South Central United Food & Commercial Workers

Unions and Employers Health & Welfare Trust

SUMMARY PLAN DESCRIPTION

A Benefits Booklet Describing the

Health and Welfare Benefit Program

offered for you and your eligible dependents

PLANS A, B & C

This Benefits Booklet Applies to:

Employees Represented by UFCW Locals 455 and 540 and
Individuals Employed by Locals 455 and 540

April 2021

PREFACE:
IMPORTANT INFORMATION

TERMS AND CONDITIONS OF THE FUND

This booklet describes the terms and conditions governing the South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust (the "Fund"). By law, the Board of Trustees (the "Trustees") possesses the right to amend, modify or terminate any and all Participants' and Dependents' benefits, change eligibility rules and vary the contributions, if any, required from Participants. If you have questions not answered by this booklet, please contact the Plan Office.

NO AGENT MAY INTERPRET THE FUND DOCUMENTS

Only the Plan Office and/or appropriate benefit administrators may answer questions relating to the Fund and the benefits described in this Summary Plan Description ("SPD"). Employer representatives, Union representatives and the Fund's individual Trustees are not authorized to bind the Fund regarding a Plan's benefits or eligibility requirements. Only the full Board of Trustees or the appropriate benefits administrator can issue Fund interpretations. If you want information regarding any provision of this booklet or any of the Fund documents, contact the Plan Office.

NO GUARANTEE

None of the benefits provided by the Fund are guaranteed by the Trustees, any participating Employer, Union or any other individual or entity. The Fund's benefits originate only from Fund assets collected and available for such purposes. The Board of Trustees reserves the right to interpret, amend, modify or terminate in its sole discretion all or a part of this SPD and other Fund documents and to take any action it deems appropriate to preserve the financial stability of the Fund.

DETERMINATION BY TRUSTEES BINDING

A Board of Trustees—representing the Employees, selected by participating Local Unions chartered by the United Food and Commercial Workers International Union, and representing the participating Employers, selected by the Employers—governs the Fund. The Trustees are responsible for the operation of the Fund and the benefits provided from the Fund. They interpret the Fund documents, prescribe procedures for the operation of the benefit Plans and determine (a) who will be eligible Participants and Dependents, (b) the type and amount of benefits provided and (c) the medium for providing benefits.

The Trustees or, where Trustee responsibility has been delegated to others, such delegates shall have complete authority to apply and interpret this document and to determine the level of proof that will be required to establish eligibility for benefits or coverage for incurred expenses.

You should submit all questions regarding the benefit Plans, arising in any manner or between any parties or persons in connection with this Fund or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of this booklet, or as to any writing, decision, instrument or accounting in connection with the operation of the Fund, or otherwise, to the Trustees or, where Trustee responsibility has been delegated to others, to such delegates for a decision. The decision of the Trustees or their delegates will bind all persons dealing with the Fund or claiming any benefits hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court having jurisdiction over such matter.

ASSIGNMENTS

No Participant or Dependent has the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any interest in benefits to which he or she is or may become entitled under the Fund. In addition, no Participant or Dependent has the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any right (legal, equitable, or otherwise) to which he or she is or may be entitled by virtue of coverage under the Fund, including but not limited to any legal or equitable right to institute any court proceeding. Any such action shall be void for all purposes of the Fund.

The Fund may, at the sole and absolute discretion of the Trustees, pay benefits directly to an institution in which a Participant or Dependent has been admitted as an inpatient or to a provider of services or supplies in consideration for covered services or supplies rendered or to be rendered, regardless of the presence or absence of a purported assignment or other action prohibited under this provision. The direct payment by the Fund to such an institution or provider does not validate any attempted assignment or other action prohibited under this provision. The Fund may also, at the sole and absolute discretion of the Trustees, pay benefit claims directly to a Participant or Dependent regardless of any purported assignment, other action prohibited under this provision, or other form of directive by the Participant or Dependent.

PERMANENCY OF BENEFITS

The Trustees, Unions and Employers have established no deadline or termination date for the benefits described herein or the existence of the Fund. Circumstances, needs and perspectives, though, change from time to time. As a result, the Trustees reserve the right, in their sole discretion, to amend, change or terminate the benefits, the eligibility requirements or conditions for receiving a benefit and the continued operation of the Fund. The Fund can pay benefits only to the extent its assets allow and will pay no benefits following its termination and disbursement of all of its assets. No Trustee nor any Employer nor Union shall be liable, in any manner, if the Fund shall be insufficient to provide for the payment of the benefits specified herein.

The Fund may be amended, changed or terminated in accordance with the South Central United Food & Commercial Workers Unions and Employers Health & Welfare Plan and Trust Agreement (the "Trust Agreement"). The Fund may be terminated by any of the circumstances recited in the Trust Agreement, including but not limited to, the discontinuance of all Employer contributions to the Fund or the written agreement of the Unions and Employers to terminate the Fund.

If the Fund is terminated, the Trustees shall determine the disposition of all assets of the Fund, provided that such distribution shall be made only to benefit you and your Dependents and to defray the cost of doing so.

COMPLIANCE WITH PLAN PROVISIONS

Failure of the Trustees to insist upon compliance with any provision of a Plan at any time will not affect their right to insist upon compliance with such provision at any other time.

INCOMPETENCE

Payments made to you or your Dependents are subject to provisions allowing for payment to someone else where either you or your Dependent is a minor or otherwise not legally able to give a valid receipt for payment.

OVERPAYMENT

If the Fund pays any amount to or on behalf of you or your Dependent to which you or your Dependent is not entitled, the Fund may reduce future payments due to or on behalf of you or any of your Dependents by the amount of any such erroneous payment. This right of offset shall not, however, limit the rights of the Fund to recover such overpayments in any other manner.

OCCUPATIONAL INJURIES

If you are a Participant and injured on the job, immediately notify your supervisor. The Fund does not pay benefits for Occupational Illness or Injury. At your first opportunity, apply for worker's compensation benefits. If you are injured doing work as an Employee, the Fund generally does not pay benefits until you submit the final decision on your claim for worker's compensation benefits. However, at the discretion of the Trustees, the Fund may advance you benefits but you must pursue your worker's compensation claim and must agree to reimburse the Fund for any payments received.

The Fund does not advance benefits for an Illness or Injury incurred in, or arising out of, any work for pay or profit other than as an Employee. It also does not advance benefits to Dependents.

DETERMINE ELIGIBILITY FOR BENEFITS

The eligibility requirements for Plans A, B and C are described in further detail in this booklet. You bear the ultimate responsibility to confirm your eligibility for benefits. To determine your eligibility, you need to know only the date you began Employment (your "Employment Date") and the number of hours you worked in a month. If you have any question regarding your eligibility for benefits, please contact the Plan Office.

SOUTH CENTRAL UFCW UNIONS AND
EMPLOYERS HEALTH & WELFARE TRUST FUND
c/o Administrative Consulting Services
661 North Ericson Road
Cordova, TN 38018–1006
1-800-874-8499
Member Portal: www.bams.bz

IMPORTANT NOTE: The Fund imposes an enrollment requirement. Completion of the Fund's enrollment materials does not guarantee that you have satisfied a Plan's eligibility requirements and is not a guarantee of benefits. Eligibility is determined and benefits are paid only as permitted by the terms and conditions of a Plan.

SPECIAL RULE REGARDING
FUND COVERAGE FOR YOUR SPOUSE AND DEPENDENTS

The Fund offers Dependent spouse and child coverage to Employees participating in Plan A and Dependent child coverage to Employees participating in Plans B and C. "Dependent Coverage" means coverage for you and your eligible Dependents. To determine if you are eligible for Dependent Coverage pursuant to a Plan, please review the Dependent eligibility requirements in this booklet.

If you are eligible for Dependent Spouse Coverage pursuant to Plan A and your spouse is eligible for and elects medical coverage through his or her employer, your spouse's benefits will be coordinated in accordance with the rules described in this booklet. If your spouse is employed and eligible for employer-provided medical coverage but does not elect it, either (a) the Fund will pay benefits for your spouse on a primary basis if you pay a working spouse fee and the Employee and Spouse or Employee and Family self-contribution or (b) if you pay either the Employee and Spouse or Employee and Family self-contribution but not the working spouse fee, the Fund will coordinate your spouse's benefits on a secondary basis as if your spouse had elected his or her employer's medical coverage. The working spouse fee is outlined in the section entitled "Enrollment and Contribution Requirements" under the "Eligibility for Plan A" provisions of the SPD.

TABLE OF CONTENTS

INTRODUCTION

The Trustees of the Fund have adopted this Summary Plan Description ("SPD") to determine the eligibility of Employees and their Dependents for the benefits provided by the Fund and to define the nature, amount, extent, terms, conditions and method of paying such benefits. Article VII, subsection 7.2(a) of the South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust Agreement authorizes the Trustees to formulate and adopt a program of benefits. This document, entitled the "South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust Summary Plan Description," codifies the elements of such program.

The provision of benefits and the operation and administration of the Fund pursuant to this SPD shall at all times remain subject to, and be controlled by, the Trust Agreement.

All rights and powers of the Fund as provided herein shall vest in the Trustees. Consistent with their obligation to maintain, within the resources available, a sound and economical program providing reasonable benefits for Participants and Dependents, the Trustees expressly reserve the right, in their sole discretion, to:

1. establish, amend, or terminate the amount, eligibility requirements or conditions with respect to any benefit;

2. alter the method of paying any benefit;

3. amend any provision of this Summary Plan Description at any time and from time to time; and

4. interpret this Summary Plan Description.

The Fund shall pay benefits as provided in this Summary Plan Description only to the extent that the Fund's assets allow. No benefits shall be payable at any time after the Fund has terminated and all Fund assets are expended.

DEFINITIONS

CASE MANAGER/CASE MANAGEMENT

The individual or process by which you or your Dependent are provided personal service by a Case Manager to assist in obtaining the appropriate level of medical care for a particular Illness or Injury.

CONVALESCENT OR INTERMEDIATE CARE FACILITY

An institution which meets all of the following requirements: (a) is regularly engaged in providing skilled nursing care for ill or injured persons under the 24-hour-a-day supervision of a Doctor of Medicine or a Registered Nurse (RN.); (b) has available at all times the services of a Doctor of Medicine who is a staff member of a general Hospital; (c) has an R.N. on duty 24-hours-a-day; (d) maintains a complete daily medical record for each patient; (e) complies with all licensing and other legal requirements; and (f) is not, other than incidentally, a place of rest, a place for the aged, or a nursing home.

COSMETIC SURGERY OR TREATMENT

Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Board of Trustees or its designee.

COVERED CHARGES

The Reasonable and Customary charges that you or your Dependent actually incur for Medically Necessary services and supplies received by or furnished to you or your Dependent by or upon the recommendation and approval of a Physician who is attending the recipient for necessary treatment of an Injury or an Illness, to the extent such charges are not otherwise excluded or limited by the terms of a Plan.

COVERED WAGES

Wages paid by an Employer to you while an Employee. Covered Wages for purposes of the Loss of Time Benefit are further defined later in this booklet.

DEDUCTIBLE

That part of Covered Charges that must be satisfied by you or your Dependent before the Fund will pay benefits pursuant to the Schedule of Benefits. The Deductible is not considered in calculating a claims payment, and the amount excluded from consideration shall equal the Deductible listed in the Schedule of Benefits for each of you or your Dependent.

- The calendar year Deductible is applied once each year per individual.
- The Deductible per Hospital admission to a Non-Network Hospital is applied each time a Hospital confinement occurs in a Non-Network Hospital. This Deductible shall not be included in the amount necessary to satisfy the calendar year Deductible.
- The Deductible for failure to pre-certify is applied each time a Non-Network Hospital confinement occurs if the pre-certification process was not followed. This Deductible shall not be included in the amount necessary to satisfy the calendar year Deductible.

DEPENDENT

(a) Your spouse (satisfactory proof that a person is an Employee's legally married spouse must be submitted, if requested by the Plan Office);

(b) Your child, prior to his 26th birthday;

(c) Your child, unmarried, over age 25 who continues to be dependent upon you for support and maintenance and who:

(i) was covered pursuant to a Plan immediately prior to his 26th birthday, and

(ii) on reaching age 26 and thereafter, is incapable of self-support due to mental or physical disability (satisfactory proof of the child's uninterrupted continuation of incapacity and dependency since attaining age 26 must be submitted as requested by the Trustees).

(d) The term "child" includes

(i) A natural child;

(ii) an adopted child (or child placed for adoption); or

(iii) a step-child or foster child.

EMERGENCY

For purposes of medical benefits, an "Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which is severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

(a) the individual's health would be placed in serious jeopardy;

(b) bodily function would be seriously impaired;

(c) there would be serious dysfunction of a bodily organ or part; or

(d) the condition would significantly worsen without medical treatment.

EMPLOYEE

Any employee of an Employer on whose behalf payments are required to be made to the Fund by an Employer pursuant to a collective bargaining or other written agreement with a Union or with the Trustees but not including any person who is prohibited by law from being covered pursuant to the Fund or whose inclusion would cause the Fund to lose its tax-exempt status. An active Employee is any Employee who is considered active by the Employer and carried on the Employer's payroll records. In this booklet, an Employee may be referred to as "you."

EMPLOYER

Any food, drug or discount employer which

(a) on or after the effective date of the Fund has a collective bargaining or other written agreement with the Union or the Trustees requiring periodic contributions to be made to the Fund;

(b) signs a copy of the Trust Agreement, any predecessor to the Trust Agreement or participation agreement;

(c) is accepted for participation in the Fund by the Trustees or was a party to the Trust Agreement dated June 18, 1969, or any predecessor trust agreement; and

(d) makes contributions to the Fund as required by the agreement providing for such contributions.

The term "Employer" may also include the Union if such organization becomes obligated pursuant to a participation agreement with the Trustees to contribute to the Fund for its Employees on substantially the same basis upon which other participating Employers are contributing to the Fund, is accepted for participation in the Fund by the Trustees and makes contributions to the Fund as required by the participation agreement.

EMPLOYMENT

The state of being employed as an Employee of an Employer in a position requiring contributions to the Fund by the Employer on behalf of the Employee pursuant to a collective bargaining or other written agreement with the Union or with the Trustees.

EMPLOYMENT DATE

An Employee's first date of Employment. If a person's Employment terminates and resumes within 30 days, he will retain the same Employment Date as immediately prior to the termination of his Employment; if a person experiences more than a 30-day interruption in his Employment, the date he resumes Employment will become his new Employment Date.

EXPERIMENTAL

Services, supplies and procedures that require approval by an agency of the U.S. Government that has not yet received approval. Experimental treatments, services and supplies are also those which have progressed to limited human application but lack wide recognition as proven and effective in clinical medicine. The Trustees are authorized to determine whether a medical treatment, supply or service is "Experimental" for purposes of a Plan. The fact that a Physician has prescribed, ordered, recommended or approved the treatment, service or supply does not in itself make it eligible for payment.

FUND

The South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust.

HOSPICE

An autonomous centrally-administered program that, under the direction of a licensed Physician, provides a continuum of home out-patient and homelike in-patient care for the terminally ill patient, if:

(a) Such care is available 24 hours a day, 7 days a week;

(b) the program is established and operated in accordance with the applicable laws of the jurisdiction in which it is located; and

(c) where licensing is required by law, the agency or organization operating such program has been licensed and approved by the regulatory authority having responsibility for licensing under the law.

"Terminally ill" and "terminal illness" refers to a medical prognosis of limited survival of six months or less at the time of referral to a Hospice.

HOSPITAL

An institution participating in the preferred provider Network, a member Hospital of a National Association of Private Psychiatric Hospitals (for Mental and Nervous Conditions only) or an institution which meets all of the following requirements:

(a) Is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff of duly-qualified Physicians;

(b) continuously provides 24-hour-a-day nursing service by or under the supervision of registered graduated nurses and is operated continuously with organized facilities for operative surgery on the premises; and

(c) is not, other than incidentally, a place of rest, a place for the aged, or a nursing home; and

(d) is lawfully operated as a hospital (as described in (a), (b) and (c) above) in the jurisdiction in which it is located.

HOUR

One hour for which a contribution occurs to the Fund pursuant to a collective bargaining agreement or other written agreement with the Fund.

HOUR BANK

The collection of accounts maintained by the Fund on your behalf to record the number of Hours for which contributions are made on your behalf and as otherwise maintained pursuant to the Fund.

ILLNESS

The state of being sick or diseased, an ailment, being unwell.

INJURY

Traumatic damage to some part of the body.

MEDICALLY NECESSARY

Generally speaking, a service, treatment or supply that is appropriate and necessary for the treatment of the condition in question and provided consistent with the accepted standards of the medical community. However, only those services, treatments or supplies that are so determined by the applicable outside service organization shown in the Schedule of Benefits, pursuant to a more complete definition on file with the Plan Office, will actually be "Medically Necessary."

The fact that a Physician prescribes, orders, recommends or approves a hospitalization, service, treatment or supply does not, in itself, make it Medically Necessary. The Trustees or their delegate are authorized to determine whether a medical plan, supply or service is "Medically Necessary" for purposes of the Fund.

MENTAL AND NERVOUS CONDITION

A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, including substance and/or chemical abuse. Disorders, conditions and diseases as defined from time to time

within the mental disorder section of the International Classification of Diseases (ICD-10-CM) manual, which includes, among other things, autism, depression, schizophrenia and substance abuse.

MILITARY SERVICE

Service in the uniformed services as defined in the Uniform Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

NETWORK

The network of Physicians, Hospitals and other providers that have agreed to discounted prices for their services. This Network is provided through a contract with an outside service organization shown in your Schedule of Benefits.

NON-OCCUPATIONAL ILLNESS OR INJURY

An Illness or Injury arising out of or in the course of any activity that does not pertain to any occupation or employment for remuneration or profit.

OCCUPATIONAL ILLNESS OR INJURY

An Illness or Injury arising out of or in the course of any work for remuneration or profit.

OTHER HOSPITAL SERVICES AND SUPPLIES

The actual charges made by the Hospital, on its behalf, for services and supplies rendered to and required for treatment of you or your Dependent, for which you or your Dependent incurs a legal obligation to pay, other than charges for Room and Board, the outside professional services of any Physician and any private-duty nursing (including intensive nursing care by whatever name called), regardless of whether such services are rendered under the direction of the Hospital or otherwise.

OUT-OF-POCKET AMOUNTS

The amount of Covered Charges other than the penalties, or any other costs (whether pursuant to any Plan) paid by you or your Dependent and not paid by the Fund. Out-of-Pocket amounts exclude amounts paid as vision, dental, podiatric. Out-of-Pocket amounts also exclude charges from Non-Network Providers and charges for which other coverage is available.

PARTICIPANT

Any Employee or former Employee who is eligible for benefits provided hereunder. Throughout this booklet, a Participant may be referred to as "you."

PHYSICIAN

A doctor of medicine, osteopathy, podiatry, chiropractic, dentistry, clinical psychology or nurse practitioner who is licensed by the appropriate agency of the state in which the services, as to which claim is made, are performed and who is acting within the scope of his license. A Doctor of Optometry will not be recognized as a Physician except under the Vision Care Benefit.

PLAN

A plan of benefits provided by the South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust.

PLAN YEAR

The 12-month period ending on the last day of February each and every year.

PRE-CERTIFICATION

The required process of certifying a period of Hospital confinement as appropriate and Medically Necessary. The pre-certification process may be performed under a contract with an outside service organization.

PREVENTIVE CARE

Any service, treatment or supply that is not for the diagnosis or treatment of an Injury or an Illness and for which benefits are provided under the section titled "Covered Charges" below.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A judgment, order or decree issued by a state court or a state-controlled administrative process and which the Trustees or their designee determines to be a Qualified Medical Child Support Order ("QMCSO") pursuant to ERISA section 609(a).

