plan must also be submitted to the Fund's UR/UM vendor and must include designated behavior intervention techniques appropriate to the targeted behaviors, rein-forcers to be utilized, and strategies for generalization of learned skills with quantifiable criteria for progress and interval evaluation. The plan of care should also include planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria with appropriate interval documentation and reassessments submitted for review as required by the Trust's Behavior Health utilization management entity;

(iv) parents or custodial adults must be involved in training in behavior techniques so that they can provide additional hours of intervention and there must be ongoing documentation of parental involvement and therapy;

(v) all services must be pre-certified to be eligible for coverage; and

(vi) the Plan of Care must also include an assessment of availability and utilization of appropriate community resources including but not limited to services offered through local school districts or early intervention services for pre-school age children.

- up to 25 hours of therapies per week may be covered and pre-certification will be required for ongoing care at not more than six-month intervals.
- ongoing coverage will require appropriate documentation of all the elements above as well as documenting an appropriate response to therapy. Therapy will not be custodial in nature. Custodial Care with regard to ABA therapies is defined as care provided when the member has failed to show continuous

improvement in physical and or mental function with appropriate therapy as described above, and is therefore considered not likely to result in further significant improvement with continued therapy.

- services must be provided by (a) in network providers where available; and (b) individuals appropriately licensed by the state and/or certified by the Behavior Analyst Certifying Board, whether the services are provided in network or out of network.

Smoking Cessation Program

An Eligible Employee or Eligible Dependent Spouse who completes the Plan's Smoking Cessation Program through the American Cancer Society or other designated service provider may have his or her Calendar Year deductible waived for the next following Calendar Year.

Prescription Drug Benefit (All Participants)

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.

For "short-term" prescription drug needs, you should have your prescription filled at a participating pharmacy (explained below).

For drugs that are used on a long-term or ongoing basis, you must use the Mail Order Program to fill your prescription—see page 43.

Prescription Drug Co-Payments

You are not required to meet a deductible under the Prescription Drug Benefit. Instead, you will be required to pay a minimal Co-payment when you have a prescription filled. Co-payments are based on tiers to encourage the most cost-effective use of the Prescription Drug Benefit.

Prescription Drug ID Cards

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 Customer Service at the Benefits Fund Office at 800-621-5133.

Participating Pharmacy Program

The Prescription Drug Benefit is managed by the Fund's Pharmaceutical Benefits Manager (PBM), WellDyneRx, a prescription benefit manager with a large network of participating pharmacies.

You receive the highest level of benefits when you fill your prescription at a participating pharmacy. When you purchase your prescription from a non-network pharmacy, you will have to pay the applicable Co-payment, in addition to the amount above what a network participating provider would charge for your medication.

Many, but not all, large chain pharmacies and small independent pharmacies are participating pharmacies. Should you have any problem locating a participating pharmacy, please contact WellDyneRx at 888-479-2000 or visit wellview.welldyne.com.

If for some reason you cannot use a WellDyneRx 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.

Prescriptions Filled through the Mail Order Program

You must use the Mail Order Program when you need to have a prescription filled for a maintenance drug. Maintenance drugs are drugs that are used on a long-term or ongoing basis to treat chronic Illnesses.

If you obtain a maintenance drug at a retail pharmacy instead of through the Mail Order Program, your prescription will be limited to a 30-day supply (instead of 90-day) and the Co-pay will be the 90-day Co-payment amount.

When you order by mail, you will pay the amount specified in the Summary of Benefits applicable to your Plan Classification.

Contact WellDyneRx at 888-479-2000 for information on which drugs are preferred drugs and for instructions on using the Mail Order Program.

You will always pay the lowest of the designated Co-pay, contracted price, or actual selling price of a covered drug.

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 Plan. Your Doctor or pharmacist can assist you in substituting generic drugs when appropriate.

Specialty Drugs—Require Purchase by Mail

Specialty drugs are medications that may require special storage, handling, or administration (such as injection or infusion) or are for conditions where it may be beneficial to monitor the drug therapy or an underlying medical condition. Examples of such drugs are Atripla, Enoxaparin, Humira, Enbrel, and Truvada.

The Fund Administrator, in consultation with the Fund's Medical Consultant and with approval by the Trustees, periodically identifies which drugs are specialty drugs. Inquiries as to whether any drug is on the current specialty drugs list should be directed to the Benefits Fund Office.

Under the Prescription Drug Benefit, specialty drugs can be obtained only by mail through US Specialty Care. Specialty drugs are not covered if obtained at a local pharmacy.

To obtain your specialty drug:

- complete the "Patient Prescription Form" available from the Benefits Fund Office or from US Specialty Care at 800-641-8475;
- complete all sections except Physician Information and Clinical Information. Note that you may use your UFCW ID# instead of your Social Security number on the form;
- have your Doctor complete the Physician Information and Clinical Information; and
- you or your Doctor should fax the completed form to US Specialty Care at 800-530-8589. Or you may mail it to US Specialty Care, PO Box 4517, Englewood CO 80155-4517.

A professional from US Specialty Care will call you to confirm when and where you would like your prescription drugs delivered (along with any needed supplies). Drugs are packaged in unmarked, temperature-controlled containers and can be delivered to any secure location of your choice.

US Specialty Care pharmacists and staff are available to answer any questions. They can give you detailed instructions and support for how and when to take your drugs. They also offer refill reminder calls.

You can reach US Specialty Care at 800-641-8475, FAX at 800-530-8589, or by mail at PO Box 4517, Englewood CO 80155-4517.

Covered Prescription Drugs

The Plan covers the following:

- Legend Drugs that are lawfully obtainable only from an individual licensed to dispense drugs upon the prescription of a Physician;
- injectable insulin;
- needles and syringes to administer injectable insulin;
- needles and syringes for any other medically-approved use, up to a 30-day supply;
- blood glucose testing strips;
- certain drugs when specifically approved by the Board of Trustees; and
- lancets.

Coverage of drugs related to treatment of the Hepatitis C Virus will be determined by the Fund's medical consultant who will apply the current guidelines of the American Association for the Study of Liver Diseases.

What is Not Covered

Expenses for the following are not covered:

- research drugs;
- non-Legend or over-the-counter drugs, except as otherwise specifically noted;
- drugs dispensed for use by the Eligible Employee or Eligible Dependent when Medically Confined;
- contraceptives or implanted drugs or devices, regardless of intended use;

- drugs or products used for smoking cessation, including Nicorette and nicotine transdermal patches, except as required by the ACA;
- drugs used as an aid to weight loss;
- drugs that require approval by the Benefits Fund Office prior to dispensing when such prior approval has not been obtained;
- drugs that are intended to promote fertility;
- non-drug items, including but not limited to nutritional supplements, regardless of intended use;
- more than a 30-day supply of a drug, except for a 90-day supply of a drug as determined from time to time by the Trustees or as determined by the Plan's pharmacy benefit manager to be primarily prescribed for maintenance of a chronic condition;
- any prescription order or refill for which the pharmacist's Usual and Customary charge to the public is less than the Co-pay amount payable by an Eligible Employee or Eligible Dependent;
- Experimental drugs, drugs intended for Experimental treatment as determined by the Trustees, or drugs not approved by the U.S. Food and Drug Administration for the condition, dose, rate or frequency prescribed;
- any drugs for which an acceptable, Medically-Necessary and Appropriate reason for continued long-term drug usage has not been established; or that are not covered or are excluded because of their intended use including, but not limited to, drugs used for cosmetic purposes such as "Retin-A" or, in the opinion of the Trustees, because of their potential abuse;
- drugs (except Lupron) consumed at the time and place of prescription;
- drugs in excess of the quantity specified in the prescription order;
- drugs that will be covered by any Workers' Compensation law, Medicare, or similar governmental program, or any other prescription program or group plan unless prohibited by federal law;

- drugs payable under a governmental program or a pharmaceutical industry Co-pay assistance program unless payments under such programs are coordinated with the Plan under specific provisions or policies adopted by the Board of Trustees;
- any prescription order or refill filled outside the United States, except for emergencies;
- drugs intended for any purpose other than the manufacturer's published use, as specifically approved by the U.S. Food and Drug Administration, or drugs prescribed in quantities in excess of the dosage recommended by the manufacturer;
- drugs to promote hair growth;
- vitamins, except prescription pre-natal vitamins;
- the difference in cost between a Brand-Name Drug and a Generic Drug when a Generic Drug is available and medically appropriate but a Brand-Name Drug is requested, except when medical exigency is present as determined by the Trustees;
- appliances and devices;
- blood and blood plasma, immunization agents, and biological sera;
- erectile dysfunction drugs in excess of six tablets per 30 days;
- lifestyle drugs; and
- specialty drugs when dispensed by a retail pharmacy instead of by mail through US Specialty Care or other program that has been approved by the Trustees.

