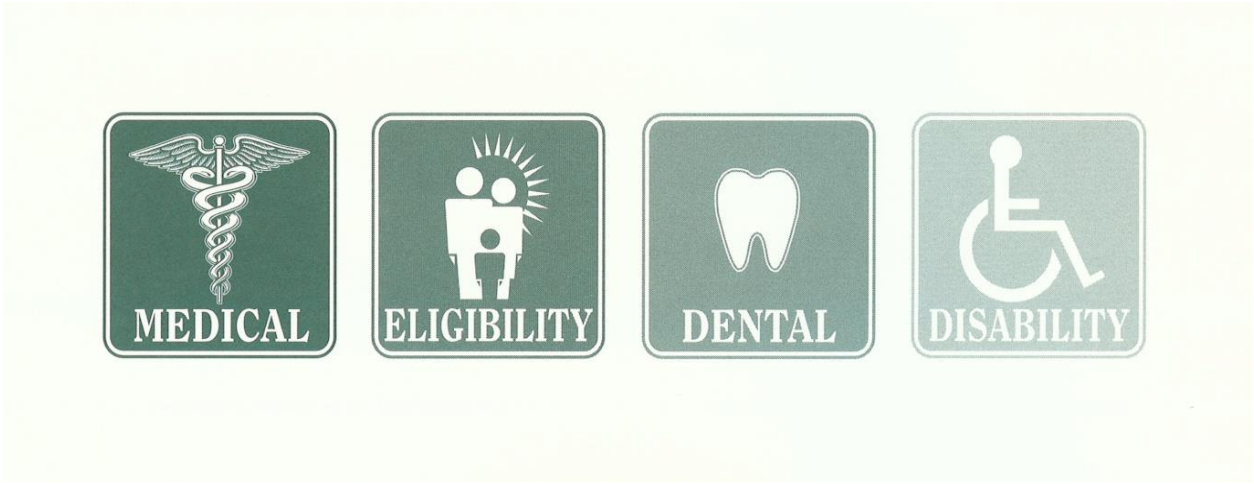

UFCW
a VOICE for working America
SERVING ITS MEMBERS AND THE COMMUNITY Local 1529

UNITED FOOD AND COMMERCIAL WORKERS
LOCAL NO. 1529 AND EMPLOYERS
HEALTH AND WELFARE
PLAN AND TRUST

SUMMARY PLAN DESCRIPTION FOR ACTIVE EMPLOYEES

Revised July 2017

Please refer to the Benefits and Enrollment Booklet and
Summary of Benefits and Coverage for additional details regarding this Plan.

Summary Plan Descriptions and Electronic Consent:

SPD's and SBC's, as well as other plan information can be found on www.bams.bz. You can access them through the website however you also have the option to request a hard copy free of charge. To request a hard copy, please send a request to the Administration Office.

United Food & Commercial Workers Union Local 1529 and Employers Health and Welfare Plan and Trust

BENEFITS CLAIMS AND TRUST OFFICE

Administrative Consulting Services of Tennessee, Inc.
661 N. Ericson Rd.
Cordova, TN 38018

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United Food & Commercial Workers Union Local 1529 and Employers Health and Welfare Plan and Trust

To All Eligible Employees:

We are pleased to supply you with this revised booklet describing the benefits provided by the Health and Welfare Plan and Trust.

Some of the benefits described in this booklet are insured through insurance companies or bound by policy contracts, and others are self-funded through your Health and Welfare Plan and Trust.

Your Health and Welfare Plan (the Plan) includes medical and prescription drug benefits for all eligible employees as well as dental, vision, accident and sickness, life, and accidental death and dismemberment benefits for select employees.

The booklet furnishes a brief description of the benefits to which you are entitled, the rules governing these benefits, and the procedures that should be followed when making a claim. Also included is certain information concerning the administration of the Plan and your rights under the Employee Retirement Income Security Act (ERISA) of 1974.

It is and has always been the intention of the Trustees to operate the Plan in strict conformity with all federal laws and regulations on a nondiscriminatory basis. The Trustees will continue to make changes whenever necessary to maintain compliance with such laws.

Several changes have been made in the Plan since the last booklet was issued. Therefore, you should read this booklet carefully to become familiar with the benefits that the Plan provides to you.

Any questions you may have should be directed to the Benefits Claims and Trust Office where the staff will be happy to assist you.

Sincerely yours,

BOARD OF TRUSTEES

IMPORTANT! This booklet furnishes a Summary Plan Description of these benefits to which you are entitled. However, in the event of a discrepancy, the language contained in the Plan Document and the other applicable instruments will govern. You may review these documents at the Administrative Office or copies may be obtained at a reasonable charge. This booklet also contains the rules governing these benefits and the procedures that should be followed when making a claim.

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SUMMARY OF ELIGIBILITY PROVISIONS

There are three Plans of Benefits, Plan A, Plan B, and Plan C for which an employee may become eligible. The eligibility for each of these Plans is based on certain requirements, such as the number of hours the employee works for an Employer, and the length of time the employee has been employed by the Employer.

Plan A: Employees on payroll and qualified as of July 1, 2001, shall continue to be eligible for the plan identified by the Health and Welfare Plan & Trust as Plan A. **(Closed Plan).**
***Effective January 1, 2016, at each Open Enrollment, these employees can choose to elect coverage in Plan B or Plan C as opposed to Plan A, thereby reducing the required weekly employee premium. If a Plan A eligible employee elects to enroll in Plan B or Plan C, the employee can elect Plan A during a future Open Enrollment period.**

Plan B: Full and part-time employees on the payroll and qualified after July 1, 2001, shall be eligible for a schedule of benefits identified as Plan B.
***** Effective January 1, 2016, at each Open Enrollment, these employees can choose to elect coverage in Plan C as opposed to Plan B, thereby reducing the required weekly employee premium. If an election is made to enroll in Plan C, the employee can elect Plan B during a future Open Enrollment period.**

"**Plan C:** Full-time employees hired after July 1, 2005 and part-time employees hired after January 1, 2005, shall be eligible for a schedule of benefits identified as Plan C. After thirty-six (36) months of Plan C eligibility, the employee will move to Plan B.
*****Effective January 1, 2016, after thirty-six (36) months of Plan C eligibility, the employee will be eligible to elect Plan B, otherwise they will remain in Plan C. If an election is made to stay in Plan C or enroll in Plan B, the employee can elect either Plan B or Plan C during a future Open Enrollment period. Employees will have 60 days to enroll in Plan B from the date they qualify to enroll in Plan B.**"

Courtesy Clerks, Fuel Clerks, and Students under age 18: Effective January 1, 2016, a courtesy clerk, fuel clerk, or student under age 18 with access to coverage through another source will become eligible for health and welfare benefits on the first day of the first calendar month immediately following nine months of employment if he/she has maintained an average of thirty hours per week (360 hours) under current eligibility rules. Coverage is for the employee only. Dependents and spouses cannot be added.

DEPENDENT ELIGIBILITY

Eligible Dependent. "Eligible Dependent" means the following:

A. The Spouse of a Full-Time Eligible Employee. The term "Spouse" shall mean an individual who is married to the Full-Time Eligible Employee in a legally recognized civil or religious ceremony, and who is not legally separated from the Full-Time Eligible Employee. A Full-Time Eligible Employee's common law spouse shall be considered a Spouse for purposes of this Plan if the Full-Time Eligible Employee and his alleged spouse offer proof in a form satisfactory to the Board of Trustees that the couple fulfill all of the conditions of a common-law marriage which the Full-Time Eligible Employee's state of domicile requires.

B. A child of a Full-Time Eligible Employee provided that the child:
   1. has not yet attained age 26
   2. is incapable of sustaining employment because of a Total Disability, according to a Physician's statement, before the child reaches age 26, and the child was covered under this Plan immediately before attaining age 26, provided the child is "dependent" on the Full-Time Eligible Employee for support and remains disabled after age 26. Proof of such disability must be filed within 31 days after the dependent child attains the maximum age of 26.

C. For purposes of this this Plan, "child" means a natural born child or an adopted child of a Full-Time Eligible Employee. In addition, any of the following shall be classified as a child subject to the support requirement described below:
   1. A stepchild of an Eligible Full-Time Employee, who is dependent upon the Eligible Full-Time Employee for support.
   2. Any other child, the care, custody, and control of whom is that of the Full-Time Eligible Employee pursuant to a court order, including a guardianship, who is dependent upon the Eligible Full-Time Employee for support.
   3. A grandchild who has been dependent on the Full-Time Eligible Employee for support at least 9 months during a calendar year and is living in the Full-Time Eligible Employee's household.
   4. For purposes of subparagraphs 1, 2, and 3 only, a child shall be deemed not dependent upon the Full-Time Eligible Employee for support unless the Full-Time Eligible Employee includes the child as a dependent on the Full-Time Eligible Employee's federal income tax return, or a court has issued a Qualified Medical Child Support Order requiring this Plan to maintain coverage for such child.

D. A Full-Time Eligible Employee shall be deemed an Eligible Dependent if his/her spouse is an Employee of the same Employer and is an Eligible Person under this Plan. Coverage will be primary as a Full-Time Eligible Employee, and secondary as an Eligible Dependent under Article X ("Coordination of Benefits")."

TERMINATION OF ELIGIBILITY
Certificate of Coverage

When your coverage terminates, you will receive a "Certificate of Coverage." The certificate provides information regarding the period of coverage under the Plan. You may also request a copy of the certificate at any time within 24 months after your coverage terminates. If your dependent loses eligibility separately and the Administrative Manager is notified that the dependent is no longer an Eligible Dependent, a separate certificate will be provided for that dependent; this certificate may also be requested within 24 months after the dependent's coverage has been terminated.

Except as provided in the applicable Collective Bargaining Agreement, an Eligible Employee's coverage will terminate upon the earliest of the following dates:

- The last day of the month for which an Employer Contribution is made on the Employee's behalf;
- The date this Plan terminates;
- The Employee's death;
- The date the Employee enters Active Duty in the Uniformed Services, unless coverage is continued as required by USERRA; or
- The date the Employee becomes covered under the United Food and Commercial Workers Local Union No. 1529 and Employers Health and Welfare Plan and Trust for Retirees

Except as provided in the applicable Collective Bargaining Agreement, an Eligible Dependent's coverage shall terminate on the earliest of the following dates:

- The date the Dependent no longer satisfies the definition of Eligible Dependent;
- The date the Eligible Employee is no longer in a class of Employees eligible for Dependent coverage;
- The date the eligible dependent reaches age 26
- Upon discontinuance of all dependent coverage under this Plan; or
- Upon termination of eligibility of a deceased Active Employee;
- Upon termination of the associated Active Employee's eligibility

For a full list of employee and dependent eligibility requirements, please see the Plan Document and Benefits and Enrollment Booklet.

NOTE: This booklet does not cover benefits that may be available to retirees. The terms and conditions of those benefits are described in a separate booklet that is available from the Benefits Claims and Trust Office.

COMPREHENSIVE MEDICAL COVERAGE

DESCRIPTION OF BENEFITS

For most Eligible Expenses, the Plan provides benefits at the applicable Coinsurance percentage after the Calendar Year Deductible has been satisfied. Benefits are subject to:

(1) the requirements of the Utilization Management Program;

(2) the Plan's Usual and Customary Charges;

(3) any annual or lifetime maximums on specific conditions or services set forth in the Benefits and Enrollment Booklet; and

(4) the Exclusions from Coverage set forth below.

DEDUCTIBLE

Before the Plan begins to provide benefits for most Eligible Expenses, each Eligible Person must satisfy the Calendar Year Deductible set forth in the Benefits and Enrollment Booklet. Once two (2) Eligible Persons in the same family each satisfy the Deductible during the same Calendar Year, the Deductible will be considered satisfied for all Eligible Persons in that family for the remainder of that Calendar Year.

EMERGENCY ROOM DEDUCTIBLE

Each visit to the emergency room of a Hospital is subject to an additional and separate Emergency Room Deductible. This Emergency Room Deductible will be waived if:

(1) the patient is admitted to the Hospital directly from the emergency room;

(2) the emergency room visit is for the treatment of a life-threatening or limb-threatening Accidental Injury that occurred within a reasonable time proximity to the emergency room visit; or

(3) had the emergency room visit not occurred, the patient's life could have been placed in danger, or serious impairment of the patient's bodily functions could have occurred.

COINSURANCE

After any applicable Deductibles have been satisfied, the Plan will reimburse Eligible Expenses in accordance with the Coinsurance percentages set forth in the Benefits and Enrollment Booklet.

OUT-OF-POCKET MAXIMUM

Once the out-of-pocket amount paid by an Eligible Person for Eligible Expenses in a Calendar Year reaches the Out-of-Pocket Maximum set forth in the Benefits and Enrollment Booklet, the Plan would reimburse at 100% of the allowable in network charges for the remainder of the calendar year. The following expenses do not apply toward the Out-of-Pocket Maximum:

(1) the Calendar Year Deductible;

(2) any copayments for In-Network Physician office visits;

(3) any Coinsurance the Eligible Person must pay for failure to comply with the requirements of the Utilization Management Program; and

(4) any copayments, coinsurance, or other costs associated with benefits other than comprehensive medical benefits, such as prescription drug, dental, and vision benefits.

In addition, any Coinsurance the Eligible Person must pay for failure to comply with the requirements of the Utilization Management Program is not subject to reimbursement at 100% once the Out-of-Pocket Maximum has been satisfied.

MAXIMUM BENEFITS FOR CERTAIN SERVICES AND CONDITIONS

The Plan will reimburse Eligible Expenses for certain services and conditions only up to the Calendar Year, annual and/or lifetime maximums set forth in the Benefits and Enrollment Booklet.