REASONABLE AND CUSTOMARY CHARGE

The fee as reasonably determined by the Claim Administrator, which is based on the fee which the Physician, or Dentist, Podiatrist, Psychologist, Clinical Social Worker, Chiropractor or Optometrist who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, or Dentists, Podiatrists, Psychologists, Clinical Social Workers, Chiropractors or Optometrists of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if the Claim Administrator reasonably determines that the Reasonable and Customary Charge for a particular service is unreasonable because of extenuating or unusual circumstances, the Reasonable and Customary Charge for such service shall mean the reasonable fee as reasonably determined by the Claim Administrator but in no event shall the reasonable fee be less than the Reasonable and Customary Charge.

RESIDENTIAL TREATMENT CENTER

An institution which meets all of the following requirements:

(a) is established and operated in accordance with any applicable state law;

(b) is accredited by either the JCAHO or the Commission on Accreditation of Rehab Facilities ("CARF");

(c) provides a program of treatment approved by a Physician;

(d) has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient; and

(e) provides at least the following basic services:

(i) Room and Board (if the Medical Plan provides for In-Patient benefits at a treatment center);

(ii) Conducts evaluation, diagnosis and treatment plans;

(iii) Offers individual, group and/or family counseling;

(iv) Provides referral and orientation to specialized community resources.

(f) the treatment provided meets the generally accepted behavioral health standards of care for the condition or impairment for which the individual is being treated; and

(g) is not a custodial or group home.

ROOM AND BOARD

All charges for room, board, general duty nursing and any other charges by whatever name such charges are called, which are made by the Hospital at a daily or weekly rate and which are regularly made by the Hospital as a condition of occupancy for the class of accommodations occupied, for which the Employee or Dependent incurs a legal obligation to pay, including charges for intensive nursing care when combined with a charge for a coronary care unit or intensive care unit but not including charges for outside professional services by Physicians nor charges for intensive nursing care by whatever name called. For a Network Hospital, the Room and Board rate shall equal the Network-negotiated rate.

SCHEDULE OF BENEFITS

The benefits enumerated in the section of this booklet designated "Schedule of Benefits."

TERMINALLY ILL INDIVIDUAL

An individual whose life expectancy, pursuant to the written certification of a Physician, extends no longer than six months.

TOTAL DISABILITY

Your complete inability to perform any and every duty pertaining to your occupation or employment or the complete inability of a Dependent to perform the normal activities of a person of like age and sex.

TRUST

The assets of the Fund held in trust by the Trustees.

TRUST AGREEMENT

The South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust Agreement as originally effective June 18, 1969, and as thereafter amended from time to time.

UNION

Union Locals 455 and 540 or their successors by consolidation or merger of any such Unions and any other local union affiliated with the United Food & Commercial Workers International Union. Any local union affiliated with the United Food & Commercial Workers International Union, which:

(a) On or after the effective date of this Fund, enters into or maintains a collective bargaining or other written agreement with an Employer requiring the Employer to make periodic contributions to the Fund;

(b) signed a copy of the Trust Agreement, any predecessor Trust Agreement or a Participation Agreement; and

(c) is accepted for participation in the Fund by the Trustees or was a party to the Trust Agreement dated June 18, 1969, or any predecessor Trust Agreement.

UTILIZATION REVIEW

The process of monitoring the treatment of you or your Dependent. This process is performed by an outside service organization shown in your Schedule of Benefits.

ELIGIBILITY RULES

The Fund shall provide the benefits described herein, pursuant to the Plans listed below, to you and your Dependent spouse and children (Plan A) or to you and your Dependent children (Plan B or C) without physical or medical examination or other requirements except the recipient's compliance with the rules contained herein. If you qualify for benefits pursuant to more than one Plan during a calendar year, any benefits received by you or your Dependents pursuant to one Plan will offset the benefits available pursuant to the other Plans. You may earn eligibility based on Hours worked for Plan A, B or C benefits but at no time can you be eligible for more than one Plan of benefits. The Fund provides the following benefit classes: Plan A, Plan B and Plan C. Eligibility for Plans A, B and C is based on Hours worked, as described below. Hours worked in one month qualify you and your Dependents for coverage two months after the work month. Part-time fuel clerks are eligible to participate in the Plan on the same terms and conditions as other eligible part-time Employees.

CHART OF WORK MONTHS AND CORRESPONDING BENEFIT MONTHS

HOURS WORKED IN	PROVIDE COVERAGE IN
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

ELIGIBILITY FOR PLAN C

The eligibility rules differ depending on your Employment Date, which is defined in the Definitions section of this SPD, and your status as a full-time Employee or a part-time Employee, as classified by your Employer. All Employees hired after April 15, 2016 must commence participation in Plan C pursuant to the following rules.

Initial Eligibility. You and your Dependent children shall become eligible for Plan C on the earlier of (i) the first day of the calendar month following two consecutive calendar months after you complete 1,200 hours of Employment with your Employer, or (ii) the first day of the month after you complete 12 full calendar months of Employment with your Employer, provided you will not be eligible until after you have worked 80 hours in any

two consecutive months of Employment and your Dependent children are not eligible until after you have worked 120 hours in any two consecutive months of Employment. If you fail to satisfy the foregoing requirement, then you are eligible on the first day of the second calendar month after you work 80 hours (or 120 hours for Dependent child coverage) in any two consecutive months (but no earlier than the 13th month of Employment).

An Employee shall receive no Hour Bank credit or benefit for contributions occurring on his behalf while covered by Plan C.

Enrollment and Contribution Requirements. To receive benefits for Plan C, you must enroll in the Fund within the applicable timeframe when you become eligible if you want coverage for yourself and your Dependent children. If you do not enroll within the applicable timeframe when you first become eligible, you may not enroll until the next regular enrollment period unless you qualify for special enrollment as explained below. Failure to enroll in the Fund will not affect your eligibility to receive Loss of Time, Death and Accidental Death and Dismemberment Benefits. If you become eligible for Plan A benefits during the calendar year and you are not currently enrolled in the Fund, you cannot enroll in the Fund (and begin receiving Plan A benefits) until the next regular enrollment period unless you otherwise qualify for special enrollment. You will, however, become eligible for Plan A Loss of Time, Death and Accidental Death and Dismemberment Benefits when you first become eligible for Plan A.

You will receive enrollment materials from the Plan Office after you satisfy the eligibility criteria outlined above. If you do not receive enrollment materials and you believe you are eligible, contact the Plan Office at 1-800-874-8499. Receiving the enrollment materials is not a guarantee that you are actually eligible for benefits. If you receive enrollment materials and you do not believe you are eligible, contact the Plan Office.

All Employees must agree to the withholding of self-contributions from their direct compensation prior to commencing or continuing coverage in Plan C.

The self-contribution rate is as follows:

Employee Only	$6 per week
Employee and children	$12 per week

Continuing Eligibility. To remain eligible for Employee-only Plan C benefits, you must work at least 80 hours each month for which your Employer is required to make contributions. Your Dependent children's eligibility for Plan C benefits shall continue for all months for which you are eligible for Dependent coverage pursuant to Plan C, provided you accumulate at least 120 hours in the second month preceding the month for which coverage is sought, subject to the termination of eligibility provisions described below.

In addition, your enrollment in the Fund will expire at the end of each calendar year. To continue your eligibility for Fund benefits, you must enroll in the Fund at each regular enrollment period subsequent to your initial enrollment.

Termination of Eligibility. Your continuation as a Participant in Plan C shall terminate as of the earliest of the following dates:

(a) The last day of the month in which your Employment terminates provided you achieved eligibility for benefits for that month by Hours worked. (For example, if you terminate Employment on August 15 and otherwise qualify for Fund coverage for August through Hours worked in June, you will have coverage through August.);

(b) The day you enter full-time Military Service;

(c) If your Employment with an Employer terminates, the day on which you become employed by an employer not participating in the Fund;

(d) The day on which you become eligible for Plan A or B benefits; or

(e) The first day of the next calendar year unless you qualify, and affirmatively and timely enroll, for Plan C in such year.

Except in special limited circumstances, if your Employer ceases contributing to the Fund, your eligibility for benefits will cease as of the last day in which members of your Employment unit worked Hours for which your Employer contributed. For example, if your Employer's last contribution for your unit covered Hours worked through June 30, your eligibility for benefits would cease on June 30.

Rehire. If you terminate and resume Employment within 30 days, you will retain your original Employment Date; if you experience more than a 30-day interruption in your Employment, the date you resume Employment will be your new Employment Date. As a result, if you become eligible for Plan C, terminate Employment and are then rehired by an Employer within 30 days of the date you terminated Employment, you will not be required to re-satisfy the requirement described in the section titled "Initial Eligibility" in order to continue benefits under the Fund. You will be eligible for Plan C benefits as described in the "Continuing Eligibility" section of the SPD.

Transfer to Plan A or B. While you are classified as a part-time employee by your Employer, you shall be required to participate in Plan C until the end of the month in which you reach your third anniversary of your Employment Date with your Employer; thereafter, you shall be eligible for Plan B. However, if your Employer classifies you as a full-time employee, and you meet the Plan A eligibility requirements, you can begin participating in Plan A pursuant to that Plan's rules.

Termination Due to Military Service. If your status as a Participant in Plan C terminates because of entrance into full-time Military Service, upon leaving Military Service you shall resume participation in the same eligibility status as of the date you entered Military Service, provided you return to work for an Employer within 90 days from date of discharge or within 90 days following recovery from a disability continuing since discharge. If you do not meet the above requirements, you shall forfeit all Hours credited to your Hour Bank account.

The Fund does not maintain an Hour Bank for Plan C Participants.

ELIGIBILITY FOR PLAN B

The eligibility rules differ depending on your Employment Date, which is defined in the Definitions section of this SPD, and your status as a full-time Employee or a part-time Employee, as classified by your Employer.

Initial Eligibility. The date you become eligible for benefits depends on your Employment Date and whether you are classified as a full-time or part-time Employee. Your Employer, consistent with the governing collective bargaining agreement, will designate whether you are a full-time or part-time Employee. If you were hired after April 15, 2016, and you are not classified as full-time by your Employer, then you must first participate in Plan C until the end of the month in which you reach your third anniversary of your date of hire with your Employer; thereafter, you and your Dependent Children are eligible to participate in Plan B, provided you work the required monthly hours (80 hours for Employee coverage; 120 hours for Dependent Children Coverage). Alternatively, if you were hired by your Employer before April 15, 2016, then you commenced participation in Plan B pursuant to the following rules:

(a) Initial Eligibility for Full-Time Employees. You shall become eligible for Plan B benefits on the first day of the calendar month following two consecutive calendar months after you complete 480 hours of Employment with your Employer.

(b) Initial Eligibility for Part-Time Employees. You shall become eligible for Plan B benefits on the first day of the calendar month following two consecutive calendar months after you complete 475 hours of Employment with your Employer during your first six months of Employment. The six-month period is inclusive of the partial month in which you are hired (e.g., if hired January 15, the six-month period runs through June 30). If you fail to satisfy the foregoing requirement, then you are eligible on the first day of the second calendar month after you work 80 hours in any two consecutive months following the initial six-month testing period.

An Employee shall receive no Hour Bank credit or benefit for contributions occurring on his behalf while covered by Plan B.

Enrollment and Contribution Requirements. To receive benefits for Plan B, you must enroll in the Fund within the applicable timeframe when you become eligible if you want coverage for yourself and your Dependent children. If you do not enroll within the applicable timeframe when you first become eligible, you may not enroll until the next regular enrollment period unless you qualify for special enrollment as explained below. Failure to enroll in the Fund will not affect your eligibility to receive Loss of Time, Death and Accidental Death and Dismemberment Benefits. If you become eligible for Plan A benefits during the calendar year and you are not currently enrolled in the Fund, you cannot enroll in the Fund (and begin receiving Plan A benefits) until the next regular enrollment period unless you otherwise qualify for special enrollment. You will, however, become eligible for Plan A Loss of Time, Death and Accidental Death and Dismemberment Benefits when you first become eligible for Plan A.

You will receive enrollment materials from the Plan Office after you satisfy the eligibility criteria outlined above. If you do not receive enrollment materials and you believe you are eligible, contact the Plan Office at 1-800-874-8499. Receiving the enrollment materials is not a guarantee that you are actually eligible for benefits. If you receive enrollment materials and you do not believe you are eligible, contact the Plan Office.

All Employees must agree to the withholding of self-contributions from their direct compensation prior to commencing or continuing coverage in Plan B.

The self-contribution rate varies depending on your Employment Date. The self-contribution rate is as follows for employees hired before October 1, 2010:

Employee Only	$5 per week
Employee and children	$10 per week

For employees hired after September 30, 2010, the rate is as follows:

Employee Only	$6 per week
Employee and children	$12 per week

Continuing Eligibility. To remain eligible for Employee-only Plan B benefits, you must work at least 80 Hours (60 hours if hired before October 1, 2010) each month for which your Employer is required to make contributions. Your Dependent children's eligibility for Plan B benefits shall continue for all months for which you are eligible for Dependent coverage pursuant to Plan B, provided you accumulate at least 120 hours in the second month preceding the month for which coverage is sought, subject to the termination of eligibility provisions described below.

In addition, your enrollment in the Fund will expire at the end of each calendar year. To continue your eligibility for Fund benefits, you must enroll in the Fund at each regular enrollment period subsequent to your initial enrollment.

Termination of Eligibility. Your continuation as a Participant in Plan B shall terminate as of the earliest of the following dates:

(a) The last day of the month in which your Employment terminates provided you achieved eligibility for benefits for that month by Hours worked. (For example, if you terminate Employment on August 15 and otherwise qualify for Fund coverage for August through Hours worked in June, you will have coverage through August.);

(b) The day you enter full-time Military Service;

(c) If your Employment with an Employer terminates, the day on which you become employed by an employer not participating in the Fund;

(d) The day on which you become eligible for Plan A benefits; or

(e) The first day of the next calendar year unless you qualify, and affirmatively and timely enroll, for Plan B in such year.

Except in special limited circumstances, if your Employer ceases contributing to the Fund, your eligibility for benefits will cease as of the last day in which members of your Employment unit worked Hours for which your Employer contributed. For example, if your Employer's last contribution for your unit covered Hours worked through June 30, your eligibility for benefits would cease on June 30.

Rehire. If you terminate and resume Employment within 30 days, you will retain your original Employment Date; if you experience more than a 30-day interruption in your Employment, the date you resume Employment will be your new Employment Date. As a result, if you become eligible for Plan B, terminate Employment and are then rehired by an Employer within 30 days of the date you terminated Employment, you will not be required

to re-satisfy the requirement described in the section titled "Initial Eligibility" in order to continue benefits under the Fund. You will be eligible for Plan B benefits as described in the "Continuing Eligibility" section of the SPD.

Termination Due to Military Service. If your status as a Participant in Plan B terminates because of entrance into full-time Military Service, upon leaving Military Service you shall resume participation in the same eligibility status as of the date you entered Military Service, provided you return to work for an Employer within 90 days from date of discharge or within 90 days following recovery from a disability continuing since discharge. If you do not meet the above requirements, you shall forfeit all Hours credited to your Hour Bank account.

The Fund does not maintain an Hour Bank for Plan B Participants.

ELIGIBILITY FOR PLAN A

The eligibility rules differ depending on your Employment Date, which is defined in the Definitions section of this SPD, and your status as a full-time Employee or a part-time Employee, as classified by your Employer.

The date you become eligible for benefits depends on your Employment Date and whether you are classified a full-time or part-time Employee. Your Employer, consistent with the governing collective bargaining agreement, will designate whether you are a full-time or part-time Employee.

(a) Initial Eligibility for Full-Time Employees. You must work a total of 240 hours in any two consecutive months to become eligible. Eligibility occurs the first day of the second month following that two-month period. However, in no event can you become initially eligible prior to the first day of the 13th month of Employment. Notwithstanding the foregoing, you become eligible for Plan A as of the date your Dependents become eligible for Plan A if that date is earlier than the foregoing rule.

(b) Initial Eligibility for Part-Time Employees with Employment Date on or Before September 30, 2010. If you are a part-time Employee with an Employment Date on or before September 30, 2010, you must work a total of 240 hours in any two consecutive months to become eligible. Eligibility occurs the first day of the second month following that two-month period. However, in no event can you become initially eligible prior to the first day of the 24th month of Employment.

(c) Initial Eligibility for Part-Time Employees with Employment Date After September 30, 2010. You are not eligible for Plan A if you are a part-time Employee and your Employment Date is after September 30, 2010. If your classification changes from part-time to full-time employment, you will be eligible for Plan A in accordance with subsection (a) above.

Enrollment and Contribution Requirements. To receive benefits pursuant to Plan A, you must enroll yourself, if you are not already enrolled, and enroll your Dependents, if you want Dependent coverage, within the applicable timeframe after you become eligible. If you become eligible for Plan A benefits before, or at the commencement of, a calendar year and you do not timely enroll in the Fund, you cannot enroll in the Fund (and begin receiving Plan A benefits) until the next regular enrollment period unless you otherwise qualify for special enrollment. Failure to enroll in the Fund will not affect your eligibility to receive Loss of Time, Death and Accidental Death and Dismemberment Benefits.

If you have not already enrolled in the Fund when you become eligible for Plan A benefits, you may not enroll in the Fund until the next regular enrollment period unless you qualify for special enrollment as explained below. Additionally, if you did not enroll your Dependents within the applicable timeframe when they first become eligible, you may not enroll your Dependents in the Fund until the next regular enrollment period unless your Dependents qualify for special enrollment as explained below. **If you do not enroll yourself and your**

Dependents within the applicable timeframe when you first become eligible for any Fund benefits or during a subsequent regular enrollment period, you and your Dependents will be ineligible for Fund benefits during the remainder of that calendar year unless you and/or they qualify for special enrollment.

You will receive enrollment materials from the Plan Office after you satisfy the eligibility criteria outlined above. If you do not receive enrollment materials and you believe you are eligible, contact the Plan Office at 1-800-874-8499. Receiving the enrollment materials is not a guarantee that you are actually eligible for benefits. If you receive enrollment materials and you do not believe you are eligible, contact the Plan Office.

All Employees must agree to the withholding of self-contributions from their direct compensation prior to commencing or continuing coverage in Plan A.

The self-contribution rates vary depending on the coverage you select and your Employment Date. Presently, the self-contribution rates are as follows for employees hired before October 1, 2010:

Employee Only	$5 per week
Employee and Spouse Only	$28.08 ($44.62 if your working spouse fails to elect available health coverage through his or her employer) per week
Employee and Children Only (excluding Spouse)	$10 per week
Employee and Family	$33.08 ($49.62 if your working spouse fails to elect available health coverage through his or her employer) per week

For employees hired after September 30, 2010, the rates are as follows:

Employee Only	$6 per week
Employee and Spouse Only	$29.08 ($48.62 if your working spouse fails to elect available health coverage through his or her employer) per week
Employee and Children Only (excluding Spouse)	$12 per week
Employee and Family	$35.08 ($54.62 if your working spouse fails to elect available health coverage through his or her employer) per week

Dual Coverage. For spouses who are both employed by the same participating Employer in the Plan and who are both eligible for and enrolled with the same coverage type, the following weekly premiums shall be charged:

Employees hired on or before 9/30/2010

	Spouse One	**Spouse Two**
Employee + spouse	$5	$23.08
Family	$10	$23.08

Employees hired after 9/30/2010

	Spouse One	**Spouse Two**
Employee + spouse	$6	$23.08
Family	$12	$23.08

For the purpose of the Dual Coverage rules, "Spouse One" shall be the spouse with the earlier Employment Date, and "Spouse Two" shall be the spouse with the later Employment Date.