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

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 134.

Vision Benefit (Plan Classifications D5-Tier A and LU Only)

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 expenses for:

- complete eye examination including dilation of pupils and/or relaxing of focusing muscles by drops and refraction for vision by a legally qualified ophthalmologist or optometrist; and
- new or replacement frames and/or lenses (including contact lenses) prescribed by an ophthalmologist or optometrist, including fitting.

The Plan pays 100% of the covered charges, up to the maximum benefit shown on the applicable Summary of Benefits.

What is Not Covered

The following expenses are not covered:

- any expenses that exceed the maximum amount during any Calendar Year;
- lenses that do not require a prescription; and
- anything excluded under the General Exclusions and Limitations listed beginning on page 61.

Dental Benefit (Plan Classifications D5-Tier A and LU Only)

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 Dental Benefits

You may pay a deductible per calendar year for the dental services you receive. However, the deductible will not apply to diagnostic and palliative treatment, listed on page 50.

For specific information regarding your dental coverage, refer to the applicable Summary of Benefits for your Plan Classification.

Dental Network of America (DNoA) Network

The Plan participates in the Labor Dental PPO Network through Dental Network of America (DNoA). You can save on your dental care when you use a general or specialty dentist who participates in the network because they offer discounted fees. This will reduce the amount of your out-of-pocket costs after your UFCW dental benefit is paid. In addition, network dentists will file your claims for you.

If you choose not to use DNoA's Labor Network Dentist, nothing will change. Your UFCW Dental Benefits will remain the same whether you use a dentist from within or outside the Labor Dental PPO Network and the Benefits Fund Office will continue to handle dental claim payment. All services are covered at the same benefit level. However, if you ever need a specialist such as an oral surgeon or an orthodontist, consider using a Labor Dental PPO Network specialist.

You will receive an ID card(s) in the mail that will allow you to access Labor Dental PPO Network dentists and obtain discounts. The ID card can be used to access the Labor Dental PPO Network in Illinois and nationwide.

To find out if your dentist is in the DNoA network, or to find a new dentist and maximize your savings, do any of the following:

- visit the Dental Network of America (DNoA) website at www.dnoa.com.
- call DNoA at 866-522-6758 between 8:00 a.m. 6:00 p.m. (Central Standard Time).

If you would like to nominate your dentist for inclusion in the Labor Dental PPO Network, contact DNoA at 866-522-6758 for a recruitment package to be sent directly to your dentist.

Covered Dental Expenses

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

Diagnostic and Palliative 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 two calendar years;
- fluoride treatments; and
- sealants.

Other Dental Services

- tooth extractions;
- amalgam and resin-based composite filling restorations for decaying or broken teeth;
- onlays and crowns;

- apace 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; and
- initial fitting and replacement of complete and partial dentures and bridges; replacements will be payable once every five years.

Orthodontic Benefits

Covered orthodontic expenses are payable up to the lifetime maximum benefit shown in the applicable Summary of Benefits. Covered expenses include only the charges for the following services and supplies:

- the appliance, placement of the appliance, continuing treatment;
- any preliminary studies performed;
- cephalometric radiographs;
- diagnostic casts; and
- retainers and retainer devices.

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, diphenhydramine, saline solutions or Cortisone;
- hydrostatic appliance;
- occlusal guards;
- diagnostic casts;
- facebow transfer;
- hinge axis mounting; and
- CT scans.

Alternate Dental 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.

Dental 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 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:

- the replacement of a Prosthesis more often than once every five years, except for:

  (i) replacement that is needed because of the first time placement of an opposing full denture or the extraction of natural teeth;

  (ii) a permanent Prosthesis that replaces an interim complete or partial denture or other temporary Prosthesis;

  (iii) replacement of a Prosthesis that, while in the

mouth, has been damaged beyond repair as a result of an accident that occurs while covered;

- replacement of a lost or stolen appliance;
- any expense covered under the Comprehensive Medical Expense Benefit;
- consultations;
- services or supplies for the treatment of temporomandibular joint disorders or to alter vertical dimension, except as provided in this benefit;
- expenses for procedures that are Experimental in nature, or are not generally recognized by the dental profession for the condition being treated;
- customization of 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;
- procedures or surgeries that are undertaken for primarily cosmetic reasons, except those orthodontic procedures previously listed;
- periodontal scaling procedures on patients not manifesting Case Type II, III or IV periodontal disease;
- complete series (including bite wings) of X-rays more than once each Calendar Year provided that this limitation will not apply to Medically Necessary treatment for an Eligible Employee or Eligible Dependent who is under 19 years of age;
- panoramic X-rays more than once each Calendar Year provided that this limitation will not apply to Medically Necessary treatment for an Eligible Employee or Eligible Dependent who is under 19 years of age;
- periapical X-rays (single film) taken on the same day as covered complete series X-rays are taken;
- prophylaxis treatments in excess of four per Calendar Year, as follows: up to two for dental prophylaxis (ADA Codes 1110/1120); up to four for periodontal prophylaxis (ADA Code 4910) provided that they are performed as adjunctive periodontal treatment rendered with respect to active

periodontal treatment provided that this limitation will not apply to Medically Necessary treatment for an Eligible Employee or Eligible Dependent who is under 19 years of age;

- temporary bridgework and temporary crowns, except when a temporary crown is needed due to a fractured tooth; and
- anything excluded under the General Exclusions and Limitations listed beginning on page 61.

Schedule of Dental Benefits

Dental benefits are paid according to a Summary of Benefits. Refer to Appendix E (beginning on page 142). The table 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.

Income Protection Benefit (Plan Classifications D5-Tier A and LU Only)

This benefit provides you with a basic level of income if you become disabled and are unable to perform all of the duties of your employment because of a non-occupational Injury or Illness. Disability benefits are payable only to active, Eligible Employee.

Income Protection 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 injury
- 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 12 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 14.

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:

- disability resulting from Illness or Injury for which you are not under the regular care of a Physician;
- disability arising out of or in the course of any occupation, employment, or self-employment; or for which you have a right to payment under any Workers' Compensation law or occupational disease law;
- Illness or loss for which you are entitled to benefits or reimbursement under any motor vehicle insurance plan, insurance settlement, or any third party settlement or agreement;
- disability resulting from a loss, problem, complaint, pain or ailment which did not arise from an objectively determined and documented medical impairment;

- disability incurred by owner-operators, non-Employee operators, proprietors, owner-Employees, partners, commission-only Employees, non-bargaining unit Employees, or any person participating on a voluntary basis;

- periods for which you receive remuneration from any employer or any source for work or services performed; or

- periods after a Contributing Employer closes all stores in the geographical area of the Plan's operation or ceases to be a Contributing Employer.

