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LOCAL 1500

PART TIME EMPLOYEES GROUP BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

4/19

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PLAN MANAGER'S MESSAGE

LOCAL 1500 WELFARE FUND
425 MERRICK AVENUE
WESTBURY, NY 11590
TEL: 800-522-0456
TEL: 516-214-1300

April 1, 2019

Dear Participant:

As you know, the Board of Trustees of the UFCW Local 1500 Welfare Fund has always been deeply concerned with the overall welfare of Fund Participants. It has always been our objective to provide the best possible benefits consistent with the assets available to the Fund.

In this Summary Plan Description you will find the description of your Group Term Life Insurance and Group Accidental Death and Dismemberment Insurance, both currently underwritten by the Anthem Life & Disability Insurance Company. You will also find a summary of coverage under the Dental Benefits and the Optical (Vision Care) Benefits provided directly by the Fund.

Be sure to read this Summary Plan Description carefully so you will better understand your benefits. On pages 32-33 you will find claim procedures so you can avoid errors which may lead to delays in the processing of your claims.

The entire cost of these benefits is paid by the Fund from employer contributions obtained through collective bargaining negotiations between contributing employers and UFCW Local 1500, AFL-CIO.

As this Summary Plan Description contains the benefits afforded under the Plan, keep it in a safe place for ease of future use.

It gives the Welfare Fund Board of Trustees great satisfaction to make these benefits available to you.

Fraternally yours,
Anthony G. Speelman
Plan Manager

GENERAL INFORMATION

NOTE: If you are not literate in English, you may be eligible for assistance in the language in which you are literate. Please call Associated Administrators, LLC at (855) 266-1500 for more information.

NOTA: Si no saben leer y escribir en Inglés, usted puede ser elegible para recibir asistencia en el lenguaje no-Inglés en el que está alfabetizada. Por favor llame Associated Administrators, LLC en (855) 266-1500 para más información.

ELIGIBILITY

WHO IS ELIGIBLE FOR COVERAGE?

All part-time employees covered under a collective bargaining agreement between an employer and UFCW Local 1500, AFL-CIO which requires the employer to contribute to the Welfare Fund on behalf of such employees and/or part-time employees covered under other written agreements between an employer and the Welfare Fund which requires the employer to contribute to the Welfare Fund on behalf of such employees.

WHEN WILL YOU BECOME COVERED?

You will become covered for yourself and your eligible spouse (eligible spouses are covered for Dental and Optical Benefits only) on the first day of the month following the date you complete 6 months of continuous part-time employment with a contributing employer in a position for which the employer is required to make contributions to the Fund pursuant to a collective bargaining or other written agreement. If you are not working on the day you would ordinarily become covered (for reasons other than health), your coverage will be delayed until you return to work.

However, **PLEASE NOTE**, if you are an employee working part-time for a contributing employer to the UFCW Local 1500 Welfare Fund and you are covered under the UFCW Local 1500 Welfare Fund Full-Time Plan as a dependent, you will **NOT** be eligible for any coverage under the UFCW Local 1500 Welfare Fund Part-Time Plan. Under no circumstances can you receive coverage under the UFCW Local 1500 Welfare Fund Full-Time Plan and the UFCW Local 1500 Welfare Fund Part-Time Plan. Should your dependent coverage under the UFCW Local 1500 Full-Time Plan terminate, you are advised to contact the Fund Office immediately and notify them of the change in your coverage status.

WHO IS AN ELIGIBLE SPOUSE?

An eligible spouse is the individual to whom you are lawfully married (unless legally separated). Such spouse is eligible ONLY for the Dental and Optical benefits.

If you are declining enrollment for your lawful spouse because your spouse has other health coverage, you may, in the future, be able to enroll your spouse in this Plan, provided you request enrollment within 30 days after the other coverage ends. In addition, if you have a newly acquired spouse, you may be able to enroll your newly acquired lawful spouse in the Plan, provided that you request enrollment within 30 days after the marriage. You must submit proper documentation (i.e., certificate of marriage) with your request. Coverage for your newly enrolled spouse will on the first day of the month following proper notification.

TERMINATION

WHEN WILL COVERAGE TERMINATE?

Coverage will terminate for both you and your eligible spouse at the end of the calendar month during which (1) you cease to be an eligible employee, (2) your employer ceases to be a contributing employer or (3) the Group Insurance and/or Benefit Plan is discontinued. In addition, your spouse's coverage will also terminate when he/she is no longer your spouse (i.e., you divorce) or you become legally separated.

Additionally, if you enter a designated branch of the United States Armed Forces and you are an eligible employee as defined by the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), you can continue coverage under the Plan in accordance with the USERRA for up to twenty-four (24) months of military service. You must elect to keep your coverage under the Plan pursuant to USERRA and must pay the full cost of continuing that coverage. Moreover, if you elect to continue coverage under the Plan pursuant to USERRA, you may not then elect COBRA coverage when your continued coverage ends. Likewise, if you elect COBRA coverage during this period, you may not then enroll in the Plan pursuant to USSERA when your COBRA continuation coverage ends. If the period of military service is less than thirty-one (31) days, there will not be a charge for this coverage. If you do not elect to have coverage during the period of military service, upon re-employment after such leave you are entitled to have coverage reinstated on the date you return to work without a waiting period (except in the case of certain service-related disabilities).

If you terminate employment, you are urged to contact the Welfare Fund Office immediately. Also, please see COBRA continuation coverage, pages 49-53.

WHAT HAPPENS WHEN I RETIRE?

If you retire, all benefits terminate. However, if you retire and you are receiving a pension under the UFCW Local 1500 Pension Plan, you may be eligible to receive a self-funded Death Benefit. Eligibility for this retiree death benefit depends on several factors, such as your age, length of service, etc. (See page 7 for details). You should contact the Fund Office to ascertain if you are eligible for the Part-Time Retiree self-funded Death Benefit prior to your retirement. (See also, COBRA continuation coverage, pages 49-53).

EXTENSION OF BENEFITS FOR DISABILITY & WORKERS' COMPENSATION

WHAT HAPPENS IF I CANNOT WORK DUE TO ILLNESS OR ACCIDENT?

If you become disabled after becoming covered under the Plan and are unable to work due to illness or accident, your coverage will continue for a period of six (6) months or until you are able to return to work, whichever occurs first. The six (6) month period begins on the first day of the month following the onset of your disability.

If your disability is the result of an accident or illness covered or eligible for coverage under Workers' Compensation Law, coverage for both you and your eligible spouse will be extended for an additional six (6) months, for up to a maximum total of twelve (12) months or until you return to work, whichever occurs first.

Please note, any period of extended coverage, due to your death or your inability to work due to a disability and/or Workers' Compensation leave will be deducted from any period of COBRA coverage you elect. However, you and your eligible spouse receiving COBRA coverage may be entitled to an 11 month extension of COBRA coverage, for up to a maximum of 29 months, if the Social Security Administration determines you to be totally disabled. (See COBRA section pages 49-53).

MEMBER ONLY BENEFITS

GROUP TERM LIFE INSURANCE
UNDERWRITTEN BY ANTHEM LIFE AND DISABILITY INSURANCE COMPANY

Your Group Term Life Insurance is underwritten by Anthem Life and Disability Insurance Company (hereinafter "Anthem"). The Group Case Number is AL00006573. The full description of benefits is contained in the Certificate of Insurance ("Certificate"). A copy of the Certificate of Insurance is at the Fund Office. If you would like a copy of the Certificate, contact the Fund Office. This description is solely intended to be an outline of important facts and rules contained in the Certificate of Insurance.

The Benefit

The benefit depends on how long you have been employed. Benefits are available while you are covered under the Local 1500 Welfare Fund as an active Participant. The benefits are listed in the Schedule of Benefits.

During the first year of employment+	$ 2,500
After the first year of employment+	$ 12,500*

+ You must satisfy the required waiting period under the Plan before your Group Term Life Insurance becomes effective.

*Upon retirement, the Fund provides a self-funded Death Benefit for those eligible retirees who are receiving a pension under the UFCW Local 1500 Pension Plan. The amount provided by the Fund is $1,000. This benefit is available for retirees who (1) are actively employed and covered by the Welfare Fund immediately prior to retirement and (2) are at least age 55 with at least 25 years of credited service under the Pension Plan. The age and service requirements will not apply to employees retired on a disability pension. If you have any questions about your eligibility for the self-funded death benefit upon your retirement, please contact the Fund Office.

Beneficiary

Beneficiary is defined as the person you have chosen to receive the life insurance and/or accidental death benefits upon your death. You may name any beneficiary you like. You must file the name of the beneficiary or beneficiaries with the Fund Office. You may change your beneficiary whenever you wish, without the consent of the present beneficiary and subject to applicable law. To change your beneficiary, you must file a change of beneficiary form with the Fund. The change will take effect as of the date the form is signed. A beneficiary cannot be changed by a Power of Attorney.

If there is a beneficiary listed, your life insurance benefit and accidental death benefit, if applicable, is payable to that beneficiary. If there is more than one beneficiary listed, but you do not specify the share(s) to be received, all beneficiaries will share your life insurance and accidental death benefit, if applicable, equally. If the beneficiary dies before you, that beneficiary's interest will end and the insurance will be shared equally by any remaining beneficiaries, unless the beneficiary form states otherwise.

Any amount of insurance for which there is no beneficiary at your death will be payable in equal shares to the first of the following categories of surviving beneficiaries: (a) your legal spouse; (b) your natural and legally adopted children; (c) parents; (d) siblings; (e) estate.

If you and your beneficiary die from the same accident and the order of deaths cannot be determined, your benefit will be paid as if you survived the beneficiary.

Burial Expense: If Anthem receives documentation that an individual incurs expenses for your burial, that person may receive part of your Group Term Life Insurance. Anthem, at its option, may pay that person up to $500.00. If more than one person has incurred an expense for your burial, Anthem, at its option, may apply any portion of the burial expenses to the individuals. If an amount is so paid, Anthem will deduct that amount from your insurance benefit and that amount will not be paid to any beneficiary.

Insurance During Total Disability
(Waiver of Premium)

If you become totally disabled* before you reach age 60, the policy contains a provision under which your Group Term Life Insurance may be extended, at no cost to you, as long as you remain totally disabled.

> * You are considered totally disabled if you are unable to perform the Material and Substantial Duties of any occupation for which you are or may become reasonable qualified by education, training or experience. You will not be considered to be totally disabled on any day that you are actively at work.

You must request extended coverage from Anthem and Anthem must receive initial proof of total disability no later than 12 months after the date your total disability began. Your request must establish that (1) you are totally disabled and that such disability began before you were 60; (2) you are still totally disabled; and (3) your total disability has continued for at least 6 months.

You must give written proof of continued total disability when requesting the waiver of premium coverage and as reasonably required by Anthem. Anthem reserves the right to have you examined by a physician of its choosing, at its expense, whenever reasonably necessary, but not more than once a year after two (2) years of total disability.

If you die while your life insurance benefit is extended due to total disability, your life insurance is payable when Anthem receives written proof that (1) your disability continued until your death; and (2) all of the above conditions have been met.

If you die within one year after your Total Disability started but before you give Anthem proof of Total Disability, written notice of your death must be given to Anthem within one year after your death and that your Total Disability continued until your death.