From time to time, the Trustees may change the self-contribution rates recited above. Contact the Plan Office to learn the currently applicable self-contribution rate.

Continuing Eligibility and Hour Bank. After you become initially eligible, the Fund shall credit all Hours worked and reported for you in excess of 120 per month to an Hour Bank account established and maintained on your behalf. You will continue to be eligible during any month in which the Hours worked and reported for the corresponding eligibility month, plus Hours (if any) withdrawn from your Hour Bank, equal 120. For this purpose, Hours worked in a month shall be used to determine the eligibility status two months after the work month. As an example, 120 Hours worked in March will provide eligibility for May. In this example, the month of April is an "administrative lag" month. The maximum number of Hours which may accumulate in your Hour Bank equals 119. **Your enrollment in the Fund will expire at the end of each calendar year. To continue your eligibility for Fund benefits, you must enroll in the Fund at each regular enrollment period subsequent to your initial enrollment.**

In addition, the Fund will continue your eligibility for benefits up to six months, without charging your Hour Bank, during periods of time lost due to Illness or Injury (on or off the job). Your benefits will continue for up to one month for a personal leave of absence without charging your Hour Bank. If the Fund continues your eligibility while paying you Loss of Time benefits or during a personal leave of absence, your Hour Bank will remain unchanged as of the commencement date of the Illness or Injury which entitles you to Loss of Time benefits or as of the commencement date of your personal leave of absence. In cases involving Workers Compensation benefits, you must submit proof sufficient to establish the beginning and ending dates of disability. A copy of the disability checks will suffice. To receive the one-month extension of benefits for a personal leave of absence, you must also submit satisfactory proof for the existence of a personal leave.

After continued eligibility expires, you may then be eligible to elect continuation coverage by making self-payments. You should contact the Plan Office if you believe that you are eligible for continuation coverage and you have not received notice from the Plan Office.

Termination of Eligibility. Your continuation as a Participant in Plan A shall terminate as of the earliest of the following dates:

(a) On the last date of the month in which your Employment with a Participating Employer terminates provided you achieved eligibility for benefits for that month by Hours worked or through the Hour Bank. (For example, if you terminate Employment on August 15 and otherwise qualify for Fund coverage for August through Hours worked in June, or through the Hour Bank, you will have coverage through August.);

(b) The day you enter full-time Military Service;

(c) If your Employment with an Employer terminates, the day on which you become employed by an employer not participating in the Fund;

(d) The day on which you fail to qualify for Plan A benefits based on hours worked yet you may satisfy the hours requirements for Plan B benefits; or

(e) The first day of the next calendar year unless you qualify, and affirmatively and timely enroll, for Plan A in such year.

Except in special limited circumstances, if your Employer ceases contributing to the Fund, your eligibility for benefits will cease as of the last day in which members of your Employment unit worked Hours for which your Employer contributed. For example, if your Employer's last contribution for your unit covered Hours worked through June 30, your eligibility for benefits would cease on June 30.

Rehire. If you terminate and resume Employment within 30 days, you will retain your original Employment Date; if you experience more than a 30-day interruption in your Employment, the date you resume Employment will become your new Employment Date. As a result, if you become eligible for Plan A, terminate Employment and are then rehired by an Employer within 30 days of the date you terminated Employment, you will not be required to re-satisfy the requirement described in the section titled "Initial Eligibility" in order to continue benefits under the Fund. You will be eligible for Plan A benefits as described in the "Continuing Eligibility" section of the SPD.

Termination Due to Military Service. If your status as a Participant in Plan A terminates because of entrance into full-time Military Service, upon leaving Military Service you shall resume participation in the same eligibility status and with the same Hour Bank credit, if any, as of the date you entered Military Service, provided you return to work for an Employer within 90 days from date of discharge or within 90 days following recovery from a disability continuing since discharge. If you do not meet the above requirements, you shall forfeit all Hours credited to your Hour Bank account.

Reinstatement of Eligibility and Forfeiture of Hour Bank. If you are no longer eligible for benefits due to insufficient Hours worked, including those supplemented by your Hour Bank, the Fund will retain the remaining Hours in the Hour Bank for up to three months from the last month of your eligibility. If you do not work sufficient Hours, with those supplemented from your Hour Bank, to be eligible during the three-month period, you will forfeit all Hours in your Hour Bank account and again be required to meet the initial eligibility requirements of the Fund.

DEPENDENT ELIGIBILITY

Your Dependent spouse and children are eligible for coverage if you participate in Plan A. Your Dependent children are eligible for coverage if you participate in Plan B or C.

Initial Eligibility for Plan A. The Dependent spouse and children of a Plan A Participant shall become eligible for benefits on (1) the first day of the month that is immediately following two complete calendar months after the Employee completes 1,200 hours of employment with his Employer (e.g., if Employee completes 1,200 hours May 15, Dependents would commence participation August 1), or if later, on the date the individual first becomes your Dependent, provided you agree to pay the required self-contribution described in the "Eligibility" section.

Initial Eligibility for Plan B or C. The Dependent children of a Plan B or C Employee shall become eligible for benefits at the same time as the Employee, subject to the Employee electing coverage for himself and his children and paying the required co-premium.

Continuing Eligibility. Your Dependents' eligibility for Plan A benefits shall continue for all months for which you are eligible for Dependent coverage pursuant to Plan A, subject to the termination of eligibility provisions described below. Your Dependent children's eligibility for Plan B or C benefits shall continue for all months for which you are eligible for Dependent coverage pursuant to Plan B or C, provided you accumulate at least 120 hours in the second month preceding the month for which coverage is sought, subject to the termination of eligibility provisions described below. For example, if you work 120 hours in May, your Dependent children would be eligible for coverage in July. Conversely, if you work 100 hours in May, you would be eligible for Employee-only coverage in July, but your Dependent children would not be eligible for coverage in July.

Working Spouse Fee. If your spouse is eligible for coverage provided by his or her employer and does not elect such coverage, you will be charged a monthly fee that will be deducted from your paycheck to cover your spouse under Plan A in order to maintain primary benefits for your spouse. If you do not agree to pay the working spouse fee in this circumstance, then the Plan will pay secondary (reduced) benefits on behalf of your spouse as described in the "Coordination of Benefits" section of the SPD. If your spouse elects the coverage provided by his or her employer, you will not be charged the working spouse fee and your spouse's benefits under Plan A will be coordinated in accordance with the Coordination of Benefits rules described herein.

Termination of Dependent Eligibility. Your Dependents' eligibility for benefits shall terminate on whichever of the following dates occurs first:

(a) the first day of the month following the date such individual ceases to be your Dependent pursuant to the terms of the Fund;

(b) the date that you become ineligible for Dependent coverage;

(c) in the event of your death, the last day of the month for which your Hour Bank would provide continued coverage;

(d) the first day of the first month for which you cease all coverage pursuant to the Fund;

(e) the first day of the first month you cease making contributions necessary to cover the Dependent; or

(f) The first day of the next calendar year unless your Dependent qualifies, and you affirmatively and timely enroll your Dependent, in such year.

CONTINUATION OF COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

You and your Dependents may make self-payments for continuation coverage pursuant to COBRA if you or your Dependent loses coverage due to certain events called "qualifying events." The length of this continuation period depends upon the reason coverage was lost. The period of continuation coverage is as follows.

18 Months - Employees (and their Dependents). You and your Dependents may continue coverage for 18 months if coverage is lost or modified due to one of the following qualifying events:

(a) termination of your Employment (unless due to gross misconduct); or

(b) reduction in hours creating a lack of hours for eligibility resulting in a change or termination of coverage.

Special rules apply if your Employment was terminated due to your Military Service. You should contact the Plan Office for more information on the length of coverage available to you if you terminated Employment for this reason.

Extension of 18-Month Period. The following situations may extend the 18-month period under the preceding paragraph:

(a) if a qualifying event that would entitle your Dependent to 36 months of continuation coverage occurs within the 18-month period, the 18-month period may be extended an additional 18 months (for a total of 36 months);

(b) the 18-month period may be extended to a maximum of 29 months if the Social Security Administration determines that you or one of your Dependents was disabled in accordance with Title II or XVI of the Social Security Act on the date of your reduction in hours or termination of employment or during the first 60 days of continuation coverage. To be eligible for the extra 11 months of coverage, you or your disabled Dependent must notify the Plan Office within 60 days of the Social Security Administration's determination of disability, or, if later, within 60 days of your loss of coverage or reduction in hours. The self-payment amount for the extra eleven months will be increased to the maximum amount allowed by law. You or your Dependent must also advise the Plan Office if it is later determined that you or your Dependent is not disabled under Title II or XVI of the Social Security Act within 30 days of such determination. This 11-month extension is available to all members of the disabled person's family who were covered pursuant to this continuation coverage;

(c) if you are entitled to Medicare at the time of your termination of employment or reduction in hours, your Dependents will be eligible to continue coverage for up to 36 months measured from your Medicare entitlement, or 18 months measured from the date of your termination of Employment or reduction in hours, whichever period is longer.

36 Months (Dependents of Employees). Your Dependents may continue coverage for 36 months if coverage is lost due to one of the following qualifying events:

(a) your death;

(b) your divorce or legal separation; or

(c) the Dependent's loss of Dependent status.

Notice. In the event your Dependents lose coverage due to one of the above events, they must advise the Plan Office of such event within 60 days of its occurrence to be entitled to 36 months of continuation coverage. If notice of such event is not provided within 60 days, your Dependents will have waived any rights to continuation coverage pursuant to a Plan.

If the qualifying event is your termination of Employment or reduction of hours of Employment or your death, the Employer must notify the Plan Office of the qualifying event. The notice must contain sufficient information to enable the Plan Office to determine the identity of the Plan, the Employee, the qualifying event and the date of the qualifying event.

Notices that you or your Dependents are required to provide must be sent to the Plan Office, c/o Administrative Consulting Services, 661 North Ericson Road, Cordova, TN 38018-1006 (telephone number 1-800-874-8499). All notices must be in writing and must include the following information:

(a) The names of persons entitled to COBRA coverage;

(b) Your name (if different);

(c) The address and telephone number of the persons entitled to COBRA coverage;

(d) The nature of the event (e.g., divorce, disability determination or second event);

(e) The date of the event; and

(f) Copies of any written documentation of the event, such as a divorce decree

A notice that does not contain all of the required information will not be considered adequate notice. Failure to supplement the notice with the additional information necessary to meet the content requirements will result in the loss of the right to elect continuation coverage.

Election of Continuation Coverage. You must continue all of the same coverage you had prior to your loss of coverage except you cannot maintain coverage for Death, Accidental Death and Dismemberment and Loss of Time Benefits.

If you and/or your Dependents, if any, wish to continue coverage pursuant to a Plan, such coverage must be elected by the later of 60 days after the election form is sent by the Plan Office or 60 days after the termination of coverage date shown on the election form. The monthly charge for this continuation coverage will be indicated on the election form. If you experience a special enrollment event after you elect COBRA continuation coverage, you should contact the Plan Office in accordance with the Special Enrollment procedures.

Cost of Continuation Coverage. Generally, you or your Dependent must pay for the entire cost of COBRA continuation coverage. The cost of continuation coverage will be established periodically by the Trustees but will not exceed 102% of the total cost of the coverage to the Fund (including both employer and employee contributions) for coverage for similarly situated active Participants. In the case of an extension of continuation coverage due to disability, the Fund may charge up to 150% of the cost of the coverage for the period of extended coverage.

The first payment, which must include payments for any months retroactive to the date you and/or your Dependent lost coverage pursuant to a Plan, is due no later than 45 days after the date you, or your Dependents, sign the election form and return it to the Plan Office. All payments must be in the form of a check or money order payable to the Fund.

Subsequent monthly payments will be due on the first day of the calendar month for which coverage is to be provided with a grace period of 30 days. For example, the self-payment for coverage in August would be due August 1 and accepted no later than August 31. You and/or your Dependent must, however, make all retroactive payments before your and/or your Dependent continuation coverage becomes effective. In addition, once your continuation coverage terminates for non-payment of premium, it cannot be reinstated. You are solely responsible to make all monthly payments by the due date. The Fund will not provide you with invoices or regular billings. Please contact the Plan Office to determine the amount you owe for this continuation coverage.

If you and/or your Dependent elect continuation coverage, you and/or your Dependent must pay the full cost of the coverage as shown on the election form. Be aware that any claims received for expenses incurred on or after the termination date stated on the election form will not be payable unless the applicable payments are made on time.

If you qualified for Dependent coverage as an active employee, and you or your Dependent have a newborn child, adopt a child or have a child placed with you or your Dependent for adoption (for which you or your Dependent have financial responsibility) while COBRA continuation coverage is in effect, you or your Dependent may add such child to your or your Dependent's coverage. You or your Dependent must notify the Plan Office, in writing, within 31 days of the birth, adoption or placement and provide documentation of such birth, adoption or placement in order to have this child added to your or your Dependent's coverage.

Termination of Continuation Coverage. If you and/or your Dependents elect this continuation coverage and make timely self-payments, the benefits provided to any qualified beneficiary (*i.e.*, you or your Dependents) may be continued for the maximum period (18, 29 or 36 months, as applicable). However, if one of the following events occurs before the appropriate period expires, your or your Dependent's right to continue coverage will terminate the day of such event:

(a) coverage will terminate for a covered person if he or she becomes covered pursuant to a group health insurance plan. Please contact the Plan Office for details;

(b) coverage will terminate for a covered person if he or she becomes entitled to Medicare;

(c) a correct payment for coverage is not made by the due date; or

(d) the Plan which last provided you active benefits is terminated.

In order to protect your family's rights, you should keep the Plan Office 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 Plan Office.

This notice does not fully describe the continuation coverage available pursuant to a Plan. More information about the continuation coverage and your rights pursuant to a Plan is available from the Plan Office.

Please note special rules apply if you become disabled while making self-payments to the Fund. Please contact the Plan Office for more information.

SELF-PAYMENT

If you reject coverage pursuant to COBRA, you may continue Plan A, B or C coverage pursuant to this Self-Payment section. However, once an election is made for either Self-Payment or COBRA, the other method cannot be chosen.

If you participate in Plan A and your eligibility terminates, you may continue benefits for up to six consecutive months by self-paying your own contributions to the Fund as follows: If you (i) retire or (ii) you are laid off or

granted a maternity leave or leave of absence due to Illness or Injury, you may continue as a Participant hereunder by making self-payments to the Fund for a period not to exceed six months.

If you participate in Plan B or C and receive the Loss of Time Benefit from the Plan, you may continue benefits under this Self-Payment section by self-paying your own contributions to the Fund for a period of up to three months immediately following the termination of the Loss of Time Benefit.

Each self-payment shall be in the amount specified from time to time and shall be in the form of a check or money order payable to the Fund. The first payment must be received by the Fund within 35 days after the event disqualifying you for coverage pursuant to Employer contributions. The Trustees may waive the 35 day limit in individual cases for good cause shown.

You must begin such payments with a payment for the first month following the termination of coverage provided by Employer contributions and may make such payments for only consecutive months thereafter. Payments for second and subsequent months must be received in the Plan Office by the first day of each such month.

It is your ultimate responsibility to determine the necessity for making self-payments to continue coverage.

Please note that the Loss of Time Benefit for Plan A shall be available if you lost coverage due to insufficient Hours while remaining at work for an Employer participating in the Fund. If you terminate Employment, you are not eligible to continue coverage pursuant to this self-payment provision.

IMPACT OF CERTAIN LIFE EVENTS ON YOUR FUND COVERAGE AND ELECTION RIGHTS

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QMCSO is any judgment, decree or order relating to the benefits of this Fund for the child of an Employee. It may be issued pursuant to state domestic relations law, including community property law. It may be issued to enforce a law relating to medical child support under the Social Security Act. The order must originate in a court of competent jurisdiction or through an administrative process under state law. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained from the Plan Office.

If your child is the subject of a QMCSO, the child must be considered an alternate recipient pursuant to the Fund. Upon the Fund's decision that an order is a QMCSO, the Fund must provide coverage to the child. Coverage may not be subject to Fund requirements such as custody, claimed on taxes or 50% support. The initial enrollment period is also waived for that child, assuming the child satisfies the Dependent eligibility requirements. The following rules will govern when the Fund must enroll a child pursuant to a QMCSO:

(a) If an Employee does not enroll the child, the Fund must recognize the child's right to be enrolled as an alternate recipient. The custodial parent or legal guardian of the child may also exercise this right.

(b) If an Employee is eligible but not enrolled, the Fund must enroll both the Employee and the child because the Employee's enrollment is necessary for the child to receive Dependent coverage.

(c) If an Employee is ineligible because the Employee has not yet satisfied the waiting period or Hours worked requirement, the Fund is not required to enroll the child until the Employee satisfies these requirements. However, upon satisfaction of the waiting period and Hours worked requirements, the Fund will enroll both the Employee and the child pursuant to the QMCSO.

Enrollment pursuant to a QMCSO will automatically authorize the appropriate periodic withholding from the Employee's direct compensation to cover himself and the child.

As stated above, a child must be considered an alternate recipient pursuant to the Fund. An alternate recipient will be treated as an Employee by the Fund for the purpose of reporting and disclosure under ERISA. The custodial parent or legal guardian may have this right on behalf of the alternate recipient. The alternate recipient must receive all information needed to be enrolled in and receive benefits from the Fund. The alternate recipient must be provided with a copy of this Summary Plan Description. Any payments made by the Fund must be made to the alternate recipient or the provider of service. Payment may also be made to the custodial parent or legal guardian.

MILITARY SERVICE

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") is a federal law providing protections for Employees who leave Employment for Military Service. For Fund purposes, USERRA applies only to health coverage (i.e., medical, dental, drug, vision). Disability and death benefits are not subject to USERRA.

If you satisfy USERRA's eligibility requirements, you are entitled to elect continuation coverage for yourself and your Dependents during your absence from Employment for Military Service. You are also entitled to immediate reinstatement in the Fund upon your return from Military Service as if you had been continuously employed during the Military Service. If you do not satisfy USERRA's eligibility requirements, you are not entitled to any of the protections described in this section.

Continuation of Coverage During Military Service. The law requires that coverage by the Fund continue during a leave covered by USERRA. Coverage must be the same as provided to similar active employees; thus, if coverage changes for similar active Employees, it will also change for the person on leave. The Employee's cost of such coverage will equal:

(a) For leaves of 30 days or less, no charge;

(b) For leaves of 31 days or more, the COBRA premium (up to 102% of the full contribution).

You will be deemed to be on military leave of absence effective on the date you leave Employment to enter Military Service. If your leave of absence is less than 31 days, your Fund coverage will be continued as though you were actively at work for the duration of the leave. If your leave of absence is 31 days or more, your Fund coverage will terminate as of the date you begin your military leave of absence, subject to the USERRA continuation of health coverage provisions described below.

If you fail to provide advance notice of your military service, your Fund coverage will terminate on the date you leave Employment to enter Military Service, and you will not be eligible to continue coverage unless the failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees determine that your failure to provide advance notice is excused, you may elect to continue coverage retroactive to the date your military leave of absence began, provided that you elect such coverage and pay all amounts required for the continuation coverage, as discussed below.

After the Fund receives notice of your military leave of absence, you will have the option of continuing your same class of coverage pursuant to the Fund. USERRA continuation coverage is similar, but not identical, to COBRA continuation coverage. The rules for election of continuation coverage are the same as the COBRA election rules described in this SPD, provided that the COBRA election rules do not conflict with USERRA. If you do not elect continuation coverage within the applicable COBRA timeframe, you will lose the right to USERRA continuation coverage and such right will not be reinstated.