Life Insurance Benefit and Accidental Death & Dismemberment (AD&D) Benefit (Plan Classifications D5-Tier A and LU Only)

This is an explanation of the Health Plan's life insurance and AD&D policy and is your certificate while you are insured. The policy is issued by BlueCross BlueShield 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 will control.

Life Insurance

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.

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, your application is due:

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

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 (Plan Classifications D5-Tier A and LU Only)

Accidental Death & Dismemberment (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 57). 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:

  (i) as a passenger in a commercial aircraft that is on a regularly scheduled passenger flight;

  (ii) as a passenger or pilot of a chartered flight; or

  (iii) 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:

- Any bodily Illness or Injury for which the Eligible Employee or Eligible Dependent for whom a claim is made is not under the regular care of a Physician.
- Services or supplies that are not Medically Necessary and Appropriate.
- Any Illness, Injury, or Dental Service that arises out of or in the course of any occupation or employment, or for which an Eligible Employee or Eligible Dependent has received or is entitled to receive benefits under a Workers' Compensation or occupational disease law.
- Unless the governmental program provides otherwise, any expense for government-provided services given to a person:

  (i) under any plan or program established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political

subdivision of the United States, or of any other country or any political subdivision of any other country; or

(ii) under any plan or program in which any government participates other than as an employer;

- Services and supplies that the person is entitled to receive from the Uniformed Services medical care facilities or under any program of the Veterans Administration ("VA") when allowed by law. However, services and supplies received from a Veterans Administration Hospital for care of a non-service related disability will be covered to the extent that the Plan would have considered such charges as Covered Expenses had the VA not been involved.
- Services provided by a person who normally resides in the Eligible Employee's household or who is the parent, Spouse, child, brother or sister of the Eligible Employee or his Eligible Dependent.
- Cosmetic surgery or treatment, or complication thereof, except as otherwise permitted (e.g., reconstructive surgery following a mastectomy).
- Services or supplies for weight reduction by diet control, behavior modification, with or without drugs, or surgery, except for treatment covered, as specified in this SPD, for nutritional counseling, non-surgical bariatric treatment, or bariatric surgery.
- Skin or fat removal surgery for any reason.
- Diagnosis, testing or treatment of infertility.
- Hormone therapy, artificial insemination or any other direct attempt to induce or facilitate fertility or conception.
- Gender reassignment surgery or any associated pharmacotherapy, except as specified otherwise in this SPD. For information about the Plan's coverage policy for gender dysphoria, refer to Appendix H of the Plan Document.

- Breast reduction surgery, except for reconstruction due to breast cancer.
- Prophylactic mastectomy and BRCA testing expenses (except to the extent BRCA testing is an ACA preventive service) that have not been Pre-authorized in writing by the Benefits Fund Office and in accordance with the Fund's Prophylactic Mastectomy and BRCA Testing Policy adopted by the Board of Trustees, as amended from time to time.
- Covered Expenses for services and supplies for the care and treatment of an Illness or Injury resulting from an Intentionally Destructive Act by an Eligible Employee or Eligible Dependent who is not of diminished capacity due to a physical or mental impairment that would preclude reasonable compliance with treatment ordered by a Physician.

  Except in the situation where the Eligible Employee or the Eligible Dependent leaves an acute care facility against the medical advice of the treating Physician, the limitation on benefits specified in the applicable Summary of Benefits will not be imposed by the Plan until the Eligible Employee or Eligible Dependent has been advised in writing of the requirements necessary to maintain compliance with treatment and receive unreduced benefits; nor will it be applied to case(s) of domestic violence.
- Treatment of a condition or related condition that is a result of the commission of a felony, a result of war or any act of war, whether war is declared or undeclared, or a result of participating in a riot.
- Snoring cessation and snoring correction devices for any reason.
- Vision therapy.
- Procedures for surgical correction of myopia and/or refractive errors.
- Marriage counseling or treatment for anti-social behavior that is not the result of a mental, nervous, or substance use disorder.
- Physical examinations or medical certificates required for employment.
- Examinations or treatment ordered by a court in connection with legal proceedings 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.

- Immunizations, routine examinations, or screenings and other preventive care, except as specifically provided under the Comprehensive Medical Expense Benefit.
- Personal hygiene, convenience, or comfort items including, but not limited to, such items as televisions, telephones, first aid kits, physical fitness equipment, air conditioners, humidifiers, saunas, and hot tubs.
- Home blood pressure monitoring or home uterine monitoring equipment for any reason.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury and as provided under the Comprehensive Medical Expense Benefit), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- Routine foot care such as the cutting and trimming of toenails.
- Routine circumcision of newborns.
- Educational services, supplies, or equipment (except for nutritional counseling), including but not limited to, computers, software, printers, books, tutoring, and visual aids even if they are required because of an Illness or Injury.
- 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.
- Over-the-counter supplies, drugs, and medicines, except as otherwise specifically noted.
- Naturopathic or homeopathic services and substances.
- Completion of a routine claim form or routine supplemental report.

- Experimental, Investigational, or Unproven Services.
- Blood storage expenses, 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 related to donation of an organ or tissue.
- Expenses related to procurement from a donor of a human organ or tissue for transplant.
- Expenses for ultrasound guidance for outpatient arthrocentesis or therapeutic joint injections, IV sedation utilized in conjunction with outpatient epidural or other pain management interventional injections, or procedures that have not been pre-certified in writing by the Benefits Fund Office.
- Expenses related to a surrogate pregnancy.
- Reversal of a surgical procedure.
- Repair of, or operating supplies for, durable medical equipment, including portable oxygen in excess of one tank when an oxygen concentrator is leased or purchased.
- Shoes for any reason.
- Muscle stimulators in excess of $500.
- Cochlear implants or similar implantable devices designed to restore, improve, or augment hearing, except as provided for under the Plan's allowance for a hearing aid.
- Custodial Care, except when provided by a Hospice.
- Covered Expenses for Home Health Care will not include services or supplies, regardless of where or by whom they are provided, that:

  (i) a person without medical skills or background could provide or be trained to provide, provided that this will not preclude coverage by the Plan for training for such person to provide the Home Health Care at the sole discretion of the Trustees; or

(ii) are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury or functional ability.

- All genetic testing for the purposes of screening for the presence of occult disease, or for risk stratification for the development of clinically absent or unapparent disease, or for the evaluation of possible prophylactic surgical treatment, will be excluded with the exception of the following:

  (i) Governmentally-mandated neonatal testing and testing performed in association with amniocentesis and other covered related or equivalent procedures.

  (ii) Testing where a definitive diagnosis of breast cancer or other hematologic or oncologic diagnosis has been made to determine the medical appropriateness of therapy subject to all Medical Necessity, Experimental/ Investigational, and all other relevant provisions of the Plan.

  (iii) Testing of individuals with a high probability of possessing a BRCA mutation (as defined in the Prophylactic Mastectomy and BRCA Testing Policy adopted by the Board of Trustees, as amended from time to time, which can be found attached to the Plan Document as Appendix G) and who have undergone appropriate pre-testing evaluation and counseling, and where it has been determined that the results of testing will definitively determine future treatment or modify ongoing surveillance and treatment of the Eligible Employee or Eligible Dependent. Note that BRCA testing for breast cancer will be covered in-network as a preventive service without cost sharing, and testing will not have to be pre-certified.