Your coverage under the Waiver of Premium provision will terminate the earliest of the following:

(1) You are no longer totally disabled;
(2) Three (3) months after the date Anthem requests further proof of total disability and it is not received within this period;
(3) The date you refuse to be examined by a physician after requested; and/or
(4) The date you begin to receive retirement benefits as a result of past employment with a contributing employer of the Local 1500 Welfare Fund, or with any federal, state, municipal or association retirement plan.

If your extension of benefit protection ends after you have given the first proof of continued Total Disability, you have the same rights and benefits to apply for an Individual Policy under the conversion policy listed below. However, this will not apply if you become covered again as an active Participant within 31 days after this extension of benefits ends.

To receive an extension of benefit, you must apply to Anthem. You are strongly urged to contact the Fund Office for further information if you become disabled and unable to work.

Insurance after Cessation of Total Disability

If your insurance is continued in force under this provision and is then terminated because you cease to be totally disabled or fail to submit any Proof of Total Disability that is required by Anthem, one of the following events will occur:

- If the Policy is in force and you are insured under the Policy and you are Actively at Work, you will immediately become insured under the other terms of the Policy; *or*
- If the Policy is in force but either you are not insured under the Policy or you are not Actively at Work, you will be entitled to the same conversion rights you would have been entitled to if your insurance had terminated due to the termination of your employment; *or*
- If the Policy is not in force, you will be entitled to the same conversion rights that you would have been entitled to if your insurance had terminated due to the termination of the Policy.

The period that a conversion right will apply to as described in clauses 2 and 3 will be the 31 days following the date the insurance under this provision is terminated, or any extended notice period, whichever is later.

Conversion Policy
(Change To An Individual Life Insurance Policy)

You will have the right to have Anthem issue to you an individual life insurance policy without submitting Proof of Insurability, if all or part of your insurance under the Group Policy terminates for any of the following reasons:

(1) Your employment terminates while the Group Policy is in force.
(2) Your membership in a Class terminates while the Group Policy is in force
(3) The Group Policy terminates.
(4) The Group Policy is amended to cancel the insurance on the Class of persons under which you were insured.

The policy will only be issued to you if you make a written application to Anthem and the first premium due for the policy is received at the Anthem Administrative Office within 31 days of such termination or benefit reduction, or extended notice period, if later. This is the conversion period. Then the policy will take effect on the date of termination or reduction of coverage.

The premium for the individual policy will be determined by the policy type, the risk classification to which you belong under the group policy, Anthem's published rates in effect and your age (nearest birthday) at the time of conversion.

Individual Policies Available

The policy may be on any plan, other than term insurance which Anthem is then issuing. You may continue coverage as a term insurance policy for a period of up to one year. If your insurance terminates due to your total and permanent disability, you may elect any one of the life insurance policy forms, including term insurance, customarily issued by Anthem, subject to the conditions.

In addition to any policies available from Anthem, Anthem may also make arrangements to make policies available from another insurer.

The conversion policy will be effective on the day following the date your coverage under the group policy terminated.

Limits on the Amount of Individual Life Insurance That May be Obtained

The amount of insurance you may select under the Conversion policy may not exceed the amount of insurance that has been terminated under the Group Policy, less any amount of group coverage remaining in force under the Policy.

If the Group Policy is terminated by Anthem or Local 1500 Welfare Fund, or if the Insured loses coverage, in whole or in part, due to Total Disability, the amount of insurance you may select under the Conversion Policy may not exceed the amount of insurance that has been terminated under the Group Policy, less any amount of insurance for which you may become eligible under any group life insurance policy issued or reinstated within 45 days of termination of group life coverage.

Notice of Conversion Right

The Local 1500 Welfare Fund or its authorized representative is required to give you written notice of your right to convert the group policy into an individual policy without submitting Proof of Insurability. You will be given notice of the existence of the right within 15 days before or following the event which entitles you to conversion, and you will have 31 days from the event to apply for conversion your coverage. However, if such notice is given more than 15 days but less than 90 days after the happening of such event, the time allowed for the exercise of your conversion privilege will be extended by 45 days after the giving of such notice. If such notice is not given within 90 days after the happening of the event, the time allowed for the exercise of the conversion privilege will expire at the end of such 90 days. Written notice presented to you or mailed by Local 1500 Welfare Fund, or its authorized representative, to your last known address constitutes notice for the purpose of this paragraph. In any event, all life insurance terminates at the end of the 31 day conversion period, or at the end of the extended notice period, if later, unless properly converted within said time

Death During the Conversion Period

If you should die during the 31 day conversion period and prior to becoming insured under a policy again, an amount of insurance equal to the maximum amount for which you were entitled to convert will be paid as a death benefit.

If you terminate coverage under the Plan, you are urged to contact the Fund Office for further information on your right to convert the group life insurance policy to an individual policy.

Accelerated Death Benefit for Basic Life

The Accelerated Death Benefit provides that a portion of the Basic Life benefit otherwise payable under the policy as a result of death may be paid in advance under certain circumstances. Payment is made if you are diagnosed as having a Terminal Condition, subject to the terms of the policy and this provision.

Terminal Condition is defined as a medical condition that a Physician expects to result in your life expectancy being 12 months or less from the date of the application.

To receive the Accelerated Death Benefit, the following conditions will apply:

(1) You or your legal representative must request, in writing, to have this benefit paid while the coverage is in effect.
(2) You must provide Anthem with written permission from an assignee for your life insurance benefit, if applicable.
(3) Premium payments must continue and will be based on the reduced amount of insurance.
(4) Anthem must receive proof acceptable to it that you have been diagnosed as having a Terminal Condition.
(5) You must be living at the time this accelerated benefit is to be paid.

Accelerated Benefits are payable only once with respect to any Participant.

Any amount received under this provision will reduce the amount of life insurance coverage otherwise payable under the policy. Any benefit paid under this provision will also reduce the amount of coverage you may convert to an individual policy.

Payment under this provision does not guarantee that your full life insurance benefit will eventually be paid. Insurance must still be in force at the time of your death for the remainder of the life insurance benefit to be paid. Payment under this provision releases Anthem of all liability under the policy to the extent of the payment.

Amount of Accelerate Death Benefit

The Accelerated Death Benefit is an amount equal to 50% of the Basic Life Insurance to which you are entitled on the date you apply, in writing, for this benefit. A lesser amount may be elected. However, the minimum Accelerated Death Benefit Anthem will consider is 25% of the coverage.

Payment under this provision will be made in one lump sum. If you receive an Accelerated Death Benefit and you then recover from the qualifying condition, you will not be required to refund the benefit paid.

No Accelerated Death Benefit is payable if the Terminal Condition is directly or indirectly due to or associated with a self-inflicted injury or suicidal attempt.

If the Accelerated Death Benefit is forced by a creditor or governmental agency, Anthem will honor the request only to the extent required by law.

Anthem reserves the right to have you examined by one or more physicians of its choice, at its expense. Final determination of your eligibility for this benefit will be made by Anthem.

Claim Filing Procedures

For all Life Insurance claims, please see the Anthem Life claim filing procedures appearing later in the Claim Filing Section of this book.

YOUR BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Your Group Accidental Death and Dismemberment Insurance is currently underwritten by Anthem Life and Disability Insurance Company. The Group Case Number is AL00006573. The full description of benefits is contained in the Certificate of Insurance. A copy of the Certificate is at the Fund Office. If you would like a copy of the Certificate, contact the Fund Office.

This policy pays a benefit for any of the following losses resulting from an accident through accidental means while you are insured. To be considered for Accidental Death and Dismemberment benefits, the Loss must occur within 365 days of the accident, unless otherwise specified.

Schedule of Losses

Loss of Life	The Principal Sum (Paid to your beneficiary)

For Loss of:	The Benefits Are:
Both hands	The Principal Sum
Both feet	The Principal Sum
Sight of both eyes	The Principal Sum
One hand and one foot	The Principal Sum
One hand and sight of one eye	The Principal Sum
One foot and sight of one eye	The Principal Sum
One arm and one leg (severance above elbow and below knee)	The Principal Sum
Speech and hearing in both ears	The Principal Sum
Quadriplegia	The Principal Sum
Paraplegia	The Principal Sum
Hemiplegia	The Principal Sum

For Loss of:	The Benefits Are:
One hand	One-half of the Principal Sum
One foot	One-half of the Principal Sum
Sight of one eye	One-half of the Principal Sum
Speech	One-half of the Principal Sum
Hearing in both ears	One-half of the Principal Sum

For Loss of:	The Benefits Are:
Thumb and Index Finger of the same hand	One-quarter of the Principal Sum
Both Thumbs of both hands	One-quarter of the Principal Sum
All four fingers of one hand	One-quarter of the Principal Sum
Hearing in one ear	One-quarter of the Principal Sum
Uniplegia	One-quarter of the Principal Sum

For Loss of:	The Benefits Are:
All four toes of one foot	One-eighth of the Principal Sum

For the Loss due to a Coma, a maximum of 96% of the Principal Sum, determined as the lesser of 1% of the difference between the Principal Sum and the amount of any benefits paid for any Loss arising out of the same Accident.

Principal Sum is the benefit amount which applies to you at the time of the accident. The benefit depends on how long you have been employed. Benefits are available while you are covered under the Local 1500 Welfare Fund as an active Participant.

The Principal Sum is as follows:

During the first year of employment+	$ 2,500
After the first year of employment+	$ 12,500

+ You must satisfy the required waiting period under the Plan before your Group Accidental Death & Dismemberment Insurance becomes effective.

Any amount payable for Accidental Death and Dismemberment Benefits will be paid to you, except in the case of your loss of life, in which case, payment will be made to your beneficiary, as determined in accordance with the Beneficiary Provision under the Policy.

The benefit will be payable when Anthem receives due Proof of a Loss. The benefit to be paid is the amount from the Schedule of Losses noted above, subject to any conditions or reductions of the Policy. If, as the result of any one Accident, you suffer more than one of the losses shown in the Schedule of Losses with respect to any one limb, payment will be made only for the loss for which the largest amount is payable. The total maximum amount payable for all losses will not exceed your Principal Sum, unless otherwise specified by under any applicable Additional Benefit Provision.

Proof of Financial Loss

For any benefit which is based upon determination of a person's financial loss, Anthem shall have the right to require written proof of financial loss. This includes, but is not limited to:

- Statements of income;
- Tax returns, tax statements and accountants' statements; *and*
- Any other proof Anthem may reasonably require.

Anthem may perform financial audit, at its expense, as often as it deems reasonably necessary.

Definitions

Loss means a benefit from the above Schedule of Losses and, with regard to:

- An arm, leg, hand or foot, the total and irrecoverable loss of its use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such time.
- A thumb and index finger or all four fingers of one hand, the total and irrecoverable loss of its use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such time.
- Toes, the complete severance at or above the metatarsophalangeal joints.