You have the option of applying your Hour Bank, if available, as credit to obtain continuation coverage pursuant to USERRA. If your Hour Bank is unavailable or you choose not to use your Hour Bank, you must make timely self-payments at the COBRA rate determined by the Trustees from time to time to purchase COBRA continuation coverage. If you elect to use your Hour Bank to pay for continuation coverage, you must make self-payments to maintain continuation coverage after your Hour Bank is exhausted. The COBRA payment rules apply to payment for USERRA continuation coverage, provided the COBRA payment rules do not conflict with USERRA. If you do not submit payment for all amounts required to continue coverage within the applicable COBRA timeframe, you will lose the right to USERRA continuation coverage and such right will not be reinstated.

Maximum Period of Coverage during Military Service

Continued coverage under this provision will terminate on the earlier of the following events:

(a) The date you fail to return to Employment with the Employer after completion of your leave. Employees must return to Employment within:

  (i) the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

  (ii) 14 days of completing military service, for leaves of 31 to 180 days;

  (iii) 90 days of completing military service, for leaves of more than 180 days;

(b) 24 months from the date your leave began;

(c) The date that the Fund no longer provides group health care coverage to any Employees;

(d) The day after the date you fail to elect continuation coverage as required by the COBRA continuation coverage election rules; or

(e) The first day of the month for which a timely self-payment has not been received or your Hour Bank has been exhausted.

The Fund will provide continuation coverage to the extent required by USERRA. You may also have continuation coverage rights under COBRA. As noted above, although the COBRA and USERRA provisions are similar, COBRA continuation coverage and USERRA continuation coverage are not identical. As long as you remain simultaneously eligible for both COBRA and USERRA continuation coverage, you will receive the more generous benefit rights that apply under these statutes. The COBRA and USERRA continuation coverage periods will run concurrently. Please contact the Plan Office for more information about USERRA continuation coverage.

Reinstatement of Coverage Following Military Service

USERRA requires that coverage be reinstated upon your return to work. Reinstatement will apply whether coverage pursuant to the Fund was maintained during the leave or not. To be eligible for reinstatement, you must have provided advance notice of your Military Service (unless failure to provide such notice is excused), be honorably discharged from the military service and return to work within:

(a) The first, full business day after your military service ends, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

(b) 14 days after your military service ends, for leaves of 31 to 180 days;

(c) 90 days after your military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if your Military Service causes an Illness or Injury or worsens an Illness or Injury. Your failure to return within the times stated must be due to such an Illness or Injury. In that case, you may take up to a period of two years to return to work. If, for reasons beyond your control, you cannot return to work within two years, you must return as soon as is reasonably possible. Your USERRA rights may be limited if your period of Military Service exceeds 5 years (note, however, that many periods do not count against this 5-year rule, such as periods during which you were retained on active duty due to war or national emergency).

Upon reinstatement, all provisions and limits of the Fund will apply to the extent that they would have applied had you not taken leave. The eligibility period will be waived.

These rules are intended to comply with the requirements of USERRA. The USERRA provisions will control in the event of any inconsistencies between the Fund documents and USERRA.

NOTE: For complete information regarding your rights pursuant to the Uniformed Services Employment and Reemployment Rights Act, contact your Employer.

FAMILY AND/OR MEDICAL LEAVE

The Family and Medical Leave Act of 1993 ("FMLA") enables you, if you qualify, to take up to 12 weeks of unpaid leave for your serious Illness, after the birth or adoption of a child, or to care for your seriously Ill spouse,

parent or child. The FMLA requires certain Employers to maintain health care coverage during the leave period. If you qualify and take an FMLA leave, your Fund benefits are protected. If you think that this law may apply to you, please contact your Employer.

SPECIAL ENROLLMENT AND CHANGES IN ENROLLMENT OPTION

Elect Coverage. An Employee, who—when first eligible or during an open enrollment period—declined coverage pursuant to the Fund for the Employee or the Employee's Dependent, may revise the election to include such coverage if any of the following events occurs:

(a) The Employee acquires a new Dependent through either marriage, birth, adoption or placement for adoption. The Employee and the Employee's Dependent(s) (if otherwise eligible) may elect coverage. For purposes of providing the Fund notification of an event that triggers this election, the event shall be deemed to occur on the later of: (i) the date that the Employee first becomes eligible for Dependent coverage or (ii) the date of the marriage, birth, adoption or placement for adoption.

(b) The Employee or the Employee's Dependent ceases receiving other healthcare coverage through no fault of the individual losing such coverage. The Employee and the Employee's Dependent (if otherwise eligible) may elect coverage if the individual losing coverage was covered pursuant to the lost coverage when coverage pursuant to the Fund previously was offered to that individual. If the other healthcare coverage was provided pursuant to COBRA, that coverage must be exhausted to trigger this election. If the other healthcare coverage was not provided pursuant to COBRA, that coverage must have ceased due to either:

(i) Loss of eligibility;

(ii) The individual participated in an HMO and no longer works or resides in the HMO's service area and the individual has no access to other coverage from the HMO;

(iii) The individual incurs a claim that meets or exceeds the other coverage's lifetime limit on all benefits;

(iv) The other healthcare plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or

(v) Termination of employer contributions.

(c) The Employee or the Employee's Dependent was covered under Medicaid or a State Children's Health Insurance Program ("SCHIP") and lose eligibility for coverage under such program.

(d) The Employee or the Employee's Dependent becomes eligible for financial assistance through Medicaid or SCHIP with respect to coverage under this Fund, for example, through a premium assistance subsidy.

Revoke Coverage. An Employee, who had previously elected coverage pursuant to the Fund for the Employee or the Employee's Dependent, shall be able to revoke that election if any of the following events occurs:

(a) An individual ceases to be a Dependent of the Employee;

(b) The Employee or the Employee's Dependent becomes entitled to Medicare benefits;

(c) The Employee's marital status changes, including marriage, divorce, legal separation, annulment or the death of the Employee's spouse;

(d) The residence of the Employee or the Employee's Dependent changes. The change in the individual's residence must result in that individual becoming eligible (or ceasing to be eligible) for coverage by the Fund or another employer-provided health benefit program for that change to constitute a change in residence.

(e) Adoption proceedings involving the Employee terminate; and

(f) The employment status of the Employee or the Employee's Dependent changes. Such a change in employment status may include, but is not limited to, a termination or commencement of employment, a reduction in hours, a strike or lockout or a commencement of (or return from) an unpaid leave of absence. In addition, the change in the individual's employment status must result in that individual becoming eligible (or ceasing to be eligible) for coverage by the Fund or another employer provided health benefit program for that change to constitute a change in employment status.

Procedure. To elect or revoke coverage pursuant to the Fund, the Employee must submit a written explanation of the event that triggers this change in coverage to the Plan Office within 31 days of the occurrence of the triggering event, except as noted below:

(a) Upon the birth of a child, an individual may enroll the newborn child at any time during the calendar year of birth, provided required employee co-premiums are paid retroactive to the date of birth (and further provided that, if the child is born in the month of December, the individual can enroll the newborn child within 31 days of the date of birth, even if this period extends into the following calendar year); or

(b) If an individual loses other healthcare coverage because he or she incurs a claim that would meet or exceed a lifetime limit on all benefits, the Employee must submit a written explanation within 31 days of the date that a claim is denied due to this limit; or

(c) If an individual loses eligibility for Medicaid or SCHIP coverage or becomes eligible for financial assistance under Medicaid or SCHIP, the Employee or Dependent must submit a written explanation within 60 days of (1) the loss of eligibility for Medicaid or SCHIP coverage or (2) the date the Employee or Dependent become eligible for financial assistance under Medicaid or SCHIP.

The Employee's written explanation must include the date that the relevant event occurred and all information and evidence the Plan Office reasonably deems necessary to evaluate the event. If needed, the Plan Office may require additional information from the Employee regarding this event before accepting the change in coverage.

Effective Date. If the Employee provides the Fund sufficient and timely notice, the Employee's election or revocation of coverage generally will become effective the first day of the first calendar month beginning after the date the Fund receives the request for special enrollment. In the case of birth, adoption or placement for adoption, coverage will become effective on the date of such birth, adoption or placement for adoption if the Employee provides the Fund sufficient and timely notice. However, if the Fund does not receive sufficient and timely notice for this special enrollment election, coverage will not commence until the Employee otherwise becomes eligible to elect coverage pursuant the Fund's open enrollment period or otherwise.

SCHEDULE OF BENEFITS

COMPREHENSIVE MEDICAL BENEFIT

The Comprehensive Medical Benefit is provided to all eligible Participants, provided you and your eligible Dependents enroll in a Plan and, if required elsewhere herein, you agree to the withholding from direct compensation of the applicable amounts.

The following schedule describes the benefits payable for the most common medical benefits. The schedule describes the benefits by indicating the amount the Fund will pay for the described service. The exception is where the schedule refers to a "co-pay." In that instance, the "co-pay" listed is the amount you must pay for the described service.

"Network Provider" refers to participating providers in the participating provider organization ("PPO"). To find out what providers are "Network Providers," you should contact Blue Cross Blue Shield of Illinois at 1-800-367-8309 or, alternatively, check your provider directory at the Internet address listed below:

- Blue Access for Members (Member Portal): https://www.bcbsil.com/

- Member Mailing Address: Blue Cross and Blue Shield of Illinois
  P.O. Box 805107
  Chicago, IL 60680-4112

When benefits are paid as a percentage, this means the Plan will pay (1) a percentage of the allowed amount with respect to a network provider (as determined by the provider contract between the provider and the PPO), and (2) a percentage of the Reasonable and Customary Charge with respect to a non-network provider.

PLANS A, B AND C

	Plan A	Plan B	Plan C
Deductible (applies before Percent Payable) • Per Person Per Calendar Year/Per Family* Per Calendar Year • Admission to a Non-Network Hospital • Failure to Pre-Certify if Required Before Admission to Non-Network Hospital * At least two individuals must each satisfy the individual Deductible to satisfy the family Deductible	 $350/$700 $250 $300	 $350/$700 $250 $300	 $450/$900 $250 $300
Percent Payable, unless otherwise specified below • Network • Non-Network Percent Payable also applies to Hospital Outpatient Procedures, Hospital Outpatient Surgery, Urgent Care and Physical/Occupational Therapy	 80% 50%	 75% 50%	 70% 50%
Emergency Room	$100 co-pay (waived if admitted), then Percent Payable is 80%	$100 co-pay (waived if admitted), then Percent Payable is 75%	$200 co-pay (waived if admitted), then Percent Payable is 70%
Medical Out-of-Pocket Maximum (Applies to Network Charges Only) ▪ Benefits for Network medical expenses will be paid at 100% when your Out-of-Pocket expenses (excluding Deductibles, penalties, prescription drugs, non-covered items, excess charges, non-Network charges and co-pays) reach this amount (Individual/Family) Note: The out-of-pocket maximum will not apply when coordination of benefits is available. The family will satisfy the family Out-of-Pocket maximum when the total amount of the family's out-of-pocket expenses for all family members equal the family Out-of-Pocket maximum	$4,000/$8,000	$4,000/$8,000	$4,500/$9,000

	Plan A	Plan B	Plan C
Affordable Care Act Out-of-Pocket Maximum (Applies to Network Medical and Prescription Drugs Combined) ▪ Network medical and prescription drugs will be paid at 100% when your Out-of-Pocket expenses (including Network medical and prescription drugs, but excluding non-Network charges) reach this amount (Individual/Family)	$8,150/$16,300 (As of January 1, 2021, and as indexed by the IRS for subsequent years. The Plan limit lags IRS calendar year limit by one year due to fiscal year.)	$8,1300/$16,300 (As of January 1, 2021, and as indexed by the IRS for subsequent years. The Plan limit lags IRS calendar year limit by one year due to fiscal year.)	$8,150/$16,3000 (As of January 1, 2021, and as indexed by the IRS for subsequent years. The Plan limit lags IRS calendar year limit by one year due to fiscal year.)
Hospital Room and Board Daily Maximum Allowable Charge • Network • Non-Network	80% Semi-Private 50%	80% Semi-Private 50%	80% Semi-Private 50%
Convalescent Care Facility Maximum Duration	30 days	30 days	30 days
Physician's Office Visits (M.D. and D.O. Only) • Network • Non-Network	$25 co-pay 50%	$25 co-pay 50%	$25 co-pay 50%
Preventive Care Benefit (Percent Payable) • Network (no deductible) • Non-Network	100% Not covered, other than the following vaccinations which shall be covered at the Network percentage: • Flu/H1N1 vaccinations for Dependents. • Shingles and pneumonia vaccinations for Employees and Dependents in accordance with CDC guidelines.	100% Not covered, other than the following vaccinations which shall be covered at the Network percentage: • Flu/H1N1 vaccinations for Dependents. • Shingles and pneumonia vaccinations for Employees and Dependents in accordance with CDC guidelines.	100% Not covered, other than the following vaccinations which shall be covered at the Network percentage: • Flu/H1N1 vaccinations for Dependents. • Shingles and pneumonia vaccinations for Employees and Dependents in accordance with CDC guidelines.
Chiropractic Expense • Maximum Charges Per Visit	$25	$25	$25

	Plan A	Plan B	Plan C
• X-Rays (in connection with chiropractic treatment) – Maximum Per Calendar Year – Percentage Payable for X-Rays (chiropractic-related)	One set of chiropractic x-rays per year 50%	One set of chiropractic x-rays per year 50%	One set of chiropractic x-rays per year 50%
Podiatric Expense (without M.D./D.O. referral) • Maximum Charges per Visit with Surgery • Maximum Charges per Visit without Surgery • Maximum Visits per Week • Maximum Visits per Calendar Year	 $50 $25 1 6	 $50 $25 1 6	 $50 $25 1 6
Virtual Consultations with MDLIVE	The Plan pays 100% and you do not pay a Deductible or copayment for using BCBSIL's MDLIVE program	The Plan pays 100% and you do not pay a Deductible or copayment for using BCBSIL's MDLIVE program	The Plan pays 100% and you do not pay a Deductible or copayment for using BCBSIL's MDLIVE program
Other Virtual Consultations (NOT with MDLIVE)	The Plan pays the amount that would be payable for an in-person visit	The Plan pays the amount that would be payable for an in-person visit	The Plan pays the amount that would be payable for an in-person visit
Mental and Nervous Expense – including drug and alcohol abuse treatment Inpatient Daily Maximum for Room, Board and Miscellaneous (All Charges) • Network • Non-Network Outpatient Care • Network • Non-Network	 80% Semi-Private 50% $25 co-pay 50%	 80% Semi-Private 50% $25 co-pay 50%	 80% Semi-Private 50% $25 co-pay 50%

DEATH BENEFIT

The Fund's Death Benefit is provided on behalf of eligible Employees and Dependents in Plans A, B and C only.

Amount of Benefit for Plans A, B and C

Employee Death Benefit: 100% of annual Covered Wages, $3,000 minimum

Dependent Death Benefit: Spouse: $2,000

Children: $1,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Fund's Accidental Death and Dismemberment Benefit is available only to eligible Employees in Plans A, B and C only.

Amount of Benefit

Principal Sum	50% of the Death Benefit
Loss	
Life	Principal Sum
Both Hands	Principal Sum
Both Feet	Principal Sum
One Hand and One Foot	Principal Sum
Sight of Both Eyes	Principal Sum
One Hand and Sight of One Eye	Principal Sum
One Foot and Sight of One Eye	Principal Sum
One Hand	One-Half Principal Sum
One Foot	One-Half Principal Sum
Sight of One Eye	One-Half Principal Sum

LOSS OF TIME BENEFIT

The Fund's Loss of Time Benefit is available only to eligible Employees in Plan A, B or C who miss work due to certain qualifying Non-occupational Illness or Injury. Employees in Plans B and C must have two years of Employment to be eligible for the Loss of Time Benefit.

	Plan A	**Plan B**	**Plan C**
Amount of Weekly Benefit	60% of Salary	50% of Salary	50% of Salary
Maximum Weekly Benefit	$350	$300	$300
Maximum Benefit Period	26 Weeks	13 Weeks	13 Weeks

Benefit Begins

Benefits begin on the 5th day of Illness or Injury.

DENTAL BENEFIT

The Fund's Dental Benefit is provided to eligible Employees and Dependents in Plans A, B and C. The benefit available pursuant to the Fund depends, in part, on your Employment Date.

DHMO for Plans A, B and C

Note: Benefits are available only if a Network Dentist is used.

Office Visit	$5 Participant co-pay
Diagnostic	No Participant co-pay
Preventative	No Participant co-pay
Sealant/Tooth	$6 Participant co-pay
Restorative Amalgam	$10-$18 Participant co-pay
Crown	$255 Participant co-pay
Root Canal	$105-$248 Participant co-pay (depending on location)
Orthodontic	$1,500 lifetime maximum

Indemnity Option (if eligible)

No Deductible, benefits subject to Reasonable and Customary Limits

Maximum Fund Payment Per Calendar Year

- Plan A $1,500 (not applicable to children under age 18)
- Plan B $1,000 (not applicable to children under age 18)
- Plan C $1,000 (not applicable to children under age 18)

Percent Payable on all Covered Charges, up to the Maximum Payment Per Year

- Plan A 80%
- Plan B 75%
- Plan C 70%

Orthodontic Benefit (up to age 19) available for Plan A Only

- Lifetime Maximum $1,500
- Percent Payable, up to the lifetime maximum 50%

PRESCRIPTION DRUG BENEFIT

The Fund's Prescription Drug Benefit is provided to eligible Employees and Dependents in Plans A, B and C.

Type of Drug	Participant Pays (not to exceed cost of drug)
Brand Name Drugs	$20 co-pay & 20% of cost
Generic Drugs	$5 co-pay
Voluntary Mail Order 90-Day Supply	
• Brand Name Drugs	$50
• Generic Drugs	$5

VISION CARE BENEFIT

The Fund's Vision Care Benefit is provided to eligible Employees and Dependents in Plans A, B and C. The Vision Care Benefit is provided by Davis Vision.

Amount of Benefit

You and your eligible Dependents are entitled to receive benefits for the Covered Charges not more frequently than every 12 months.

COMPREHENSIVE MEDICAL BENEFITS
FOR ALL PLANS (A, B and C)

The "Comprehensive Medical Benefit" covers most of the Reasonable and Customary Charges that you incur for the Medically Necessary diagnosis and treatment of a Non-occupational Illness or Non-occupational Injury. This benefit is payable not only for Hospital expenses but also for Physician's bills and Other Hospital Services and Supplies. It covers medical expenses for serious or prolonged disabilities, in-patient or out-patient treatment of Mental and Nervous conditions, including alcoholism and drug abuse. In general, the Comprehensive Medical Benefit covers your expenses for most Illnesses or Injuries, serious or ordinary. If you or your Dependent incurs Covered Charges during a calendar year in excess of the Deductible requirement (if any) with respect to such Covered Charges, the Fund will, subject to the terms and conditions of this document, pay to, or on behalf of, you or your Dependent the applicable percentage of such Covered Charges as shown in the Schedule of Benefits. The Fund will pay benefits to, or on behalf of, your Dependents only if they are eligible for, and properly enrolled in, the Plan.

With respect to Covered Charges to which the Deductible requirement is applicable, benefits are not payable for Covered Charges used to satisfy the Deductible requirement or incurred during such calendar year prior to the date the Deductible requirement is satisfied.

In any calendar year, the aggregate amount of benefits payable for all Covered Charges with respect to any one of you or your Dependents (regardless of any interruption in your or your Dependents' coverage pursuant to this Fund, regardless of your or your Dependents' movement between Plans hereunder and regardless of any change in your or your Dependents' status from Participant to Dependent or vice versa) shall not exceed the Comprehensive Medical Benefit maximum shown in the Schedule of Benefits applicable to you or your Dependent.