- Infection control and medical waste disposal.
- Dental services, except as provided 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.
- Prescription or non-prescription weight loss agents.
- Smoking cessation programs not sponsored by the Fund.
- Expenses for and related to travel for an Eligible Employee, an Eligible Dependent, or a Physician.
- Treatment received outside the United States or Canada except for emergency first aid limited to the extent and at the currency rate of exchange or appropriate value of services solely determined by the Trustees.
- Telephone calls between a Physician or other provider and any patient, other provider, or representative of the Plan for any purpose whatsoever.
- Any services or supplies:

  (i) for which no charge is made; or

  (ii) for which the person is not legally required to pay.
- Deductible or Co-pay amounts.
- Amounts in excess of Usual and Customary Charges.
- Expenses incurred while coverage is not in force.
- Any service not determined to be a Covered Expense.
- Expenses that a person would not have incurred or would not be required to pay if this coverage or other coverage did not exist.
- More than one medical office visit, Hospital room, or wound-care facility charge billed on the same day by the same provider.
- Failure to keep a scheduled visit.

- No expense will be covered under more than one benefit provision of any Plan Classification.
- Expenses for which complete documentation of the claim, including reports and records if needed, has not been received by the Fund.
- If an Eligible Employee is employed by more than one Contributing Employer, the benefits provided to the Eligible Employee will be no greater than if the Eligible Employee was employed by only one Contributing Employer.
- If an Eligible Employee or an Eligible Dependent is covered under more than one Plan Classification, the benefits provided will be payable under the Plan Classification providing the largest benefit.
- Benefits provided under any one Plan Classification will be reduced by benefits provided under any other Plan Classification and by benefits previously provided under any other category of a Plan Classification.
- If an Eligible Employee changes Plan Classifications, the benefits previously paid will reduce the benefit maximums payable under the new Plan Classification by the amount paid.
- Expenses incurred by a Medicare Eligible Employee or Medicare Eligible Dependent for which the Centers for Medicare and Medicaid Services ("CMS") deny payment to a Hospital because of CMS' "never events" policy, as amended from time to time, and for whom Medicare would pay primary to the Plan under the Plan's coordination of benefits order.

Self-Audit Program

The Self-Audit 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 Self-Audit 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.

Self-Audit Program Guidelines

For purposes of the cash incentive, only Hospital expenses that the Plan covers, not telephone bills, television rental, newspapers, etc., will 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 if you are also covered by another group medical plan).

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 Self-Audit 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 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 Self-Audit Program payment is considered income to you and should be reported to the Internal Revenue Service.

Filing a Claim and Claim Information

Many health care providers will submit your claims for you. Be sure to show your ID card so your provider knows where to submit your claim. If your provider does not submit your claim for you, it is then your responsibility to do so. For prompt processing of your claims, please follow the detailed information in Appendix A, beginning on page 99.

You should submit your claims to the Benefits Fund Office as soon as possible. If you do not file a claim for benefits within 90 days (but no later than 12 months in limited circumstances) 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 online at ufcwmidwest.org or by contacting the Benefits Fund Office during normal business hours:

Phone: 800-621-5133, FAX: 847-384-0197

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

United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
Attn: Claims Department
2625 Butterfield Rd, Suite 208E
Oak Brook, IL 60523

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 Midwest Unique ID number 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 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 will pay its benefits before a plan that 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 legally 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 legally separated or divorced, their plans will pay medical benefits for Eligible Dependents as follows:

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

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

(iii) 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.

(iv) 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 will 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 will be primary.

- If any plan has a provision which results in lower benefits being paid because of the existence of this Plan, this Plan will 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 is 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 is 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. 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, 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 you settle a claim or obtain a judgment, 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, insurance company, or other organization for whom such payments were made.

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 will offset any amount improperly paid and/or terminate future coverage for the Participant and covered family members.

Claims Appeal Procedures

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

The procedure to file an appeal is summarized below. For more detailed information, refer to Appendix A, beginning on page 99.

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 adverse benefit determination including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- reference to the specific Plan provision(s) on which the denial is based;
- description of any additional material or information required in order to make the claim valid;
- a statement that you are entitled to receive upon request free access to and copies of documents relevant to the claim;
- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

- if the denial of a claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request
- if the denial of a claim was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement must be provided that such rule, guideline, protocol, or criteria will be provided free of charge, upon request;

If you do not agree with the claim denial decision, you may file an appeal within 180 days 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:

Fund Administrator
Claim Appeal
UFCW Unions and Employers Midwest Health Benefits Fund
2625 Butterfield Road, Suite 208E
Oak Brook, IL 60523

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 Board of Trustees will be written in a clear and understandable manner and will include a specific reason for the decision.

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 Fund, 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, 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

If you, your Spouse, or your dependents lose coverage under the Plan as a result of a qualifying event, you may elect to continue coverage under COBRA. For more information on COBRA, refer to the information beginning on page 14.

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," 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 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 or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

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

If your claim for benefits 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 should it find 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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting dol.gov/ebsa.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 866-444-3272 or visit their website at dol.gov/ebsa.

Definitions

The following are definitions of specific terms and words used in this booklet. Many, if not all, with be initial-capped for ease in identification.

Benefits. Payments made to you and your Eligible Dependents pursuant to the Plan.

Benefits Fund Office. The office from which the Plan is administered. The office is located at 2625 Butterfield Rd, Suite 208E, Oak Brook, Illinois 60523.

Brand-Name Drug. A prescription drug that is an original drug product marketed under a trademarked name.

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

Coinsurance. The percentage of costs of a covered health care service an Eligible Employee or Eligible Dependent pays after the Eligible Employee or Eligible Dependent pays his or her deductible.

Collective Bargaining Agreements. The written agreement between Contributing 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 Contributing Employer to make contributions to the Fund on behalf of bargaining unit Employee-Members.

Contributing Employer. Any employer that:

- on or after the effective date has a Collective Bargaining Agreement with a Union requiring periodic contributions to be made to the Fund;
- signs a copy of the Trust Agreement or executes a Participation Agreement or in some other written manner indicates consent to be bound by the terms of the Trust Agreement, which is then filed at the administration office of the Fund;
- is accepted for participation in the Fund in accordance with the provisions of the Plan;
- makes contributions to the Fund as required by the Collective Bargaining Agreement; and
- has been accepted, and has not, by resolution of the Trustees, been terminated as a Contributing Employer because of failure, for a period of 90 days after the due date, to make contributions to the Fund as provided for in its Collective Bargaining Agreement or Participation Agreement.

The term "Contributing Employer" will also include the United Food and Commercial Workers Unions and Employers Midwest Pension Fund, the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund, the Unions, and the Illinois Food Retailers Association, provided that each has signed a copy of the Trust Agreement as an employer becoming bound by its terms and agrees to make contributions to the Fund, pursuant to a

Participation Agreement unanimously acceptable to the Trustees, upon such terms and conditions necessary to preserve an equitable relationship between the contributions made by the other Contributing Employers participating in the Plan and the benefits payable to the Employees of such other Contributing Employers.

If an employer has more than one place of business, the term "Contributing Employer" will only apply to the place or places of business covered by the Collective Bargaining Agreement requiring contributions to the Fund. A business organization will not be deemed a Contributing Employer simply because it is part of a controlled group of corporations or of a trade or business under common control, some other part of which is a Contributing Employer.

Co-pay or Co-payment. The portion of a covered expense that is required to be paid by the Participant expressed as a flat dollar amount and that is not subject to reimbursement by the Plan.

Doctor/Physician. A person who is duly licensed by the appropriate state agency of the state in which the services are performed practicing within the scope of his license, including, but not limited to:

- a Doctor of Medicine (M.D.);
- a Doctor of Osteopathy (D.O.);
- a Doctor of Dental Surgery (D.D.S.);
- a Doctor of Podiatry (D.P.M.);
- a Doctor of Chiropractic (D.C.); or
- a Doctor of Medical Dentistry (D.M.D.).