- An eye, the total and irrecoverable loss of sight.
- Speech, the complete and irrecoverable loss of speech.
- Hearing the complete and irrecoverable loss of hearing.
- Quadriplegia, the total paralysis of both upper and lower limbs provided the loss is continuous for 12 consecutive months form the date of the loss.
- Paraplegia, the total paralysis of both lower limbs provided the loss is continuous for 12 consecutive months from the date of the loss.
- Hemiplegic, the total paralysis of upper and lower limbs on one side of the body provided the loss is continuous for 12 consecutive months from the date of the loss.
- Uniplegia, the total paralysis of one limb provided the loss is continuous for 12 consecutive months from the date of loss.
- Coma, a profound state of unconsciousness from which you cannot be aroused to consciousness, even by powerful stimulation as determined by a Physician.

Motorized Vehicle for the purpose of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snow mobiles; tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. "Motorized Vehicle" does not include a medically necessary motorized wheelchair.

No Right to Convert

All Accidental Death and Dismemberment benefits terminate the day before you retire and/or when you terminate covered employment. If your Accidental Death and Dismemberment Insurance ceases or is reduced, you cannot convert this group insurance to an individual policy.

Additional Benefits Under the Accidental Death & Dismemberment Insurance

Additional Provision for Surgical Reattachment

If an accidental injury results in a loss that would otherwise be payable under the terms of the Policy, Anthem will reimburse an amount equal to 50% of the amount otherwise payable from the Schedule of Losses if a dismembered part is surgically reattached. The balance of the amount that would otherwise have been payable will be paid if after 365 days the reattachment has failed to the extent that loss of use then exists.

Satisfactory Proof of the accidental injury and surgical reattachment will be required at the time of claim.

Additional Benefit for Child Education

If a benefit due to your Accidental Loss of Life becomes payable under the policy, Anthem will reimburse the reasonable and necessary expenses actually incurred for each Dependent Child who is enrolled (or who enrolls within 365 days of Loss) as a full-time student and is under the age of 26 on the date of your death:

The Child must be:

- In an Accredited Institution for higher learning above the secondary school level; or
- At the secondary school level but who will enroll as full-time student(s) in an Accredited Institution for higher learning within 365 days after the date of your death.

Accredited Institution for higher learning means any university, college or trade school which is accredited by a regional accrediting agency that is recognized by the United States Department of Education.

The maximum Additional Benefit for Child Education will be the lowest of the following
amounts:

- 5% of Your Principal Sum per year for each dependent child;
- $5,000 per year for each dependent child;
- $40,000 for all dependent children and all years;
- The amount of expense actually incurred.

In addition, the Additional Benefit for Child Education will not exceed a maximum of 4 years, which must run consecutively from your date of death, with respect to any one dependent child.

The Additional Benefit for Child Education will be reimbursed annually upon receipt of satisfactory proof that the dependent child is attending an Accredited Institution for higher learning as a full-time student, but reimbursement will not be made for expenses incurred prior to your death, or for room, board or other ordinary living, traveling or clothing expenses.

In the event the dependent child satisfies the requirements indicated above and has reached the age of legal majority, such child will be deemed the beneficiary with respect to benefits payable under this Additional Benefit. If the dependent child satisfies the requirements indicated above and has not yet reached the age of legal majority, the benefit will be payable annually to the legal guardian of the estate of the dependent child, until such child reaches the age of legal majority.

If a benefit due to your Accidental Loss of Life becomes payable under the Policy, and you do not have a child eligible for the Additional Benefit for Child Education, a lump sum of $500 will be paid in accordance with the Beneficiary Provisions of the Policy.

Additional Benefit for Repatriation

If you sustain Accidental Loss of Life more than 75 miles from your normal place of residence and indemnity for such Loss becomes payable under the terms of the Policy, Anthem will reimburse expenses incurred for the transportation of your body, subject to all of the terms and limitations of the Policy and all of the following conditions:

- Reimbursement for all expenses under this Additional Benefit will not exceed $5,000; *and*
- Eligible expenses will include transportation of the body, and charges directly related to the preparation of the body for such transportation; *and*
- Transportation of the body will be to the first resting place (including, but not limited to, a funeral home or the place of interment) in proximity to the normal place of residence of the deceased; *and*
- Satisfactory Proof of the actual expenses is submitted at the time of claim.

The Additional Benefit will be paid to your beneficiary, as determined in accordance with the Beneficiary Provision(s) under the Policy.

Additional Benefit for Seat Belt and Air Bag

If a benefit due to your Accidental Loss of Life becomes payable under the terms of the Policy, Anthem will pay an Additional Benefit, called the Seat Belt and Air Bag Benefit, if you were wearing a Seat Belt at the time of the accident, or if you were wearing a Seat Belt and the Automobile was equipped with Air Bag(s) at the time of the Accident, subject to all of the terms and limitations of the Policy and all of the following conditions:

- The Seat Belt Benefit equals the lesser of (i) $15,000 or (ii) 10% of the amount of the Accidental Death and Dismemberment Insurance Benefit paid because of your Accidental death in accordance with the Schedule of Losses.
- The Air Bag Benefit equals the lesser of (i) $10,000 or (ii) 10% of the amount of the Accidental Death and Dismemberment Insurance Benefit paid because of your Accidental death in accordance with the Schedule of Losses.
- Satisfactory Proof that your death resulted from an Automobile Accident independent of all other causes, and that you were wearing a seat belt at the time of the Accident must be received at the time of claim. Proof that the Automobile was equipped with Air Bags may also be required.
- No payment will be made for an Air Bag Benefit if at the time of the accident you were not in a seat for which the automobile provided an Air Bag, and wearing a Seat Belt.
- A copy of the police accident report must be submitted with the claim. The report must certify the position of the Seat Belt.

No payment will be made for the Seat Belt or Air Bag benefit for any Insured who

is driving or riding as a passenger if:

- the blood alcohol of the driver or operator of the Automobile is in excess of the legal limit in the jurisdiction in which the Accident occurred; *or*
- the use of any intoxicant or drug by the driver or operator of the Automobile is determined to be a contributing cause of the Accident, whether or not the Intoxicant or drug was prescribed by a Physician.
- The Insured was riding, driving or testing a motorized vehicle used in a race or speed contest.

The Additional Benefit for Seat Belt and Air Bag will be payable to your beneficiary, as determined in accordance with the Beneficiary Provision(s) under the Policy.

For the purposes of this Additional Benefit:

Seat Belt means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Automobile means a motor vehicle licensed for use on public highways which is a self-propelled passenger vehicle that has four wheels and an internal combustion engine. It may include electric passenger vehicles and certain hybrids. It excludes all other motorized vehicles.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile that inflates upon collision to protect an individual from Injury and death.

Additional Benefit for Common Carrier

If you sustain an accidental injury which results in a loss payable under the terms of the Policy, an Additional Benefit of 25% of the Principal Sum will be paid, if your injury or loss of life is sustained while you are boarding, riding, or exiting as a fare-paying passenger in a Common Carrier.

Common Carrier means a government licensed and regulated entity that is in the business of transporting fare paying passengers. The term Common Carrier does not include:

- chartered or other privately arranged transportation; *or*
- taxis; *or*
- limousines.

Exclusions for Accidental Death & Dismemberment

The following exclusions apply to any and all Accidental Death & Dismemberment Benefits, including any Additional Benefits or Additional Provisions, unless otherwise specifically referenced.

No payment will be made for any Accidental Death and Dismemberment Benefit or under any Additional Benefit or Additional Provision for any death or loss that results directly or indirectly from, or was in any manner or degree associated with

or caused by any one or more of the following:

- Bodily infirmity or mental or emotional disorder or illness or disease of any kind, or any medical or surgical treatment, diagnostic or preventative care (unless the treatment or care is provided in connection with a loss).
- Infections, unless caused by an injury.
- Poisoning in any form, including but not limited to, ingestion or inhalation of gas, fumes, chemicals, drugs, alcohol or any combination thereof.
- Loss or injury which occurs while the Insured is in the course of operating any Motor Vehicle if the Insured's blood alcohol concentration is in excess of the legal limit in the jurisdiction in which the Accident occurred.
- Suicide or attempted suicide or intentionally self-inflicted injury.
- Committing or attempting to commit a felony, or engaging in an illegal occupation.
- War or act of war (whether declared or undeclared); service in the armed forces or auxiliary units thereto.
- Participation in any riot or insurrection.
- Being under the influence of any narcotic or intoxicant, unless administered by or taken according to the advice of a Physician.
- Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- Serving in the military of any country or subdivision of any country.

Claim Filing Procedures

For all Accidental Death and Dismemberment claims, please see the Anthem claim filing procedures appearing in the Claim Filing Section of the book.

FOR COMPLETE DETAILS OF THE POLICY, CONTACT THE FUND OFFICE AND REQUEST A COPY OF THE CERTIFICATE OF INSURANCE

MEMBER AND SPOUSE BENEFITS

DENTAL BENEFITS

The Plan provides dental benefits when services are furnished by a licensed dentist while you and your spouse are covered. You may choose any duly licensed dentist or dental surgeon. However, to assist you in getting the most for your benefit dollars, the Fund has contracted with Integrated Dental Administrators, Inc ("IDA") and DDS, Inc. ("DDS") to provide access to their networks of dental providers. Should you wish to use network dentists, go to the Fund's Website at www.ufcw1500.org to view the listing of both IDA and DDS Providers. You may also visit the DDS website at www.ddsinc.net to locate a participating provider near you or in the specialty you need. At any time, you may contact the Fund Office to locate a provider nearest to you. Again, you are not required to utilize these networks.

THE BENEFITS

The Fund will pay the fee the dentist charges for covered medically necessary dental services, up to the maximum allowance shown in the Schedule of Dental Procedures appearing in this booklet on pages 23-27.

Annual Maximum for Dental Benefits:

For You	$2,000*
For Your Spouse	$1,500*

*If you and/or your spouse are under age 19, the Fund provides pediatric dental benefits with no annual dollar maximums. However, benefits are paid pursuant to the Fund's dental schedule allowances.

Please note the following:

(1) An expense is considered to be incurred on the date the service is performed or the supply is furnished/inserted, not on the date the bill is received by the Fund.
(2) If a patient is transferred from one dentist to another during the course of treatment or if more than one dentist renders service on one dental procedure, the benefits will be determined as though one dentist furnished all treatment.

PREDETERMINATION OF BENEFITS

For services estimated to be over $500, you are required to have your dentist submit the proposed course of treatment ("Treatment Plan"), unless treatment is provided on an emergency basis. A Treatment Plan is not required to be submitted if the total charges do not exceed $500 or if emergency care is required.

A Treatment Plan is the dentist's report that (a) itemizes his/her recommended services/supplies (complete with tooth number and ADA coding), (b) shows his/her charge for each service and (c) is accompanied by supporting X-rays.

Predetermination of benefits permits resolution of any issues regarding a course of treatment before services are rendered. Both you and the dentist will be advised, in advance, of what is covered and estimated amount the Fund will pay for those covered services. Of course, you and/or your spouse must be covered by the Plan on the date services are performed regardless of any predetermination.

If a Treatment Plan is not submitted to the Fund, the Fund reserves the right to decide the benefits payable at the time the claim is submitted, taking into account alternate procedures, services or courses of treatment based upon accepted standards of dental practice.