PREFERRED PROVIDER ORGANIZATION

The Plan has entered into a contract with a Preferred Provider Organization (PPO). A PPO is a network of health care providers that agreed to provide health care services at discounted rates. When you obtain services from In-Network Providers, your out-of-pocket costs will be lower and the Plan's costs will be lower, creating savings for both you and the Plan.

Services may also be obtained from Out-of-Network Providers; however, the fees will not be discounted. In addition, Eligible Expenses for services obtained from an Out-of-Network Provider are reimbursed at a lower Coinsurance level than services obtained from an In-Network Provider, as set forth in the Benefits and Enrollment Booklet. In general, your out-of-pocket costs will be highest when you obtain services from Out-of-Network Providers.

The PPO has an extensive network of health care providers. However, some Eligible Persons may reside outside of the geographic range or "service area" of the PPO. You always have the choice of driving into the PPO service area to obtain health care services from In-Network Providers. If, however, you are unable or unwilling to do this, you may obtain services from Out-of-Network Providers, resulting in higher costs to you and the Plan.

EXAMPLE Here's an example of how using an In-Network Physician can save you money.

The following example compares what Joe would pay if he went to an In-Network Physician and an Out-of-Network Physician for an office visit for a routine illness, such as a sinus infection. This example assumes Joe has satisfied his Deductible and his Coinsurance is 60% Out-of-Network.

	In-Network Physician	Out-of-Network Physician
Charge	$150	$150
Joe's Coinsurance	$15 copayment	40%
Joe Pays	$15	$60

In the above example, **using an In-Network Physician saved Joe $45!**

LOCATING IN-NETWORK PROVIDERS

If you have access to the Internet, go to the Benefits Claims and Trust Office's website at www.bams.bz to locate an In-Network Provider in your area. Or, call the Benefits Claims and Trust Office at (901) 758-3000 or (800) 874-8499.

UTILIZATION MANAGEMENT PROGRAM

(1) The Plan maintains a Utilization Management Program, administered by the Utilization Review Company, to ensure that Eligible Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

(2) Under the terms of the Utilization Management Program, the Hospital, the Eligible Person, his Physician, or some other individual acting on behalf of the Eligible Person must contact the Utilization Review Company at the phone number on your identification card and obtain prior authorization in each of the following situations:

(a) Inpatient Admissions to a Hospital, extended care facility, Skilled Nursing Facility, rehabilitation facility, or any other facility in which the patient is expected to remain overnight. This includes Admissions for acute care, for surgery, for elective Admissions, for extended care or for any other reason.

(b) Situations when an institution, ordinary a Hospital, will be the site of patient observation.

(c) Outpatient procedures relating to septoplasty and blepharoplasty.

(d) Diagnostic imaging, including, but not limited to: MRI, CT scans of any kind, SPEC, PET, and MRA.

(e) Hospice Care.

(f) Home Health Care, including but not limited to intravenous (IV) therapy and phototherapy.

(g) Injectable and self-injectable drugs prescribed by a Physician that are anticipated to cost more than $300.

(h) Services and devices associated with the coverage of Sleep Apnea.

(3) Prior authorization may be required for other services and supplies as added to this list by the Board of Trustees from time to time. A current listing of the services and supplies that require prior authorization may be obtained from the Utilization Review Company or the Benefits Claims and Trust Office.

(4) Even though the Hospital, a Physician, or some other individual acting on behalf of the Eligible Person may make the call, the Eligible Person is still responsible for ensuring that the call is made.

(5) The call for prior authorization must be made PRIOR TO obtaining non-emergency outpatient care that requires prior authorization in accordance with the above list. For any inpatient admission, the call must be made within one business day following the admission.

(6) Prior authorization for each of the situations described above must be obtained regardless of whether the care is obtained from an In-Network Provider or Out-of-Network Provider. If in doubt, contact the Utilization Review Company.

(7) Failure to obtain the necessary prior authorization will result in a penalty of a 10% lowering of the Coinsurance that would otherwise apply, as set forth in the Benefits and Enrollment Booklet. Coinsurance that an Eligible Person must pay for failure to obtain prior authorization does not apply toward the Out-of-Pocket Maximum and is not subject to reimbursement at 100% once the Out-of-Pocket Maximum has been satisfied.

MAKE THE CALL!

You MUST call the Utilization Review Company at the phone number on your identification card PRIOR TO obtaining any of the non-emergency services on this list. For Hospital Admissions, you must call the Utilization Review Company within one (1) business day following the Admission. If you do not obtain authorization for these services, there will be a 10% lowering of the Coinsurance that would otherwise apply. That means if the Plan normally pays 80% Coinsurance, it would only pay 70%. Instead of you paying 20% Coinsurance, you would have to pay 30% Coinsurance (that is, more than the normal Coinsurance). On a bill of $15,000 for a hospitalization, you would be responsible for $4,500 instead of just $3,000. In addition, the 10% or $1,500 penalty cannot be applied toward your Out-of-Pocket Maximum and is not subject to reimbursement at 100% once the Out-of-Pocket Maximum is satisfied.

ELIGIBLE EXPENSES

Comprehensive Medical benefits are provided for the following Eligible Expenses:

(1) The following Hospital services and supplies:

(a) Room and board charges for each day of a Hospital stay.

(b) Meals and special diets.

(c) Administration of blood, blood plasma and blood typing.

(d) Use of operating room including cystoscopic room and cast room.

(e) Anesthesia charges.

(f) Oxygen and Physician prescribed drugs.

(g) Lab and x-ray examination, radiation treatment.

(h) Use of radium and radioactive substances.

(i) Basal metabolism examinations.

(j) Electrocardiograms.

(k) Electroencephalograms.

(l) Physical therapy.

(m) Dressings and casts.

(n) Orthopedic Braces.

(o) Ambulatory appliances.

(p) Prosthetic appliances.

(2) The following Home Health Care services and supplies:

(a) Care by a registered nurse (RN).

(b) Physical therapy if connected with the illness or injury for which the Eligible Person receives Home Health Care services.

(c) Services of a home health aide, as long as a family member cannot perform those services. The aide must be an employee of the Home Health Care Agency or working under the Agency's supervision. The aide must also be trained in the care of the sick and must work under the supervision of a home health care professional.

(d) A 30-day supply of medical supplies that are necessary for the proper at-home treatment of the illness or injury for which the Eligible Person receives Home Health Care services. The supplies must be provided by the Hospital from which the Eligible Person is discharged or by a pharmacy.

(e) Laboratory tests and X-rays provided by the Hospital from which the Eligible Person was discharged, or by a medical laboratory. The tests must be connected with the illness or injury for which the Eligible Person was treated in the Hospital.

When it will be in the best medical and personal interest of an Eligible Person, the Administrative Manager, acting pursuant to guidelines adopted by the Trustees, may authorize, provide, and pay for health care case management services in lieu of the institutional and/or professional services provided for under the Plan.

(3) The following Skilled Nursing Facility services and supplies:

(a) Room and board.

(b) Meals and special diets.

(c) General nursing services.

(d) Use of special treatment rooms.

(e) Laboratory services.

(f) Physical therapy.

(g) Oxygen and other gas therapy.

(h) Drugs, biologicals and solutions provided for cure and treatment and used while in the facility.

(i) Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings and casts.

(4) Hospice Care services and supplies that meet all of the following conditions:

(a) At least 24 hours prior to initiating Hospice Care, the Eligible Person has submitted a statement from his attending Physician and the Hospice Care Physician attesting to the fact that he is terminally ill with a life expectancy of six months or less.

(b) The Hospice Care is in lieu of any other Plan benefits and coverages.

(c) The Eligible Person or the responsible family member has submitted to the hospice providing care a statement that contains the following items:

(i) The name of the designated hospice;

(ii) The Eligible Person's or the responsible family member's acknowledgment that he understands that certain Plan benefits and coverages are waived by electing Hospice Care benefits;

(iii) The effective date of the Eligible Person's or the responsible family member's election of the Hospice Care benefits;

(iv) The name of the Eligible Person; and

(v) The signature of the Eligible Person or the responsible family member.

(5) Maternity and obstetrical care for the Eligible Employee and Eligible Dependent spouse, only, including expenses incurred for obstetrical procedures in a Birthing Center. A Birthing Center is defined as a facility licensed under state law, as applicable, to provide obstetrical care and treatment. The Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal delivery, or less than 96 hours following a cesarean section, or requiring a Physician to obtain authorization from the Plan (or its Utilization Management Company) for prescribing a length of stay not in excess of those periods.

(6) The following expenses related to the transplant of an organ, provided the transplant is not considered Experimental or Investigational and the patient is admitted to a transplant center

program in a medical center approved either by the federal government or the appropriate state agency of the state in which the center is located:

(a) Patient screening;

(b) Organ procurement and transportation;

(c) Surgery for the patient

(d) Follow-up care in the home or a Hospital;

(e) Immunosuppressive drugs.

Eligible Expenses related to the transplant of an organ performed at a Center of Excellence will be treated as In-Network services and covered as set forth in the Benefits and Enrollment Booklet. Eligible Expenses related to the transplant of an organ not performed at a Center of Excellence will be treated as Out-of-Network services and will be covered as set forth in the Benefits and Enrollment Booklet.

Expenses incurred for donation or transplant of an organ in cases where the recipient is not an Eligible Person will not be covered.

No expenses of the an organ donor will be paid, unless the expenses are incurred at a Center of Excellence and are included in the Plan's negotiated fee with the Center of Excellence.

(7) The following expenses related to tissue transplants, provided the transplant is not considered Experimental or Investigational and the patient is admitted to a transplant center program in a medical center approved either by the federal government or the appropriate state agency of the state in which the center is located:

(a) Patient screening;

(b) Tissue procurement and transportation;

(c) Surgery for the patient

(d) Follow-up care in the home or a Hospital;

(e) Immunosuppressive drugs.

Expenses incurred for donation or transplant of tissue in cases where the recipient is not an Eligible Person will not be covered.

(8) Ambulance transportation to or from the nearest Hospital that is equipped to treat the Eligible Person’s condition, when provided in connection with an Accidental Injury or Medical Emergency.

(9) Blood, including the cost of blood plasma expanders and the cost of blood plasma.

(10) Prescription Drugs and medications while an Inpatient.

(11) Durable Medical Equipment, such as a wheelchair or hospital bed. The rental or purchase of such equipment will be covered not to exceed the purchase price.

(12) Cost and administration of anesthetics.

(13) Inhalation therapy for treatment of a respiratory condition by inhalation of water vapors, oxygen or other substances.

(14) Medical supplies such as oxygen, surgical dressings and colostomy bags. Items usually stocked in the home for general use, such as adhesive bandages, petroleum jelly and thermometers, are not covered.

(15) Medical services performed by a Physician. This includes Inpatient Hospital visits, consultations, house calls and office visits.

(16) Casts, splints, trusses, crutches, orthopedic braces and other prosthetic appliances when needed in connection with an illness or injury. Prosthetic appliances include:

(a) Artificial limbs and eyes;

(b) The first lenses following cataract surgery.

Eligible Expenses include the fitting, adjustment and replacement of orthopedic braces and prosthetic appliances. Replacement of such prostheses will be limited to no more often than once every period of twenty-four consecutive months. Support hose and dental braces are not covered.

(17) Rental of an artificial kidney machine and any Medically Necessary supplies needed for dialysis. Home testing related to the dialysis treatments is also covered. Benefits for home hemodialysis do not include furniture, installation charges, other setup charges and maintenance.

(18) Diagnostic laboratory and x-ray examinations (other than dental x-rays not necessitated by an injury); x-rays, radium and radioactive isotopes therapy.

(19) Expenses incurred for chiropractic treatment.

(20) Expenses incurred for podiatry treatment or surgery.

(21) Inpatient and outpatient treatment of a Mental or Nervous Disorder up to the maximum number of days and/or visits set forth in the Benefits and Enrollment Booklet.

(22) Outpatient speech therapy and occupational therapy services up to the maximum amount set forth in the Benefits and Enrollment Booklet.

(23) Outpatient physical therapy services up to the maximum amount set forth in the Benefits and Enrollment Booklet.

(24) Preventive and wellness services, and routine physical examinations, injections, and immunizations.

(25) Routine medical care for newborn infants.

(26) Allergy injections and sera.

(27) Mammograms.

(28) Therapeutic abortions.

(29) Sterilization.

(30) Charges for breast reconstruction following a mastectomy. Eligible Expenses include:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas. Eligible Expenses are limited to one such prosthesis and no more than two associated bras per period of twelve consecutive months.

PREVENTIVE CARE

The following services are covered at 100% when services are performed and coded as Preventive and performed at an In-Network provider:

(1) Well-baby and well-child care

(2) Annual pap smear and pelvic exam

(3) Bone density test for women age 65+

(4) Annual mammogram for age 40+

(5) Immunizations: Hepatitis A-B, Diphtheria, Tetanus, Pertussis, Homophiles Influenza type B, Polio, Pneumococcal conjugate, Varicella, Measles, Mumps, Rubella and annual flu shot

(6) Annual routine office visit physical exam

(7) Tetanus/Diphtheria Booster every 10 years after age 18

(8) Total Cholesterol screening once every 5 years

(9) Colorectal cancer screening:

  (a) Annual fecal occult blood test plus flexible sigmoidoscopy once every 5 years for age 50+;or

  (b) Colonoscopy every 10 years for age 50+; or

  (c) Double contrast barium enema every 5 years for age 50+

(10) Annual digital rectal exam and prostate specific antigen test for age 45+

(11) Labs, pathology, chest x-ray, and EKG (when processed in a Physician's Office and as preventive care)

Understanding Preventive vs. Diagnostic Services:

Preventive services are those performed on a person who:

(1) Has not had the Preventive screening done before and does not have symptoms or other abnormal studies abnormalities; or

(2) Has had screening done within the recommended interval with the findings considered normal; or

(3) Has had diagnostic services results that were normal after which the physician recommendation would be for future Preventive screening studies using the preventive service intervals.