The annual Deductible requirement, if any, shown in the Schedule of Benefits applies to each of you and your Dependents each calendar year. The annual Deductible requirement with respect to any one individual shall be satisfied only by charges incurred by such individual within a given calendar year. The Schedule of Benefits may impose additional Deductibles which each of you and your Dependents individually must satisfy before the payment of benefits hereunder.

Any co-insurance payment by the Fund will be made in the applicable percentage as shown in the applicable Schedule of Benefits, subject to the Deductible requirement (if any).

If you or your Dependent becomes eligible for a different plan hereunder, any benefits paid under Plan A, B or C shall reduce any maximum annual or lifetime benefits payable by the Plan for which you or your Dependent is then currently eligible.

If, after meeting the applicable Deductible requirement and co-insurance provision, your or your Dependents' total eligible Out-of-Pocket expenses exceed the applicable Out-of-Pocket maximum expense shown in the applicable Schedule of Benefits, the Fund will pay 100% of the Covered Charges incurred in excess of the Out-of-Pocket expense maximum as outlined in the Schedule of Benefits.

Other provisions herein to the contrary notwithstanding, at any time during a calendar year or during your or your Dependents' lifetime (if relating to a lifetime maximum), the aggregate amount of benefits payable for all Covered Charges with respect to any individual (regardless of any interruption in the coverage with respect to you and your Dependents pursuant to the Fund, regardless of your or your Dependents' movement between plans hereunder, and regardless of any change in your or your Dependents' status from Participant to Dependent or vice versa) shall not exceed the maximum shown in the Schedule of Benefits as then applicable to you and your Dependent.

FEDERAL LAWS AFFECTING THE COMPREHENSIVE MEDICAL BENEFIT

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act requires the Fund to provide coverage for a minimum period of time for hospital stays in connection with the birth of a child, if the mother and/or child is otherwise covered by the Fund. The Fund may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of a newborn child or a newborn child to less than 48 hours following a normal 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

Under Federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, prostheses and physical complications of all stages of mastectomy, including lymphedemas. Benefits for reconstructive breast surgery will be provided on the same basis as other surgical procedures covered by the Fund.

Genetic Information Nondiscrimination Act of 2008

As required by the Genetic Information Nondiscrimination Act of 2008, the Fund does not discriminate based on "genetic information," as defined by federal law. Subject to a few limited exceptions, the Fund will not request or require disclosure of your or your Dependent(s) genetic information. The Fund considers genetic information to be "protected health information" as defined by federal law and handles genetic information in accordance with the federal privacy regulations.

IMPORTANT NOTICE ABOUT NETWORK PROVIDERS

The Fund has entered agreements with networks of Hospitals, Physicians, dentists, optometrists and pharmacies to provide you with quality health care at reduced costs. However, using these designated providers is your voluntary decision. The Fund makes no representation regarding the quality of services provided and the Fund is not responsible for care rendered by the provider.

COMPREHENSIVE MEDICAL BENEFITS
COVERED CHARGES

"Covered Charges" are the Reasonable and Customary charges of the type set forth below which you or your Dependent actually incurs for Medically Necessary medical care, services and supplies received by or furnished to you or your Dependent by or upon the recommendation and approval of a Physician who is attending you or your Dependent for a necessary treatment of an Injury or Illness to you or your Dependent, to the extent such charges are not otherwise excluded or limited by the terms and conditions of a Plan. The Fund will pay benefits to, or on behalf of, your Dependents only if they are eligible for, and properly enrolled in the Plan.

IN-PATIENT HOSPITAL CHARGES

The Reasonable and Customary Charges actually made to you or your Dependent by a Hospital while you or your Dependent is confined as an in-patient in such Hospital including:

(a) Daily Room and Board, including general nursing care, except that the excess, if any, of the amount actually charged by the Hospital per day for daily Room and Board and general nursing care over the applicable maximum daily benefit shown in the applicable Schedule of Benefits shall not be included as a Covered Charge pursuant to a Plan;

(b) Daily intensive or coronary care accommodations, including intensive or coronary care nursing care. The term "intensive or coronary care accommodations" means an accommodation which is exclusively reserved for critically and seriously ill patients requiring constant audio/visual observation as prescribed by the Physician attending you or your Dependent and which provides Room and Board, specialized registered nursing care and other nursing care and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the Hospital facilities.

(c) Other Hospital Services and Supplies required for and rendered to you or your Dependent in direct connection with treatment of you or your Dependent.

OUT-PATIENT HOSPITAL CHARGES

The Reasonable and Customary Charges actually made to you or your Dependent by a Hospital, in its own behalf, for Other Hospital Services and Supplies required for and furnished to you or your Dependent, while not confined as an in-patient in such Hospital, in connection with an Injury or Illness or in connection with, and at the time of, a surgical operation or procedure performed in the Hospital by a Physician as a result of an Injury or Illness.

SURGICAL CHARGES

The Reasonable and Customary Charges actually made to you or your Dependent by a Physician as a surgical fee or fees for a surgical operation or procedure performed on you or your Dependent.

ADMINISTRATION OF ANESTHETICS

The Reasonable and Customary Charges actually made to you or your Dependent by a professional anesthetist or by a Physician for the administration of anesthetics to you or your Dependent.

PHYSICIAN'S CHARGES

The Reasonable and Customary Charges actually made to you or your Dependent by a Physician for each visit not involving the performance of a surgical operation or procedure or the administration of anesthetics.

MENTAL AND NERVOUS CONDITIONS

The Reasonable and Customary Charges actually made to you or your Dependent by a Physician, Hospital or Residential Treatment Center, as limited by the Schedule of Benefits of the applicable Plan. No benefits are payable for testing or treatment related to learning capacity or ability.

CHIROPRACTIC CHARGES

The Reasonable and Customary Charges actually made to you or your Dependent by a chiropractor not to exceed the allowable charge per visit, the co-insurance percentage and the maximum as specified in the Schedule of Benefits of the applicable Plan. X-rays will be payable as specified in the Schedule of Benefits.

PODIATRIC CHARGES

The Reasonable and Customary Charges actually made to you or your Dependent by a podiatrist not to exceed the maximum number of visits, the allowable charge per visit, the co-insurance percentage and the maximum as specified in the Schedule of Benefits of the applicable Plan. If a Doctor of Medicine ("M.D.") or Doctor of Osteopathy ("D.O.") recommends, in advance, specific podiatric care or surgery, the Fund will then consider all Reasonable and Customary Charges for that specified care or surgery.

RADIOLOGY OR LABORATORY EXAMINATION

The Reasonable and Customary Charges actually made to you or your Dependent for x-ray, radiotherapy (including the use of x-ray, radium, cobalts, MRI, CT, PET or other radioactive substances) or laboratory examination required for and rendered to you or your Dependent.

VIRTUAL VISITS.

Charges for virtual non-emergency consultations with a Physician in a telemedicine program approved by the Trustees (MDLIVE or any successor telehealth program), and virtual visits with a Physician outside of the Trustees' approved telemedicine program. Virtual consultations through the Trustees' telehealth vendor are paid by the Plan at 100%, and virtual visits with a provider outside of the Trustees' approved telehealth program shall be paid under the Plan's normal plan of benefits that would be payable for an in-person visit with the provider.

The current telehealth vendor is MDLive and can be contacted as follows:

- Call MDLIVE at 888-676-4204
- Go to MDLIVE.com/BCBSIL
- Text BCBSIL to 635-483
- Download the MDLIVE app

SERVICES OF A REGISTERED GRADUATE NURSE, LICENSED PRACTICAL NURSE OR A PHYSICAL THERAPIST

The Reasonable and Customary Charges actually made to you or your Dependent for Medically Necessary services rendered to you or your Dependent by a registered graduate nurse ("R.N."), licensed practical nurse ("L.P.N.") or a physical therapist, who:

(a) is not your spouse or child;

(b) is not your brother, sister or parent or your spouse's brother, sister or parent; or

(c) does not ordinarily reside in your home; and

(d) does not provide any personal or custodial care or sitting services.

PREVENTIVE CARE BENEFIT

The Plan intends to comply with preventive services as required under the Affordable Care Act and interpretive guidance. The Plan covers items or services with an A or B rating as recommended or defined by the U.S. Preventive Service Task Force, immunizations recommended by the Centers for Disease Control (CDC), preventive care and screenings for infants, children and adolescents supported by Health Resources and Services Administration (HRSA) and screenings for women supported by HRSA subject to the following:

(a) Preventive care benefits covered under the Affordable Care Act are not payable under other portions of the Plan.

(b) The Plan will use reasonable medical management techniques to control costs of services provided under the Affordable Care Act. However, if the Plan does not have an in-network provider to provide a particular preventive care item or service, the Plan will cover the item or service provided by a non-network provider without cost-sharing, upon receipt of substantiating documentation.

(c) If a preventive care benefits item or service is billed separately from an office visit, and the primary purpose is not the delivery of such preventive care item or service covered under the Affordable Care Act, then the Plan will impose the applicable deductible and coinsurance with respect to the office visit.

(d) The following services are excluded from the preventive care benefits, unless otherwise required under the Affordable Care Act:

(i) Testing or examination related to non-occupational accidental bodily injury or sickness or pregnancy (including resulting child birth or complications);

(ii) Testing or examination related to or as a condition of employment or to the issuance of any insurance policy;

(iii) Services that are not consistent with preventive care benefits under the Affordable Care Act;

(iv) Additional testing or services to confirm an illness or injury diagnosed as a result of a preventive care examination or procedure;

(v) Preventive care services under the Affordable Care Act are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Other services are covered under the applicable Plan medical benefits.

Preventive Care Benefits are also subject to all general Plan exclusions and limitations.

OTHER MEDICAL SERVICES AND SUPPLIES

Reasonable and Customary Charges actually made to you or your Dependent for the following:

(a) By an ambulance service which customarily renders ambulance transportation in the usual course of its business for Medically Necessary transportation of you or your Dependent to or from a local Hospital; by regularly scheduled airline or railroad or by air ambulance from the city or town in which you or your

Dependent becomes disabled to and from the nearest Hospital qualified to provide special treatment incident to such Injury or Illness.

(b) For artificial eyes, limbs or portions of limbs, provided that only one such prosthesis will be covered per lifetime per eye, limb or portion of limb; however, the replacement of prostheses for Dependent children after the initial replacement will be considered if the subsequent replacement is due to the natural growth of the child.

(c) For casts, splints or crutches.

(d) For a truss, brace or support prescribed by a Physician as a direct result of an Injury or Illness.

(e) For the rental of durable medical equipment as prescribed by a Physician. In regard to Covered Charges for durable medical equipment, the Trustees will make the final determination as to whether such equipment will be purchased or rented. The Trustees must be provided with the rental price and the purchase price of the equipment. The Fund will not pay in excess of total purchase price for the rental of durable medical equipment.

(f) For rental of a wheelchair or Hospital-type bed.

(g) For oxygen and rental of mechanical equipment required for the treatment of respiratory issues.

(h) For anesthetics, blood or blood plasma and other solutions which are administered intravenously.

(i) By a Convalescent or Intermediate Care Facility for confinements which commence immediately after a discharge from a Hospital, provided that benefits are limited to a period of 30 days following Hospital confinement.

(j) By a Hospice for the care and treatment of a Terminally Ill Patient.

(k) Dental expenses subject to all the terms and conditions recited herein.

(l) Prescription drug expenses subject to all the terms and conditions recited herein.

(m) For Preventive Care Benefits.

(n) For Medically Necessary speech therapy services provided by a speech therapist with respect to a Dependent who is under age 10 and who has been diagnosed by a Physician with an autism spectrum disorder.

ALTERNATE BENEFIT

A Plan may, at its option, provide a Case Management program to assist you or your Dependent to obtain medical care from the most appropriate source. The Case Manager may schedule or suggest methods and providers of care which may not be specifically covered by a Plan, in which case the cost of these special care facilities and treatment will be covered as any other expense pursuant to a Plan. If you or your Dependent chooses a more expensive treatment program than that scheduled or suggested by the Case Manager, the Fund reserves the right to pay benefits based on the most cost-effective alternate treatment plan.

EXCLUSIONS AND LIMITATIONS

Except as specifically provided, no benefits will be payable pursuant to a Plan for the following services or supplies:

(a) Expenses Not Deemed Medically Necessary. Charges for treatment, Hospital admission, level of care, procedure, service or supply that the Trustees or their delegate deems not Medically Necessary. A Hospital admission primarily for observation, evaluation or diagnostic study that could be provided adequately and safely on an out-patient basis is not Medically Necessary. The Case Manager or precertification Utilization Review Organization may also determine Medical Necessity as it relates to the above types of charges. "Medically Necessary" means a service or supply provided for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, mental illness, substance use disorder, condition or disease or its symptoms that meets the following criteria:

(i) in accordance with generally accepted standards of medical practice;

(ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the person's illness, injury, mental illness, substance use disorder or disease or its symptoms;

(iii) not mainly for the convenience of the person, a physician or other health care provider; and

(iv) is the most appropriate, most cost-efficient level of service, supply or drug that can be safely provided to a person and that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment.

A minimum hospital stay of up to 48 hours in connection with childbirth for the mother and newborn child following a normal vaginal delivery and a minimum hospital stay of up to 96 hours in connection with childbirth for the mother and newborn child following a cesarean section shall be considered Medically Necessary. If a hospital stay in excess of the above noted time periods is requested, the hospital stay in excess of the above noted time periods will be considered to be Medically Necessary if it is appropriate and consistent with the diagnosis of a particular condition in accord with accepted standards of community practice and could not have been omitted without adversely affecting the person's condition or the quality of medical care.

(b) Experimental or Investigational Drugs and Medical Procedures. Charges for treatment, services, supplies and procedures that the Trustees or their delegate deem Experimental. Experimental or Investigational means the use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet recognized as acceptable general medical practice and any such items requiring federal or governmental agency approval for which such approval has not been granted at the time the service was provided. The Trustees have the sole authority to determine whether the treatment shall be considered "experimental or investigational" for the purposes of this Plan.

Notwithstanding the above, to the extent required under the Affordable Care Act, the Plan will not deny as Experimental or Investigational any qualified individual (as defined below) the right to participate in an approved clinical trial (as defined below); deny, limit or impose additional conditions on the coverage of routine patient costs (as defined below) for items and services furnished in connection with participation in the approved clinical trial; and will not discriminate against any qualified individual who participates in an approved clinical trial. For purposes of this section, the following definitions apply:

(i) "Routine patient costs" include items and services typically provided under the Plan for an eligible individual not enrolled in an approved clinical trial. However, such items and services do not include [a] the investigational item, device or services itself; [b] items and services not included in the direct clinical management of the patient, but instead are solely provide din connection with data collection and analysis; or [c] a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

(ii) "Qualified individual" is a group health plan participant or beneficiary who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either the referring health care professional is a participating provider and has concluded that the participant's or beneficiary's participation in the approved clinical trial would be appropriate; or the participant or beneficiary provides medical and scientific information establishing that the individual's participation in the approved clinical trial would be appropriate.

(iii) "Approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is either:

[a] Approved or funded by one of the following:

(1) The National Institute of Health,

(2) The Centers for Disease Control and Prevention,

(3) The Agency for Health Care Research and Quality,

(4) The Centers for Medicare and Medicaid Services,

(5) A cooperative group or center of any of the above entities or the Department of Defense or Department of Veterans Affairs,

(6) A qualified non-governmental research entity identified in the guidelines issues by the National Institutes of Health for center support grants, or

(7) The Department of Veterans Affairs, the Department of Defense, or the Department of Energy if certain conditions are met.

[b] Conducted under an investigational new drug application reviewed by the Food and Drug Administration, or

[c] A drug trial that is exempt from having such an investigational new drug application.

(iv) "Life-threatening condition" is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

If an in-network provider is participating in an approved clinical trial and the in-network provider will accept the qualified individual as a participant in the approved clinical trial, the qualified individual is required to use the in-network provider instead of a non-network provider.

(c) Entity Not a "Hospital". Charges in or by a hospital that do not meet the definition of "Hospital" contained herein.

(d) Government Hospital. Charges in or by a Hospital, institution or other facility owned or operated by the United States government, or any agency or instrumentality, except for services or care rendered to a veteran in a Veterans Administration hospital for a non-service-related disability.

(e) Non-Emergency Hospital Confinements. Charges for non-emergency Hospital confinements that commence between noon Friday and noon Sunday.

(f) Hospital Confinements in Excess of Pre-Certified Limit. Charges for Hospital confinements that exceed the number of days certified by the Fund's Pre-Certification/Utilization Review Organization.

(g) No Legal Obligation. Charges that would not have been made in the absence of this coverage or that you or your Dependent have no legal obligation to pay.

(h) Blood or Blood Plasma Refunds. Charges for blood or blood plasma for which the Hospital or other supplier makes a refund to or on behalf of you or your Dependent either as a result of the operation of a group blood bank, private donor or otherwise.

(i) Cosmetic Surgery. Charges for medical care, services or supplies, received or furnished in connection with, or as the result of any cosmetic surgery or complications resulting from such surgery, except (a) disfigurement caused by a Non-occupational Injury sustained in an accident; and (b) charges in connection with and as a result of an abnormal congenital condition in a child. Notwithstanding the foregoing, as outlined earlier in the Plan, Federal law requires the Plan to pay for the following when requested by the covered person in consultation with her Physician: (1) reconstruction of the breast on which a mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications of all stages of mastectomy, including lymphedemas.

(j) Eye and Hearing Care. Charges for eye refraction, eye glasses, except as specifically provided pursuant to the Vision Care Benefit, and hearing aids.

(k) War. Charges for medical care, services or supplies received or furnished in connection with or as a result of any Injury or Illness resulting from or caused, directly or indirectly, wholly or partly, by (i) war or any act of war, whether declared or undeclared; (ii) service in any military, naval or air force of any country while such country is engaged in war, whether declared or undeclared; (iii) police duty as a member of any military, naval or air force organization; (iv) insurrection; (v) any atomic explosion or other release of nuclear energy (except only when being used solely for medical treatment of an Injury or Illness) whether in peace or in war and whether intended or accidental; or (vi) participation in a riot.

(l) Crime. Charges for medical care, services or supplies received or furnished in connection with or as a result of an Injury or Illness resulting from participation in, or in consequence of having participated in, the commission of an assault or felony, provided, however, that this exclusion shall not apply with respect to an Injury or Illness resulting from or as a consequence of an act of domestic violence or resulting from a medical condition (such as depression).

(m) Work Related. Charges for any medical care, services or supplies received or furnished in connection with or as a result of (a) any Illness or Injury which arises out of, or in the course of, any employment or occupation for compensation or profit; or (b) any Illness or Injury for which benefits are payable by any workers' compensation law, occupational disease law or any other legislation of similar purpose.

(n) Dental. Charges for a dental service or procedure, dental work or treatment, other than oral surgery, except as specifically provided pursuant to the Dental Benefit, and charges in connection with and as a result of Injuries to natural teeth sustained in an accident, except the initial replacement of such natural teeth. Charges for dental prosthetic appliances, the fitting of any thereof, except as may be required on account of a Non-occupational Injury to a physical organ sustained in an accident.

(p) Dependent Child's Pregnancy. Charges related to the Pregnancy of a Dependent child.

(q) Voluntary Sterilization. Charges for reversal of voluntary sterilization, and voluntary sterilization expenses for Dependent children.

(r) Infertility. Charges for confinements, treatments (including drug therapy) or services of any type relating to the restoration of fertility or the promotion of conception, including but not limited to artificial insemination and in-vitro fertilization.