EXCLUSIONS & LIMITATIONS

Along with all general Plan exclusions, the Dental Benefit does not cover:

1. Anything not ordered by a dentist; anything not necessary for dental care; anything experimental or not accepted by the American Dental Association standards of dental practices; charges in excess of those usually made when there is no coverage; or charges in excess of usual and customary charges in the geographic area.
2. Orthodontics (a program to straighten teeth). See Orthodontic Benefit on pages 27-28.
3. Expenses for crowns or appliances, if made solely for periodontal involvement and to stabilize or splint mobile teeth.
4. Expenses for replacement of a lost prosthetic appliance.
5. Fees for the replacement of any full or partial dentures; fixed bridgework or crowns, if benefits for these appliances had previously been provided by the Fund, unless three (3) years have elapsed from the installation of any such appliances. The exclusion also applies to the replacement of a prosthetic appliance by fixed bridgework within a three - (3) year period. However, if an immediate (temporary) denture, for which the charge was less than the allowance in the schedule, is replaced by a permanent denture within a three - (3) year period, the Fund will pay the difference between the schedule allowance for the permanent denture and the charge for the immediate (temporary) denture.
6. Fees for removable partial maxillary or mandibular replacement with a partial denture, unless three (3) or more permanent teeth are missing from either the right or left quadrants of the maxilla or mandible.
7. Services and supplies solely for cosmetic purposes.
8. Dental implants and their related charges and attachments, including but not limited to crowns over implants.
9. Night guards.
10. Provisional/temporary crowns. These are considered included within the allowance for a permanent crown.

See the Coordination of Benefit Section on page 48 for details of the Plan's payment of benefits for claims where you or your spouse are covered by more than one dental plan.

Integrated Dental Administrators, Inc. (IDA) & DDS, Inc. Copayments

The dentists on the IDA and DDS, Inc. panels will accept the Fund's reimbursement as payment in full for most services. However, there are copayments for certain procedures.

The following are co-payments you may be charged when you receive certain service(s) from an IDA or DDS, Inc. provider:

Procedure	Total Fee	Plan Payment	Member Co-payment
Prosthodontic Work			
Maryland Bridge Retainer	$ 220.00	$ 170.00	$ 50.00
Metallic Inlay 1 Surface	100.00	80.00	20.00
Metallic Inlay 2 Surface	150.00	100.00	50.00
Metallic Inlay 3 Surface	200.00	120.00	80.00
Oral Surgery			
Panorex Film	$ 52.00	$ 42.00	$ 10.00
Partial Bony Impaction	175.00	110.00	65.00
Complete Bony Impaction	220.00	110.00	100.00
Cystectomy	120.00	72.00	48.00
Incision and Drainage	50.00	30.00	20.00
Apicoectomy: 1 Root	220.00	108.00	112.00
Apicoectomy: 2 Roots	335.00	216.00	119.00
Apicoectomy: 3 Roots	450.00	324.00	156.00
Periodontic Work			
Periodontal Consultation	$ 50.00	$ 30.00	$ 20.00
Osseous Surgery	450.00	300.00	150.00
Mucogingival Surgery	350.00	108.00	242.00

Neither the Fund nor the Trustees have a financial interest in or control over IDA and DDS, Inc., and, therefore, assume no liability for damages incurred while using a provider associated with this network.

SCHEDULE OF DENTAL PROCEDURES

EXAMINATIONS, PROPHYLAXES AND X-RAYS. **MAXIMUM PAYMENT**

Examination and charting
Maximum: twice during any 12-month period.....$ 18.00
Prophylaxis
Maximum: twice during any 12-month period.....18.00
Topical application of fluoride
Maximum: twice during any 12-month period.....12.00
14 Standard X-rays or Panorex X-ray
Maximum: once during any 12-month period if performed by a different dentist (once during any 36 month period if performed by the same dentist).....42.00
4 Bitewing X-rays
Maximum: twice during any 12-month period.....9.60
Intra-oral film, occlusal view (in lieu of standard x-rays, edentulous jaws)
Maximum: one each jaw during coverage, each film 2.85
Tempromandibular joint film.....14.40
Anterior-posterior film, head and jaws 10.00
Lateral film of head and jaws 8.00

EXTRACTIONS

Impacted teeth:
Upper third molars, each.....85.00
Other than upper third molars, each 85.00
Deep Sedation/General Anesthesia* – 1st 30 minutes.....75.00
Deep Sedation/General Anesthesia* – Additional 15 minute increments ...45.00
Inhalation of Nitrous Oxide, anxiolysis*.....50.00
Intravenous conscious sedation* - 1st 30 minutes.....75.00
Intravenous conscious sedation* - Additional 15 minute increments 45.00
Intravenous moderate conscious sedation*- Each 15 minute increment.... 50.00
Non-Intravenous conscious sedation* - 50.00

*The anesthesia benefits noted above are available ONLY FOR extractions of impacted wisdom teeth.

Malposed tooth (demonstrable by x-ray)
A tooth having markedly enlarged roots requiring bone removal.....72.00

SCHEDULE OF DENTAL PROCEDURES (Continued)

	MAXIMUM PAYMENT
Surgical Extractions (sutures included)	$ 110.00
Routine extractions, each tooth	40.00
FILLINGS	
Per surface	22.00
Maximum per tooth	60.00
Gold or porcelain inlays (as substitutes for fillings)	
One Surface	80.00
Two Surfaces	100.00
Three or more Surfaces: Maximum, one tooth	120.00
PALLIATIVE	
Emergency visit for relief of pain	30.00
PERIODONTIA	
For service provided by a Dentist who is a Board Certified Specialist*:	
Root scaling, prophylaxis, medication and minor bite correction:	
Each treatment	43.00
Maximum in any 12-month period	420.00
Gingivectomy, each quadrant consisting of a minimum of 5 teeth	240.00
Gingivectomy, each quadrant consisting of less than 5 teeth-Per tooth	43.00
Placement of Antimicrobial Agents	50.00
For Service provided by a Dentist who is not a Board Certified Specialist*:	
Root scaling, prophylaxis, medication and minor bite correction:	
Each Treatment	29.00
Maximum in any 12-month period	288.00
Gingivectomy, each quadrant consisting of a minimum of 5 teeth	108.00

SCHEDULE OF DENTAL PROCEDURES (Continued)

MAXIMUM PAYMENT

Gingivectomy, each quadrant consisting of less than
5 teeth-Per tooth ..... $ 22.00
Placement of Antimicrobial Agents 50.00

*A dentist who is certified to specialize in Periodontia by the American Board of periodontology will be deemed to be a Board Certified Specialist.

ORAL SURGERY (Other than Extractions)

Fracture of Jaw (if not covered by any other benefit issued under a group plan)
Lower jaw, closed reduction 132.00
Upper or Lower jaw, open reduction 216.00
Removal of cysts, including necessary extractions 72.00
Apicoectomy 108.00
Retrograde filling 24.00
Alveolectomy, maximum per jaw 96.00
Biopsy 36.00
Closure of oral antral fistula 72.00
Removing labial frenum 54.00

ROOT CANAL THERAPY

Regular Procedures as follows:
Removal of pulp and filling canal
First canal, per tooth 192.00
Each additional canal, same tooth 96.00
Pulp Capping, Maximum per tooth 14.00

SPACE MAINTAINERS (up to age 19 only)

Acrylic 72.00
Metal 90.00

BEDSIDE CALL (Home or Hospital) 30.00

DENTURES, Full or Partial

Full, immediate or permanent, total for one or both
Maximum, each jaw 420.00

SCHEDULE OF DENTAL PROCEDURES (Continued)

	MAXIMUM PAYMENT
Partial, bilateral, chrome cobalt alloy or gold base, 2 or more full cast clasps with occlusal rests acrylic attachments and porcelain or acrylic teeth, either jaw, each	$ 420.00
Adding teeth to partial denture to replace natural teeth not part of existing denture, first tooth	30.00
each additional tooth	18.00
Obturator (not including denture)	72.00
Rebasing, one per denture per 3-year period	90.00
Relining, one per denture per 3-year period	90.00

BRIDGEWORK, FIXED

Abutment crowns or jackets	360.00
Post	60.00
Pontics	300.00
Maryland Bridge Abutment	168.00

BRIDGEWORK, REMOVABLE

Steel with clasps and lugs (Nesbett)	
One tooth	60.00
Two teeth	72.00
Three teeth	84.00

JACKET CROWNS TO RESTORE NATURAL TEETH (not repairable by fillings)

Anterior and Posterior teeth (other than stainless steel)	360.00
Stainless steel crown…	72.00

REPAIR OF PROSTHETIC APPLIANCES

Dentures, Acrylic

Repairing body	30.00
Replacing broken teeth, per tooth	30.00
Replacing broken teeth not requiring other repairs:	
First tooth	30.00
Each additional tooth	30.00

SCHEDULE OF DENTAL PROCEDURES (Continued)

	MAXIMUM PAYMENT
Replacing clasp, clasp intact	$36.00
Replacing broken clasp with new clasp	60.00

BRIDGEWORK

Replacing broken pin facing with Bryant's or Steele's repairs	30.00
Reattaching broken Steele's facing, post on backing intact	30.00
Replacing broken Steele's facing, post on backing broken	35.00

The Fund will determine a consistent maximum payment for a dental procedure not listed, provided it is not excluded by the terms of the Plan.

ORTHODONTIC BENEFIT
(MEMBER AND SPOUSE)

The Plan provides the following benefits for orthodontic treatment (a program to straighten teeth) for a person who is less than age 19 on the date the treatment commences and who is covered for Dental Benefits. However, to assist you in getting the most for your benefit dollars, the Fund has contracted with Integrated Dental Administrators, Inc ("IDA") and DDS, Inc. ("DDS") to provide access to their networks of dental providers. Should you wish to use network dentists, go to the Fund's Website at www.ufcw1500.org to view the listing of both IDA and DDS Providers. You may also visit the DDS website at www.ddsinc.net to locate a participating provider near you or in the specialty you need. At any time, you may contact the Fund Office to locate a provider nearest to you. Again, you are not required to utilize these networks.

THE BENEFITS

The benefit pays 100% of the eligible charges, up to the amount shown below and up to the maximum noted below.

Maximum orthodontic benefit is as follows:

For treatment made by a dentist who is a Board Certified Specialist ..... $ 1,822*

For treatment made by a dentist who is not a Board Certified Specialist 706*

FEE SCHEDULE OF ORTHODONTIC PROCEDURES

	MAXIMUM PAYMENT
For services provided by a Dentist who is a Board Certified Specialist*	
Diagnosis and initial orthodontic appliance	$ 252.40
Active treatment per month of treatment	72.00
Maximum 20 months	1,440.00
Passive treatment per six months of treatment	43.20
Maximum 18 months	129.60
For services provided by a Dentist who is not a Board Certified Specialist*	
Diagnosis and initial orthodontic appliance	72.00
Active treatment per month of treatment	29.00
Maximum 20 months	580.00
Passive treatment per six months of treatment	18.00
Maximum 18 months	54.00

*A dentist who is certified to specialize in orthodontia by the American Board of Orthodontics will be deemed to be a Board Certified Specialist.

Integrated Dental Administrators and DDS, Inc. Copayments

Below please find the fee allowance that pertains to services rendered by an In-Network, Board Certified Orthodontist.