(4) Has a Preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the Preventive service (e.g. polyp removal during a Preventive colonoscopy), the therapeutic service would still be considered Preventive.

Diagnostic services are done on a person who:

(1) Had abnormalities found on previous Preventive or diagnostic studies that require further diagnostic studies; or

(2) Had abnormalities found on previous Preventive or diagnostic studies that would recommend a repeat of the same studies within shortened time intervals from the recommended Preventive screening time intervals; or

(3) Had a symptom(s) that required further diagnosis.

Even when your appointment is for a Preventive exam, you may receive other services during that exam that are not Preventive care services. For example, your doctor may check on a chronic condition such as diabetes. When your doctor determines that you have a medical issue present, the additional screenings and tests after this diagnosis are no longer considered Preventive. **This means you may be responsible for paying different share of the cost than you do for your Preventive care services. Diagnostic = Deductible applies.**

When you have some risk factors or symptoms, your doctor may order one of the tests listed in the Preventive Health Care Guidelines as a "diagnostic service" to diagnose what's wrong. It's the same service, but it's not preventive care; see the examples below.

- ✓ **If you have a chronic disease** and your doctor runs certain tests to monitor your condition, these are not considered preventive and will be subject to your deductible.

- ✓ **If your doctor runs additional, non-routine tests** to diagnose or confirm the diagnosis for a health condition during a preventive care exam, those tests are not considered preventive. Your deductible will apply.

- ✓ **If you require follow-up visits or treatments** for a condition found during a preventive exam, your deductible will apply to those visits or treatments.

EXCLUSIONS FROM COVERAGE

GENERAL EXCLUSIONS

No payment will be made for expenses incurred by Eligible Persons:

(1) For or in connection with an injury or sickness for which the Eligible Person is entitled to benefits under any Workers' Compensation or similar law;

(2) To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the Eligible Person resides at the time the expenses are incurred;

(3) For charges the Eligible Person is not legally required to pay;

(4) For charges which are in excess of Usual and Customary Charges; or for services or supplies which are not Medically Necessary; or not directly related to a covered illness or covered injury; or have not been recommended by a Physician;

(5) For sickness or injury arising out of war, declared or undeclared; participation in a riot; or commission of a felony;

(6) For loss incurred while engaged in military, naval or air service;

(7) For health services and associated expenses for cosmetic procedures, including, but not limited to, pharmacological regimens, nutritional procedures or treatments, plastic surgery and non-Medically Necessary reconstructive surgery, or services or supplies for cosmetic surgery, except that correction of defects incurred through traumatic injuries will be covered. For the purpose of this limitation, the term cosmetic surgery means any surgical procedure intended to improve physical appearances but does not correct or materially improve physiologic function and/or is not Medically Necessary. Under no circumstance will this Plan cover the surgical procedure known as rhinoplasty;

(8) For an illness, condition, or injury directly or indirectly caused by the patient's ingestion or inhalation of alcohol, narcotics, barbiturates, hallucinogens, marijuana, amphetamines, sleeping pills, tranquilizers, habit forming or addictive drugs, airplane glue, similar compounds or drugs, or an overdose by the patient of medicine of any kind (except for an Eligible Dependent under 8 years of age), including, but not limited to, treatment of Mental Health and Substance Abuse Disorders, as listed in the Diagnostic and Statistical Manual of Mental Disorders-IV, provided, however, that this exclusion shall not apply to the treatment of depression;

(9) In excess of the maximum number of Inpatient days or Outpatient visits set forth in the Schedule of Benefits;

(10) In excess of the Calendar Year and/or lifetime maximum benefits for treatment of temporomandibular joint disorders set forth in the Schedule of Benefits;

(11) Before an Eligible Person’s coverage hereunder becomes effective;

(12) For non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, employment counseling, back-to-school, return-to-work services, work hardening programs, driving safety and services, training, educational therapy, or other non-medical ancillary services for learning disabilities, developmental delays, autism, attention deficit hyperactivity disorder, or mental retardation. The only exception to this exclusion is for expenses incurred for educational services provided by a certified nutritionist, a registered dietician, a Physician, or under a Physician's supervision to treat gestational diabetes, which will qualify as Eligible Expenses if such services otherwise qualify as Eligible Expenses;

(13) For or in connection with the pregnancy of a dependent daughter or a nontherapeutic abortion performed on a dependent daughter;

(14) For charges incurred for surgical treatment of Obesity as defined to mean the physical state in which excessive fat is stored in various sites in the body or as an increase in body weight beyond the limitation of skeletal and physical requirements. No benefits or coverages are provided for the surgical treatment of the condition of Obesity.

(15) For expenses incurred for radial keratotomy, lasik surgery, and any other refractive surgical procedures on the eye other than those expenses covered in the Vision Plan;

(16) Obstructive Sleep Apnea ("OSA") unless the following requirements have been met;

(a) The diagnosis is based upon polysomnography ("PSG") in which a type 1 study has occurred.

(b) The PSG was pre-authorized.

(c) The PSG results in a recommended treatment of continuous positive airway pressure ("CPAP"), which is determined to be medically necessary by meeting one of the following criteria:

(i) Apnea/Hypoxia Index ("AHI") > 15 as documented by PSG, or

(ii) AHI > 5 and < 15 as documented by PSG when accompanied by symptoms of OSA or when accompanied by hypertension, chronic heart disease, or history of stroke.

(d) The Plan will cover the PSG and the CPAP to the extent that the CPAP consists of a nasal mask, nasal pillows/prongs, full face mask and OracleTM oral mask up to the annual and/or lifetime benefits provided in the Schedule of Benefits. Any other devices that are part of the CPAP must be pre-certified individually for medical necessity.

(e) All treatment by surgery is excluded unless all of the following requirements are met:

(i) The surgery is pre-authorized and determined to be medically necessary, and

(ii) A therapeutic trial of CPAP has been completed and determined to be ineffective.

(f) Any other methods of diagnosis or treatments, including but not limited to home/portable sleep studies, multiple sleep latency testing ("MSLT"), maintenance of wakefulness

testing ("MWT"), Watch PATTM, Sleep StripsTM, Actigraphy, evaluation or treatment for Upper Airway Resistance Syndrome ("UARS"), and snoring related arousals without OSA, are excluded.

(17) For services or supplies billed by health care providers not specifically listed as covered in this Plan;

(18) For research studies and Experimental and Investigational services, treatment, drugs, procedures, and any related expenses;

(19) For charges for the completion of claim forms and mailing fees;

(20) For services provided in a medical department or clinic run by an Employer which is not open to the general public;

(21) For vitamins even if they are prescribed by the Eligible Person's Physician, except pre-natal vitamins prescribed by the Eligible Person's Physician;

(22) For contraceptives, except for generic, oral prescription contraceptives;

(23) For all expenses for Hospital and professional care when the constant, skilled medical services of a Hospital or other health care specialist are not required. This includes private duty nursing services that are primarily non-medical in nature;

(24) For Residential or Supportive care;

(25) For services or supplies for which no charge is made in the absence of benefits provided by this Plan;

(26) For charges for mileage costs or other travel expenses except as otherwise provided in this Plan;

(27) For charges for handling fees, unless directly related to test results;

(28) For financing or collection charges;

(29) For therapeutic devices or appliances purchased over the counter such as support garments and other non-medical substances regardless of their intended use;

(30) For health services and associated expenses for infertility services and/or testing, including in vitro fertilization, gamete intrafallopian transfer ("GIFT") procedure, zygote intrafallopian transfer ("ZIFT") procedures, embryo transport, surrogate parenting, donor semen, and related costs, including collection and preparation, home child birth, non-Medically Necessary amniocentesis, and service and supplies related to elective abortions;

(31) For health services and associated expenses for sex transformation procedures, treatment of sexual inadequacies and dysfunction, or reversal of voluntary sterilization, penile implants, and other devices or treatment related to male impotency;

(32) For megavitamin therapy except intravenous megavitamin therapy, as well as treatment for hair loss, nicotine addiction, smoking cessation, appliances and personal comfort items such as air conditioners and humidifiers;

(33) For health services and associated expenses resulting from an Eligible Person's documented refusal to comply with treatment prescribed by the Eligible Person's Physician;

(34) For orthognathic surgical and related procedures and expenses;

(35) For genetic counseling, testing, screening and related procedures;

(36) For treatment of varicose veins, including vein stripping, and sclerotic therapies, and any other invasive therapy or procedures, cardioscans, and ultrafast CT scans;

(37) For hearing aids and cochlear implants;

(38) For private duty nursing;

(39) For donation or transplant of an organ or tissue in cases where the recipient is not an Eligible Person;

(40) For routine eye care, eye glasses, and contact lenses except when covered in the Vision Plan;

(41) For services performed on or to teeth, nerves of teeth, or gingivae or alveolar process, except for tumors or cysts or treatment rendered within 90 days of an Accidental Injury to correct injury to sound natural teeth except when covered in the Dental Plan;

(42) For any non-emergency weekend admission to a Hospital between noon Friday and 2:00 p.m. Sunday;

(43) For breast prostheses in excess of one per period of 12 consecutive months, and associated bras in excess of 2 per period of 12 consecutive months. (The prostheses and bras must be necessitated by a mastectomy for cancer treatment.);

(44) For replacement of prostheses (other than breast prostheses) more often than once every period of 24 consecutive months;

(45) For which a claim is filed later than one year from the date of service;

(46) For services to address intentional self-inflicted injuries, unless related to a physical health condition;

(47) For care, services, or treatment required as a result of complications from a treatment not covered under the Plan;

(48) For expenses associated with missed appointments.

PRESCRIPTION DRUG EXCLUSIONS

No payment will be made for charges for:

(1) Drugs (including dosages) which are lawfully obtainable without a prescription, except insulin;

(2) Medical supplies and equipment, therapeutic devices, or appliances, including support garments and other nonmedical substances regardless of their intended use; provided, however, that this exclusion shall not apply to needles, syringes, and alcohol swabs used in the injection of medications;

(3) Any charge for the administration of a Prescription Drug or insulin except in the case of the injection of vaccines;

(4) Drugs labeled "Caution: limited by federal law to investigational use" or drugs that are Experimental and Investigational, even though a charge is made to the Eligible Person; provided, however, that subject to prior authorization this exclusion shall not apply to medications which have been approved by the FDA but are being prescribed for "off label" uses recommended by the Eligible Person's Physician;

(5) Refilling of a Prescription Drug in excess of the number specified by Physician or any refill dispensed after one year from the order of a Physician;

(6) Prescription Drugs which may be properly received without charge under local, state, or federal programs and any drug to the extent payment or benefits are provided or made available from local, state, or federal programs, whether or not that payment or benefits are received, except as otherwise provided by the law;

(7) Contraceptives, including diaphragms, contraceptive jellies and ointments, foams and devices, except for generic, oral prescription contraceptives

(8) Vitamins (other than prenatal vitamins requiring a prescription), cosmetics, dietary supplements, health, or beauty aids;

(9) Drugs which are not Medically Necessary;

(10) More than one monthly dosage of Imitrex or any similar drug prescribed for the relief of migraine headaches;

(11) Appetite suppressants and drugs for weight control;

(12) Infertility medications;

(13) Nicotine patches or gum;

(14) Drugs for cosmetic purposes only;

(15) Bulk chemical powders;

(16) Benefits excluded from coverage under General Exclusions

(17) Prescription Drugs classified as "Maintenance Medications" unless those prescribed in a 90-day supply, are dispensed through mail-order program or an approved applicable retail pharmacy, and are taken according to the instructions of the Physician prescribing the drug.

DENTAL EXCLUSIONS

No payment will be made for charges for:

(1) More than one oral and/or periodic examination per Eligible Person per 6 month period by the same dentist;

(2) More than one charge for the same services or course of treatment (except for preventive care), even though the Eligible Person is transferred from one dentist to another in the course of treatment or more than one dentist renders service on one dental procedure (benefits will be determined just as though one dentist had finished all treatment);

(3) Orthodontia or other course of dental treatment which began when the claimant was not an Eligible Person under this Plan;

(4) Replacement of complete or partial dentures under this Plan unless the Eligible Person was eligible hereunder for one year prior to replacement;

(5) Expenses incurred for lost or stolen appliances (bridgework and dentures);

(6) Any replacement of a previous denture which was covered under this Article V either as an initial complete denture or as a replacement, which is not separated from such prior treatment by 5 years during which the Eligible Person was eligible hereunder.

(7) Any professional fees whatsoever other than the fees of the dentist performing the treatment or others providing services under the supervision of the dentist;

(8) Dental expenses incurred after termination of insurance or for prosthetic devices and the fitting thereof which were ordered while the claimant was not an Eligible Person hereunder;

(9) Orthodontia for Employees, Eligible Dependent Spouses, or Eligible Dependents who have attained 19 years of age;

(10) Benefits excluded from coverage under General Exclusions;

(11) Panorex by the same dentist unless separated by 6 months;

(12) Expenses incurred for cosmetic or aesthetic purposes;

(13) Expenses due to Accidental Injury arising out of, and in the course of, such Eligible Person's employment; or

(14) Expenses which are not necessary, or are not recommended and approved by a dentist or expenses which are unreasonable.