Eligible Dependent. Any or all of the following individuals, when eligible under a Plan Classification:

- the Eligible Employee's lawful Spouse;

- those children of the Eligible Employee as described below. For this purpose, "children" described in paragraphs (i), (ii) and (iii) below include the Eligible Employee's child through the last day of the month in which the child attains age 26; "children" described in paragraph (iv) below include the Eligible Employee's child through the last day of the month in which the child attains age 19:

  (i) natural children;

  (ii) step-children, if the stepchild's natural parent resides in the Eligible Employee's home;

  (iii) legally adopted children or those for whom adoption proceedings have been started and the children are placed in the Eligible Employee's home by a licensed placement agency for the purpose of adoption or if the children have been living in the Eligible Employee's home as foster children for whom foster care payments are being made and a petition for adoption has been filed; and

  (iv) children for whom the Eligible Employee has legal responsibility as the result of a court order if the child(ren) is a first degree relative of the Eligible Employee who was covered under the Plan on December 1, 2010.

- those children of the Eligible Employee who have reached their 26th birthday but are unmarried and incapable of self-sustaining employment by reason of mental or physical handicap, provided:

  (i) such incapacity commenced prior to the last day of the month in which the child attained age 26, and

  (ii) such children reside with the Eligible Employee permanently and regularly for more than one-half of the year or live in a treatment center and are primarily dependent on the Eligible Employee for more than one-half of their financial support and maintenance, and

  (iii) the Eligible Employee submits satisfactory proof of such incapacity after the upper age limit is reached. The Fund may require, at reasonable intervals following the date the child reaches the age limit, subsequent proof of continuing incapacity and dependency. The

Trustees reserve the right to have such children examined by a Physician of their choice to determine the existence of such incapacity.

- If both Spouses are Eligible Employees and each are eligible for dependent coverage, their children are considered Eligible Dependents of both.
- An Eligible Dependent who becomes covered under the Plan as an Eligible Employee will no longer be considered an Eligible Dependent.

Employee or Eligible Employee. An individual who satisfies the conditions for eligibility.

Fund Administrator. A person or entity 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.

Health Care Provider. May include, but is not limited to, the institutions or persons listed below legally licensed and/or legally authorized to practice or provides medical care or diagnostic treatment to sick or injured persons under the laws of the state or jurisdiction in which the services are rendered:

- Home health agency;
- Ambulatory care facility;
- Licensed ambulance service;
- Practitioner;
- Physician;
- Hospital;
- Laboratory;
- Skilled nursing facility;
- Hospice;
- Psychologist;

- Licensed clinical social worker;
- Licensed social worker;
- Licensed clinical professional counselor;
- Occupational, physical, respiratory or speech therapist;
- Certified alcohol and drug counselor;
- Licensed nurse practitioner; and
- Residential treatment facilities.

Hospital. An institution that:

- is accredited by The Joint Commission or other similar credentialing entity recognized by the Centers for Medicare & Medicaid Services ("Medicare") or successor entities;
- is approved by Medicare as a Hospital;
- is mainly engaged in providing inpatient medical care for diagnosis and treatment of an Illness or Injury, and routinely makes a charge for such care;
- is supervised by a staff of Physicians on the premises;
- provides, on the premises, 24 hour nursing services by registered graduate nurses; and
- is operated with organized facilities for operative surgery on the premises, except for the following institutions:
  - (i) mental/psychiatric Hospitals;
  - (ii) drug/alcohol rehabilitation Hospitals; and
  - (iii) physical rehabilitation Hospitals.
- does not include any institution:
  - (i) that is run mainly as a rest, nursing, or convalescent home; or
  - (ii) for which any part is mainly for the care of the aged; or
  - (iii) that is engaged in the schooling of its patients; or
  - (iv) that does not meet all of the requirements of Section 2.30(a) of the Plan.

Illness. Any marked, pronounced deviation from a normal, healthy state. Illness also includes pregnancy.

Injury. Any damage to the body that is the result of an unintended and unforeseen event.

Intentionally Destructive Act. An intentionally destructive act includes, but is not limited to, knowingly failing to comply with a prescribed course of treatment, such as:

- failing to take prescribed medication;
- failing to enroll in and complete a prescribed course of treatment which has been recommended by a Physician after an appropriate evaluation, such as for chronic or acute conditions including, but not limited to, hypertension, diabetes or substance abuse;
- failing to complete other similar medically appropriate treatment or testing which is prescribed by a Physician, including completion of a course of treatment in an inpatient acute care facility or leaving an acute care facility against the medical advice of the treating Physician; and
- self-administered overdose.

Medically Necessary or appropriate. A medical service, supply, treatment or confinement will be determined to be "Medically Necessary" by the Plan Sponsor if it meets all the following requirements:

- is provided by or under the direction of a Physician or other Health Care Provider who is licensed and authorized to provide or prescribe it;
- is determined by the Plan Sponsor or its designee to be necessary in terms of generally accepted medical standards in the U.S.; and
- is determined by the Plan Sponsor to meet all of the following requirements:

  (i) it is consistent with the symptoms or diagnosis and treatment of the Illness or Injury;

  (ii) it is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or health care facility;

(iii) it is an "Appropriate" service or supply given the patient's circumstances and condition;

(iv) it is the most "Cost-Efficient" supply or level of service that can be safely provided to the patient;

(v) it is safe and effective for the Illness or Injury for which it is used; and

(vi) for Hospital Confinement, it cannot be safely provided on an outpatient basis.

The fact that a Physician or other Health Care Provider orders or recommends a service, supply, treatment or confinement does not in itself make them Medically Necessary.

- A medical service, supply, treatment or confinement will be considered to be "Appropriate" if:

(i) it is a diagnostic procedure that is called for by the health status of the patient, and is:

- as likely to result in information that could affect the course of treatment as; and
- no more likely to produce a negative outcome than

any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

(ii) it is care or treatment that is:

- as likely to produce a significant positive outcome as; and
- no more likely to produce a negative outcome than

any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

Mental or Nervous Disorder. A mental Illness or organic or functional nervous disorder that is identified as a mental or nervous disorder in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Participation Agreement. A written agreement in form or content acceptable to the Trustees pursuant to which an employer consents to be bound by the Trust Agreement and adopts the Plan.

Plan. The United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan, as amended from time to time.

Plan Classification. Any of several plans of benefits provided by the Fund. A participant is eligible for the plan of benefits for which his Contributing Employer makes the required contributions, as determined by the Trustees from time to time.

Spouse. The Eligible Employee's Spouse of the opposite or same sex when the marriage complies with the laws of the state in which the ceremony was performed.

Totally Disabled/Total Disability. The inability of an Eligible Employee to perform all the duties of his employment for which a Contributing Employer's contributions are payable to the Plan 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 under the care of a Physician for treatment consistent with the disability during the entire period of disability.

Trustees. The persons appointed pursuant to the provisions of the Trust Agreement and who are responsible for the operation and administration of the Plan and Fund, sometimes collectively referred to as the "Board of Trustees" or the "Board."

Union. Any local union affiliated with United Food and Commercial Workers International Union, AFL-CIO & CLC that has been or will become a party to the Trust Agreement and the Plan.

Usual and Customary Charge.

- With respect to a provider outside of the geographic area served by the PPO, the charge for Medically Necessary services or supplies will be determined by the Plan Sponsor or its designee to be the lowest of:
  - (i) the usual charge by the Health Care Provider for the same or similar service or supply; or
  - (ii) no more than 85% of the "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply; or
  - (iii) the Health Care Provider's actual charge.
- With respect to a PPO provider and any other provider within the geographic area served by the PPO, the Usual and Customary Charge means the charges set forth in the agreement between the PPO provider and the PPO or the Plan.
- The "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the Fund Administrator who will use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity.
- No provision of this Plan requires the Plan to pay benefits based on the charges submitted by a proprietary provider of a medical supply or service.

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. Refer to the section entitled "Statement of Rights Under the Employee Retirement Income Security Act of 1974" beginning on page 83.