Total Orthodontic Fee 2,400.00
Local 1500 Welfare Fund Reimbursement 1,822.00
Patient Co-payment.....578.00

PREDETERMINATION OF BENEFITS

An "Orthodontic Treatment Plan" is a report on a form satisfactory to the Fund that, among other things, describes the recommended treatment, gives the estimated charge and is accompanied by cephalometric X-rays, study models and other supporting evidence.

Eligible charges are charges for an orthodontic procedure that (a) is contained in an "Orthodontic Treatment Plan" that has been reviewed by the Fund prior to services being rendered and which has been returned to the dentist showing estimated benefits and (b) is required by an over bite of at least four millimeters, crossbite, or protrusive or retrusive relationship of at least one cusp.

EXCLUSIONS & LIMITATIONS

Along with all General Plan Exclusions, the Orthodontic Benefit does not cover or coverage is limited as follows:

1. If treatment commenced before the patient became covered by this Plan, the maximum number of months of treatment provided by the Plan will be reduced by each month of active or passive orthodontic treatment rendered before the commencement of the patient's coverage by this Plan.

2. Retainers, bite plates and removable appliances are not covered.

3. Anything not ordered by a dentist; anything not necessary for dental care; anything experimental or not accepted by the American Dental Association standards of dental practices; charges in excess of those usually made when there is no coverage; or charges in excess of the usual and customary charges for such services in the geographic area.

4. Expenses for crowns or appliances, if made solely for periodontal involvement and to stabilize or splint mobile teeth.

5. Expenses for replacement of a lost or broken appliance.

See the Coordination of Benefit Section on page 48 for details of the Plan's payment of benefits for claims where you or your spouse are covered by more than one dental plan.

OPTICAL (VISION CARE) BENEFITS
(MEMBER AND SPOUSE)

In an effort to assist you in getting the most from your benefit plan, the Fund has agreements with Vision Screening, Inc., General Vision Services, Inc. (GVS), Comprehensive Professional Services, Inc. (CPS) and New County Optical to provide access to their respective network providers. You are not required to use these networks and may still use your own Optometrist or Ophthalmologist. However, you should be aware that if you do use an out-of-network provider, you will probably have higher out-of-pocket expenses. Should you wish to use a provider associated with one of these networks, you can contact the Fund Office to locate a provider nearest to you. You can also visit the CPS website (www.cpsoptical.com), the Vision Screening website (www.vscreening.com) and the GVS website (www.generalvision.com) to locate a provider near you. Additionally, the GVS website provides you and your eligible spouse the option of going online to schedule an appointment and view frames available under the Plan.

Please be advised that neither the Fund nor the Trustees have a financial interest in or control over any of the above networks or their providers, and, therefore, assume no liability for damages incurred while using a provider associated with these networks.

Benefits are provided for eye examinations, eyeglass lenses, frames and contact lenses.

THE BENEFITS

The Fund will pay the charges for covered eye examinations and supplies, up to the amount listed in the following Schedule of Benefits.

If you and/or your spouse are under age 19, the Fund provides pediatric optical benefits with no annual dollar maximums. However, benefits are paid pursuant to the Fund's fee schedule allowances for vision benefits. Additionally, any frequency limitations noted in the fee schedule will remain, unless they contradict the guidelines for pediatric optical services at the time services are rendered.

Regardless of age, all eye examinations must be performed by a duly licensed Optometrist or Ophthalmologist.

SCHEDULE OF OPTICAL BENEFITS

EYE EXAMINATION	**MAXIMUM PAYMENT**
Without Ophthalmological tests	$ 8.00
With Ophthalmological tests	16.00

LENSES+

Single vision lenses	28.00
Bi-focal lenses	42.00
Tri-focal lenses	70.00
Lenticular lenses	166.00
Contact lenses (in lieu of lenses and frames)	75.00
Contact lenses (in lieu of lenses and frames) for **GVS ONLY**	100.00
Contact lenses (medically necessary)	264.00

+Maximum Payment for Lenses indicates the benefit for two (2) individual lenses.

FRAMES 35.00

EXCLUSIONS

Along with all General Plan Exclusions, the Optical Benefit does not cover:

1. More than one eye examination in any 12 consecutive months.
2. More than two lenses in any 12 consecutive months.
3. More than one pair of frames in any 24 consecutive months.
4. Contact lenses, except as noted above.
5. Sunglasses, whether prescription or otherwise.
6. Replacement of lost, stolen or broken lenses or frames furnished under this benefit.
7. Eye examinations required (a) as a condition of employment which the employer is required to provide by a labor agreement or (b) by a government body.
8. Special procedures such as orthoptics and visual training, or medical or surgical treatment of the eye.
9. Charges in excess of those usually made when there is no optical coverage or in excess of usual and customary charges in the geographic area.

10 Any service not necessary for vision care.

See the Coordination of Benefit Section on page 48 for details of the Plan's payment of benefits for claims where you or your spouse are covered by more than one optical plan.

GENERAL PLAN EXCLUSIONS

The Local 1500 Welfare Fund Basic Part-Time Plan does not cover:

1. Hospital or Medical treatment of any kind.
2. Injury or sickness which arises out of, or in the course of, any occupation for profit for which there is Workers' Compensation or Occupational Disease Law Coverage.
3. Expenses for services or supplies to the extent they are provided under any governmental plan or law under which the individual is, or could be, covered.
4. Charges for services or supplies furnished by or for (a) the U.S. Government, or (b) any other government unless payment is legally required.
5. Charges in excess of those usually made when there is no coverage or in excess of usual and customary charges in the geographic area.
6. Any injuries or complications thereof arising out of any motor vehicle accident, including but not limited to cars, motorcycles and boats.
7. Services received as a result of an act of war (declared or undeclared) occurring while covered.
8. Examinations in connection with cosmetic surgery. However, cosmetic surgery is not considered to include reconstructive surgery which is incidental to or follows surgery for injury or disease to the involved party.
9. Criminal acts by a covered person, including aiding and abetting the commission of a crime (excluding domestic violence).
10. Injuries sustained during participation in a riot or insurrection, whether or not such participation in a riot was a criminal act or committed while under the influence of alcohol, narcotics or other substance.
11. Services for injuries due to "high risk" activities. Such "high risk" activities are evaluated on a case by case basis to determine the likelihood of injury at the time the activity occurred.

GENERAL PLAN INFORMATION

CLAIM FILING PROCEDURES

Life and AD&D Insurance
Underwritten by Anthem Life & Disability Insurance Company

In case of the death of a Participant or accidental injury to a Participant, contact the Welfare Fund Office immediately by telephone at 516-214-1300 or 1-800-522-0456 for a claim form. The proper claim forms will be furnished to your beneficiary in case of your death or to you or your authorized representative in case of injury.

The claim form will have instructions on how to complete the form. The claim form must be fully completed. Incomplete claim forms may be cause for delay in processing.

If the claim for benefits is for your death, Anthem may require an autopsy, unless it is prohibited by law. The cost for any such examination is paid by Anthem.

Proof of Loss

Anthem must be given written proof of the loss for which claim is made. This proof must cover the occurrence, character and extent of that loss and must identify you as the claimant, your address and the Fund's group policy number. For a claim for loss of life, a certified copy of the death certificate must be provided to the carrier. It must be furnished within 90 days after the date of the loss, except that:

1) If any coverage provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end.

2) If payment is to be made for charges incurred during a calendar year, the proof for that calendar year must be furnished within 90 days after its end.

A claim will not be considered valid unless the proof of loss is furnished within these time limits. However, it may not be reasonably possible to do so. In those cases, the claim will still be considered valid if the proof is furnished as soon as reasonably practicable. Please note, unless the delay in supplying proof is caused by your legal incapacity, the required proof must be furnished no later than 1 year from the specified time.

For a claim for Waiver of Premium, notice must also be given during your lifetime and during the period of total disability.

How to File Dental & Orthodontic Claims

When you know it is necessary for you to be treated by a dentist, you may contact the UFCW Local 1500 Welfare Fund Office for a dental claim form before visiting the dentist. You and/or your provider may also submit the universal American

Dental Association claim form in lieu of the Fund's dental claim form. Be sure that the claim form is fully completed and be sure that your identification number is included on the form.

The completed claim form, for either pre-certification of eligibility and/or benefit coverage, must be submitted, by the Participant or the dentist, to the following address:

Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
P.O. Box 1095
Sparks, MD 21152-1095

Payment of the claim will be made directly to you, unless you have assigned the payment to the dentist.

For claims involving pre-certification, the claim should be submitted when the approved procedures have been completed.

No claims will be eligible if submitted after two (2) years from the date of service.

How to File a Vision Care Claim

If you choose to go to a participating provider, General Vision Services, Inc. ("GVS"), Vision Screening, Inc., Comprehensive Professional Systems, Inc. (CPS) networks and New County Optical will submit the claim on your behalf.

If you choose to use an Out-of-Network provider, you will need to submit the claim for benefits. You should contact the UFCW Local 1500 Welfare Fund Office for a Vision Claim Form before visiting the Optometrist or Ophthalmologist. Complete the "Claimant's Statement" portion of the claim form. Upon completion of the work, the Optometrist or Ophthalmologist must complete the "Doctor Statement" portion of the claim form. Submit the claim form to the following address:

Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
P.O. Box 1095
Sparks, MD 21152-1095

No claims will be eligible if submitted after two (2) years from the date of service.

For all claims processed by Associated Administrators, LLC, you can check the status of a claim, at any time of day or night, by visiting www.associated-admin.com. Select the UFCW Local 1500 Welfare Fund page under the "Your Benefits" tab. Click on the MemberXG Benefit System link at the top of the page to create an account and review your claims.

CLAIM APPEAL PROCEDURES

Appeals for Group Term Life and Group Accidental Death & Dismemberment (AD&D) Insurance

Underwritten by Anthem Life & Disability Insurance Company

Claims for Life Benefits (Other Than Waiver of Premium) and AD&D

If you or your beneficiary's claim for benefits is totally or partially denied, Anthem will provide you written notice. This notice will give the reason(s) for the denial. If you or your beneficiary/beneficiaries do not agree with the reason(s) given, you may request a reconsideration of the claim.

To do so, you or your beneficiary/beneficiaries must write to Anthem within 60 days after receipt of the notice of denial. You or your beneficiary/beneficiaries should indicate why you believe the claim was improperly denied and include any additional information, data, questions or comments you believe are appropriate. Unless Anthem receives a request for additional information, you or your beneficiary/beneficiaries will be advised of Anthem's decision within 60 days after Anthem receives the request for reconsideration. The address to mail your request for reconsideration will be on the initial denial and is contained in the Certificate of Insurance held at the Fund Office.

Claims for Waiver of Premium

A decision for a Waiver of Premium claim will be made by Anthem within 45 days of the date the claim is filed. Under special circumstances, this decision may take up to another 60 days. You will be notified, in writing, of the reason for the delay, if any. Anthem will send written notification of its determination.

If you do not understand Anthem's decision or you disagree, you may request a review of the denied claim within 180 days of receipt of written notice that your claim has been denied. You may also review the pertinent documents and submit comments in writing.

Anthem will make a decision within 45 days after your request for review is made, unless circumstances of the claim require an extension, in which event the decision will be made as soon as possible, but not longer than 90 days after the request for review is made.