EXTENDED HOSPITALIZATION BENEFITS

If an Eligible Person is hospitalized at the time they lose eligibility, such person will continue to be eligible for themselves only, until such person is discharged from the Hospital.

COORDINATION OF BENEFITS AND SUBROGATION

APPLICABILITY

This Coordination of Benefits ("COB") provision applies to the Plan when an Eligible Employee or Eligible Dependent has health care coverage under more than one plan. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of the Plan are determined before or after those of another plan. The benefits of the Plan:

(1) Will not be reduced when, under the order of benefit determination rules, the Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in the Section "Effect on the Benefits of the Plan."

DEFINITIONS

A "plan" is any of these which provides benefits or services for, or because of, medical, vision or dental care or treatment (other than Weekly Accident and Sickness Benefits):

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan as required or provided by law. This includes a no-fault automobile insurance law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are in excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"Primary Plan"/"Secondary Plan." The order of benefit determination rules state whether the Plan is a primary plan or secondary plan as to another plan covering the Eligible Person. When the Plan is a primary plan, its benefits are determined before those of the other plan and without considering the other

plan's benefits. When the Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, the Plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

"Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under the Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES
(Coordination of Benefits)

When there is a basis for a claim under the Plan and another plan, the Plan is a secondary plan that has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of the Plan; and

(2) Both those rules and the Plan's rules require that the Plan's benefits be determined before those of the other plan.

The Plan determines its order of benefits using the first of the following rules that applies:

(1) Nondependent/Dependent. The benefits of the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan that covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

   (a) Secondary to the plan covering the person as a dependent; and

   (b) Primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

(2) Dependent Child/Parents Not Separated or Divorced. If the Plan and another plan cover the same child as a dependent of different persons, called "parents":

   (a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

   (b) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

However, if the other plan does not have a rule based on the birthdays of the parents but instead has a rule based upon the gender of the parent; the rule based upon the gender of the parent will determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. If the responsible parent fails, refuses or neglects to comply with the court order, the Plan nevertheless will coordinate as if the responsible parent has paid the medical or dental expenses. A copy of the divorce decree may be requested by the Plan.

(4) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, member or subscriber longer are determined before those of the plan that covered that person for the shorter time.

(5) Dual Employees. If a husband and a wife are each covered under the Plan as employees, dependent benefits will be provided and coordinated as if they were provided under another group health plan. This means the Eligible Person's benefits as an employee will pay first and the Eligible Person's dependent benefits will be paid second.

(6) Active/Inactive Employee. The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

EFFECT ON THE BENEFITS OF THE PLAN

This Section applies when, in accordance with "Order of Benefit Determination Rules," the Plan is a secondary plan as to one or more other plans. In that event, the benefits of the Plan may be reduced under this Section. Such other plan or plans are referred to as "the other plans" in the following Section.

Reduction in the Plan's Benefits. The Benefits of the Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under the Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not the claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of the Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

COORDINATION WITH HEALTH MAINTENANCE ORGANIZATIONS

If a dependent spouse is entitled to coverage under another group health insurance program through that spouse's employer or otherwise and is entitled to and does choose a Health Maintenance Organization ("HMO") as an alternative method of receiving coverage thereunder, that HMO will be the primary insurer and the Plan the secondary insurer with respect to the spouse, whether or not the spouse elects to actually use the HMO in a particular instance. If the spouse's HMO would normally be the primary insurer with respect to coverage for dependent children, then coverage for those children under the Plan will be secondary, whether or not the spouse elects to actually use the HMO in a particular instance.

The Plan will not be responsible for medical expenses incurred that could have been paid or would otherwise be payable under the spouse's HMO had the spouse actually used the spouse's HMO for the care and services for which those expenses were incurred. If the spouse's HMO is considered the primary insurer hereunder and is not utilized, the Plan will only pay for medical expenses covered under the Plan that are in excess of the expenses that would have been covered had the spouse utilized the spouse's HMO for primary coverage.

All other matters regarding coordination of benefits with a spouse's HMO will be determined pursuant to the Plan's general provisions regarding coordination of benefits with other group health insurance programs.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Plan must give the Plan any facts it needs to pay the claim.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under the Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under the Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by the Plan is more than it should have paid under this provision, it may recover the excess from one or more of:

(1) The persons it has paid or for whom it was paid;

(2) Insurance companies; or

(3) Other organization.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

MEDICARE

All Eligible Persons should apply for coverage under Parts A and B of Medicare (or Medicare + Choice) as soon as they approach eligibility by reason of attained age or qualifying disability. Expenses covered or made available by Medicare are carved out from coverage under the Plan. Then, remaining covered expenses under the Plan are paid subject to the Deductible, Coinsurance, and maximums of the Plan.

PLAN'S RIGHT TO SUBROGATION

In the event that an Eligible Person receives any benefits (the "Benefits") under the Plan arising out of any loss, injury, or illness (the "Injury") for which the Eligible Person has asserted or may assert any claim or right to recovery against a third party or parties or his, her, or their insurer(s), except against any insurer on any policy of insurance issued to and in the name of such Eligible Person, then any payment or payments by the Plan for such benefits shall be made on the condition and with the agreement and understanding that the Plan shall be reimbursed by the Eligible Person to the extent of, but not exceeding, the amount or amounts received by the Eligible Person (the "Recovery") from such third party or parties or his, her, or their insurer(s) (the "Responsible Party"), whether by way of settlement or in satisfaction of any judgment(s) or otherwise.

The Eligible Person shall reimburse the Plan, starting with the first dollar that the Eligible Person receives from the Responsible Party, no matter whether the Recovery is designated as actual or punitive damages, costs or expenses, medical expenses, pain and suffering, lost wages, workers' compensation, disability payments, loss of consortium, loss of work payments, emotional distress, or otherwise, and the Eligible Person shall continue to reimburse the Plan until all Benefits related to the Injury are reimbursed or the full amount of the Recovery is paid to the Plan, whichever occurs first.

The Plan has the right to first recovery and the "make whole" doctrine is not applicable to the Plan's subrogation and reimbursement rights. The Plan has the right of first reimbursement for all Benefits paid related to the Injury, such first reimbursement to be paid out of any Recovery the Eligible Person is able to obtain, even if the Eligible Person has not been fully compensated for the Injury.

If it becomes necessary for the Eligible Person to retain an attorney in order to obtain a Recovery or to recover Benefits paid by the Plan relating to the Injury, the amount to be reimbursed to the Plan may, at the sole discretion of the Trustees, be reduced by the Plan's pro rata share of those attorneys' fees and expenses.

If the Trustees retain an attorney to recover any amounts that are owed under this Section, then the Eligible Person shall be liable for, in addition to all amounts outlined in the previous paragraphs, all costs of collection of the Plan, including the Plan's reasonable attorneys' fees and expenses. As a means of collecting the amount owed under this Section, the Plan may, in addition to any other means allowed by law, set off future Benefits to the Eligible Person or lessen the reduction allowed by the Plan for the Eligible Person's attorneys' fees and expenses incurred in obtaining the Recovery. However, this Section shall not limit the Plan's right to collect its attorneys' fees and expenses and shall be cumulative with all other rights the Plan may have to collect its attorneys' fees and expenses.

As security for all amounts due to the Plan under this Section, the Plan shall be subrogated to all of the claims, demands, actions, and rights of recovery of the Eligible Person against the Responsible Party or his, her, or their insurer(s) to the extent of any and all Benefits paid under the Plan. The Eligible Person shall execute and deliver any instruments and documents requested by the Trustees and shall do whatever else the Trustees shall deem necessary to protect the Plan's rights. The Eligible Person shall take no action to prejudice the Plan's rights to such reimbursements and subrogation. The Trustees may withhold any Benefits to which the Eligible Person is entitled under the Plan until the Eligible Person executes and delivers any such instruments and documents as may be requested by the Trustees.

Prior to the payment of Benefits under the Plan to an Eligible Person or assignee of an Eligible Person for injuries, expenses, or losses for which a third party is or may be liable in whole or part, the Eligible Person or assignee or both may be required to execute a written subrogation and reimbursement agreement in form and substance satisfactory to the Board of Trustees.

CLAIM DETERMINATION AND APPEAL PROCEDURES

The Trustees retain the right to amend, revise or terminate this program at any time by action duly taken by them and the design of the Plan and its operations are subject to the express terms, conditions and provisions of the agreements between the Trustees and to all provisions of the Plan Document, rules and regulations duly promulgated by the Trustees to implement the same and other Plan documents.

DEFINITIONS

ADVERSE BENEFIT DETERMINATION

The term "Adverse Benefit Determination" means any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan.
Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the Eligible Person pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that there is no discretion exercised by the pharmacy in not filling the prescription).
Similarly, if a "preferred" (or "in-network") Physician or Hospital declines to render services to an Eligible Person unless the Eligible Person pays the entire cost, and the provider exercises no discretion on behalf of the Plan, such a decision is not considered an Adverse Benefit Determination.

CLAIM

The term "Claim" means a request for a benefit made by a claimant in accordance with the Fund's reasonable procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of the Plan are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered a Claim. However, if a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a Claim.

A request for prior approval of a benefit that does not require prior approval by the Plan is not considered a Claim. However, requests for prior approval of a benefit where the Plan does require prior approval (e.g., Hospital preadmission certification) are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. Similarly, interactions between Eligible Persons and "preferred" (or "innetwork") Physicians and Hospitals do not constitute Claims in cases where the providers exercise no discretion on behalf of the Plan. If a Physician, Hospital or pharmacy, which does not exercise discretion, declines to render services or refuses to fill a prescription unless the Eligible Person pays the entire cost, the Eligible Person should submit a Post--Service Claim for the services or prescription as described under Claim Procedures, below.

CONCURRENT CLAIM
The term "Concurrent Claim" means a Claim for an ongoing course of treatment to be provided over a period of time or number of treatments, which is reconsidered after an initial approval is made that results in a reduction, termination or extension of a benefit.

DISABILITY CLAIM
The term "Disability Claim" means a Claim that requires a finding of Total Disability as a condition of eligibility (e.g., claims for Weekly Disability Income Benefits). Furthermore, claims for the extension of death benefits during Total Disability would be considered Disability Claims unless the determination of disability is made by a party other than the Plan for purposes other than a benefit determination under the Plan (e.g., a determination by the Social Security Administration).

POST-SERVICE CLAIM
The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Concurrent, Urgent or Disability Claim.

PRE-SERVICE CLAIM
The term "Pre-Service Claim" means a Claim for a benefit (either in whole or in part) for which the Plan requires approval before medical care is obtained.

RELEVANT DOCUMENTS
A document, record or other information is "relevant" to a Claim if it was relied upon in making the benefit determination, submitted, considered or generated in the course of making the benefit determination, demonstrates compliance with the administrative processes and safeguards required by the regulations, or constitutes the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

URGENT CLAIM
The term "Urgent Claim" means a Claim for medical care or treatment that, if nonurgent care standards were applied, would seriously jeopardize the life or health of the Eligible Person or the ability of the Eligible Person to regain maximum function or, in the opinion of a Physician with knowledge of the Eligible Person's medical condition, subject the Eligible Person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

CLAIM PROCEDURES

PRE-SERVICE CLAIMS

(1) A Pre-Service Claim is a Claim for a benefit for which the Plan requires approval before medical care is obtained. The Plan requires prior authorization of all Hospital Admissions and of other services and treatments specified in the Utilization Management Program section of the Summary Plan Description. Thus, precertification of a Hospital Admission (or of any other service or treatment for which prior authorization is required) would be treated as a Pre-Service Claim. Pre-Service Claims (that is, requests for prior authorization) must be submitted by calling the Utilization Management Company at the phone number on your identification card.

(2) For properly filed Pre-Service Claims, the claimant will be notified of a decision within 15 days from receipt of the Claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Utilization Management Company. The claimant will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

(3) If an extension is needed because the Utilization Management Company needs additional information from the claimant, the claimant will be notified, before the end of the initial 15 day period, of the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days has elapsed or the date the claimant responds to the request (whichever is earlier). The Utilization Management Company then has 15 days to make a decision on the Claim and notify the claimant of the determination.

(4) If a claimant improperly files a Pre-Service Claim, the claimant will be notified as soon as possible but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a Claim. The claimant will only receive notice of an improperly filed Pre-Service Claim if:

   (a) the claimant communicates with a person customarily responsible for handling Plan benefit matters about a potential Pre-Service Claim, and

   (b) the Claim includes (i) the patient's name, (ii) the patient's specific medical condition or symptom, and (iii) the patient's specific treatment, service or product for which approval is requested.

(5) Unless the claim is refiled properly, it will not constitute a Claim.

URGENT CLAIMS

(1) Urgent Claims must be submitted by calling the Utilization Management Company at the phone number on your identification card.

(2) The Utilization Management Company will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Claim, and notifies the Utilization Management Company of such, it will be treated as an Urgent Claim.

(3) The Utilization Management Company will respond to the claimant with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim by the Utilization Management Company. The determination will also be confirmed in writing.

(4) If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Utilization Management Company will notify the claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The claimant must provide the specified information within 48 hours. If the information is not provided to the Utilization Management Company within that time, the Claim will be denied.

(5) Notice of the decision will be provided no later than 48 hours after the Utilization Management Company receives the specified information or the end of the 48hour period given for the claimant to provide this information, whichever is earlier.

(6) If a claimant improperly files an Urgent Claim, the Utilization Management Company will notify the claimant as soon as possible but not later than 24 hours after receipt of the Claim, of the proper procedures to be followed in filing a Claim. Unless the claim is refiled properly, it will not constitute a Claim.