(s) Abortions. Charges for abortion for you or your spouse, unless the life of the woman would be endangered by carrying the fetus to term or if medical complications arise from previously attempted abortions.

(t) Transplant. Charges incurred by the donor in connection with human organ or transplant surgery.

(u) Weight Management and Physical Fitness Exclusions. Charges for medical or surgical treatment of obesity, including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, and any complications thereof.

(v) Routine Examinations Not Specifically Covered. Charges related to a routine checkup or physical examination or diagnostic x-ray and laboratory examination, except as specifically provided herein.

(w) Excess of Reasonable and Customary Charges/DRG. Charges in excess of the Reasonable and Customary Charge.

(x) Preventive Care. Charges for Preventive Care except as specifically provided herein.

DEATH BENEFIT

DEATH BENEFIT FOR EMPLOYEES

The Death Benefit is available to Employees in Plans A, B and C (collectively the "Plan" for this section).

Amount of Benefit. Upon your death, the Fund will pay to your designated beneficiary the highest of: (a) wages paid by the Employer to you in the calendar year preceding the year of death; (b) wages paid by the Employer to you in the year of death; or (c) $3,000.

Benefit Payable to Designated Beneficiary. The benefits for loss of life will be payable to the beneficiary you designate in the manner required by the Fund. If, at the time of death, there is no designated beneficiary with respect to all or any part of the benefits or if the designated beneficiary does not survive you, the benefits will be paid to the surviving person or persons in the first of the following classes of your beneficiaries:

(a) Your spouse;

(b) Your child or children;

(c) Your parents;

(d) Your brothers and sisters; or

(e) Your estate.

In determining such person or persons, the Fund may rely upon an affidavit by a member of any of the classes of preference beneficiaries. If two or more persons within a class become entitled to benefits as beneficiaries, they shall share equally. In the event that no beneficiary exists or no beneficiary can be found and you die without an estate, then no benefit shall be awarded or granted pursuant to the Plan and no estate shall be created due solely to any potential death benefit which may be awarded in accordance with the terms of the Plan.

The Fund may pay any benefits for loss of life that are payable to a minor or incompetent to the legally-appointed guardian of the minor or incompetent, or, if no such guardian exists, to such adult or adults as have, in the Trustees' opinion, assumed the custody and principal support of such minor or incompetent. Payment to one described above will release the Fund from all other liability to the extent of the payment made.

Termination of Marriage. Designation of your spouse as your Death Benefit beneficiary shall immediately and automatically cease upon the dissolution of your marriage to that spouse by divorce, annulment or any event other than your death. Any person applying for the Death Benefit who is the decedent's former spouse must identify himself or herself to the Fund as such; otherwise such person may be subject to penalties for fraud.

Changing Your Beneficiary. You may designate a beneficiary or may change a previously designated beneficiary by filing a properly completed beneficiary card. Such designation or change, when received by the Fund, shall take effect as of the date the written notice is received by the Fund, whether or not you are living at the time of such receipt. Any payment made by the Fund prior to receipt of such designation or change shall fully discharge the Fund to the extent of such payment regardless of intervening events, such as your divorce, the birth of a child, etc. Please contact the Plan Office to obtain a Beneficiary Card.

The right to change a beneficiary is reserved to you and the consent of the beneficiary or beneficiaries shall not be required to change a beneficiary. If you designate more than one beneficiary and fail to specify their respective interests, the beneficiaries shall share equally.

Death Benefit Policies and Procedures. The Fund shall have the power to issue policies and procedures regarding administration of death benefit claims. The Trustees shall have sole discretion in interpreting the terms of the Plan and any policies and procedures issued to determine the correct beneficiary and payment of benefits.

Claim Limitations. Any individual who wishes to be considered as a potential beneficiary must notify the Fund within 90 days from the date of the Participant's death, and failure to do so will bar suit against the Fund for benefit payments made to another beneficiary or to the Participant's estate. Additionally, all claims for Death Benefits must be filed with the Plan within three years from the date of death. Claims filed after this three-year deadline will not be eligible for payment.

Continuing the Death Benefit During Periods of Total Disability. If you terminate active Employment prior to your 60th birthday as a direct result of a Total Disability incurred prior to February 1, 2001, coverage equaling the amount applicable to you at the termination of your active Employment shall continue during the period of the continuous Total Disability. This continuation provision does not apply to any individual who incurs a Total Disability after January 31, 2001. However, the Death Benefit shall continue during any period that you are receiving coverage pursuant to the Self-Payment program.

After the Total Disability has been established by proof satisfactory to the Trustees for a period of at least one year, the Fund may, at its option, require reconfirmation of the Total Disability by proof satisfactory to the Trustees and furnished at your expense. At any time during, but not more frequently than once each twelve months, the period in which this benefit is extended, the Fund may require proof of continuing Total Disability and may require that a Physician of its choice examine you.

No payment will be made on account of your death when benefits are extended under this provision, unless written notice of death is received by the Fund within one year after the date of death.

The Death Benefit extended under this provision will automatically terminate:

(a) If you cease to suffer a Total Disability except that, if you return to active Employment and again becomes a Participant, the benefit will continue upon payment of contributions by your Employer to the Fund for you;

(b) If you refuse to submit to any physical examination required by the Fund;

(c) If you fail to provide proof of continuation of Total Disability; or

(d) If you attain age 62.

DEATH BENEFIT FOR DEPENDENTS

The Dependent Death Benefit is available for Dependents of Participants in Plans A, B and C. Your Dependent is eligible for this benefit if the Dependent satisfies the Fund's definition, the Employee is enrolled in the Plan and you are a Participant eligible for Plan A, B or C.

Amount of Benefit. The amount of benefit in force on the life of his Dependent is determined in accordance with the Schedule of Benefits.

Benefit Payable to You. Upon the death of your eligible Dependent, the Fund will pay you a lump sum, as beneficiary. If you do not survive your eligible Dependent, the benefits will be payable in accordance with the "Beneficiary" provisions as shown under the Employee Death Benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Fund's Accidental Death and Dismemberment Benefit is available to Employees in Plans A, B and C only.

Amount of Benefit. If you, while eligible hereunder, sustain an accidental Injury and, as a result of that Injury, suffer, directly and independently of all other causes and within 90 days of the Injury, one of the specific losses described below, the Fund shall pay the amount of benefit provided below for the loss suffered.

In no event shall the total amount payable for all your losses suffered as a result of any one accident exceed the maximum amount indicated in the Schedule of Benefits, and no loss sustained prior to such accident will be included in determining the amount payable. All claims for Accidental Death and Dismemberment Benefits must be filed with the Plan within three years from the date of the accident. Claims filed after this three-year deadline will not be eligible for payment.

Benefit For Loss of Life. Benefits for loss of life are payable according to the principal sum specified in the Schedule of Benefits. The benefit will be payable to the beneficiary specified by the beneficiary provisions of your Death Benefit.

Benefit For Dismemberment. Benefits for dismemberment are payable to you as follows:

(a) The principal sum specified in the Schedule of Benefits is payable for the following losses:

  (i) both hands;

  (ii) both feet;

  (iii) one hand and one foot;

  (iv) one hand or one foot and the irrevocable loss of sight of one eye from accidental Injury; or

  (v) the irrevocable loss of sight of both eyes from accidental eye Injury;

(b) One half of the principal sum specified in the Schedule of Benefits is payable for the following losses:

  (i) one hand;

  (ii) one foot; or

  (iii) the irrevocable loss of sight of one eye from accidental Injury.

Loss of sight means total and irrevocable loss of sight. Loss of hand means severance of the hand at or above the wrist. Loss of foot means severance of the foot at or above the ankle.

Exclusions. No benefit will be payable for loss resulting directly or wholly from:

(a) Intentional self-inflicted injury or suicide;
(b) Bacterial infections (except pyogenic infections occurring simultaneously with and in consequence of bodily injury for which benefits are otherwise payable);
(c) Bodily or mental infirmity or eye illness of any kind;
(d) The commission of or the attempt to commit a felony by you; or
(e) War or an act of war or service in any military, naval, or air force of any country while such country is engaged in war, or policy duty as a member of an military, naval, or air organization.

LOSS OF TIME BENEFIT

The Fund's Loss of Time Benefit is available only to eligible Employees in Plan A, B or C who miss work due to certain qualifying Non-occupational Illness or Injury. Employees in Plan A are eligible for the Loss of Time Benefit at the same time they become eligible for Plan A Comprehensive Medical Benefits. Employees in Plans B and C must have two years of Employment to be eligible for the Loss of Time Benefit.

For purposes of this benefit, "Covered Wages" shall mean the current hourly rate times the average Hours you worked as an Employee during the last eight weeks immediately preceding the date of your Total Disability.

Amount of Benefit. If you suffer a Total Disability due to a Non-occupational Injury or a Non-occupational Illness, the Fund will pay you weekly benefits at the rate, and beginning with the dates, shown in the Schedule of Benefits, but in no event prior to the first day of treatment by Physician. Benefits are payable as long as the Total Disability exists, but not for longer than the maximum benefit period, as shown in the Schedule of Benefits, during any one period of Total Disability.

Exclusions. Benefits are not payable for a disability due to (a) an Occupational Illness or Injury; (b) intentional self-inflicted injury; (c) your commission of, or attempt to commit, a felony; or (d) war or an act of war or service in any military service of any country while such country is engaged in war, or police duty as a member of any military service organization.

Benefits are not payable for periods of disability during which you are not under the direct care of a Physician. However, benefits are not payable for periods of disability during which professional care is being provided exclusively by a chiropractor, unless such treatment is certified as Medically Necessary by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) prior to the chiropractic or podiatric treatment. In addition, benefits are payable for periods of disability during which professional care is being provided exclusively by a podiatrist only if the disability relates to foot or ankle issues; otherwise such treatment must be certified as Medically Necessary by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) prior to the podiatric treatment.

Successive Periods of Disability. Successive periods of Total Disability, due to the same or related causes, are considered one period of Total Disability unless they are separated by your return to active Employment with an Employer for a two-week period. During such return, you must work all of the regular working days and hours for which you were scheduled immediately preceding your Total Disability, unless the subsequent Total Disability is due to an Illness or an Injury entirely unrelated to the previous Total Disability.

DENTAL BENEFIT

The Dental Benefit is available to Employees and Dependents in Plans A, B and C.

If you or your Dependent has incurred charges for routine oral examinations and dental treatment during a calendar year, the Fund will pay to you or your Dependent an amount equal to the applicable covered portion shown in the Schedule of Benefits. The Fund will pay benefit to, or on behalf of, your Dependents only if they are eligible for, and properly enrolled in, the Plan. The amount of benefits payable shall not exceed the applicable maximums shown in the Schedule of Benefits.

Benefit Options

Texas Participants. If your Employment Date occurs on or before April 3, 2004 (June 12, 2004 for Employees represented by Local 540), you and your Dependents may elect either the Dental HMO (the "DHMO") option, provided by Delta Dental, or the Indemnity option. If your Employment Date occurs after April 3, 2004 (June 12, 2004 for Employees represented by Local 540), you and your Dependents are eligible only for the DHMO, provided you reside in the DHMO service area. If you do not reside in the DHMO service area, you may elect the Indemnity Option.

Louisiana Participants. If your Employment Date occurs before January 1, 2018, you and your Dependents may elect either the DHMO option, provided by Delta Dental, or the Indemnity option. If your Employment Date occurs on or after January 1, 2018, you and your Dependents are eligible only for the DHMO, provided you reside in the DHMO service area. If you do not reside in the DHMO service area, you may elect the Indemnity Option.

DHMO

The Trustees have contracted to maintain the DHMO option with Delta Dental. A copy of the contract is available for your inspection through the Plan Office. If you have any questions or concerns relating to the Dental Benefit pursuant to the DHMO, please contact Delta Dental at:

DeltaCare USA DHMO
1-800-422-4234
www.deltadentalins.com
Group Number: 78955

INDEMNITY OPTION

Covered Charges. If you or your Dependent undergoes a dental operation or procedure performed by a licensed dentist (or hygienist with respect to prophylaxis) and such dental operation or procedure was performed while you were covered by Plan A, B or C, the Fund will pay the applicable percentage of the Dental Covered Charges incurred, but not to exceed the applicable maximum as shown in the Schedule of Benefits for any calendar year.

The Fund covers charges actually made to you or your Dependent by a licensed dentist (or hygienist with respect to a prophylaxis) for routine oral examinations and dental treatment up to the maximum benefit shown in the Schedule of Benefits.

Exclusions. No dental benefits shall be payable for the following charges:

(a) Orthodontic treatment or any dental appliances, except as specified in the Schedule of Benefits.

(b) Temporomandibular joint dysfunction (TMJ) treatment.

(c) Treatment performed for cosmetic purposes.

(d) Treatment by other than a legally qualified, licensed dentist, except charges for dental prophylaxis performed by a licensed dental hygienist under the supervision and direction of a qualified and licensed dentist.

(e) Services or supplies received as a result of dental disease, defect or Injury due to an act of war, declared or undeclared.

(f) Expenses incurred for dental procedures performed upon a Dependent child involving crowns, bridges or dentures unless they are performed with respect to permanent teeth, or in the case of nonpermanent teeth, are performed solely for the purpose of maintaining the proper space between teeth, and following Injury and resulting tooth loss; however, the Fund will reimburse expenses for crowns on nonpermanent teeth up to the Reasonable and Customary Charges for an amalgam filling.

Claims and questions regarding the Indemnity Option should be directed to the Plan Office.

SOUTH CENTRAL UFCW UNIONS AND
EMPLOYERS HEALTH & WELFARE TRUST FUND
c/o ADMINISTRATIVE CONSULTING SERVICES
661 North Ericson Road
Cordova, TN 38018–1006
1-800-874-8499

If you have questions about the Delta Dental network, including how to locate a network dentist, you can contact them at 1-800-521-2651.

PRESCRIPTION DRUG BENEFIT

The Fund's Prescription Drug Benefit is available to all Employees and Dependents in Plans A, B and C. The Trustees have contracted to maintain a Prescription Drug Program with OptumRx. OptumRx provides administrative services with respect to your Prescription Drug Benefit, such as claims administration.

You will become eligible for this benefit based on the eligibility rules for your Plan (Plan A, B or C). At that time, you should receive a packet of materials, including an identification card necessary to obtain drug benefits.

Consult your Schedule of Benefits for further details. The contract between OptumRx and the Trustees recites the terms and conditions of the Prescription Drug Benefit, a copy of which is maintained by the Plan Office and is available for review upon request.

To the extent that any rule of general applicability contained in this SPD conflicts with any specific provision governing this Prescription Drug Benefit, the rules governing the Prescription Drug Benefit shall control.

If you have any questions regarding the Prescription Drug Benefit, please contact OptumRx at 1-888-354-0090.

NETWORK REMINDER

When using your Prescription Drug Card from OptumRx, please utilize your Exclusive Pharmacies. The Exclusive Pharmacies are those pharmacies as provided by Kroger and its affiliates (or certain other OptumRx network pharmacies if there is no Kroger pharmacy in your area).

You must use your drug card to receive benefits, except in emergency situations. This may include circumstances where your Exclusive Pharmacy may be closed.

SPECIALTY DRUGS

Specialty drug medications (generally meaning self-injectable drugs—excluding insulin—or oncology or transplant drugs) will be delivered directly to you by mail order. You do not obtain these medications at a retail pharmacy, clinician's office or any other source. If you have questions, please contact OptumRx at 1-888-354-0090.

VISION CARE BENEFIT

The Fund's Vision Care Benefit is available to Employees and Dependents in Plans A, B and C. The Trustees have contracted to maintain the Vision Care Benefit with Davis Vision. Davis Vision funds the Vision Care Benefit and provides administrative services, such as claims administration and a provider Network. The Vision Care Benefit is governed by the terms of the contract maintained between Davis Vision and the Plan.

Covered Charges

As limited by the Schedule of Benefits, you and your eligible Dependent are entitled to the following vision benefits:

In-Network If you use a provider in the Davis Vision network, the following benefits are provided at no charge (except as specified) when visiting a participating provider, but not more than once in a 12-month period:

(a) **Vision Exam**.....***every 12 months***

(b) **Prescription Glasses**

Lenses.....***every 12 months***

- Single vision or standard multi-focal lenses

Covered Lens Options

- UV Protection, Tints, Scratch Coating

Frame.....***every 12 months***

- *$130 allowance for a wide selection of frames*

(c) **Contact Lenses (in lieu of eyeglasses)**

- **No copay**.....***every 12 months***

Includes fitting/evaluation, contact lenses and up to two follow-up visits. If disposable contacts selected, up to four boxes are included. A $130 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection. Toric, Gas Permeable and Bifocal contact lenses are examples of contact lenses that are outside of the covered contacts that are provided for no copay.

Out-of-Network If you do not use a provider in the Davis Vision network, the following benefits are available up to the specified dollar caps, but not more than once in a 12-month period:

Vision exam	*Up to $40*
Single vision lenses	*Up to $40*
Bifocal lenses	*Up to $60*
Trifocal lenses	*Up to $80*
Lenticular	*Up to $80*
Frame	*Up to $45*
Contacts (elective)	*Up to 105*
Contacts (necessary)	*Up to $210*

Elective contact benefits are reduced by any network fitting/evaluation fee if out of network. Contacts are considered necessary at the provider's discretion for one or more of the following conditions: following cataract

surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; or with certain conditions of keratoconus.

Limitations Applying to Vision Care Benefit The following services/materials are excluded from coverage under the Vision Care Benefit:

(a) Post-cataract lenses.

(b) Sunglasses, plain or prescription.

(c) Replacement of lenses and/or frames which have been lost or broken. (Minor repairs and minor adjustments will be undertaken at no cost to you or your Dependents.)

(d) Medical or surgical treatment for eye diseases which require the services of a Physician. However, if examination discloses that such treatment is required, the patient will be advised, and, if requested, given names of ophthalmologists and/or Physicians for his consideration. Under no circumstances will the Fund be responsible for a patient's selection from among such names.

(e) Services or materials for which the patient may be compensated by a worker's compensation law or other similar employer's liability law, or services which the patient, without cost, obtains from any federal, state, county, city or other government organization.

If you have any questions regarding Vision Care Benefit, please contact Davis Vision.

Davis Vision
1-800-999-5431
www.davisvision.com

You may also call the Fund's toll-free number
1-800-874-8499

COORDINATION OF BENEFITS

If you or any of your Dependents are covered by another health plan (the "Other Plan"), the benefits the Fund paid on behalf of you or your Dependent will be coordinated with any benefits payable by the Other Plan. This system of paying claims eliminates double payment for the same Illness or Injury and at the same time reimburses you for the medical, dental or vision expenses you incur, within the limits imposed by the Fund and the Other Plan.

The "Other Plan" is any plan pursuant to which medical, vision or dental benefits are provided, including:

(a) group, blanket or franchise insurance coverage;

(b) group Blue Cross or Group Blue Shield coverage and other group prepayment coverage;

(c) any coverage pursuant to governmental programs (other than Medicare) required or provided by statute;

(d) any coverage pursuant to union welfare plans, employer organization plans, employee benefit plans (self-funded or insured), or labor-management trusteed plans; and

(e) any insurance/health coverage, including an individual policy of insurance, which is a result of a court decree which establishes financial responsibility.

If a Dependent is eligible for medical care or treatment provided by a health maintenance type of organization ("HMO") which is offered on a dual choice basis by his employer or the employer of his parent and does not utilize the services, facilities or providers covered by such an organization, the Dependent will not be eligible for benefits from a Plan.

The Fund will assume that you or your Dependent has taken all actions necessary to receive payment of benefits payable by the Other Plan, regardless of whether you or your Dependent has actually taken all such necessary steps.