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 Fund

United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
2625 Butterfield Rd, Suite 208E
Oak Brook, IL 60523
Telephone: 800-621-5133
FAX: 847-384-0197
Website: ufcwmidwest.org

The Trustees of the Plan* are:

Employer Trustees	Union Trustees
Brian Jordan	Robert O'Toole
Derek Kinney	Steve M. Powell
William R. Seehafer	Jonathan Willigman

The Alternate Trustees of the Plan* are:

Employer Trustees	Union Trustees
	Omar Arias
	Mary Gavrilos
	Mario Marin
	Nick Morrissey

**as of this printing*

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

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 will 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. The Board of Trustees is the Plan Sponsor.

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 Fund Administrator 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. The amount of employer contributions, and the Employees on whose behalf contributions are made, is determined by the provisions of the Collective Bargaining Agreements. The Benefits Fund Office will provide, upon written request, information as to whether a particular employer is contributing to the Fund on behalf of Employees working under the Collective Bargaining Agreement.

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

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

Type of Plan. This Plan is maintained for the purpose of providing death, disability, medical, prescription drug, vision and dental benefits. The Plan benefits are summarized in the applicable Summary of Benefits for your Plan Classification.

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 1.

Claim Procedure. The procedure to follow for filing a claim for benefits is summarized beginning on page 72. If all or any part of your claim is denied, you may appeal that decision. See Appendix A for detailed information on how to file a claim or how to appeal a claim denial.

Type of Administration. The Fund currently self-insures the medical, dental, prescription drug and income protection benefits provided under the Plan. Network providers are as follows:

Medical Network Provider
BlueCross BlueShield of Illinois
www.bcbs.com
800-810-BLUE (2583)

Dental Network Provider
Dental Network of America (Labor Dental PPO Network)
www.dnoa.com
866-522-6758

Prescription Drug Network Provider
WellDyneRx
www.wellview.welldyne.com
888-479-2000

Life and Accidental Death & Dismemberment Benefits Provider
BlueCross BlueShield
www.bcbsil.com/ancillary/employees
800-367-6401

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 will terminate or the Plan otherwise terminates, the Trustees will determine the

disposition of any assets in the Trust remaining after all expenses of the Fund have been paid, provided that any such distribution will 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, 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.

Appendix A. Claim Procedures

Internal Claims and Appeal Procedures

This describes the procedures followed by the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance abuse, dental, vision, hearing aid, prescription drug, income protection, death, and accidental death and dismemberment benefits.

The Plan's internal claims and appeal procedures are designed to provide an Eligible Employee and his or her Eligible Dependents with full, fair, and fast claim review so that Plan provisions are applied consistently with respect to an Eligible Employee and his or her Eligible Dependents and other similarly situated Participants and dependents. With respect to health benefit claims, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies an Eligible Employee or Eligible Dependent's initial claim for benefits (known as an "adverse benefit determination"), that Eligible Employee or Eligible Dependent has the right to appeal the denied claim under the Plan's internal appeals process.

General Information

Claims Administrator(s)

The Fund Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Zenith American Solutions 2625 Butterfield Rd, Suite 208E Oak Brook, IL 60523 800-621-5133 or 312-649-1200 zenith-american.com	• Medical Pre-Service and Post-Service Claims • Mental Health/ Substance Use Disorder Urgent, Concurrent, Pre-Service and Post-Service Claims • Income Protection Benefit Claims • Death Benefit Claims • Accidental Death and Dismemberment Claims • Vision Pre-Service and Post-Service Claims • Dental Pre-Service and Post-Service Claims • Hearing Post-Service Claims
ActiveHealth Management 3200 Highland Avenue Downers Grove, IL 60515 855-210-8738 activehealth.com	• Urgent, Concurrent and Pre-Service Medical Claims
WellDyneRx 500 Eagles Landing Drive Lakeland, FL 33810 888-479-2000 wellview.welldyne.com	• Pre-Service drugs • Post-Service Claims for out–of-network retail drugs

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Discretionary Authority of Fund Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Fund Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;

- a reduction of a benefit resulting from the application of any Pre-Authorization decision, source-of-Injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or

- a rescission of coverage, whether or not there is an adverse effect on any particular health or disability/income protection benefit. An adverse benefit determination does not include rescissions of coverage with respect to accidental death and dismemberment insurance/death benefits.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Doctor or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Culturally and Linguistically Appropriate Notices

All notices sent to claimants relating to internal claims and appeal review for health and disability/income protection benefits will contain a notice about the availability of Spanish language services. Assistance with filing a claim for internal review in Spanish is available by calling 800-621-5133. Notices relating to internal review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-621-5133.

Definition of a Claim

A claim is a request for a Plan benefit made by an Eligible Employee or his or her Eligible Dependent (also referred to as "claimant") or his or her authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits.

There are four categories of health claims as described below:

- ***Pre-Service Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)** - A Pre-Service Claim is a claim that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for medical, mental health, substance abuse, and prescription drug benefits.
- ***Urgent Care Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or if the pre-approval process would jeopardize the claimant's life or health.
- ***Concurrent Claims*** **(applicable to medical, mental health, and substance abuse benefits)** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- ***Post-Service Claims*** **(applicable to medical, mental health, substance abuse, dental, vision, hearing aid, and prescription drug benefits)** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered a Post-Service Claim.

Income Protection Benefit Claims

An Income Protection Claim is a request for benefits during a period of disability. Income Protection Claims are filed after a Participant suffers a disability and benefits are paid if the Claims Administrator determines that the Participant has suffered a disability as defined by the terms of the Plan.

Accidental Death and Dismemberment Insurance/Death Benefit Claims

An Accidental Death and Dismemberment Insurance/Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the Participant or the death of a covered dependent. A claim for Accidental Death and Dismemberment Benefits may also be filed by a Participant after he or she has provided the Plan with proof of a bodily loss.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- be received by the Fund Administrator or Claims Administrator (as applicable);

- name a specific individual Participant and his/her Social Security number or Unique ID Number;
- name a specific claimant and his/her date of birth;
- name a specific medical condition or symptom;
- provide a description and date of a specific treatment, service, or product for which approval or payment is requested (must include an itemized detail of charges);
- identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- when another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- not made in accordance with the Plan's benefit claims filing procedures described in this section;
- made by someone other than an Eligible Employee, his or her Eligible Dependent, or an Eligible Employee's (or his or her Eligible Dependent's) authorized representative;
- made by a person who will not identify himself or herself (anonymous);
- a casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- a request for prior approval where prior approval is not required by the Plan;
- an eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and be allowed to file an appeal;

- the presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, an Eligible Employee or Eligible Dependent may file a claim with the Plan; or

- a request for an eye exam, lenses, frames, or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, an Eligible Employee or his or her Eligible Dependent may file a claim with the Plan.

If an Eligible Employee or his or her Eligible Dependent submits a claim that is not complete or lacks required supporting documents, the Fund Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims should be filed within 90 days following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than 12 months from the date the charges were incurred.

A claim for the Income Protection Benefit must be submitted within two weeks of the onset of the disability. Subsequent reports confirming care and treatment must be submitted every three weeks thereafter.

Written notice of Illness or Injury upon which a claim for any other benefit may be based must be given to the Benefits Fund Office within 90 days of the date on which an expense was first sustained for an Illness or Injury for which benefits may be claimed.

The period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by an Eligible Employee, his or her Eligible Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will NOT automatically be considered an Eligible Employee or his or her Eligible Dependent's authorized representative.

Health Care Claims – Decision Timeframes

Pre-Service Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits)

Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. An Eligible Employee or his or her Eligible Dependent will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided the Eligible Employee or his or her Eligible Dependent is given written (or electronic, if applicable) notification before the expiration of the initial fifteen (15) day determination period.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify the claimant in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, the Eligible Employee or Eligible Dependent will have up to 45 days from the notification date to supply the additional information. If the Eligible Employee or Eligible Dependent does not provide the information during the 45-day period,

the claim will be denied (i.e., an adverse benefit determination). During the period in which the Eligible Employee or Eligible Dependent is permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives the Eligible Employee or Eligible Dependent's response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable).