(7) With respect to an Urgent Care Claim, a health care professional with knowledge of the Eligible Person's medical condition shall be permitted to act as an authorized representative.

CONCURRENT CLAIMS

(1) A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made by the Utilization Management Company as soon as possible. In any event, the Eligible Person will be given enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

(2) Any request by a claimant to extend an approved Urgent Claim will be acted upon by the Utilization Management Company within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to extend approved treatment that does not involve an Urgent Claim will be decided according to the guidelines for Pre-Service or Post Service Claims, as applicable.

POST SERVICE CLAIMS

(1) In order for a request for benefits to be considered a Post Service Claim, a claim form must be completed by the Eligible Person or, as applicable, the Hospital, Physician or other health care provider, and submitted to the Benefits Claims and Trust Office together with itemized bills any other information that might reasonably be required to determine if a claim is properly payable under the Plan. Claim forms are available from the Benefits Claims and Trust Office. Additionally, the Benefits Claims and Trust Office will mail claim forms to Eligible Persons, and will use reasonable efforts to make claim forms available upon an Eligible Person's request at the Employer's establishment.

(2) The itemized bill(s) must include the following information:

(a) Patient's name;

(b) Date of service;

(c) Type of service or procedure code;

(d) Diagnosis or diagnosis code;

(e) Billed charges;

(f) Provider's federal taxpayer identification number (TIN); and

(g) Provider's billing name and address.

(3) The Claim must be submitted to the Benefits Claims and Trust Office within 90 days from the date of service. Failure to submit a Claim within the 90 day period will not invalidate or reduce a Claim if it is shown not to have been reasonably possible to give such notice within the required time and that notice was given as soon as was reasonably possible. **In no event will a Claim be processed if received by the Benefits Claims and Trust Office more than 12 months from the date of service.**

(4) Claims should be submitted to the Benefits Claims and Trust Office.

(5) Eligible Persons may assign medical benefits if they do so in writing not later than the time the Claim is filed. Where benefits are assigned, the Plan will pay benefits provided on account of Hospital, Physician, or medical service directly to the Hospital or person providing the services. Coverage and benefits are not assignable without consent of the Plan. Except as provided in this Section or as otherwise provided by law, benefits due under the Plan are not assignable nor subject to attachment, garnishment or other legal process for debts of Eligible Persons.

(6) Ordinarily, claimants will be notified of decisions on Post Service Claims within 30 days from the Fund's receipt of the Claim. This period may be extended one time by the Fund for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified, before the end of the initial 30 day period, of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

(7) If an extension is required because the Fund needs additional information from the claimant, the Fund will issue a request for additional information that specifies the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45 day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the request for additional information until either 45 days has elapsed or until the date the claimant responds to the request (whichever is earlier). The Fund then has 15 days to make a decision on the Claim and notify the claimant of the determination.

(8) If the Fund determines that additional information is required from the claimant, the Fund may issue a combined request for additional information and notice of Adverse Benefit Determination. The notice of Adverse Benefit Determination would only be applicable if the claimant fails to provide any information within 45 days. In this case, the Fund would not issue a separate notice of Adverse Benefit Determination if the claimant failed to submit any information within 45 days. The combined notice will clearly state that the Claim will be denied if the claimant fails to submit any information in response to the Fund's request, and will satisfy the content requirements of both the request for additional information and the notice of Adverse Benefit Determination. When the combined notice is used, the timeframe for appealing the Adverse Benefit Determination begins to run at the end of the 45 day period prescribed in the combined notice for submitting the requested information.

DISABILITY CLAIMS

(1) Disability Claims must be submitted to the Benefits Claims and Trust Office in writing, using the appropriate application form. An application form may be obtained by contacting the Benefits Claims and Trust Office.

(2) The Fund will make a decision on the Claim and notify the claimant of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, it will notify the claimant of the reason for the extension and indicate when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days from the time the Fund notifies the claimant of the extension. The period for making a decision may be extended an additional 30 days, provided the Fund notifies the claimant, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

(3) If an extension is needed because the Fund needs additional information from the claimant, the extension notice will specify the information needed. In that case, the claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45 day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days has elapsed or until the date the claimant responds to the request (whichever is earlier). The Fund then has 30 days to make a decision on the Claim and notify the claimant of the determination.

AUTHORIZED REPRESENTATIVES

(1) An authorized representative, such as a spouse or an adult child, may submit a Claim on behalf of an Eligible Person if the Eligible Person has previously designated the individual to act on his behalf. An Appointment of Authorized Representative Form (or similar form), which may be obtained from the Benefits Claims and Trust Office, must be used to designate an authorized representative. The Fund may request additional information to verify that the designated person is authorized to act on the Eligible Person's behalf.

(2) A health care professional with knowledge of the Eligible Person's medical condition may act as an authorized representative in connection with an Urgent Claim without the Eligible Person having to complete an Appointment of Authorized Representative Form.

NOTICE OF INITIAL BENEFIT DETERMINATION

The claimant will be provided with written notice of the initial benefit determination. If the determination is an Adverse Benefit Determination, the notice will include:

(1) the specific reason(s) for the determination;

(2) reference to the specific Plan provision(s) on which the determination is based;

(3) a description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;

(4) a description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;

(5) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;

(6) if an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;

(7) if the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge; and

(8) for Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).

APPEAL PROCEDURES

APPEALING AN ADVERSE BENEFIT DETERMINATION

(1) If a Claim is denied in whole or in part, or if the claimant disagrees with the decision made on a Claim, the claimant may appeal the decision.

(2) Appeals of Adverse Benefit Determinations regarding Pre-Service Claims, PostService Claims and Disability Claims must be submitted in writing to the Benefits Claims and Trust Office within 180 days after receipt of the notice of Adverse Benefit Determination and must include:

(a) the patient's name, address and telephone number;

(b) the patient's Social Security Number;

(c) the claimant's name, address and telephone number, if different;

(d) the Employee's place of employment;

(e) the date of service;

(f) the type of Claim;

(g) the date of the Adverse Benefit Determination; and

(h) the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

(3) Appeals of Adverse Benefit Determinations regarding Urgent Claims must be submitted in writing to the Benefits Claims and Trust Office within 180 days after receipt of the notice of Adverse Benefit Determination.

(4) Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be submitted in writing to the Benefits Claims and Trust Office. For a Concurrent Claim that involves termination or reduction of previously approved care, there is no set timeframe for appeal; however, the appeal must be completed before the care is terminated or reduced. For a Concurrent Claim regarding an extension of care, the appeal timeframe will be the timeframe for an Urgent, Pre-Service or Post Service Claim, whichever category applies to the appeal.

THE APPEAL PROCESS

(1) The claimant shall have the opportunity to submit written comments, documents, records and other information for consideration during the appeal, even if such information was submitted or considered as part of the initial benefit determination. The claimant will be provided, upon written request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his Claim.

(2) Neither the Eligible Person nor any representative of such Person is entitled as a matter of right to appeal personally before the Board of Trustees, and no hearing will be required to be held in connection with any such appeal.

(3) A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not be a subordinate of the person who made the initial Adverse Benefit Determination on the Claim and will not give deference to the

initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

(4) If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary or was Experimental and Investigational), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon written request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on his Claim, without regard to whether the advice was relied upon in deciding the Claim.

TIMEFRAMES FOR NOTICES OF APPEAL DETERMINATIONS

(1) Pre-Service Claims. Notice of the appeal determination for Pre-Service Claims will be sent within 30 days of receipt of the appeal.

(2) Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal.

(3) Concurrent Claims. Notice of the appeal determination for a Concurrent Claim that involves a termination or reduction of previously approved care will be sent before the care is terminated or reduced. Notice of the appeal determination for a Concurrent Claim that involves an extension of care will be sent based on the timeframes for an Urgent, Pre-Service or Post Service Claim, whichever category applies to the appeal.

(4) Post Service Claims. Ordinarily, decisions on appeals involving Post Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for appeal. However, if the request is received within 30 days of the next regularly scheduled meeting, it will be considered at the second regularly scheduled meeting following receipt of the appeal. In special circumstances, an extension until the third regularly scheduled meeting following receipt of the appeal may be necessary. The claimant will be advised in writing in advance if this extension will be necessary. Once a decision on the appeal has been reached, notice of the appeal determination will be sent as soon as possible, but no later than 5 days after the decision has been reached.

(5) Disability Claims. Notice of the appeal determination for Disability Claims will be made in the same manner as for Post Service Claims.

CONTENT OF APPEAL DETERMINATION NOTICES

The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

(1) the specific reason(s) for the determination;

(2) reference to the specific Plan provision(s) on which the determination is based;

(3) a statement that the claimant is entitled to receive reasonable access to and copies of all Relevant Documents pertaining to the Claim, upon written request and free of charge;

(4) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;

(5) if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and

(6) if the determination was based on Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

DECISION FINAL AND BINDING

A decision on review of any Claim made under the Plan in accordance with the Claims and Appeals Procedure shall be final and binding on all persons.

WHEN A LAWSUIT MAY BE FILED

The claimant may not file a lawsuit to obtain benefits until after he has requested an appeal and a final adverse decision has been reached on the appeal, or until the appropriate timeframe described above has elapsed since the claimant filed a request for review and has not received a final decision or notice that an extension will be necessary to reach a final decision.

If you fail to pursue the administrative appeal procedures described above, your failure will constitute a failure to exhaust your administrative remedies, which failure will legally prevent you from filing suit in federal or state court.

COBRA CONTINUATION COVERAGE

An Eligible Employee may elect continuation coverage under this Section as required under the Consolidation Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Under COBRA, a Qualified Beneficiary has the right to continue the same medical benefits for which he was eligible at the time of the Qualifying Event. Death Benefits, the Accidental Death and Dismemberment Benefit, and the Weekly Accident and Sickness Benefits are excluded.

A "Qualified Beneficiary" is an Eligible Employee and/or his Eligible Dependents that are covered under the Plan on the day before a Qualifying Event.

A "Qualifying Event" is any of the following events that would result in loss of coverage for a Qualified Beneficiary:

(1) Termination of employment, for any reason other than gross misconduct

(2) An employee loses eligibility for failure to work the required number of hours in the corresponding work period;

(3) The death of the Eligible Employee;

(4) The eligibility of an Eligible Employee for Medicare;

(5) The divorce or legal separation of the Eligible Dependent spouse from the Eligible Employee; or

(6) A dependent child ceases to satisfy the definition of an Eligible Dependent.

An Election Period is the 60-day period that commences on:

(1) The date the Qualified Beneficiary would otherwise lose coverage under the Plan by reason of a Qualifying Event of divorce, legal separation, or cessation of dependent child status; or

(2) With respect to other qualifying events, the date the Qualified Beneficiary receives notice from the Administrative Manager of his right to elect COBRA continuation coverage.

ENTITLEMENT TO COBRA CONTINUATION COVERAGE

Each Qualified Beneficiary who would otherwise lose coverage under the Plan as a result of a Qualifying Event will be entitled to elect, within the Election Period, to continue coverage under the Plan in accordance with the provisions of this Section. A Qualified Beneficiary's entitlement to COBRA continuation coverage will not be conditioned upon evidence of insurability. If and to the extent the provisions of this Section are determined to be inconsistent with any amendment of the applicable laws or the regulations to be promulgated there under, the provisions of such law and/or regulations will supersede the provisions of this Section.

MAXIMUM PERIOD OF COVERAGE

If the Qualifying Event is termination of employment or the failure of an employee to work the required hours of covered work, the maximum period of continuation coverage for such participant and his Eligible Dependents will be 18 months commencing from the day coverage would otherwise terminate; however, if a second Qualifying Event occurs within such 18-month period, the maximum period of coverage may be extended as described below.

If an Eligible Employee become entitled to Medicare, and within 18 months thereafter has a Qualifying Event of termination of employment or failure to work the required hours of covered work, the maximum period of coverage for Eligible Dependents is 36 months after the date of Medicare entitlement.

If the Qualifying Event is any event other than that described above, the maximum period of continuation coverage will be 36 months, commencing from the date coverage would otherwise terminate.

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

(1) The last day of the last period for which contributions are made, if the Qualified Beneficiary fails to make any contributions required under this Section;

(2) The date on which the Qualified Beneficiary becomes covered as an employee or as a dependent under any other group health plan, and is not subject to any exclusions or limitations with respect to any preexisting condition under such other plan;

(3) The date on which the Qualified Beneficiary becomes entitled to benefits under Medicare;

(4) The date that is 18 months, 29 months or 36 months, as the case may be, after the date of the Qualifying Event, pursuant to the provisions of this Section; or

(5) The date on which the Plan is discontinued by the Trustees.

Should you become eligible for continuation of coverage under COBRA, more details of the benefits and payment amount for such coverage can be obtained from the Benefits Claims and Trust Office.

ENTITLEMENT TO COBRA CONTINUATION COVERAGE FOR DISABLED EMPLOYEES

If you or your Eligible Dependent is entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the Eligible Person who is determined to be entitled to Social Security disability income benefits and for any other Eligible Persons who become eligible as a result of the same Qualifying Event, for up to 11 additional months, if:

(1) The disability occurred on or before the start of COBRA continuation coverage or within the first 60 days of COBRA continuation coverage; and

(2) The disabled Eligible Person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration within the 18-month COBRA continuation period; and

(3) You or the disabled person notifies the Plan of such in writing a determination within that 18-month period.

This extended period of COBRA coverage will end at the earliest of the following:

(1) The end of 29 months from the date of the Qualifying Event;

(2) 30 days after the last day of the month in which Social Security determines the person is no longer disabled (this must be reported to the Plan within 30 days after its date of issuance by Social Security);

(3) Pursuant to the applicable termination provisions of this Section specifying when coverage ends.