You will receive Anthem's written decision, which will include the reason(s) for the decision, along with references to the Policy provisions on which it is based.

Legal Action

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after Written Proof of Loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time Written Proof of Loss. Legal action with respect to a claim that has been denied, in whole or in part, shall be contingent upon having obtained Anthem's reconsideration of that claim, as explained above

Types of Health Claims
(Dental, Orthodontic and Vision Benefits)

There are four (4) basic types of health care claims:

Pre-Service. A pre-service claim is a claim for benefits where prior authorization is required. Failure to obtain prior authorization of a pre-service claim will result in a denial and/or reduction of benefits for such service unless:

(1) It was not possible for you to obtain prior authorization; or

(2) the prior authorization process would jeopardize your life or health.

Urgent Care. An urgent care claim is a type of a pre-service care claim. An urgent care claim is a claim for medical care or treatment for a medical condition that:

- Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Post-Service. A post-service claim is a claim for Fund health care benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services which form the basis for your claim. A claim regarding rescission of coverage will be treated as a post-service claim.

Concurrent Care. A concurrent care claim is a claim that is reconsidered after it was initially approved and the reconsideration results in:

- Reduced benefits; or
- A termination of benefits.

Timing of Determination of Health Care Claims
(Dental, Orthodontic and Vision Benefits)

The deadline for making a determination about your health care claim differs depending on the types of claim you have, as shown in the following paragraphs:

Urgent Care Claims: An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally as soon as possible, but no later than 72 hours and then will be confirmed in writing within three days after the oral notice. If additional information is needed from you to process your claim, you will be notified as soon

as possible, but no later than 24 hours after receipt of your claim. You will then have up to 48 hours to respond. You will then be notified of the Fund's benefit determination on the urgent care claim as soon as possible, but no later than 24 hours after the earlier of the receipt of the information or the end of the period of time allowed to you in which to provide the information.

Pre-Service Claims: An initial benefit determination will be made within 15 calendar days from receipt of your pre-service claim. If additional time is necessary to make a benefit determination on your pre-service claim due to matters beyond the control of the Fund, the Fund may take up to 15 additional calendar days to make a benefit determination. You will be informed of the extension within the initial 15-day deadline. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 15 days after receipt of your claim. You will have up to 45 days to provide the requested information. You will then be notified of the Fund's benefit determination on the pre-service claim as soon as possible, but no later than 15 days after the earlier of the receipt of the information, or the end of the 45-day time period allowed to you in which to provide the information.

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

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

Concurrent Care Claims: While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a previously approved claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Fund will act on your request in the same manner as urgent care claims.

If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, you will be given written notice of a decision about your claim.

If A Claim Is Denied

(Dental, Orthodontic and Optical Claims)

An adverse benefit determination (*i.e.*, a "denial") of a health care claim is defined as:

1. A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on a determination of an individual's eligibility to participate in the Fund's coverage, or that a benefit is not a covered benefit;

2. A reduction in or denial of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and/or

3. Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Notice of Health Care Claim Denials

(Dental, Orthodontic and Optical Claims)

If your claim is denied, you will be provided with written notice of a denial of the claim (whether denied in whole or in part). This notice will:

- Include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);

- State that, upon your request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided. However, a request for this information will not be treated as a request for an internal appeal or external review;

- State the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Fund standards used in denying the claim;

- Reference the specific provision(s) on which the determination is based;

- If relevant, describe any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;

- Provide a description of the Fund's internal appeal procedures

(including voluntary appeals) and external review processes, along with the applicable time limits and information on how to initiate an appeal;

If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;

- If the denial was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the decision, applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge;
- Contain a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal; and
- Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes. The Fund will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Fund can deny your claim on appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

Internal Appeals of Health Care Claims
(Dental, Orthodontic and Optical Claims)

If your claim for health care benefits is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for an appeal of the claim. Your request for appeal must be made in writing to the Board of Trustees within 180 days of the date of the denial. Please send your appeals of denied health care benefits to the Board of Trustees at the following address:

The Board of Trustees
Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
PO Box 1095
Sparks, MD 21152

Upon request, and without charge, you have the right to reasonable access to and copies of documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was

submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service. You have the right to submit written comments, documents, records and other information relating to your claim. The review will take into account all such information submitted by you, without regard to whether that information was submitted or considered in the initial benefit determination.

A different person/entity will review your claim other than the one who originally denied the claim. The reviewer will not be the subordinate of the person/entity who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including additional documents and comments that you may submit.

If your claim was denied on the basis of a medical judgment, a health care professional who has appropriate training and experience in a relevant field of medicine, and who is neither an individual who was consulted in connection with the initial denial nor a subordinate of any such individual, will be consulted. You will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.

Timing of Appeal Decision of Health Care Claims
(Dental, Orthodontic and Optical Claims)

The Fund's decision on your appeal will be made within the following time frames:

Urgent Care Claims: A decision will be made as soon as possible, but not later than 72 hours after receipt of your appeal.

Pre-Service Claims: A decision will be made within 30 calendar days from receipt of your appeal.

Post Service Claims: A decision will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, it will be considered at the second regularly scheduled meeting following receipt. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request may be necessary. You will be advised in writing in advance if this will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Concurrent Care Claims: A determination will be made before termination of your benefit.

Notice of Decision on Appeal of Health Care Claims
(Dental, Orthodontic and Optical Claims)

The decision on any review of your appeal will be given to you in writing. The notice of a denial of an appeal will include:

- Information sufficient to identify the claim, including date of the service, health care provider, and claim amount;
- A statement that, upon your request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided to you. However, a request for this information will not be treated as a request for a voluntary appeal or external review;
- A statement you may receive, upon request and free of charge, access to copies of documents relevant to your claim;
- The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any standards used in denying the claim;
- Reference to the specific provision(s) on which the determination is based;
- If relevant, any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the Fund's internal appeal procedures and external review processes, along with the applicable time limits and information on how to initiate an appeal;
- A statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal;
- If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;
- If the determination was based on the absence of medical necessity, the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge;
- The following statement: "You and your plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency."
- Disclose the availability of, and contact information for, any applicable

ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes.

NOTE: The Fund will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of the appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Fund can issue a denial on appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

Limitation on When a Lawsuit or External Review May Be Started

You may not seek external review or start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on your appeal, or until the appropriate time frame in which the Fund must decide your appeal, as described above, has expired and you have not received a final decision on your appeal or notice that an extension will be necessary to reach a final decision. However, the law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Fund has failed to follow such procedures.

External Reviews of Health Care Claims
(Dental, Orthodontic and Optical Claims)

If your appeal of a claim is denied, whether it's a pre-service, post-service, or urgent care claim, you may request further review by an Independent Review Organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

External reviews are only available for the following types of denials of claims:

- A denial that involves medical judgment, including those based on the Fund's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.
- External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Fund.

Your request for external review of a denial must be made, in writing, within four (4) months of the date that you receive the denial you are appealing. Because the Fund's internal review and appeals process generally must be exhausted before external review is available, typically external review of claims will only be available for denials of appeals (and not initial claim denials).

1. Preliminary Review

(a) Within five (5) business days of the Fund's receipt of your external review request, the Fund will complete a preliminary review of the request to determine whether:

- You are/were covered by the Fund at the time coverage for the health care item or service is/was requested or, in the case of a retrospective review, were covered at the time the health care item or service was provided;
- The denial does not relate to your failure to meet the Fund's requirements for eligibility;
- You have exhausted the Fund's internal claims and appeals process; and
- You have provided all of the information and forms required to process an external review.

(b) Within one (1) business day of completing its preliminary review, the Fund will notify you in writing as to whether your request meets the threshold requirements for external review. If applicable, this notification will inform you:

- If your request is complete and eligible for external review, or
- If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272), or
- If your request is not complete, the notice will describe the information or materials needed to make it complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

2. Review by an Independent Review Organization (IRO)

If the request is complete and eligible, the Fund will assign the request to an Independent Review Organization or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Fund has contracted with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you, in writing, of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).

(b) Within five (5) business days after the assignment to the IRO, the Fund will provide the IRO with the documents and information it considered in making its denial determination.

(c) If you submit additional information related to your claim, the assigned IRO must, within one (1) business day, forward that information to the Fund. Upon receipt of any such information, the Fund may reconsider its denial of the claim which is the subject of the external review. Reconsideration by the Fund will not delay the external review. However, if upon reconsideration, the Fund reverses its original denial of the claim, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. However, the IRO will be bound to observe the terms of the Fund's plan of benefits to ensure that the IRO decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Fund's requirements for coverage, including the standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of an item or service. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Fund, reports from appropriate health care professionals, appropriate practice guidelines, the applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

(e) The assigned IRO will provide written notice of its final external review decision to you and the Fund within 45 days after the IRO receives the request for the external review.

(f) The assigned IRO's notice of its decision will contain the following information, unless such information is inconsistent with applicable current law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);

- The date the IRO received the assignment to conduct the review and

the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding, except to the extent that other remedies may be available to you or the under applicable State or Federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

Expedited External Review of Health Claims
(Dental, Orthodontic and Optical Claims)

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial of an appeal that involves a medical condition for which the time to complete a standard external review would seriously jeopardize your life or health or your ability to regain maximum function; or, you receive a denial of an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review of Expedited External Reviews

Immediately upon receipt of the request for expedited external review, the Fund will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in Section 1(a), are met. The Fund will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in Section 1(b).

Review by an Independent Review Organization (IRO)

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Fund will assign an IRO. The Fund will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review noted above. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the internal claims and appeals process. However, the IRO will be bound to observe the terms of the Fund's plan of benefits to ensure that the IRO decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Fund's requirements for coverage, including the Fund's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of an item or service, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision, in accordance with Section 2.(f) above, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Fund.

After External Review

If, upon external review, the IRO reverses the denial of your claim, upon the Fund's receipt of notice of such reversal, the Fund will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Fund may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision. If the final external review upholds the denial of the claim, the Fund will not provide coverage or payment for the reviewed claim. If you are dissatisfied, you may seek judicial review as permitted under ERISA Section 502(a).

FINANCING

The Plan is financed by contributions made by Contributing Employers pursuant to collective bargaining agreements with the UFCW Local 1500 or written participation agreements with the Fund's Board of Trustees.

All of the Plan assets are held in trust by the Board of Trustees of the Welfare Fund for the Participants and beneficiaries of the Plan. The Board of Trustees has the ultimate responsibility for the management of Fund assets.

No benefits of the Plan shall, in any manner or to any extent, be assignable or transferable by the Participant, except that an assignment of benefits to a provider of the covered services is permitted.

The assets of the Fund must be used only for the benefit of the Participants and beneficiaries. If all of the Plan benefits have been provided by the assets of the Fund and there is still money left over, the money must be used to provide benefits. Under no circumstances may money, which has been properly contributed to the Fund ever be returned to any Employer or to the Union. In addition, no Participant can receive any of the contributions made to the Fund, except in the form of benefits.