Urgent Care Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits)

In the case of an Urgent Care Claim, if a health care professional with knowledge of an Eligible Employee or his or her Eligible Dependent's medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Fund to be that Eligible Employee or Eligible Dependent's authorized representative, bypassing the need for completion of the Plan's written authorized representative form.

The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. If during the review, additional information is required, the claimant will be notified within 24 hours and will be provided at least 48 hours to provide the information.

If the claimant does not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination).

The Claims Administrator will orally communicate its decision telephonically to the Eligible Employee or Eligible Dependent and his or her health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

Concurrent Claims (applicable to medical, mental health, and substance abuse benefits)

If a decision is made to either extend the duration or number or treatments previously approved or to reduce or terminate an ongoing course of treatment or number of treatments that was approved, an Eligible Employee or his or her Eligible Dependent will be provided with a written (or electronic, as applicable) notification.

The Fund will inform the claimant of the decision on a Concurrent Claim involving Urgent Care within 24 hours after receiving the claim, if the claim is received within 24 hours before the expiration of the previously approved time period for the treatment or number of treatments. The Claim will be processed according to the Plan's internal claims processing procedures and the timeframes applicable to an Urgent Care Claim, as described elsewhere in this section.

A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal claims processing procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as described elsewhere in this section.

Post-Service Claims (applicable to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug claims)

Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. An Eligible Employee or his or her Eligible Dependent will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify the claimant in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, the Eligible Employee or Eligible Dependent will have up to 45 days from the date of notification to supply the additional information. If the Eligible Employee or Eligible Dependent does not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which the Eligible Employee or Eligible Dependent is permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date that the Claims Administrator receives the Eligible Employee or Eligible Dependent's written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable).

Disability/Income Protection Claims – Decision Timeframes

Claims for Disability/Income Protection benefits will be decided no later than 45 days after receipt by the appropriate Claims Administrator. An Eligible Employee or his or her Eligible Dependent will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided the Eligible Employee or his or her Eligible Dependent is given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies the Eligible Employee or his or her Eligible Dependent of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided the Eligible Employee or his or her Eligible Dependent is notified of the additional delay, before the expiration of

the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify the Eligible Employee or his or her Eligible Dependent in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, the Eligible Employee or his or her Eligible Dependent will have 45 days after his or her receipt of the notice to supply the additional information. If the Eligible Employee or his or her Eligible Dependent does not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which the Eligible Employee or his or her Eligible Dependent is permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives the Eligible Employee or his or her Eligible Dependent's written response to the request for information. The Claims Administrator then has 30 days to make a decision and notify the Eligible Employee or his or her Eligible Dependent in writing (or electronically, as applicable).

Accidental Death and Dismemberment Insurance or Death Benefit – Decision Timeframe

Generally, an Eligible Employee or his or her Eligible Dependent will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator, you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies an Eligible Employee or his or her Eligible Dependent's initial claim, in whole or in part, that Eligible Employee or Eligible Dependent will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- identify the claim involved (and for health benefit claims – include the date of service, health care provider, claim amount if applicable, and denial code and its corresponding meaning);
- give the specific reason(s) for the denial (and for health benefit claims – include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- if the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- reference the specific Plan provision(s) on which the denial is based;
- describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- with respect to health and income protection benefit claims, upon request and without charge, the opportunity for reasonable access to copies of all documents, records, and other information relevant to an initial claim for benefits;
- provide an explanation of the Plan's internal appeal processes along with time limits and information about how to initiate an appeal for health benefit claims;

- contain a statement that the Eligible Employee or his or her Eligible Dependent has the right to bring civil action under ERISA section 502(a) following an appeal;
- with respect to health and income protection benefit claims, if the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement of such criteria relied upon to deny the claim will be provided to the Eligible Employee or his or her Eligible Dependent, upon request and without charge;
- if the denial of a health care claim or income protection claim was based on Medical Necessity, Experimental treatment, or a similar exclusion or limit, an explanation regarding the scientific or clinical judgment for the denial will be provided to the Eligible Employee or his or her Eligible Dependent upon request and without charge;
- with respect to disability/income protection claim, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;
- for Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- with respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist the Eligible Employee or his or her Eligible Dependent with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, an Eligible Employee or his or her Eligible Dependent will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to an Eligible Employee or his or her Eligible Dependent and his or her health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

Health Care Claims

Applies to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits)

If an initial health care claim is denied (in whole or in part) and an Eligible Employee or his or her Eligible Dependent disagrees with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following the date of initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

Income Protection Claims

If an initial Disability/Income Protection Claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following the date of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

Accidental Death and Dismemberment Insurance/Death Benefits

If an initial accidental death and dismemberment /death benefit claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an appeal. You have 180 calendar days following the date of initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 180-day period.

Internal Appeals Process

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan at the following address:

Board of Trustees
United Food and Commercial Workers
Unions and Employers
Midwest Health Benefits Fund
2625 Butterfield Rd, Suite 208E
Oak Brook, IL 60523
800-621-5133

Appeal requests involving Urgent Care Claims may be made orally by calling the Board of Trustees at the telephone number listed above.

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process and upon written request, the Plan will provide you with:

- reasonable access to and copies of all documents, records, and other information relevant to your initial claim for benefits, upon request and without charge;
- the opportunity to submit to the Plan written comments, documents, records, and other information relating to your initial claim for benefits;
- with respect to health and disability/income protection benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;
- a full and fair review by the Plan that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, not Medically Necessary, or appropriate, the fiduciary or fiduciaries will:
    - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment;
    - is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
    - the Plan will provide, upon request, the identification of medical or vocational experts

whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

Health Care Claims

Pre-Service Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits). A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.

Urgent Care Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits). This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

Concurrent Claims *(applicable to medical, mental health, and substance abuse benefits).* You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Board of Trustees. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

Post-Service Claims *(applicable to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits).* The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you in writing (or electronically, as applicable) of the benefit determination no later than five (5) calendar days after the benefit determination is made.

Income Protection Benefit Claims. The Plan will make an appeal determination no later than the date of the meeting immediately following the Plan's receipt of your written request for an appeal, unless the request for an appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary the Plan must provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you of the benefit determination no later than five (5) calendar days after the benefit determination is made.

Notice of Adverse Benefit Determination upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- the specific reason(s) for the adverse benefit determination including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive upon request free access to and copies of documents relevant to the claim;
- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- if the denial of a claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request; and
- if the denial of a claim was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement must be provided that such rule, guideline, protocol, or criteria will be provided free of charge, upon request.

This concludes the appeal process under this Plan.

Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing, on a form provided by the Fund, as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan.

The Plan requires you (or a parent or legal guardian of a claimant who is a minor) to provide a signed statement declaring your designation of an authorized representative and specifically authorizing the representative to seek benefits on your behalf. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Administrator).

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.*, notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is your legal Spouse, parent, grandparent, or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative until you revoke the designation in writing, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Fund Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Limitation on When a Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. With respect to health and disability/income protection benefits, the law also permits you to pursue your remedies under section 502(a) of the Employee

Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.

No lawsuit may be started more than three years after the end of the year in which services were provided, or, if the claim is for disability benefits, more than three years after the start of the disability.

Elimination of Conflict of Interest

With respect to health and disability/income protection benefits, to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

Culturally and Linguistically Appropriate Notices

All notices relating to external review sent will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling 800-621-5133. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 800-621-5133.

Appendix B. Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. The effective date of this notice is September 23, 2013.