It is the Qualified Beneficiary's responsibility to report the termination of disability or provide notice that the person is no longer disabled.

ENTITLEMENT TO COBRA CONTINUATION COVERAGE FOR SECOND QUALIFYING EVENTS

If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan in a timely manner.

This extension may be available to the spouse and any dependent children receiving continuation coverage if:
(1) The employee or former employee dies,
(2) Becomes entitled to Medicare benefits (under Part A, Part B, or both), or
(3) Gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child,

but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

CONTRIBUTION REQUIREMENT

Entitlement to COBRA continuation coverage under the provisions of this Section is conditioned upon payment of monthly contributions in such amounts as established by the Trustees from time to time, not to exceed 102% of the applicable premium.

If an Eligible Person is determined to be entitled to Social Security disability income benefits and extends coverage for up to 11 additional months, the monthly contributions for those 11 months will increase by an amount determined by the Trustees, not to exceed 150% of the applicable premium.

The initial premium payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment generally must cover the period of coverage from the date of COBRA election, retroactive to the date of the loss of coverage due to the Qualifying Event. Premiums for successive periods of coverage are due on the date stated in the notice with a maximum 30-day grace period for payments. Payment is considered to be made on the date it is sent to the Administrative Manager. If the premium is not paid within 30 days after its due date, COBRA continuation coverage will end as of the first day of that period of coverage and cannot be reinstated. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and, if the shortfall is not paid within 30 days of the date the notice is received, COBRA continuation coverage will end as of the first day that monthly period of coverage.

NOTICE AND ELECTION REQUIREMENTS

(1) The Trustees provide this document as written notice of the COBRA continuation coverage provisions of the Plan to each Eligible Person at the time coverage under the Plan commences.

(2) An Employer should notify the Administrative Manager in writing within 30 days of the following Qualifying Events:

(a) An employee loses eligibility for failure to work the required number of hours in the corresponding work period;

(b) The death of the Eligible Employee; or

(c) The eligibility of an Eligible Employee for Medicare.

Completion of the Employer remittance form will be sufficient notice. However, the participant or other Qualified Beneficiary should also notify the Administrative Manager if any such Qualifying Event occurs, in the event there is a delay or oversight in the Employer's transmittal of information to the Administrative Manager.

(3) The Eligible Employee or other Qualified Beneficiary is responsible for notifying the Administrative Manager in writing within 60 days of the following Qualifying Events. Failure to provide such written notice within 60 days will result in loss of eligibility for continuation coverage.

(a) The divorce or legal separation of the Eligible Dependent spouse from the Eligible Employee; or

(b) A dependent child ceases to satisfy the definition of an Eligible Dependent.

(4) Upon receipt of the notices described in this Section, numbered (2) and (3) above, the Administrative Manager will notify each affected Qualified Beneficiary at his last known address of his independent right to continuation coverage and provide him with an enrollment form. Notice to a Qualified Beneficiary who is the spouse of the participant will be deemed notice to all other Qualified Beneficiaries residing with the spouse at the time notification is made.

(5) Upon receipt of such notice or entitlement to continuation coverage, each Qualified Beneficiary may elect such coverage by completing and returning the enrollment form to the Administrative Manager within the Election Period.

In order to protect your family's rights, it is required that you keep the Administrative Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrative Manager. All notices will be sent to your last known address.

The Self-Funded Plan of Benefits document contains complete COBRA and plan information. For any additional inquiries, please contact the Fund Office.

DEATH AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

DEATH BENEFIT

In the event of the Eligible Employee's death, the Principal Sum set forth in the Benefits and Enrollment Booklet will be paid pursuant to the "Designation of Beneficiary" Section.

ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

If an Eligible Employee who is Actively at Work sustains an Accidental Injury that directly causes one of the following losses within 90 days of the date of such injury, the Plan will pay the amount set forth in the Benefits and Enrollment Booklet pursuant to the "Designation of Beneficiary" Section.

Loss	Benefit
Loss of one hand by severance at or above the wrist	One-half the Principal Sum
Loss of one foot by severance at or above the ankle	One-half the Principal Sum
Irrecoverable loss of the sight in one eye	One-half the Principal Sum
Any combination of two or more of the losses listed above	Principal Sum
Loss of life	Principal Sum

The total benefit for all losses resulting from the same accident may not exceed the Principal Sum.

Death benefits are assignable. Benefits for loss of life will be paid to the Eligible Employee's named beneficiary. All other benefits will be paid under the Eligible Employee's name.

DESIGNATION OF BENEFICIARY

The Eligible Employee's beneficiary is the person(s) named by him on his enrollment card or latest change of beneficiary request. The beneficiary may be changed in accordance with rules provided by the Trustees. Consent of the beneficiary will not be required to change the beneficiary. If an Eligible Employee designates a spouse as a beneficiary and if such designation is followed by their divorce, such designation will become void as of the date of divorce, and the former spouse will not be entitled to any death benefits unless the Eligible Employee re-designates the former spouse as a beneficiary subsequent to the divorce. Except as otherwise provided in any policy, no change of beneficiary will be effective unless received by the Benefits Claims and Trust Office before the Eligible Employee's death.

If an Eligible Employee dies and there is no surviving beneficiary, or a beneficiary was not named by the Eligible Employee, then the Plan may pay the benefits at death as follows:

(1) To the legal representative of the deceased Eligible Employee; or

(2) If there is no probate administration, to the survivors in the following order of priority and upon evidence acceptable to the Plan of their status and priority:

(a) Spouse;

(b) Children, in equal shares;

(c) Parents;

(d) Brothers and sisters, in equal shares; or

(e) Employee's estate.

Payment to persons described above will release the Trustees and any insurance company from all further liability to the extent of the payment made.

CONTINUATION OF DEATH BENEFITS DURING TOTAL DISABILITY

If an Eligible Employee becomes Totally Disabled, as defined below, the Death Benefit Principal Sum in effect on the day of the Eligible Employee's last day of Active Employment will be extended in accordance with the provisions of this Section. This provision does not apply to Accidental Death and Dismemberment Coverage.

PERMANENT TOTAL DISABILITY

If the Eligible Person submits to the Insurance Company (or Benefits Claims and Trust Office, if the benefit ceases to be insured), within one year after the date on which the Plan ceases to pay premiums for the Eligible Person, proof that the Total Disability has existed continuously and that it commenced before such Person's 60th birthday, such Person's death benefit coverage will be extended without further payment of premiums for one year from the date proof is received by the Insurance Company (or Benefits Claims and Trust Office, if the benefit ceases to be insured) so long as the Eligible Employee remains Totally Disabled continuously during said period. Thereafter, the Eligible Person's death benefit coverage will be extended without further payment of premiums for further periods of one year provided that such Person submits to the Insurance Company (or Benefits Claims and Trust Office, if the benefit ceases to be insured) annual proof of continuous Total Disability.

NOTICE OF CLAIM

No payment will be made for a Totally and Permanently Disabled Person's Death unless the Insurance Company (or Benefits Claims and Trust Office, if the benefit ceases to be insured) receives notice of such Person's death within one year after the date of death.

TERMINATION OF COVERAGE

The extension of death benefits described in this Section will terminate upon the earliest of the following events:

(1) When such Person ceases to be Permanently and Totally Disabled;

(2) If such Person refuses to submit to a physical examination required by the Insurance Company (or Benefits Claims and Trust Office, if the benefit ceases to be insured);

(3) If the Person fails to provide adequate or timely proof of continuation of Total Disability;

(4) When such Person attains normal retirement age; or

(5) When such Person converts to an individual policy, as described below.

CONVERSION

When an Eligible Employee's coverage ends due to termination of eligibility under the Plan, group life insurance may be converted, without medical evidence of insurability, to an individual policy customarily issued by the life insurance company. This provision applies to the extent that death benefits are provided through an insurance company. It does not apply if death benefits should become self-funded by the Plan; nor does it apply to Accidental Death and Dismemberment Coverage.

EXCLUSIONS FROM COVERAGE

Benefits provided under this Section will, except as otherwise provided in this Section, be governed by the terms and provisions of any life insurance company group policy for which the Plan contracts from time to time. Accidental Death and Dismemberment Benefits are not payable for any loss to which a contributing cause is:

(1) Intentional self-inflicted injury or intentional self-destruction while sane or insane;

(2) Disease, bodily or mental infirmity, ptomaine, bacterial infection (except infections caused by pyogenic organisms that occur with and through an accidental cut or wound), or disease or illness of any kind;

(3) Participation in a riot;

(4) Duty as a member of any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization;

(5) War or any act of war, declared or undeclared; or

(6) Participation in the commission of a felony.

WEEKLY DISABILITY INCOME BENEFIT

If a full-time Eligible Employee is Totally Disabled and under the direct and continuous care of a Physician as the result of an injury or sickness and, as a result, is completely prevented from performing the duties of his occupation or employment, the Plan may pay a Weekly Disability Income Benefit.

WAITING PERIODS

Weekly Disability Income Benefits are subject to the waiting periods for injury or sickness set forth in the Benefits and Enrollment Booklet.

AMOUNT OF BENEFITS PAYABLE

The amount of weekly benefits, if any, is set forth in the Benefits and Enrollment Booklet.

MAXIMUM BENEFIT PERIOD

Weekly Disability Income Benefits are limited to the maximum benefit period set forth in the Benefits and Enrollment Booklet. In order for this benefit to be renewed, the Eligible Employee must return to work for six (6) consecutive months.

LIMITATIONS

Benefits are not payable for any period of Total Disability:

(1) prior to the first day you are treated by a Physician;

(2) during which you are not under the direct and continuing care of a Physician;

(3) that occurs prior to the date you become eligible for benefits;

(4) during which you are employed for compensation, profit or gain;

(5) when the eligible employee is on leave of absence or layoff due to lack of work;

(6) for benefits excluded from coverage

GENERAL PROVISIONS

RELEASE OF INFORMATION

In order to process an Eligible Person's claims correctly, it may be necessary to obtain additional information from medical records or other sources. As a condition of coverage under the Plan, the Eligible Person agrees that the Administrative Manager may have access to the additional information. Any information related to an Eligible Person's claim will be kept strictly confidential and will be used only to administer the benefits available under the Eligible Person's coverage in accordance with all applicable laws.

PHYSICAL EXAMINATIONS

After an Eligible Person has a claim filed in their behalf by a service provider, the Administrative Manager has the right to ask that the Eligible Person have one or more physical examinations. Additionally, unless it is forbidden by law, the Administrative Manager has the sole right and opportunity to arrange an autopsy in the event of death. These exams, the purpose of which is to assist in the determination of whether services are payable, will be at the Plan's expense.

SELECTION OF PHYSICIANS AND FACILITIES

The Plan pays benefits for certain health care expenses, but the Plan does not provide hospital or medical services. Accordingly, the Plan is not responsible for any acts of omission by Hospitals or other facilities, or by Physicians, other professionals, or any facility staff member.

AMENDMENT TO OR TERMINATION OF PLAN OR BENEFITS

The Plan's Board of Trustees is empowered to change or amend the Plan at any time including, but expressly not limited to, reducing benefits, amending the Plan's eligibility rules, or discontinuing all or part of the Plan. Benefits will terminate when the Plan, or any applicable portion thereof, is terminated. If required by law, any insurance carriers providing benefits hereunder may change the terms of coverage upon 30 days advance written notice to the Trustees.

CLAIM PROCEDURES

The procedures governing claims for benefits (including receiving benefit determinations and appealing claims that are denied in whole or in part, as well as the applicable time limits) are furnished automatically, without charge, as a separate document.

LEGAL ACTIONS

No legal action may be brought until at least 60 days after the Eligible Person has a completed claim form submitted or other written proof of his claim, and has exhausted the Plan's Claims and Review

Procedures. Additionally, no legal action may be brought more than three years after a claim form or other written proof of the Eligible Person's claim was supposed to have been submitted.

PAYMENT OF BENEFITS LIMITED TO PLAN

Benefits as authorized under the Plan will be paid as long as the Plan can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no self-funded benefits will be payable except those that can be provided under the Plan, and no person will have any claim for self-funded benefits against the Board of Trustees, Employers or Union.

CHANGE OF ADDRESS

It is the Eligible Person's responsibility to notify his Employer and the Administrative Manager of his address and changes of address.

PAYMENT OF BENEFITS IN EVENT OF DEATH

If an Eligible Person dies before payment of benefits, benefits will be paid as provided in this Section. Where benefits are payable directly to the Provider under the terms and conditions of the Plan, such payment will not be affected by the intervening death of the Eligible Person. Where benefits are payable to the Eligible Person, the Administrative Manager will pay the amount of unpaid benefits as follows:

(1) If a probate administration is commenced in the Probate Court of the county in which the Eligible Person was domiciled at the time of his death, the Administrative Manager will make prompt payment of the amount of the unassigned but unpaid benefit to the legal representative of the deceased Eligible Person appointed by the Probate Court, upon receipt of a Certificate of Official Character from said legal representative.

(2) If a probate administration is not commenced on behalf of the deceased Eligible Person, the Administrative Manager will make prompt payment of the amount of the unassigned but unpaid benefit to the survivors in the following order or priority and upon evidence acceptable to the Administrative Manager of their status and priority: a) spouse; b) children, in equal shares; c) parents; d) brothers and sisters, in equal shares; and e) next of kin.

MISSTATEMENTS

If any facts relevant to the existence or amount of coverage are misstated, the true facts will determine whether or not, and how much, coverage is in force.