PLAN INTERPRETATIONS & DETERMINATIONS

Notwithstanding any other provisions of this Plan, the Board of Trustees is responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees shall have exclusive authority and discretion:

- To determine whether an individual is eligible for any benefits under the Plan;
- To determine the amount of benefits, if any, an individual is entitled to from the Plan;
- To determine or find facts that are relevant to any claim for benefits from the Plan;
- To interpret all of the Plan's provisions;
- To interpret all of the provisions of the Summary Plan Description;
- To interpret the provision of any collective bargaining agreement or written participation agreement involving or impacting the Plan;
- To interpret the provisions of the Trust Agreement governing the operation of the Plan;
- To interpret all of the provisions of any other document or instrument involving or impacting the Plan
- To interpret all of the terms used in this Plan and all of the other previously mentioned agreements, documents and instruments and;
- To amend, modify, or discontinue all or part of the Plan whenever, in their sole and absolute discretion, conditions so warrant.

All such determinations and interpretations made by the Trustees:

- Shall be final and binding upon any individual claiming benefits under the Plan and upon all employees, all employers, the Union, and any party who has executed any agreement with the Welfare Fund Trustees or the Union;
- Shall be given deference in all courts of law to the greatest extent allowed by applicable law; and
- Shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, acted in an arbitrary and/or capricious manner.

Incompetence

If the Trustees determine that a person entitled to benefits from the Plan is unable to care for his/her affairs because of illness, accident, or incapacity (either physical or mental), payment which would otherwise be made to that person shall be made to that person's duly appointed legal representative. In the event no legal representative shall have been appointed, such payment shall, in the discretion of the Trustees, be made to that person's spouse, child or such person who shall have care and custody of that person.

Cooperation

Every claimant will furnish to the Trustees all such information, in writing, as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. Failure on the part of the claimant to comply with such requests promptly and in good faith, will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may, from time to time, adopt such formulas, methods and procedures as they consider advisable.

Mailing Address of Claimant

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last recorded by the Trustees and a letter sent by first class mail to such claimant is returned, any payments due the claimant will be held without interest until payment can be successfully made. Be sure to inform the Trustees immediately, of any change of address.

Recovery of Payment

The Trustees have the right to recover any overpayment or payment made in error to you or to a third party on your behalf, and/or any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted. Such a recovery may be made by reducing other benefit payments made to you or on your behalf, by commencing a legal action or by such other methods as the Trustees, in their sole and absolute discretion, determine to be appropriate.

COORDINATION OF BENEFITS

The UFCW Local 1500 Welfare Fund Basic Part-Time Plan contains a Coordination of Benefits (hereinafter "COB") provision. Pursuant to the COB provision, if a covered individual is covered by more than one health plan, this Plan will coordinate with the other plan so that the total amount paid on any claim by all plans will not exceed 100% of the allowable benefit payable under this Plan. This provision applies to the Dental, Orthodontic and Optical Benefits. In other words, there is no duplication of benefits permitted.

An "allowable" expense is any necessary, reasonable and customary expense covered, at least in part, by the plan.

"Plans" mean these types of dental, orthodontic and optical benefits: (a) a governmental program/plan provided or required by statute, including Medicare or any governmental plan, (b) the No-Fault provision of any Motor Vehicle insurance statute, (c) any group benefit/insurance plan, (d) group or group-type plans, including franchise or blanket benefit plans, (e) any coverage sponsored by, or provided through, a school or other educational institution, (f) any personal insurance or medical payments coverage available under a homeowners insurance policy.

When a claim is submitted, a determination is made as to which plan covering the claimant is the primary plan and which plan is the secondary plan. The primary plan pays its benefits without regard to any other plans. Thereafter, the secondary plan reviews what would have been paid if it were the primary plan and compares that amount to what the primary plan actually paid. The secondary plan then adjusts its benefit payment accordingly so that the total benefits paid will not exceed the allowable expense under the secondary plan. In other words, the Local 1500 Welfare Fund Basic Part-Time Plan will not pay more than it would have paid without the COB provision and it will not pay benefits if the primary plan has paid an amount equal to or more than what this Plan allows or would have paid. No duplication of benefits is permitted.

To determine whether a plan is primary or secondary, the following order is used: A plan without a COB provision is always the primary plan. If all plans have a COB provision, the plan covering the patient directly (as the Participant), rather than as a Participant's dependent, is primary. If the above does not apply, the plan covering the patient longest is primary.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (hereinafter "COBRA") provides that you and your covered spouse can continue coverage under certain circumstances where coverage would otherwise terminate (called "qualifying events"). Please note, the Life and AD&D Insurance is not provided for under COBRA continuation coverage. This section outlines your rights and obligations with respect to COBRA continuation coverage provided under the Plan. During the COBRA continuation of coverage period, you will pay the full cost to the Plan of coverage for a similarly situated active Participant plus a 2% administrative fee (or in the case of a disability extension of coverage, 150% of the cost of coverage). COBRA continuation coverage does not include the Group Term Life Insurance or Group Accidental Death and Dismemberment Insurance. If your coverage terminates, you have the right to convert your Group Term Life Insurance to an individual policy. You must request conversion within 31 days of your termination. You are urged to contact the Fund Office for information on your conversion rights upon termination for the Group Term Life Insurance. There is no right to convert the Group Accidental Death and Dismemberment Insurance.

You have a right to choose COBRA continuation coverage for up of 18 months if you lose your coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you become entitled to Medicare benefits within 18 months of a termination or reduction of hours, your spouse may be eligible for additional coverage, as set forth below.

If you are the spouse of a Participant and you are covered by the Plan, you have the right to choose COBRA continuation coverage for yourself (for Dental and Optical benefits only) if you lose group health coverage under the Plan for any of the following four (4) reasons:

- The death of your spouse entitles you to up to 36 months of continued benefit coverage;
- Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with a contributing employer, entitles you to up to 18 months of continued benefit coverage;
- Divorce or legal separation from your spouse entitles you up to 36 months of continued benefit coverage; or
- Your spouse's enrollment in Medicare entitles you to 18 or 36 months of continued benefit coverage depending upon the qualifying event. (Note: entitlement to Medicare is not a second qualifying event if it would not have caused a loss of coverage absent the first qualifying event).

An 18-month period of COBRA coverage may be extended for up to an additional 11 months (for a total of up to 29 months of COBRA coverage) if the you or your spouse covered under COBRA are determined to have been disabled (under Title II or XVI of the Social Security Act) as of the date of the your termination

or reduction in hours. The disabled individual must notify the Plan Administrator within 60 days of the later of: (1) the date of the Social Security Administration's disability determination; or (2) the date on which the individual is informed of his/her obligation to provide a disability notice (either through the Summary Plan Description or the initial COBRA notice) and, in all cases, before the end of the 1 8 month continuation period. There will be an increase in the cost for such extended coverage to 150% of the cost to the Plan to cover a similarly situated Participant.

The 11 month disability extension also will apply if the you or your covered dependent becomes disabled at any time within the first 60 days of his/her initial 18-month period of COBRA continuation coverage, provided that the Plan Administrator is timely notified of the disability determination, as described above.

If the conditions for the 11-month extension are met, the 11-month extension is also available to a disabled individual's non-disabled dependent spouse who is entitled to COBRA coverage.

Additional qualifying events, called second qualifying events, may occur while an 18-month period of continuation coverage is in effect. These events include the death of the Participant, divorce from the Participant, and Medicare entitlement. If the entitlement to Medicare occurs within 18 months before the Participant terminates employment or loses coverage due to reduced hours, then COBRA may be extended to his/her dependent spouse (for applicable benefits only) for the longer of (i) 18 months from the termination of employment or a reduction in hours or (ii) 36 months from the date of Medicare entitlement. If the entitlement to Medicare occurs after the Participant terminates employment, then the Medicare coverage must be evaluated as if the first qualifying event had not occurred. If Medicare entitlement would not have caused you to lose coverage while an active Participant, it will not be an event that would be considered a second qualifying event. If you die or you and your dependent spouse divorce or legally separate, your spouse (for applicable benefits only) may extend his/her COBRA coverage for up to a maximum of 36 months from the date of the original COBRA coverage. In no event will coverage extend beyond 36 months after the loss of coverage due to the initial qualifying event. You or your dependent spouse must notify the Plan Administrator if a second qualifying event occurs during your continuation coverage period, as provided above.

Your COBRA coverage will end before the expiration of the applicable period for any of the following eight (8) reasons:

- The Plan no longer provides group health coverage;
- Your continuation coverage premium is not timely paid in full;
- After electing continuation coverage, you become covered under another group health plan.

- You become entitled to Medicare benefits (under Part A, Part B or both) after election of continuation coverage; or
- Coverage has been extended for up to twenty-nine (29) months due to disability and/or there has been a final determination that the individual is no longer disabled;
- Your employer stops participating in the Plan after you become eligible for COBRA and your employer establishes a new plan or joins an existing plan that makes health coverage available to a class of employees formerly covered under this Plan.
- For any reason the Plan would terminate you or your spouse's coverage if not receiving continuation coverage (such as fraud); or
- The Plan is terminated.

If COBRA continuation coverage terminates earlier than the maximum continuation period available, you will receive a Notice of Termination of Continuation Coverage. This notice will state the reason why the coverage is terminated early, the date coverage will end, and any rights you may have to elect an alternative group or individual coverage.

Procedures for Notice from Employees or Qualifying Beneficiaries

Your employer has the responsibility to notify the Plan Administrator, in writing to the Fund Office, within 30 days of the date of your death, termination of employment, reduction in hours of employment or your Medicare entitlement.

You and/or your spouse must inform the Plan Administrator, in writing to the Fund Office, of the commencement or termination of a Social Security disability or if he/she ceases to be a dependent under the Plan, such as in a divorce or legal separation. Such notice must be given to the Plan within 60 days of the later of: (1) the date of the event, (2) the date on which the coverage would end under the Plan because of the event, or (3) the date on which you or your spouse is informed of the obligation to provide notice and the procedure for providing the notice.

If you, your eligible spouse, or your Employer fail to give written notice of a qualifying event within the time periods specified above and, as a result, the Plan pays a claim for a person whose coverage terminated due to a qualifying event and who does not elect COBRA Coverage under this provision, then the you, your spouse or the Employer, as appropriate, must reimburse the Plan for any claims that should not have been paid. If you or your eligible spouse fail to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the individual was his/her spouse, or the Trustees may, in their sole discretion, initiate a lawsuit to collect the amount due.

When the Plan Administrator and/or COBRA Administrator is notified of one of these events, you will be notified, in writing, within 60 days of such notice, that

you have the right to choose COBRA coverage or that the Plan Administrator has determined that you are not eligible for the requested COBRA continuation coverage. If it is determined that you are not eligible for continuation coverage, the Plan will provide you with a Notice of Unavailability of Continuation Coverage, which will provide an explanation of why you are not entitled to the coverage.

Under the law, you or your eligible spouse (for applicable benefits only) must inform the Plan Administrator, in writing, that you want COBRA coverage within 60 days of the later of:

- The date you or your eligible spouse (for applicable benefits only) ordinarily would have lost coverage because of one of the events described above, or
- The date you receive notice of your right to elect continuation coverage.

If you do not timely and properly choose COBRA coverage, your coverage under the Plan will end.