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:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- 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 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 Doctor the name of your treating radiologist so that the Doctor 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, and pre-certifications). For example, the Plan may tell a treating 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. However, no genetic information can be used or disclosed for underwriting purposes. 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 that You be Given an Opportunity to Agree or Disagree Prior to the Use or Release. Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person

you indicate is involved in your health care or is helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

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:

- For treatment, payment and health care operations.
- Enrollment information can be provided to the Trustees.
- Summary health information can be provided to the Trustees for the purposes designated above.
- When required by law.
- 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.
- 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.

- 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).

- 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.

- 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.

- 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.

- 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.

- 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.

Uses and Disclosures that Require Your Written Authorization. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

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, (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket). 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.

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.

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. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

"*Protected Health Information*" (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.

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.

You or your personal representative will be required to submit a written request for access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

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.

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.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request for an amendment of the PHI in your designated record set.

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: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2004; 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.

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.

Such requests should be made to the Plan's Privacy Official.

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.

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:

- a power of attorney for health care purposes;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of an un-emancipated 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 September 23, 2013, 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.

If the revised version of this Notice is posted on the Plan's website, www.ufcwmidwest.org, you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the 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. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

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

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

The Plan Sponsor will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;
- ensure that the adequate separation discussed in Item (d) above, specific to electronic PHI, is

supported by reasonable and appropriate security measures;

- ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- report to the Plan any security incident of which it becomes aware concerning electronic PHI.

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.

Notification of Breach. The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

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.

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 2625 Butterfield Rd, Suite 208E, Oak Brook, IL 60523, 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 information below can help you decide whether or not you want to join a Medicare drug plan. If you defer enrollment in Part D, you will need this Appendix C (or the similar notice that you will receive each year from the Benefits Fund Office) in order to avoid paying a higher premium (a penalty).

Your Prescription Drug Benefits and Medicare Prescription Drug Coverage

If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The UFCW Plan has determined that your existing, active UFCW Plan prescription drug coverage is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current UFCW Plan coverage will be affected. Your coverage under the UFCW Plan will be coordinated with your Medicare prescription drug coverage.

If you decide to join a Medicare drug plan and drop your current UFCW Plan coverage, be aware that you and your covered dependents will not be able to get this coverage back until the UFCW Plan's next open enrollment period in November.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

If you are entitled to Medicare and you drop or lose your coverage with the UFCW Plan and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about this Notice or your Current Prescription Drug Coverage

Contact the person listed below for further information. Note: You will receive a notice similar to this Appendix C each year. You will also get it before the next period you can join a Medicare drug plan, and if your UFCW Plan coverage changes. You also may request a copy of the notice at any time.

For More Information about your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit https;//www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more information about this extra help, visit Social Security on the web at socialsecurity.gov or call them at 800-772-1213 (TTY: 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Appendix D. Summary of the Cafeteria Plan

Your Employer may have adopted the “Cafeteria Plan for Employees Participating in the UFCW Unions & Employers Midwest Health Benefits Fund” (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 Fund (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 filing the enrollment form to participate in the Health Benefits Plan in a timely manner, 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 yours 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 has 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 ("SPD") for information regarding the Health Benefits Plan's benefits.

If you have any questions after reading this summary, please contact the Zenith American Solutions at 2625 Butterfield Rd, Suite 208E, Oak Brook, IL 60523 or call 800-621-5133 during normal business hours.

Appendix E. Summary of Dental Benefits

Dental benefits are paid according to a Schedule of Benefits. The following table lists some of the procedures performed most often, including the American Dental Association

Diagnostic and Palliative Treatment—No Deductible Required

Prophylaxis—Adult (maximum two treatments in any Calendar Year)	$ 83.00
Prophylaxis—Child	65.00
Oral examination	43.00
Topical application of fluoride	31.00
Topical sealant, per tooth	50.00
Radiographs	
Complete series, including bitewings (once each Calendar Year)	113.00
Periapical—single, first film	25.00
Periapical—each addition film	20.00
Bitewings—two films	38.00
Bitewings—four or more films	55.00
Panoramic X-ray (once each Calendar Year)	105.00
Palliative treatment (Emergency)	83.00
Diagnostic casts	80.00

Basic Dental Benefits

Surgical Extractions (including routine post-operative visits)	
Each single uncomplicated extraction	73.00
Surgical extraction, erupted	128.00
Removal of impacted tooth (soft tissue)	162.00
Removal of impacted tooth (partially bony)	195.00
Removal of impacted tooth (completely bony)	225.00
Surgical placement of implant	677.00
Surgical Incisions and Excisions	
Alveoplasty with extractions (per quadrant)	107.00
General anesthesia (in or out of Hospital)	249.00
General analgesia	24.00

Restorative Dentistry

Amalgam Restorations	
One surface	57.00
Two surfaces	62.00
Three surfaces	83.00
Four or more surfaces	88.00
Composite Resin Restorations	
One surface	69.00
Two surfaces	83.00
Three surfaces	93.00
Four surfaces or incisal angle	130.00
Inlay Restorations—Non-Abutment	
One surface, old	316.00
One surface, porcelain	362.00
One surface, composite	339.00
Two surfaces, gold	384.00
Two surfaces, porcelain	407.00
Two surfaces, composite	362.00
Three surfaces, metallic	388.00
Three surfaces onlay, metallic	407.00
Four or more surfaces onlay, metallic	429.00
Four or more surfaces onlay, porcelain	474.00
Four or more surfaces onlay, composite	429.00
Crowns—Non-Abutment	
Plastic prefabricated	125.00
Porcelain	483.00
Porcelain with gold	483.00
Porcelain with nonprecious metal	425.00
Porcelain with semiprecious metal	468.00
Gold full cast	468.00
Metal full cast	488.00
Stainless steel crown	170.00
Steel post and amalgam core	138.00
Cast post and gold core	170.00
Recement inlays	30.00
Recementation of crown	44.00
Sedative filling	48.00
Crown buildup-pin retention	123.00

Endodontics

Pulp capping, direct	33.00
Pulp capping, indirect	23.00
Vital pulpotomy	88.00
Root Canal Therapy	
Anterior (excludes final restoration)	327.00
Bicuspid (excludes final restoration)	388.00
Molar (excludes final restoration)	459.00
Apicoectomy (separate procedure)	338.00

Periodontics

Osseous surgery (per quadrant; minimum 4 teeth)	407.00
Periodontal scaling (full-mouth debridement prior to periodontal therapy)	74.00
Periodontal scaling and root planning; (per quadrant; minimum of 4 teeth)	100.00
Maintenance periodontal prophylaxis (following periodontal therapy)	60.00

Prosthetic Replacements

Fixed Bridgework	
Crowns—Abutment Teeth	
Porcelain, gold	308.00
Porcelain, nonprecious	282.00
Porcelain, semiprecious	287.00
Gold (full cast)	269.00
Nonprecious cast	241.00
Semiprecious cast	254.00
Pontics	
Cast gold (sanitary)	269.00
Cast nonprecious metal	241.00
Cast semiprecious metal	254.00
Porcelain, gold	308.00
Porcelain, nonprecious	282.00
Porcelain, semiprecious	287.00
Recement bridge	47.00
Complete Denture	
Upper (Maxillary)	367.00
Lower (Mandibular)	367.00

Removable Partial Denture	
Upper, resin base	367.00
Lower, resin base	367.00
Upper or lower, cast framework, resin base	424.00
Removable unilateral partial, 1 piece cast metal	282.00
Reline—Rebase	
Office reline (chairside), full denture	62.00
Office reline (chairside), partial denture	43.00
Laboratory reline, full denture	107.00
Laboratory reline, partial denture	85.00
Full denture rebase	107.00
Partial denture rebase	127.00
Space Maintainers	
Fixed or removable, unilateral	181.00
Fixed or removable, bilateral	275.00
Recementation	40.00