PRESENTMENT OF CLAIMS ON BEHALF OF PERSON WHO IS INCAPACITATED

In the event that an Eligible Person becomes incapacitated and be unable to prepare, complete, and/or execute the forms and documents prescribed by the Administrative Manager for the filing of claims

and/or receipt of benefits, the forms and documents may be signed for and on behalf of the Eligible Person by other persons as follows:

(1) In the event a guardian has been appointed by a court of competent jurisdiction for the Eligible Person, by the guardian;

(2) If no guardian has been appointed, then by the persons in the following order or priority and upon evidence acceptable to the Administrative Manager of status and priority: a) spouse; b) a child; c) a parent; or d) a brother or sister.

RECOVERY OF OVERPAYMENT

If the Administrative Manager determines that a claim has been paid or overpaid as a result of clerical error or on the basis of fraudulent or misleading statements made by the claimant, or for any other reason, then the Administrative Manager may take any necessary action to recover such payment, including, but not limited to, requiring the Eligible Person to reimburse the Plan for the amount erroneously paid or overpaid to the Eligible Person. In the event the Eligible Person, upon request by the Administrative Manager, declines to return such amount to the Fund, the Administrative Manager has the right to apply the amount erroneously paid or overpaid against subsequent benefits due until excess payments have been satisfied or to sue for recovery.

VALIDITY OF PLAN

The Plan is established in the State of Tennessee and all questions pertaining to the validity and construction of the Plan and of the acts and transactions of the parties hereto will be determined in accordance with the laws of the State of Tennessee, except as preempted by federal law.

CONSTRUCTION AND REPRESENTATIONS

The Trustees have complete authority and full discretion to construe and interpret the provisions of the Plan, and any questions about eligibility for or amount of benefits will be resolved by the Trustees. Neither the Employers nor Union nor representative of the Employers or Union is authorized to interpret the provisions of the Plan. Any interpretation of the Plan made by the Trustees will, subject to the claimant's right to legal action, be final and binding on all parties.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs) SPECIAL RULE FOR ENROLLMENT

If an order is issued by a court or through an administrative process under state law with respect to the provision of health care coverage for any of the Eligible Employee's Eligible Dependent children, the Administrative Manager or its designee will determine if the court order is a Qualified Medical Child Support Order (QMCSO) as defined by federal law, and that determination will be binding on the Eligible Employee.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws.

If an order is determined to be a QMCSO, and if the employee is an Eligible Employee under the Plan, the Administrative Manager or its designee will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren). However, no coverage will be provided for any dependent child under a QMCSO unless the participant is eligible for dependent coverage.

Upon request, you may obtain from the Benefits Claims and Trust Office, free of charge, a copy of the Plan's procedures governing QMCSOs.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

If you go into active military service for less than 31 days, you can continue your medical and dental coverage(s) during that leave period if you continue to pay your contributions for that coverage during the period of that leave.

If you go into active military service for more than 30 days, you may be able to continue your medical and dental coverage(s) at your own expense for up to 18 months. **See the Section of this document describing COBRA Continuation Coverage for a full explanation of when and how these circumstances may apply to your medical and dental coverage(s).**

Questions regarding your entitlement to this leave and to the continuation of medical and dental coverage(s) should be referred to the Benefits Claims and Trust Office.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).
If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of 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 of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

REINSTATEMENT OF COVERAGE AFTER LEAVE OF ABSENCE

Any period pursuant to any approved leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act (USERRA) will not be counted as a Break in Coverage.

If your coverage ends while you are on an approved leave of absence for family or medical leave, your coverage will be reinstated on the day you return to work covered under the collective bargaining agreement, if you return within the appropriate period after your leave of absence ends. If your coverage ends while you are on an approved military leave, your coverage will be reinstated on the day you return, or apply to return, to work covered under the collective bargaining agreement, if you return within the appropriate period specified by USERRA after your leave of absence ends. In any event, your reinstated coverage will be subject to any limitations for preexisting conditions that existed before the start of the leave of absence, and subject to all accumulated Overall, lifetime, annual and Calendar Year maximums that were incurred prior to the leave of absence.

Questions regarding your entitlement to this leave and to the continuation of medical and dental coverage(s) should be referred to the Benefits Claims and Trust Office.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Offer Free or Low-Cost Coverage for Children and Families

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP

office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you **must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

MEDICARE AND YOUR PRESCRIPTION DRUG COVERAGE

The Centers for Medicare & Medicaid Services have been working hard to implement the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This law brings the most dramatic and innovative changes to the Medicare program since it began in 1965. As you have probably heard, the Medicare Modernization Act of 2003 added a new voluntary prescription drug benefit, which was effective January 1, 2006. The information below will advise you of the new Medicare Prescription Drug Coverage and how this new Medicare coverage affects your prescription drug coverage under the UFCW Health and Welfare Plan and Trust for the Retiree Health Plan. Please read this information carefully as it may affect your coverage.

What is the Medicare Prescription Drug Coverage?

Medicare Prescription Drug Plans (PDPs) became available for Medicare-eligible retirees starting January 1, 2006. The benefits were based on a standard plan determined by Medicare. The standard plan design under Medicare is as follows:

- $250 annual deductible per person.
- Medicare pays 75% for covered drug costs between $250 and $2,250.
- After $2,250 is paid 100% is the responsibility of the individual until they reach an out of pocket expense of $3,600.
- After an individual reaches $3,600 in out-of-pocket expenses, Medicare will cover 95% of covered drug costs for the remainder of the year.

Important Notice: If you elect to take the Medicare Prescription Drug Coverage the UFCW Health and Welfare Plan and Trust (the Plan) will not coordinate as it does with your medical expenses. All deductibles and co-payments will be the responsibility of the individual enrolled in the Medicare Prescription Drug Program.

What This Means to You

The prescription drug coverage under the Plan did not change as a result of the new Medicare Prescription Drug Coverage. **You do not need to do anything to keep the prescription drug coverage you now have under the Plan other than the basic requirements to maintain eligibility, including work and premium requirements.**

As of November 15, 2005, all Medicare-eligible individuals had the opportunity to join a Medicare PDP for the first time. Those individuals who were eligible but did not join a PDP when first eligible may have to pay a penalty (a higher monthly Medicare premium) if they join a PDP in the future. If you remain in the Plan, but later join a PDP, the Plan will provide you with a Notice of Creditable Coverage to avoid any penalties. This notice will state that you have or have had prescription drug coverage. **Since your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare Coverage.**

In summary, please remember that for 2015:

- **Your current prescription drug coverage under the Plan will not change due to the new Medicare Prescription Drug Coverage.**
- **No action on your part is required to continue with your current prescription drug coverage under the Plan except the basic requirements to maintain eligibility, including work and premium requirements.**

NOTICE OF PRIVACY PRACTICES

The section below describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

The United Food and Commercial Workers Local Union No. 1529 and Employers Health and Welfare Plan and Trust (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:

Your Rights
You have the right to:
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services

- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways where reasonably necessary to protect the health and safety of the public. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI. The Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not be applied in certain situations, including disclosures to/from a health care provider as to treatment.

This Notice was originally effective April 14, 2003, and the Plan is required to comply with the terms of this Notice. The Plan reserves the right to change its privacy practices and to make the change effective for all PHI maintained by the Plan, including PHI created or received by the Plan prior to the effective date of the change and after the effective date of the change. If the Plan materially changes the terms of its privacy practices, the Plan will revise this Notice and provide you with a copy of the revised Notice within sixty days of the revision.

PRIVACY OFFICE

If you have any questions regarding the issues set forth in this Notice, please contact the Plan's Privacy Official at the following address:
The Privacy Office
United Food and Commercial Workers Local Union No. 1529 and Employers Health and Welfare Plan

661 North Ericson
Cordova, Tennessee 38018-5806
(800) 874-8499 • (901) 758-3000

SPECIAL ENROLLMENT RIGHTS UNDER THE HEALTH INSURANCE AND PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

What is Special Enrollment?

Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period.

There are two types of special enrollment – upon loss of eligibility for other coverage and upon certain life events. Under the first, employees and dependents who decline coverage due to other health coverage and then lose eligibility or lose employer contributions have special enrollment rights. For instance, an employee turns down health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan ceases. That employee then can request enrollment in her own company's plan for herself and her dependents.

Under the second, employees, spouses, and new dependents are permitted to special enroll because of marriage, birth, adoption, or placement for adoption.

For both types, the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

A special enrollment right also arises for employees and their dependents who lose coverage under a State Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

What are some examples of events that can trigger a loss of eligibility for coverage?

Loss of eligibility for coverage may occur when:

- Divorce or legal separation results in you losing coverage under your spouse’s health insurance;
- A young dependent, because of age, work, or school status, is no longer a covered "dependent" under a parent’s plan;
- Your spouse’s death leaves you without coverage under his or her plan;
- Your spouse’s employment ends, as does coverage under his employer’s health plan;
- Your employer reduces your work hours to the point where you are no longer covered by the health plan;
- Your plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time);
- You no longer live or work in the HMO’s service area;
- You have a health claim that would meet or exceed the plan's lifetime limit on all benefits.

These should give you some idea of the types of situations that may entitle you to a special enrollment right.

NOTIFICATION OF GRANDFATHERED STATUS

This group health plan believes this plan 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 that 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 1-800-874-8499. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

GROUP PLAN COVERAGE INSTEAD OF MEDICAID

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

DEFINITIONS

Whenever used in this Summary Plan Description, the following terms have the meanings stated below, unless a different meaning is plainly required by the context:

Accidental Injury

An "Accidental Injury" is one that occurs as the result of a traumatic bodily injury such as a sprain, abrasion or contusion.

Actively at Work

An Eligible Employee will be considered in "Active Employment" or "Actively at Work" with the Employer on a day that is one of the Employer's scheduled work days if the employee is performing in the customary manner all of the regular duties of his employment with the Employer on a full-time or part-time basis on that day, either at one of the Employer's business establishments or at some location to which the Employer's business requires the employee to travel. An employee will be considered in Active Employment on a day that is not one of the Employer's scheduled workdays only if he was performing in the customary manner all of the regular duties of his employment on the next preceding scheduled workday.

Active Duty

Active Duty means duty for training, including training for service in a Reserve unit, initial active duty for training, inactive duty training, full time National Guard duty and any absence needed for an examination to determine whether the eligible employee is fit to perform military duty.

Administrative Manager

"Administrative Manager" means any person or entity formally designated by the Plan's Board of Trustees to provide such administrative services as may be agreed to.

Admission

"Admission" means entry into a facility as a registered Inpatient according to the rules and regulations of that facility. An Admission ends when the Eligible Person is discharged or released from the facility and no longer registered as an Inpatient.

Calendar Year

"Calendar Year" means that period commencing at 12:01 a.m. Standard Time on January 1 and continuing until 12:01 a.m. Standard Time on the immediately following January 1.

Center of Excellence

"Center of Excellence" means a medical facility designated as such by the Board of Trustees for organ transplants.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985

Coinsurance

"Coinsurance" means the portion of Eligible Expenses for which the Eligible Person has financial responsibility. In most instances, the Eligible Person is responsible for paying a percentage of covered medical expenses in excess of the Deductible.

Custodial Care

"Custodial Care" means care designed primarily to assist an individual in managing activities of daily living including, but not limited to, assistance in bathing, dressing, eating, walking, the administration of medication that can usually be self-administered, and day care services.

Deductible

"Deductible" means the amount of Eligible Expenses the Eligible Person is responsible for paying before the Plan begins to pay benefits.

Durable Medical Equipment

"Durable Medical Equipment" means equipment covered by the Plan that can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a sickness or injury, and is appropriate for use in the home. However, the Plan will not cover maintenance or extended warranties or battery replacements for such equipment, will not cover scooters, and will not cover replacement of equipment that is necessitated by loss, theft, vandalism or abuse of the equipment. Wheelchairs and hospital beds that meet this definition of Durable Medical Equipment will be covered but reimbursement will be limited to that which is based on the cost of a standard wheelchair and hospital bed. For purposes of the Plan, orthotics will be considered Durable Medical Equipment.

Eligible Dependent

"Eligible Dependent" means:

A. The Spouse of a Full-Time Eligible Employee. The term "Spouse" shall mean an individual who is married to the Full-Time Eligible Employee in a legally recognized civil or religious ceremony, and who is not legally separated from the Full-Time Eligible Employee. A Full-Time Eligible Employee's common law spouse shall be considered a Spouse for purposes of this Plan if the Full-Time Eligible Employee and his alleged spouse offer proof in a form satisfactory to the Board of Trustees that the couple fulfill all of the conditions of a common-law marriage which the Full-Time Eligible Employee's state of domicile requires.
B. A child of a Full-Time Eligible Employee provided that the child:
    1. has not yet attained age 26
    2. is incapable of sustaining employment because of a Total Disability, according to a Physician's statement, before the child reaches age 26, and the child was covered under this Plan immediately before attaining age 26, provided the child is "dependent" on the Full-Time Eligible Employee for support and remains disabled after age 26. Proof of such disability must be filed within 31 days after the dependent child attains the maximum age of 26.
C. For purposes of this Plan, "child" means a natural born child or an adopted child of a Full-Time Eligible Employee. In addition, any of the following shall be classified as a child subject to the support requirement described below:
    1. A stepchild of an Eligible Full-Time Employee, who is dependent upon the Eligible Full-Time Employee for support.

2. Any other child, the care, custody, and control of whom is that of the Full-Time Eligible Employee pursuant to a court order, including a guardianship, who is dependent upon the Eligible Full-Time Employee for support.
3. A grandchild who has been dependent on the Full-Time Eligible Employee for support at least 9 months during a calendar year and is living in the Full-Time Eligible Employee's household.