HOW IT WORKS

The Fund will determine if it pays before or after the Other Plan according to the rules described in the next section below. If the Fund pays primary, or "first," you will be paid medical, dental or vision benefits in the amount payable pursuant to the terms of this SPD after all applicable exclusions, limitations and adjustments are applied. If the Other Plan pays first, the Fund will pay benefits up to the amount that the Fund would have paid had the Fund paid first, up to 100% of billed amount. However, the Fund will never pay benefits (a) in excess of the amount permitted by the applicable exclusions, limitations and adjustments of the applicable benefit program or (b) which, when combined with amounts payable by the Other Plan, exceed 100% of the billed charges. You may be responsible to pay the provider any remainder of the claim.

RULES FOR DETERMINATION OF WHICH PLAN PAYS FIRST

The order of benefit payments will be determined as follows:

(a) the plan covering the person as an Employee will pay first;

(b) the plan covering the person as a Dependent will pay second and will coordinate with the Other Plan.

When a person is covered as a Dependent child pursuant to both the Fund and the Other Plan, the following rules shall apply:

(i) if the Dependent's parents are not separated or divorced, the benefits of a plan which covers the child as a dependent of the parent whose date of birth, excluding year, occurs earlier in a calendar year, will be determined before the benefits of a plan which covers the child as a dependent of the parent whose date of birth occurs later in the calendar year. The order of benefit determination described in this paragraph is called the "Birthday Rule";

(ii) if a plan does not use the Birthday Rule to determine the order of benefit payment for a dependent, the rules stated in the plan which does not coordinate using the Birthday Rule shall determine the order of benefits. If the plan that does not have the Birthday Rule does not have a provision for coordinating benefits, the benefits payable will be determined pursuant to that plan before benefits payable by the Fund;

(iii) if the Dependent's parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody;

(iv) if the Dependent's parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of the plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody;

(v) for the health care expenses with respect to the child, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child; and

(c) A plan covering a person as an Employee or as a Dependent of an Employee determines its benefits before a plan covering the person under the provision of continuation coverage pursuant to federal law.

(d) When items (a) through (c) do not establish an order of benefit determination, the plan covering the person for a longer period of time will pay first.

If the Other Plan sponsored or maintained by a Dependent's employer provides that the Dependent will not be covered by the Other Plan, or covered by a reduced or alternative version of the Other Plan or, in some other manner, operates to avoid the customary operation of the Fund's Coordination of Benefits rules, if the Dependent is covered pursuant to another health plan, the Fund shall consider such a provision to have no force or effect and the Fund will coordinate benefits payable pursuant to a Plan with the benefits which would have been payable pursuant to such Other Plan if such a provision had not existed.

If the Other Plan sponsored or maintained by a Dependent's employer or former employer provides that the Fund will pay first, the Fund shall consider such a provision to have no force or effect and the Fund will coordinate benefits payable pursuant to a Plan with the benefits which would have been payable pursuant to such Other Plan if such a provision had not existed.

SPOUSAL COORDINATION OF BENEFITS

If you are eligible for, and have elected, Dependent Coverage through the Fund and your spouse is not eligible for medical coverage through your spouse's employer (if any), the Fund will pay benefits in accordance with the coordination of benefits rules described above.

If you are eligible for, and have elected, Dependent Spouse Coverage through the Fund and your spouse is eligible for medical coverage through your spouse's employer, your spouse will be subject to the following coordination of benefits rules:

(a) If your spouse elects medical coverage through his or her employer, and you pay either the monthly Employee and Spouse or Employee and Family self-contributions, the Fund will pay benefits for your spouse on a secondary basis, subject to the Fund's applicable exclusions and limitations, as described in the section entitled "How it Works."

(b) If your spouse declines coverage through his or her employer and you pay either the Employee and Spouse or Employee and Family monthly self-contributions that includes the working spouse fee, the Fund will pay primary for your spouse's claims, subject to the Fund's applicable exclusions and limitations, as described in the section entitled "How it Works."

(c) If your spouse declines coverage through his or her employer and you pay either the Employee and Spouse or Employee and Family monthly self-contributions that does not include the working spouse fee, the Fund will treat your spouse as if he or she were covered pursuant to your spouse's employer's health plan for coordination of benefits purposes. The Fund will pay second for your spouse regardless of whether your spouse's employer-provided coverage actually pays first. The Fund will assume that your spouse's employer-provided coverage paid benefits equaling 80% of each claim submitted. The Fund will pay the remainder of the claim, subject to the Fund's applicable exclusions and limitations, but not to exceed the amount that the Fund would have paid had the Fund paid the claim first.

OBTAINING AND RELEASING INFORMATION

Without the consent of or notice to any person, the Fund may obtain or release information with respect to any person when the Fund considers it necessary to do so to apply and implement this Coordination of Benefits provision (or a provision of similar purpose pursuant to the Other Plan). Any person claiming benefits through the Fund must furnish the Fund with any such information that may be needed for this purpose.

FACILITY OF PAYMENT

Whenever the Fund determines that a payment made by the Other Plan should have been made by the Fund, in accordance with this Coordination of Benefits provision, the Fund may, in its sole discretion, pay to the organization making that payment any amount the Fund determines is warranted to satisfy the intent of this provision. Any amount so paid will be considered a benefit paid by the Fund and will release the Fund from further liability for that amount.

RIGHT OF RECOVERY

Whenever the Fund determines that payments it made exceed the maximum amount of payment required to satisfy the intent of this Coordination of Benefits provision, the Fund, in its discretion, may recover the excess paid from any person to, for or with respect to whom those payments occurred or from any insurance company or any other organization.

COORDINATION WITH MEDICARE

Medicare (Title 18 of the Social Security Act of 1965) provides a comprehensive program of health insurance for persons age 65 or over. After you become eligible for Medicare, you will first be reimbursed by a Plan for expenses incurred by you or your Dependents (if eligible) if you are an active employee. If any expenses remain unpaid, you may then be reimbursed for those expenses payable by your Medicare plan, up to the maximum amount payable pursuant to the Medicare plan.

If you or your Dependent become eligible for Medicare benefits as an End Stage Renal Disease (ESRD) beneficiary, please contact the Plan Office to determine if your benefits will first be reimbursed pursuant to a Plan or pursuant to your Medicare plan.

Coordination of Medicare. Benefits payable by the Fund shall be coordinated with the benefits payable under Medicare Parts A, B and D, in accordance with the following provisions.

(a) The Fund Primary to Medicare for Employees or Spouse Age Sixty-Five (65) or Older. Benefits shall be payable under the Fund without regard to a person's entitlement or potential entitlement to Medicare if the person is not entitled and could not upon application become entitled to Medicare as an End Stage Renal Disease (ESRD) beneficiary, and such person is:

[i] age 65 or older and has "current employment status" as defined in applicable federal laws or regulations governing coordination with Medicare as in effect from time to time; or

[ii] the spouse age 65 or older of an Employee who has "current employment status" as defined in applicable federal laws or regulations governing coordination with Medicare as in effect from time to time.

(b) The Fund Primary to Medicare for Disabled Person Under Age Sixty-Five (65). Benefits shall be payable under the Fund without regard to a person’s entitlement or potential entitlement to Medicare if such person is:

[i] under age 65;

[ii] an Employee who has "current employment status" as defined in applicable federal laws or regulations governing coordination with Medicare as in effect from time to time or a Dependent of an Employee who has "current employment status" as defined in applicable federal laws or regulations governing coordination with Medicare as in effect from time to time; and

[iii] entitled or potentially entitled to Medicare as a disabled beneficiary other than as an ESRD beneficiary.

(c) ESRD Beneficiary. Benefits for covered items or services shall be payable under the Fund without regard to a person's entitlement to Medicare if the person is entitled to Medicare as an ESRD beneficiary, and not more than 30 months has elapsed since the earliest of the following months:

[i] the month in which the person began a regular course of renal dialysis if the person takes a course in self-dialysis or if the person does not take a course in self-dialysis, the fourth month of dialysis;

[ii] the month in which the person received a kidney transplant;

[iii] the month in which the person was admitted to the Hospital in anticipation of a kidney transplant that was performed within the next two months; or

[iv] the second month before the month the kidney transplant was performed, if more than two months after admission.

(d) The Fund Secondary to Medicare in All Other Cases.

[i] Coordination of Benefits. When [a], [b] and [c] do not apply, benefits otherwise payable under the Fund for Allowable Expenses shall be reduced so that the sum of benefits payable under the Fund and Medicare shall not exceed the total of such Allowable Expenses.

[ii] All Persons Eligible Considered Enrolled. Benefits shall be considered payable by Medicare Part A or B for purposes of this section whether or not the person eligible for Medicare benefits has enrolled in or applied for benefits under Medicare Parts A and B or has failed to take any other action required by Medicare to qualify for benefits.

(e) However, benefits shall not be considered payable by Medicare for purposes of this section):

[i] with regard to Medicare Part D, unless such person has enrolled in or applied for benefits under Medicare Part D; or

[ii] if a person is eligible for coverage under another employer sponsored plan with benefits equal to or greater than Medicare Part B.

(f) Definition for This Provision.

[i] "Allowable Expenses" means reasonable charges as determined by The Fund, which are for medical care and treatment of the type and kind covered under both Medicare and The Fund.

[ii] "Medicare" means Title XVIII of the Social Security Act of 1965, as amended from time to time.

SUBROGATION AND REIMBURSEMENT

What "Subrogation and Reimbursement" Means. Benefits are not payable for a Participant's or Dependent's Illness or Injury which, as determined by the Trustees, is the responsibility of a third party. The Fund, though, assists its Participants and Dependents (if otherwise eligible) in such situations by advancing them monies to cover the extraordinary expenses associated with such events. The Fund performs this service because it knows that waiting for a third party to pay for these Injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, within the limits recited elsewhere in this section and as a service to you, the Fund will pay your (or your Dependent's) expenses based on the understanding that you or your Dependent are required to reimburse the Fund in full from any recovery you or your Dependent may receive, no matter how it is characterized. This process is called "subrogation and reimbursement."

Fund's Rights to Subrogation and Reimbursement. The Fund shall be entitled to subrogation or reimbursement with regard to all rights of recovery of a Participant or Dependent or representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the Participant or Dependent (collectively, for purposes of this section, "Individual"), to the extent of any amounts which the Fund has paid or may become obligated to pay on account of any claim against any person, organization or other entity in connection with the Illness, Injury, sickness, accident or condition, including accidental death and dismemberment, to which the claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility and any employer of the Individual under the provisions of a Worker's Compensation or Occupational Disease Law and an individual policy of insurance maintained by the Individual, which may also include uninsured and/or underinsured insurance coverages. The Fund shall also be entitled, to the extent of payments made or to be made on account of the claim, to reimbursement from the proceeds of any settlement, judgment or payments from any Source that may result from the exercise of any rights of recovery by the Individual. Such subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether an Individual is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses and regardless of whether liability is admitted to or contested by any Source. Once the Fund makes or is obligated to make payments on behalf of an Individual on account of the claim, the Fund is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Individual from any Source.

Action Required of Individual. If requested in writing by the Trustees, the Individual shall take, through any representatives designated by the Trustees, such action as may be necessary or appropriate to recover payments made or to be made by the Fund from any Source and shall hold that portion of the total recovery from any Source which is due for payments made or to be made in trust for the benefit of the Fund to be paid to the Fund immediately upon recovery thereof. The Individual shall not do anything to impair, release, discharge or prejudice the rights referred to in this section. The Individual shall assist and cooperate with representatives designated by the Fund to recover payments made by the Fund and shall do everything that may be necessary to enable the Fund to exercise its subrogation and reimbursement rights described herein.

The Trustees may also require the Individual to execute a Subrogation and Reimbursement Agreement ("Agreement"), in a form provided by and acceptable to the Trustees, as a condition to receiving benefits for a claim. If the Agreement is not executed by the Individual(s), at the Fund's request, or if the Agreement is modified in any way without the consent of the Fund, the Fund may suspend all benefit payments. However, the Fund

reserves the right to pay benefits without a signed Agreement to preserve the Fund's discounts for timely payment under a PPO contract. In its sole discretion, if the Fund advances claims in the absence of an Agreement, or if the Fund advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that person's parent, the Individual (in the case of a minor dependent child), the Individual's spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Fund. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Individual agrees that out of any Source, as described above, the identified amount that the Fund has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Fund's benefit and that the Fund shall have an equitable lien by agreement which shall be enforceable if necessary under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Fund's subrogation and reimbursement rights shall apply regardless whether the Individual executes an Agreement.

Enforcement of Rights. The Fund has the right to recover amounts representing the Fund's subrogation and reimbursement interests under this section through any appropriate legal or equitable remedy, including but not limited to the initiation of a recognized cause of action under ERISA section 502(a)(3), including injunctive action to ensure the claim amounts that the Fund has advanced are preserved and not disbursed, or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment or otherwise. The Fund's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual.

Further, in the event an Individual receives monies as the result of an Illness, Injury, sickness, accident or condition and the Fund is entitled to such monies in accordance with this section and is not reimbursed the amount it has paid for such Illness, Injury, sickness, accident or condition, the Fund shall have the right to reduce future payments due to such Individual or the Employee of whom such Individual is a Dependent or any other Dependent of such Employee by the amount of benefits paid by the Fund. The right of offset shall not, however, limit the rights of the Fund to recover such monies in any other manner described in this section.

Individual's Attorney's Fees. The Fund's subrogation and reimbursement rights apply to any recovery by the Individual without regard to legal fees and expenses of the Individual. The Individual shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Illness, Injury, sickness, accident or condition, and the Fund's recovery shall not be reduced by such legal fees or expenses, unless the Trustees, in their sole discretion, have agreed in writing to discount the Fund's claim by an agreed upon amount of such fees or expenses.

Disavowal of Common Law Defenses. The Fund specifically disavows any claims that an Individual may make under any federal or state common law defense, including but not limited to the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Fund's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the Individual from any Source without regard to legal fees and expenses of the Individual and the Individual will be solely responsible for paying all legal fees and expenses. The Fund shall have a priority, first-dollar security interest and a lien on any recovery received from any Source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are

characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Illness, Injury, sickness, accident or condition.

HIPAA PRIVACY

The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan's Trustees for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

DISCLOSURE OF PHI TO TRUSTEES

Disclosures by Plan. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

(a) the Plan's Payment activities,

(b) those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and

(c) all of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

USES AND DISCLOSURES OF PHI BY THE TRUSTEES

The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations or as otherwise permitted or required by the Privacy Regulations.

PRIVACY SAFEGUARDS

The Trustees agree to:

(a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

(b) Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

(d) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

(e) Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;

(f) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(h) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;

(j) If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

(k) Ensure that adequate separation between the Plan and the Trustees is established, as described below.

ADEQUATE SEPARATION

The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

CLAIMS PROCESSING
AND PRE-CERTIFICATION

MEDICAL CLAIMS

Blue Cross Blue Shield-Illinois ("BCBS-IL") has been retained to administer medical claims processing and customer service relating to medical claims. Therefore, if you have any questions regarding medical claims for you or your Dependent, you should contact BCBS-IL at the customer service number on the back of your identification card, or refer to the following BCBS-IL contact information:

- Blue Access for Members (Member Portal): https://www.bcbsil.com/
- Member Mailing Address:

  Blue Cross and Blue Shield of Illinois
  P.O. Box 805107
  Chicago, IL 60680-4112

You may choose any provider you wish. However, if a Network provider is available and you choose a Non-Network provider, your benefit may be less. If you have any questions regarding the PPO network, you should contact BCBS-IL.

CLAIM FILING DEADLINE

All claims for medical benefits (including prescription drugs, vision and dental) must be filed with the Plan within 12 months from the date of service. Claims filed after this deadline will not be eligible for coverage.

PRE-CERTIFICATION

Pre-certification is required for ALL IN-PATIENT Hospital admissions before any costs are incurred. For emergency or urgent admissions, notification must take place by the close of the next business day.

Certification may be obtained by calling Conifer Health Solutions ("Conifer") toll free at 1-800-757-0391. During non-business hours, notification may be made through the voice mail procedures. Your doctor's office will discuss the diagnosis with Conifer and a course of treatment will be agreed upon.

Conifer will notify the doctor(s), Hospital, BCBS-IL and you of the treatment that has been approved.

If Conifer pre-certifies you or your Dependent's eligibility for benefits or the extent of coverage by a Plan, such pre-certification is not a guarantee that the Fund will pay benefits on your behalf. All benefits are paid pursuant to a Plan's terms, conditions, exclusions and limitations regarding eligibility and coverage.

Failure to pre-certify in-patient stays at Non-Network Hospitals when it is required will result in a penalty of $300. Make sure you tell your Physician you have a pre-certification requirement in your Plan.

CLAIM APPEAL PROCEDURE

The following section details the time frames applicable to the Fund in making an initial decision on a claim for benefits and also describes the Fund's appeal procedure with respect to claims for benefits.

You may name an authorized representative to act on your behalf in filing a claim, providing requested information or pursuing an appeal of an adverse decision, provided such authorization must be in writing. Please contact the Plan Office for information about naming an authorized representative.

Initial Decision on Claim.

(a) Health Claims.

(i) Urgent Care Claims. The Fund will inform you of the decision on an Urgent Care claim as soon as possible, but not later than 72 hours after the claim was filed. If, during the review, additional information is required, you will be so notified within 24 hours and will be provided at least 48 hours to provide the information. In such a case, the Fund will inform you of the decision no later than 48 hours after the additional information is submitted.

An Urgent Care claim is a claim for medical care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of you or your Dependent or subject you or your Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an Urgent Care claim will be determined by the Fund, considering the judgment of a Physician with knowledge of your or your Dependent's condition.

(ii) Pre-Service Claims. The Fund will inform you of the decision on a Pre-Service claim within 15 days of the date the claim is filed. Within that 15-day period, you will receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the end of the initial 15-day benefit determination period, by which you can expect to receive a decision.

If during the review, additional information is required, you will be so notified within the required time period for notice of a decision detailed above. You will have at least 45 days to provide such information. Following the provision of the required information, or the expiration of the time period for providing such information, the Administrator will issue a written notice of the decision.

The timing requirement for issuance of a decision will be tolled while the Administrator waits for you to provide the additional required information.

A Pre-Service claim is a claim for medical care or treatment with respect to which the Fund requires approval of the benefit in advance of obtaining medical care.

(iii) Post-Service Claims. The Fund will inform you of the decision on a Post-Service claim within 30 days of the date the claim is filed. Within that 30-day period, you will receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the end of the initial 30-day benefit determination period, by which you can expect to receive a decision.

If during the review, additional information is required, you will be so notified within the required time period for notice of a decision detailed above. You will have at least 45 days to provide such

information. Following the provision of the required information, or the expiration of the time period for providing such information, the Fund will issue a written notice of the decision. The timing requirement for issuance of a decision will be tolled while the Fund waits for you to provide the additional required information.

(iv) Concurrent Care Claims. Any request by you to extend the duration or number of treatments previously approved through a Pre-Service Claim is a Concurrent Care Claim. The Fund will inform you of the decision on a Concurrent Care Claim involving Urgent Care within 24 hours after receiving the claim, if the claim was received by the Fund at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. You may provide any additional information required to reach a decision.

(b) Loss of Time Benefit Claims. If a claim for the Loss of Time Benefit is denied in whole or in part, the Fund will inform you of the denial within 45 days of the date the initial claim was received.

(i) Extension. Special circumstances may require more time to review a claim. If so, written notice shall be provided within the 45-day period explaining the reason for the delay and setting a date upon which the notice will be issued, no later than 30 days after the end of the initial 45-day benefit determination period. If special circumstances again require more time to review a claim, a second 30-day extension may be taken subject to written notice within the initial 30-day extension and subject to the same rules as detailed above.