If you choose COBRA coverage, you are entitled to coverage that is identical to the coverage being provided under the Plan to similarly situated Participants (or their eligible spouses) except the Life Insurance and AD&D Insurance will not be provided. You have the right to convert the Group Life Insurance to an individual policy. As noted under the Life Insurance benefit section appearing earlier in this book, to convert the Group Term Life Insurance to an individual policy, you must apply within certain time frames. You must contact the Fund Office for information on your right to convert the Group Life Insurance to an individual policy.

Payment Provisions

In order to receive COBRA continue coverage under the Plan, you must pay the cost of coverage. For coverage during the 11 month Social Security Disability extension, there will be an increase in cost of coverage to 150% of the cost to the Plan. However, you do not have to provide proof of good health. A failure to provide notice of a disability or second qualifying event may affect the right to extend the continuation coverage period.

COBRA coverage requires timely monthly payments. The Trustees will determine the cost for COBRA continuation coverage. The cost will not necessarily be the same as the amount of the monthly contribution that an Employer makes on behalf of a covered employee. The cost is fixed, in advance, for a period of twelve (12) months.

The payment due date is the first day of the month in which COBRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The initial COBRA payment must include payment for the period of time dating back to the date that coverage terminated. The initial COBRA payment is due within 45 days from the date COBRA coverage is elected. Thereafter, COBRA allows for a grace period of thirty (30) days to pay any subsequent amounts due. If payment of the amount due is not received by the end of the applicable grace period, the COBRA coverage will terminate.

Once a timely election of COBRA coverage has been made, it is your responsibility to make timely payment of all required payments. The Fund will not send notice that a payment is due or that it is late or that COBRA coverage is about to be terminated due to failure to make timely payment.

The Health Insurance Marketplace

You may be able to obtain coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Marketplace permits you to find and compare private health insurance options. In the Marketplace, you can learn if you are eligible for a new kind of tax credit that lowers your monthly premiums and what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

You have 60 days from the time you lose your job based coverage to enroll in the Marketplace, as this is a "special enrollment" event. **After 60 days, your special enrollment period will end and you may not be able to enroll until the next open enrollment period.**

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during the open enrollment period. You can also terminate your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event, such as marriage or birth of a child, through the special enrollment period described above. **If you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage.** Once you have exhausted your COBRA continuation coverages, you will be eligible to enroll in Marketplace coverage through a special enrollment period. If you sign up for Marketplace coverage in lieu of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances. You can access the Marketplace for your state at www.HealthCare.gov or call 1-800-318-2596.

General COBRA Information

COBRA coverage is subject to your eligibility for coverage under the Plan. The Plan Administrator reserves the right to terminate your COBRA coverage, retroactively, if you are determined to be ineligible. Once your COBRA coverage terminates for any reason, it cannot be reinstated.

If you have any questions about COBRA continuation coverage, please contact the Fund Office at UFCW Local 1500 Welfare Fund, 425 Merrick Avenue, Westbury, NY 11590 or telephone 516-214-1300; or the Fund's COBRA Administrator, Associated Administrators, LLC, at P.O. Box 1095, Sparks, MD 21152 or telephone (855) 266-1500.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

HIPAA CERTIFICATES

If your employment terminates and you were covered under the Plan at that time or your COBRA coverage terminates, you have the right to receive a certificate of prior creditable coverage, pursuant to HIPAA. This certificate should be presented to your future employer or insurance company as proof of prior creditable coverage. Please contact Associated Administrators, LLC for further information.

HIPAA PRIVACY NOTICE

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA"), the Fund has adopted policies to safeguard the Protected Health Information (hereinafter "PHI") of all Participants and beneficiaries. A copy of such policies is provided by the Fund as a separate document. If you have any questions about the Fund's policies or wish to request such policies, contact the Fund Office.

Additionally, the privacy regulations of HIPAA require confidentiality of your PHI. PHI includes all individually identifiable health information related to your past, present, or future physical or mental health condition or to payment for health care that is maintained by the Plan or on behalf of the Plan, in connection with the Plan's provision of medical, dental, vision or pharmacy benefits. That means that unless you authorize your PHI be released to specific individual(s), in writing, (i.e., if you wish your spouse or child to be able to question any of your claim matters) the Fund and its providers/vendors will not be able to respond to this individual's inquiry. Therefore, you should contact the Fund Office and request an authorization to release your PHI if you wish another individual to be able to receive your PHI. Likewise, the Plan will not disclose your spouse's PHI without their written authorization. Once the written authorization is received by the Fund Office, the permitted individual will be able to access your PHI and, in turn, be able to handle any claim matters relating to that written authorization.

Under Federal Law, you have certain rights with respect to your PHI, including a right to see and copy the information, the right to receive an accounting of certain disclosures, when you so request, and in certain instances, amend the information. You also have the right to request that reasonable restrictions be placed on the disclosure of your PHI.

Pursuant to HIPAA, the Fund has designated a Privacy Officer, who is named in the privacy notice issued by the Fund. The function of the Fund's Privacy Officer is to ensure compliance with of the Fund's privacy policies and procedures by Fund employees and to accept and investigate any complaint made against the Fund by a Participant or beneficiary. If you wish to file a complaint for an alleged violation of your PHI, contact the Fund's Privacy Officer or you may file a complaint with the Secretary of the United States Health and Human Services Agency. If you have any questions regarding the Fund's privacy policies, contact the Fund.

Subrogation/Reimbursement (Claims Involving Third Party Liability)

Note:

This provision applies to all Participants with respect to the Dental, Orthodontic and Optical benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all Participants and covered spouses, where applicable.

General

Under the terms of the Plan, no benefits are payable if a third party may be liable for your dental, orthodontic or optical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your bills. The rules in this section govern how this Plan pays all benefits in such situations.

These rules have two purposes. First, the rules ensure that your dental, orthodontic and optical expenses will be paid promptly. Often, where there are questions of third party liability, many months pass before the third party actually pays. These rules permit this Plan to pay the expenses which would have been covered if a third party were not liable before third party liability is resolved.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once you receive any compensation with respect to the third party's liability, this Plan must be reimbursed for the amount it advanced to you.

Rights of Subrogation and Reimbursement

If you incur dental, orthodontic or optical expenses for which a third party may be liable, you are required to advise the Plan of that fact.

The Plan may pay such expenses, up to the coverage limits, provided that you agree, in writing, to repay the Plan, in full, from any settlement, judgement, or other payment that you obtain from the liable third party or an insurance carrier. The amount of the payment to the Plan may not be reduced by any expenses incurred in obtaining the recovery. The Plan is entitled to such repayment even if nothing in the judgement or settlement allocates any portion of the proceeds to medical expenses. Moreover, the Plan is entitled to repayment from any trust or fund set up for your benefit.

The Trustees will require you (or your authorized representative if you are a minor or incapacitated) and your attorney, if any, to execute this Plan's repayment/lien forms before this Plan pays any benefits related to such expenses.

No benefits will be provided unless you and your attorney, if any, sign the form. You must also notify the Plan if you retain another attorney or an additional attorney since that attorney will be required to execute the repayment/lien form as well.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

Assignment of Claim

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If you assign your claim and the Plan recovers damages from the third party, any amount in excess of the benefits paid to you, plus the expenses incurred in obtaining the recovery, will be paid to you.

Failure to Disclose and/or Cooperate

If you fail to tell this Plan that you may have a claim against a third party; if you fail to assign your claim against the third party to the Plan when required to do so (and to cooperate with the Plan's subsequent recovery efforts); if you fail to require any attorney you retain to sign the Plan's lien forms; if you and/or your attorneys fail to repay the Plan in full out of any payment you obtain from the third party or insurance carrier; you will be personally liable to this Plan for the amount owed to this Plan. The Plan may offset the amount you owe from any future benefit claims or, if necessary, take all legal action available against you to it to recoup the amount owed.

ERISA RIGHTS AND PROTECTIONS

YOUR RIGHTS UNDER ERISA

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of a summary of the annual report.

Continue Plan Coverage

Continue coverage for yourself or your spouse, where applicable, if there is a loss of coverage under the Plan as a result of a qualifying event. You or your spouse, if applicable, may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Upon request, you may receive a certificate of creditable coverage, free of charge, from your group plan or health insurance issuer when the following circumstances occur: (1) you lose coverage under the Plan; (2) when you become entitled to elect COBRA continuation coverage; (3) when your COBRA continuation coverage ceases; (4) if you request it before losing coverage; or (5) if you request it up to 24 months after losing coverage. Without evidence of termination of coverage, you may not be eligible for special enrollment rights under various plans.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the 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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. The toll-free telephone number is 1-800-998-7542.

ERISA ADMINISTRATIVE INFORMATION

(As required by the Employee Retirement Income Security Act of 1974, as amended)

1. **PLAN NAME:** UFCW Local 1500 Welfare Fund, Basic Part-Time Plan.
2. **EDITION DATE:** This Summary Plan Description is produced as of April 1, 2019.
3. **PLAN SPONSOR:** Board of Trustees of the UFCW Local 1500 Welfare Fund.
4. **PLAN SPONSOR'S EMPLOYER'S IDENTIFICATION NUMBER:** 23-7176373
5. **PLAN NUMBER:** 501 (assigned by federal government).
6. **TYPE OF PLAN:** Welfare Plan providing life insurance, accidental death and dismemberment insurance, and self-funded dental, orthodontic and optical benefits.
7. **PLAN YEAR ENDS:** December 31.
8. **PLAN ADMINISTRATOR:** Board of Trustees of the UFCW Local 1500 Welfare Fund, 425 Merrick Avenue, Westbury, NY 11590. Telephone 1-516-214-1300.
9. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Board of Trustees of the UFCW Local 1500 Welfare Fund, 425 Merrick Avenue, Westbury, NY 11590. Telephone 1-516-214-1300.
10. **TYPE OF PLAN ADMINISTRATION:** Fund administered by the Board of Trustees.
11. **TYPE OF FUNDING:** Life and Accidental Death and Dismemberment insured by Anthem Life & Disability Insurance Company. All other coverages are self-funded.
12. **SOURCES OF CONTRIBUTIONS TO PLAN:** Employers required to contribute to the UFCW Local 1500 Welfare Fund pursuant to collective bargaining agreements and/or other written agreements between the employers and the Trustees of the UFCW Local 1500 Welfare Fund.
13. **COLLECTIVE BARGAINING AGREEMENT:** This Plan is maintained in accordance with collective bargaining agreements. A copy of the relevant agreement may be obtained by you, upon written request, to the Plan Manager and is available for examination by you at the Fund Office.
14. **PARTICIPATING EMPLOYERS:** You may receive from the Plan Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.

15. **PLAN BENEFITS PROVIDED BY:** UFCW Local 1500 Welfare Fund.

16. **ELIGIBILITY REQUIREMENTS, BENEFITS AND TERMINATION PROVISIONS OF THE PLAN:** See pages 4-6 of this booklet with applicable information.

17. **NO INSURANCE UNDER THE PBGC:** Since this Plan is not a defined benefit pension plan, it does not have coverage under the Pension Benefit Guaranty Corporation.

18. **TRUSTEES:** The Plan Sponsor and Plan Administrator is the Joint Board of Trustees of the UFCW Local 1500 Welfare Fund.

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