For purposes of subparagraphs 1, 2, and 3 only, a child shall be deemed not dependent upon the Full-Time Eligible Employee for support unless the Full-Time Eligible Employee includes the child as a dependent on the Full-Time Eligible Employee's federal income tax return, or a court has issued a Qualified Medical Child Support Order requiring this Plan to maintain coverage for such child.

D. A Full-Time Eligible Employee shall be deemed an Eligible Dependent if his/her spouse is an Employee of the same Employer and is an Eligible Person under this Plan. Coverage will be primary as a Full-Time Eligible Employee, and secondary as an Eligible Dependent under the section entitled "Coordination of Benefits".

Eligible Employee

Unless the context indicates otherwise, "Eligible Employee" means any employee or former employee of an Employer who is eligible for benefits under the eligibility rules adopted by the Plan's Board of Trustees from time to time.

Eligible Expense

The term "Eligible Expense" means an expense for medical services or supplies, but only to the extent that:

(1) the services or supplies are Medically Necessary, as defined in this Section;

(2) the charges are Usual and Customary Charges, as defined in this Section;

(3) coverage for the services or supplies meets the requirements set forth in the "Eligible Expenses" Section of "Comprehensive Medical Benefits" and is not excluded, as provided under "Exclusions From Coverage"; and

(4) the maximum Plan benefits for those services or supplies have not been reached.

Eligible Person

Unless the context indicates otherwise, "Eligible Person" means either the Eligible Employee or the Eligible Dependent, or both.

Employer

"Employer" means any employer that is obligated to contribute to the Plan on behalf of its employees through a collective bargaining agreement or a written participation agreement.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Experimental and Investigational

"Experimental and Investigational" means medical, surgical, diagnostic, psychiatric, substance abuse or health care technologies, supplies, treatment, procedures, drug therapies or devices that are determined by the Board of Trustees (at the time it makes a determination regarding coverage in a particular case) to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Services, the United States Pharmacopoeia Dispensing Information, or the American Medical Association Drug Evaluations as appropriate for their proposed use; or (2) subject to review and approval by any Institutional Review Board for their proposed use; or (3) the subject of an on-going clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which their use is proposed.

Family and Medical Leave Act

Leave under the "Family and Medical Leave Act" or "FMLA" means a leave of absence, intermittent leave or leave on a reduced schedule, not to exceed twelve work weeks, as determined and certified by an Employer pursuant to the Family and Medical Leave Act of 1993, and corresponding regulations, and the Plan's policies and administrative procedures pertaining thereto.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Home Health Care and Home Health Care Agency

"Home Health Care" means intermittent skilled nursing care services provided by a licensed Home Health Care Agency. To be covered, care must be for the treatment of a sickness or injury, and must be Medically Necessary; it cannot be housekeeping, grocery shopping or other non-medical domestic services. Further, it must be ordered in writing by the patient's Physician and provided in the patient's home by a Home Health Care Agency. A Home Health Care Agency means a public or private agency that specializes in providing nursing or therapeutic services in the home, is licensed as a Home Health Care Agency, and operates within the scope of that license.

Hospice Care

The term "Hospice Care" means an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care. The goal of Hospice Care is to help terminally ill individuals continue life with minimal disruption in normal activities and uses an interdisciplinary approach to deliver medical, social, psychological, emotional and spiritual services through the use of a broad spectrum of professional and other caregivers with the goal of making the individual as physically and emotionally comfortable as possible.

Hospital

The term "Hospital" means an institution operated pursuant to law that is primarily engaged in providing, for compensation from its patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis, and that provides such facilities under the supervision of a staff of Physicians and with 24-hour-a-day nursing service by registered graduate nurses.

The term "Hospital" also includes a Mental Hospital that has no organized facility for surgery provided, if at the time a claim arises, it has a bona fide arrangement, by contract or otherwise, with an accredited Hospital to perform such surgical procedures as may be required by such facility for mentally ill or retarded persons. In no event, however, does such term include any institution or part thereof that is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged or for the care and treatment of drug addicts or alcoholics.

Immediate Relative

"Immediate Relative" means the Eligible Person's spouse, parent, child, brother or sister by blood, marriage or adoption.

Inpatient

"Inpatient" means a registered patient undergoing treatment in a health care facility for which a room and board charge is made.

Medical Emergency

"Medical Emergency" means the sudden and unexpected onset of a symptom or symptoms, including severe pain, that would lead a reasonable and prudent layperson to believe, at the time emergency services are sought, that a health condition exists that requires immediate medical attention, and that failure to obtain such immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

Medical Necessity or Medically Necessary

"Medically Necessary" means the service or supply is:

(1) Consistent with the symptoms or diagnosis and treatment of the Eligible Person's illness or injury;

(2) Appropriate with regard to standards of good medical practice, and recognized by an established medical society in the United States;

(3) Not solely for the Eligible Person's convenience or that of his Physician or the facility at which the Eligible Person receives treatment; and

(4) Performed in the least costly setting where services can be safely and appropriately provided (e.g., rendered to the Eligible Person as an Inpatient only when the services cannot be safely provided as an Outpatient).

Medicare

"Medicare" means the program established by Title XVIII of the Social Security Act, as it may be amended from time to time.

Mental or Nervous Disorder

"Mental or Nervous Disorder" means an illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual or is identified in the

current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), regardless of any underlying physical or organic cause.

Obesity

"Obesity" as used herein is defined as the physical state in which excessive fat is stored in various sites in the body or as an increase in body weight beyond the limitation of skeletal and physical requirements. No benefits or coverage is provided for the surgical treatment of Obesity.

Outpatient

"Outpatient" means someone who receives services or supplies while not an Inpatient.

Physician

The term "Physician" means, with respect to any particular medical care and services, any holder of a certificate or license issued by a governmental body authorizing such holder or licensee to perform the particular medical or surgical services.

Plan

"Plan" means United Food and Commercial Workers Local Union No. 1529 and Employers Health and Welfare Plan and Trust.

Plan Physician

"Plan Physician" means a medical and/or dental consultant who, when determined necessary and at the request of the Plan, may review any and all medical records and any other related documents necessary for the purposes of advising the Plan of his/her professional opinion regarding the Medical Necessity of the treatment plan, and if the intended treatment plan falls within the scope of standard medical practice.

Qualified Medical Child Support Order

"Qualified Medical Child Support Order" means an order issued by a court of competent jurisdiction that complies with the requirements of ERISA.

Prescription Drug

"Prescription Drug" means any medicinal substance that is required to bear the label: "Caution: Federal law prohibits dispensing without prescription." Contraceptive medications (except for generic, oral prescription contraceptives) or devices and needles and syringes are excluded.

Residential or Supportive Care

"Residential or Supportive Care" means care provided during a voluntary admission, when there is no evidence of an acute psychiatric disorder requiring confinement. This includes, but is not limited to, treatment for personality or behavioral disturbances, learning disabilities, and difficulties in adjusting to one's marital, occupational, social or cultural environment.

Skilled Nursing Facility

The term "Skilled Nursing Facility" means a facility that: provides continuous nursing services under the direction of a Physician and Registered Nurse; is a ward or wing of a Hospital, or separate facility licensed by the state in which it operates; and is accredited by the Joint Commission on Accreditation of Hospitals or is certified as a Skilled Nursing Facility under Title XIII of Medicare.

Total Disability or Totally Disabled

An Eligible Employee will be considered "Totally Disabled" during any period when, solely as a result of injury or sickness, he is completely unable to perform the duties of his customary occupation. An Eligible Dependent will be considered "Totally Disabled" during any period when, solely as a result of injury or sickness, the Eligible Dependent is prevented from engaging in substantially all of the normal activities of a person in good health of like age and sex.

Usual and Customary Charges

"Usual" means the charge made most frequently for a given service by the Physician who rendered a particular service. "Customary" means charges of Physicians generally of similar training and experience in that geographical area for the same or similar services or supplies.

"Usual and Customary Charges" refers to the allowance expense that the Plan will accept for a given treatment or procedure and that an Eligible Person is legally obligated and required to pay to the service provider. Usual and Customary Charges do not include, and no payment will be made for, charges that an Eligible Person is not legally obligated and required to pay to a service provider.

For purposes of determining Usual and Customary Charges, the Trustees will use such published data as they determine appropriate and reasonable for that purpose. The Trustees will not be limited to any specific source of data but may decide that determination will be made based on a specific data source from time to time, as they deem appropriate.

Utilization Management Company

The term "Utilization Management Company" means the organization, staffed with licensed health care professionals, operating under a contract with the Plan to administer the Plan's Utilization Management Program.

Utilization Management Program

"Utilization Management Program" means a managed care program designed to ensure the Medical Necessity, appropriateness, and cost-effectiveness of health care services. Under the Utilization Management Program, the Eligible Person, his Physician, or some other individual acting on behalf of the Eligible Person must contact the Utilization Management Company and obtain prior authorization in certain situations set forth in the Section Comprehensive Medical Coverage. Failure to obtain the necessary prior authorization will result in a penalty of a 10% lowering of the Coinsurance that would otherwise apply.

Terms Incorporated by Reference

Unless a different meaning is plainly required by the context, terms defined in the Plan's Trust Agreement will be incorporated herein by reference.

ERISA

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the United Food and Commercial Workers Union Local No. 1529 and Employers Health and Welfare Plan and Trust, 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 Benefits Claims and Trust Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Benefits Claims and Trust Office, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Benefits Claims and Trust Office is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 Administrative Manager to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Benefits Claims and Trust Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Benefits Employee Benefits Security Administration., you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration., U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration..

All benefits are subject to the Group Master Plan, Policies and Contracts that contain the provisions under which payments are made.

The Trustees have the sole and exclusive authority to determine the rules and eligibility to participate in the Health and Welfare Plan, the benefits and coverages to be provided, and the employee contribution, if any, to participate. No person has a vested right to participate in the Health and Welfare Plan or to receive any benefits or coverages from the Plan, except as expressly stated therein. The Trustees expressly retain the right to alter and amend the Plan, its benefits, coverages and funding at any time and from time to time in their sole and exclusive discretion and consistent with their fiduciary obligations.

IMPORTANT INFORMATION

ADMINISTRATOR

The Board of Trustees consists of an equal number of Union and Employer representatives, selected by the Union and the Employers who have entered into collective bargaining agreements that relate to the Health and Welfare Plan and Trust. The day-to-day administration is handled by the Benefits Claims and Trust Office. The Benefits Claims and Trust Office address and telephone number are as follows:

661 North Ericson
Cordova, Tennessee 38018-5806
(800) 874-8499 • (901) 758-3000

PLAN SPONSOR AND ADMINISTRATOR

The Board of Trustees is both the Plan Sponsor and the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants in accordance with the requirements of the Employee Retirement Income Security Act of 1974.

IDENTIFICATION NUMBER

The number assigned to the 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 62-6064101.

FISCAL YEAR

The Fiscal Year for the Plan is June 1 through May 31 of each year.

TRUST FUND

All assets are held in trust by the Board of Trustees.

TYPE OF PLAN

The Plan is maintained for the purpose of providing death benefits and medical benefits in the event of sickness or accident.

AGENT FOR SERVICE OF LEGAL PROCESS

Any of the Trustees may be served at the addresses listed below. In addition, the Plan Counsel may be served at the address located at the beginning of this booklet.

BOARD OF TRUSTEES

The names and addresses of the Board of Trustees are as follows:

UNION TRUSTEES:

Mr. Leon Sheppard, Jr.
UFCW Local Union No. 1529
8205 Macon Road
Cordova, Tennessee 38016

Mr. Rick Slayton
UFCW Local Union No. 1529
8205 Macon Road
Cordova, Tennessee 38016

EMPLOYER TRUSTEES:

Mrs. Peggy Prescott
The Kroger Company
2175 Parklake Drive NE
Atlanta, GA 30045

Mr. Rufus Wilson
The Kroger Company
800 Ridge Lake Blvd.
Memphis, Tennessee 38120

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to collective bargaining agreements between various Employers and UFCW Local Union No. 1529. The Benefits Claims and Trust Office will provide you, upon written request, copies of such collective bargaining agreements. A reasonable charge may be imposed to cover the cost of furnishing such copies. Copies of the collective bargaining agreements are also available for examination by participants at the Benefits Claims and Trust Office as required by law.

The Benefits Claims and Trust Office will also provide you, upon written request, information as to whether a particular employer is contributing to the Plan on behalf of participants working under the collective bargaining agreement. If the employer is contributing to the Plan, the Benefits Claims and Trust Office will also provide you the employer's address.

SOURCES OF CONTRIBUTIONS

The benefits described in this booklet are provided through Employer and Employee contributions. The amount of Employer and Employee contributions and the employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements.

ALTERED OR FORGED CLAIM FORMS

Any claim form or other forms submitted by or on the behalf of an employee or dependent that contains a material alteration or forged information, including signatures, will be rejected by the Benefits Claims and Trust Office, and the Board of Trustees reserves the right to forward the altered document to the local law enforcement agency for whatever legal action said agency deems to be appropriate34

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CHANGES TO REPORT

After your benefits become effective, it is necessary to notify the Benefits Claims and Trust Office of any change in your address, change in beneficiary or in the number of your dependents. This information is necessary so that proper benefits will be in force.

RETIREE ENROLLMENT

Any Retiree who becomes eligible for participation in the Retiree Program must elect to participate in the Retiree Program within 60 days after the date their participation as an Active Eligible Employee terminates. Any Retiree who does not enroll within this time period will be ineligible to thereafter enroll in or participate in the Retiree Program.