(ii) Additional Information. If, during the review, additional information is required, you will be so notified within the required time periods for notice of a decision or extension detailed above. You will have at least 45 days to provide such information. Following the provision of the required information, or the expiration of the time period for providing such information, the Fund will issue a written notice of any denial within 30 days, unless special circumstances require a second 30-day extension, subject to the rules detailed above. The timing requirement for issuance of a decision will be tolled while the Fund waits for you to provide the additional required information.

Content of Denial Notice.

If your claim is partially or wholly denied, you will receive a notice from BCBS-IL. All claim denial notices must:

(a) state the specific reason(s) for the denial and a specific reference to the pertinent Plan provision(s) on which the denial is based;

(b) describe and explain any additional material or information required of you in order to make your claim valid;

(c) explain the Fund's appeal procedure and your right to appeal the initial decision;

(d) explain that the initial decision will be a final decision unless the decision is appealed as described below;

(e) detail your right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on an appeal.

If your claim is a Health Claim that is partially or wholly denied, the notice shall also:

(a) notify you that, if a specific rule or guideline was relied upon, a copy of such rule or guidelines is available upon request;

(b) notify you that, if the determination is based upon a medical necessity or experimental treatment exclusion, a copy of an explanation of the scientific judgment supporting the determination is available upon request; and

(c) describe the expedited review process for urgent care claims, if applicable.

If your claim is a Loss of Time Benefit claim, the notice shall also:

(a) include a discussion of the decision and the basis for disagreement with or not following:

(i) A health care or vocational professional who treated or evaluated you;

(ii) A medical or vocational expert whose advice was solicited by the Plan in connection with your claim; and

(iii) A disability determination regarding your claim made by the Social Security Administration.

(b) include copies of any internal rule, guideline, protocol or similar criteria relied on, or a statement that no such rule, guideline, protocol or similar criteria was considered;

(c) notify you that, if the Plan's determination is based upon a medical necessity or experimental treatment exclusion, a copy of an explanation of the scientific judgment supporting the determination is available upon request; and

(d) state that you are entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to your claim upon request free of charge.

Appeal Procedure.

If you believe that the action taken on your Health Claim is incorrect, you have the right to appeal to the Fund for a further review. If you feel that the action taken on your Loss of Time Benefit claim is incorrect, you have the right to appeal to the Fund for a further review. The following paragraphs describe the procedure for appealing to the Fund, with such appeals reviewed by the Fund's Trustees (or a Committee designated by the Trustees).

After you receive a notice denying a claim for benefit payment which you believe is incorrect, you must notify the Fund in writing of your wish to have the claim reviewed. Such notice of appeal must be filed within 180 days from the date the written notice of denial was mailed.

The Trustees or Claims Appeal Committee ordinarily meet quarterly to render a determination on appeals of Post-Service and Loss of Time Claims received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the second regularly-scheduled meeting following the Fund's receipt of your appeal. If special circumstances require a delay in the decision, the decision will be rendered no later than the third regularly-scheduled meeting following receipt of the appeal, and the Fund will notify you of the reasons for the delay prior to any extension. The Fund will notify you of the decision within five days of the date the decision is made.

The request for review should include all information regarding the claim as well as the reason(s) you believe the original decision incorrect. Copies of any documents relevant to the claim will be provided at no cost, upon request. The review on appeal will consider all comments, documents, records and other information you submit, regardless of whether the information was submitted or considered in the initial determination. You will receive copies of all new or additional information considered, relied upon or generated during the appeal, as well as any new or additional rationale for the denial, if any. If the Health Claim decision requires medical judgment, the

Fund will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

The Fund will act on the request for review of a Health Claim within the following time periods:

Urgent Care Claims. The Fund will inform you of the decision on the review of an Urgent Care claim within 72 hours of the Fund's receipt of the request for review.

Pre-Service Claims. The Fund will inform you of the decision on the review of a Pre-Service claim within 30 days of the Fund's receipt of the request for review. You may request an expedited appeal, and the Fund will determine if your request meets the criteria. If you qualify, the Fund will notify you within a reasonable time, but not later than 72 hours after receipt of your request for an expedited review.

If the Fund denies your Pre-Service claim on appeal, you may voluntarily file a second appeal with the Trustees (or a Committee designated by the Trustees). This second appeal is voluntary and is not required prior to filing suit against the Plan. You should contact the Plan Office if you would like more information regarding bringing a voluntary appeal to the Trustees.

Post-Service Claims. If a claim is denied in whole or in part by the Fund, the claimant must submit a written appeal to the Fund for a determination. The Fund will notify the claimant of the decision on the Post-Service Claim within 60 days of the receipt of the appeal.

Concurrent Care Claims. The Fund will inform you of the decision on the review of a Concurrent Care claim within 72 hours of the Fund's receipt of the request for review if the claim involves an Urgent Care claim. The Fund will inform you of the decision on the review of a Concurrent Care claim within 30 days if the claim involves a Pre-Service claim; and in accordance with the quarterly meeting rule described above if the claim involves a Post-Service claim.

Loss of Time Benefit Claims. If you feel that the action taken on your Loss of Time Benefit claim is incorrect, you have the right to appeal to the Trustees (or a Committee designated by the Trustees) for further review. After you receive notice denying a claim for Loss of Time Benefits which you believe is incorrect, you must notify the Plan Office in writing of your wish to have the claim reviewed by the Trustees. Such notice of appeal must be filed within 180 days from the date the written notice of denial was mailed.

The request for review should include all information regarding the claim as well as the reason(s) you feel the original decision was incorrect. Copies of any documents relevant to the claim will be provided at no cost, upon request. The review on appeal will consider all comments, documents, records and other information you submit, regardless of whether the information was submitted or considered in the initial determination. During the course of review, you will be provided with any new or additional evidence or rationale relied upon or generated by the Plan, the Trustees in connection with your claim. Such new or additional evidence will be provided to you as soon as possible and sufficiently in advance of the final decision in order to give you a reasonable opportunity to respond. If the decision requires medical judgment, the Trustees will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

The Trustees shall meet quarterly to make a determination on appeals of Loss of Time Benefits received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting will be decided at the next following quarterly meeting. If special circumstances require a delay in the decision, the decision will be made no later than the third quarterly meeting following receipt of the appeal, and the Plan will notify you of the decision within five days of the date the decision is made.

You will receive the Trustees' decision in writing. Written notice on all appeals will include:

(a) The specific reason or reasons for its decision;

(b) Reference to the specific Plan provisions on which the determination was based;

(c) An explanation of the basis for the adverse benefit determination;

(d) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(e) A statement describing any further appeal procedures offered by the Plan including the Claimant's right to obtain the information about such procedures; and

(f) A statement that if the Eligible Person's appeal is denied, he or she has the right to initiate a lawsuit under ERISA section 502(a).

If your appeal involves a Health Claim, the notice must also provide:

(a) information sufficient to identify the Claim involved, including: date of service; provider; Claim amount; and any denial codes and their respective meanings;

(b) a description of any standard used to determine the denial;

(c) a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge;

(d) for a claim based on medical judgment, a statement that the Eligible Person has the right to request an external review from an independent review organization after the Plan's claims appeal procedures have been exhausted;

(e) disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes for Health Care Claims;

(f) copies of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available at no cost upon request if relevant to a claim; and

(g) a statement that a copy of the scientific or clinical judgment is available to the claimant at no cost upon request if relevant to a claim that is denied due to a medical judgment.

If your appeal involves a Loss of Time Benefit claim, the notice must also provide:

(a) a discussion of the decision and the basis for disagreement with or not following:

  (i) A health care or vocational professional who treated or evaluated you;

  (ii) A medical or vocational expert whose advice was solicited by the Plan in connection with your claim; and

  (iii) A disability determination regarding your claim made by the Social Security Administration;

(b) copies of any internal rule, guideline, protocol or similar criteria relied on, or a statement that no such rule, guideline, protocol or similar criteria was considered; and

(c) a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances will be provided free of charge upon request, if the Plan's decision is based on a medical necessity, experimental treatment or similar exclusion or limit.

External Review of Denied Health Claims. The Plan offers claimants the right to request an external review in accordance with, and to the extent required by, available guidance issued by the Departments of Health and Human Services and Labor and the Internal Revenue Service. Only Health Claims that were denied based on medical judgment and rescissions of benefits are eligible for external review (including Prescription Drug Benefit claims denied on the basis of medical necessity, experimental treatment or similar exclusion or limitation). Loss of Time and all other welfare benefit claims are not eligible for external review.

If a claimant wants to have the denied Health Claim or rescission reviewed, the claimant must send a written request for an external review to the Plan no later than four months after the date the claimant receives the notice of denial or rescission. Any claimant filing a timely request for review may submit additional materials for consideration on review, including a written explanation of and comments on the issues.

Time Limit on Lawsuits.

No lawsuit or other action against the Fund or its Trustees may be filed until you exhaust the Fund's appeal procedure. Further, in the event a claim has been reviewed pursuant to the Fund's appeal procedure and the claim has been denied, no lawsuit or other action against the Fund or its Trustees may be filed after one year from the date you or your beneficiary has been given written notice of the Trustees' decision on the appeal (or if you failed to submit an appeal, 18 months after your initial claim was denied). If this time limitation is less than that required by law, the limitation will be extended to equal with the minimum period permitted by law. The timing requirement for filing a lawsuit will be tolled until after the Trustees complete any voluntary appeals filed on Pre-Service claims.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

The Employee Retirement Income Security Act of 1974 requires that certain information be furnished to each participant in an employee benefits plan. This is your Summary Plan Description.

NAME OF THE FUND

South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust.

IDENTIFICATION NUMBERS

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 75-6232407. The Plan number assigned by the Board of Trustees is 501.

PLAN YEAR

For purposes of maintaining the Fund's records and all reports to the Department of Labor and other regulatory bodies, the fiscal year of the Fund begins on March 1 and ends on the last day of February.

TYPE OF PLAN

This Fund maintains the Plan for the purpose of providing medical, dental, vision care, prescription drug, accidental death and dismemberment, disability and death benefits.

BOARD OF TRUSTEES

Union

Rick Alleman
Secretary & Treasurer
UFCW Local 455
121 Northpoint Drive
Houston, TX 77060-3207

Shirley Rome

UFCW Local 455
121 Northpoint Drive
Houston, TX 77060-3207

Steve T. Gelios
President-UFCW Local 2008
7924 Interstate 30, Suite A
Little Rock, AR 72209-2900

Employer

Peggy Prescott
Director, Labor Relations
The Kroger Company
2175 Park Lake Drive
Atlanta, GA 30345

Don Sattler, SPHR
Health Care Manager, Labor Strategy
The Kroger Company
1014 Vine Street
Cincinnati, OH 45202

Henry B. Taylor
Senior Director of Labor Relations
The Kroger Company
19245 David Memorial Drive
Shenandoah, TX 77385

Union

Brandon Hopkins
UFCW Local 455
121 Northpoint Drive
Houston, TX 77060

Johnny Rodriguez
President
UFCW Local 540
11041 Garland Road
Dallas, TX 75218-2616

Employer

Kevin Lindsey
The Kroger Company
800 Ridge Lake Boulevard
Memphis, TN 38120

FUND ATTORNEYS
Reinhart Boerner Van Deuren s.c. and
Patrick M. Flynn, P.C.

FUND AUDITOR
Dennis G. Jenkins, C.P.A.

CONSULTANT
Horizon Actuarial Services, LLC

FUND ADMINISTRATORS
Administrative Consulting Services
Blue Cross Blue Shield-Illinois (Medical Claims Only)

FUND ADMINISTRATORS

The Fund is provided through and administered by the Trustees of the South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust. The Trustees have delegated certain administrative responsibilities to a professional Third Party Administrator, Administrative Consulting Services (ACS). ACS is responsible for certain activities, such as determining monthly eligibility under the Plan, enrollment functions, processing of claims for loss of time and death benefits and coordinating with the Plan's dental and vision providers, and performs other routine activities under the direction of the Trustees. ACS may be contacted at:

SOUTH CENTRAL UFCW UNIONS AND
EMPLOYERS HEALTH & WELFARE TRUST FUND
c/o ADMINISTRATIVE CONSULTING SERVICES
661 North Ericson Road
Cordova, TN 38018–1006
1-800-874-8499

In addition, the Trustees have retained Blue Cross Blue Shield-Illinois ("BCBS-IL") to administer the Fund's medical claims processing and customer service relating to all medical claims. You may contact BCBS-IL at 1-800-367-8309 for questions regarding medical claims.

AGENT FOR SERVICE OF LEGAL PROCESS

The Fund's agent for service of legal process is Mr. Bennett E. Choice of the law firm Reinhart Boerner Van Deuren s.c. When legal disputes involving the Fund arise, any legal documents should be served upon:

Bennett E. Choice, Esq.
Reinhart Boerner Van Deuren s.c.
1000 North Water Street, Suite 1700
P.O. Box 2965
Milwaukee, WI 53201-2965

Service of Legal Process may also be made upon any member of the Board of Trustees.

COLLECTIVE BARGAINING AGREEMENTS

Participating employers have executed collective bargaining agreements which provide for contributions to the South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust Fund in the amounts and according to the formula specified in their respective collective bargaining agreements.

Relevant provisions and the expiration date of the collective bargaining agreements and the names and addresses of the parties to the agreements may be reviewed in the Fund Administrator's Office.

FUNDING MEDIUM

Benefits are provided from the Fund's assets. The Fund's assets are accumulated pursuant to the provisions of the collective bargaining agreements and the Trust Agreement and held in trust for the purpose of providing benefits to covered Participants and Dependents and defraying reasonable administrative expenses.

The Fund provides directly from its assets medical, death, loss of time, vision and certain dental and prescription drug expense benefits. The Fund has entered into service agreements for certain dental benefits. The complete terms of these service agreements are available for review, upon request, from the Plan Office.

Blue Cross Blue Shield-Illinois ("BCBS-IL") administers medical claims processing and customer service relating to all medical claims. BCBS-IL may be contacted at 1-800-367-8309.

Delta Dental (1-800-422-4234) administers certain Fund dental benefits and provides services with respect to those dental benefits, such as claims administration and a provider network. Davis Vision (1-800-999-5431) administers and provides services, such as claims administration and a provider network, for the Fund's Vision Care Benefit.

OptumRx (1-888-354-0090) provides administrative services with respect to the Fund's prescription drug benefits, such as claims administration.

TYPE OF ADMINISTRATION

The administrative operations of the Fund are handled primarily by the Fund's Third Party Administrator, ACS. However, some Fund benefits are administered through contractual arrangements with other organizations. Specifically, the Fund's medical claims processing and customer service related to medical claims are

administered through a contract with BCBS-IL. The Fund's Vision Care Benefit, Prescription Drug Benefit and certain dental benefits provided pursuant to the Dental Benefit are administered through contract administration.

CONTRIBUTION SOURCE

Contributions to the Fund are made by contributing Employers and, under certain circumstances, by Participants. The Employer contribution rates are specified in the applicable collective bargaining agreements. The Trustees or applicable collective bargaining agreements determine appropriate self-contribution rates for Participants.

If you are required to make self-contributions to be eligible for coverage, your coverage will not be effective until you authorize the appropriate withholding from your direct compensation.

ELIGIBILITY

The Fund's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are fully described earlier in this booklet.

This Fund also requires completion of an enrollment form. The enrollment form must be completed and returned to the Plan Office in order for coverage for you and your Dependents to commence. The Plan Office must have the enrollment form prior to receiving and processing claims on you or your eligible Dependents (if applicable).

NOTICE TO THE FUND

It is important that you notify the Plan Office whenever:

1. You change your home address.
2. You want to change a Death Benefit beneficiary.
3. You are receiving worker's compensation benefits.
4. You return to work after disability ends.
5. You enter any branch of military service.
6. You acquire a new Dependent (either through marriage, birth, adoption, etc.).
7. You have a change of marital status.
8. You or your Dependent becomes eligible for other coverage (such as coverage pursuant to your spouse's employer's program).
9. You terminate Employment or your Dependent child loses eligibility by attaining the age limit.

For Further Information or Claim Forms,

Call or Write the Plan Office:

SOUTH CENTRAL UFCW UNIONS AND
EMPLOYERS HEALTH & WELFARE TRUST FUND
c/o ADMINISTRATIVE CONSULTING SERVICES
661 North Ericson Road

Cordova, TN 38018–1006
1-800-874-8499

STATEMENT OF YOUR RIGHTS

As a participant in the South Central United Food & Commercial Workers Unions and Employers Health & Welfare Trust, you are entitled to certain rights and protections provided by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS.

Examine, without charge, at the Plan Office and at other specified locations, such as worksites and union halls; all documents governing the Fund, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

CONTINUE COVERAGE

Continue coverage for yourself or Dependents if there is a loss of coverage pursuant to the Fund 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 Fund on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY FUND FIDUCIARIES

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Fund, called **"fiduciaries"** of the Fund, have a duty to do so prudently and in the interest of you and other Fund 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 frames.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Fund documents or the latest annual report from the Fund and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Fund'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 Fund fiduciaries misuse the Fund'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 frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Fund, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, 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 at 866-444-3272. You may also contact EBSA through the web at www.dol.gov/ebsa.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice
September 23, 2013

The South Central United Food & Commercial Workers Unions and Employers Health & Welfare 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:

1. the Plan's uses and disclosures of Protected Health Information (PHI);

2. your privacy rights with respect to your PHI;

3. the Plan's duties with respect to your PHI;

4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and

5. the person or office to contact for further information about the Plan's privacy practices.

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

Section 1.
Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

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

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

Uses and disclosures to carry out treatment, payment and health care operations.

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

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

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

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

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

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

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

(1) For treatment, payment and health care operations.

(2) Enrollment information can be provided to the Trustees.

(3) Summary health information can be provided to the Trustees for the purposes designated above.

(4) When required by law.

(5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice

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

(7) The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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

Uses and disclosures that require your written authorization.

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

information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2
Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right.

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

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

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

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

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

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

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

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

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

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

Right to Amend PHI

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

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

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

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

Right to Receive an Accounting of PHI Disclosures

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

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

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

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

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice.

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

A Note About Personal Representatives

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

1. a power of attorney for health care purposes;

2. a court order of appointment of the person as the conservator or guardian of the individual; or

3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

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

Section 3
The Plan's Duties

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

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted on the Plan's website, www.ufcwemprfund.org, you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

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

1. disclosures to or requests by a health care provider for treatment;

2. uses or disclosures made to the individual;

3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;

4. uses or disclosures that are required by law; and

5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

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

Summary Health Information

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

Notification of Breach

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

Section 4
Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

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

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

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at: 12160 North Abrams Road, Suite 201, Dallas, Texas 75243.

Conclusion

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

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

The South Central United Food & Commercial Workers Unions and Employers Health & Welfare Plan (the "Plan") is furnishing you this Notice as required by federal law. In most cases, the information presented in this

Notice will have a limited application to employees (and dependents) eligible for Plan coverage. It may apply to you as you are required to pay a premium for coverage under the Plan.

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage under the Plan, 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 are not eligible for Medicaid or CHIP, you will not 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, you can 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, you can 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, you can 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 are not 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).

If you live in Texas, you may be eligible for assistance paying your employer health plan premium. For further information, contact Texas – Medicaid:

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

If you live in Arkansas, you may be eligible for assistance paying your employer health plan premium. For further information, contact Arkansas – Medicaid:

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

If you live in Louisiana, you may be eligible for assistance paying your employer health plan premium. For further information, contact Louisiana – Medicaid:

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

To see the other states that have a premium assistance program, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565