FELRA & UFCW
RETIREE HEALTH & WELFARE PLAN

A Plan of the Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund

PLAN I RETIREE
SUMMARY PLAN DESCRIPTION

February 2019

The Administrative Manager:

- Receives *Participating Employer*/employee contributions
- Keeps eligibility records
- Processes claims
- Provides information about the *Fund*

Administrative Manager
Associated Administrators, LLC

Website
www.associated-admin.com

Participant Services
(800) 638-2972

Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

Fund Office
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
(301) 459-3020 or (800) 638-2972

Hours: 8:30 a.m. to 4:30 p.m., Monday through Friday

Interactive Voice Response System
You can check the status of your claims 24 hours a day, 7 days a week by using the automated phone system.
Call (800) 638-2972 and press "1" at the prompt.

With respect to all uninsured benefits described herein, this Summary Plan Description for the FELRA & UFCW Retiree Health and Welfare Plan functions as both the Plan Document and the Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and the terms contained herein constitute the terms of the Plan. With respect to all fully insured benefits described herein, the terms of the Fund's formal agreement or policy with the applicable insurer and, to the extent not inconsistent with such agreement or policy, this Summary Plan Description, constitute the terms of the Plan.

COVERED EMPLOYMENT UFCW LOCAL 27

The benefits described in this booklet apply to retirees of the *Participating Employers* as listed below who are covered by a current *Collective Bargaining Agreement* with UFCW Local 27, or a participation agreement with the Fund, requiring contributions to the Fund on their behalf and who meet all the necessary eligibility requirements, as explained in this booklet. Copies of these agreements are available upon request from the *Fund Office*.

Full-Time Retirees

1. Giant – Grocery employees hired before January 15, 1982; Meat employees hired before October 9, 1983; Non-Food employees hired before August 28, 1977.
2. Safeway – Grocery and Meat employees hired before May 1, 1983; Non-Food employees hired before August 28, 1977.

Part-Time Retirees

1. Giant – Grocery employees hired before January 15, 1982; Meat employees hired before October 9, 1983; Non-Food employees hired before August 28, 1977.
2. Safeway – Grocery employees hired before May 1, 1983; Meat employees hired before October 9, 1983; Non-Food employees hired before August 28, 1977.

* Depending on the *Collective Bargaining Agreement*s that have been in effect throughout the history of the Fund, certain retirees who are still eligible for retiree health benefits may have been employed by employers not listed here.

COVERED EMPLOYMENT UFCW LOCAL 400

The benefits described in this booklet apply to retirees of the *Participating Employers* as listed below who are covered by a current *Collective Bargaining Agreement* with UFCW Local 400, or a participation agreement with the Fund, requiring contributions to the Fund on their behalf and who meet all the necessary eligibility requirements, as explained herein. Copies of these agreements are available upon request from the *Fund Office.*

Full-Time Retirees

1. Giant – Grocery or Meat employees hired before October 23, 1983; Non-Food employees hired before August 28, 1977.
2. Safeway – Grocery or Meat employees hired before October 30, 1983; Zone A (Fredericksburg/Valley area) employees hired before December 4, 1983; Non-Food employees hired before August 28, 1977.

Part-Time Retirees

1. Giant – Grocery or Meat employees hired before October 23, 1983; Non-Food employees hired before August 28, 1977.
2. Safeway – Grocery or Meat employees hired before October 30, 1983; Zone A (Valley) employees hired before December 4, 1983; Non-Food employees hired before August 28, 1977.

* Depending on the *Collective Bargaining Agreement*s that have been in effect throughout the history of the Fund, certain retirees who are still eligible for retiree health benefits may have been employed by employers not listed here.

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Note: Certain terms in this book are defined under the "Definitions" section on page 63. Such terms will appear in *italics* throughout this book.

Dear Participant,

The FELRA & UFCW Retiree Health and Welfare Plan (the "Plan" or "Retiree Plan"), a plan of the Food Employer Labor Relations Association & United Food and Commercial Workers VEBA Fund ("the Fund"), was established as a result of collective bargaining between your *Union* and your *Participating Employer*. The contribution rate paid by your *Participating Employer* determines the level of benefits you receive. An equal number of *Trustees* have been appointed by the *Union* and the *Participating Employer*s. The *Trustees* administer the *Fund* and serve without compensation. Their authority, established under the *Fund's* Trust Agreement, includes the right to make rules about your eligibility for benefits and the level of benefits available. The *Trustees* have the power to interpret, apply and construe the terms of the Plan and make factual determinations regarding the Plan's construction, interpretation, and application. Further, the *Trustees* may amend the rules and benefit levels at any time and may terminate the Plan. If the *Trustees* terminate the Plan, your rights and the distribution of assets will be determined under the terms of the Trust and applicable law. Participants and beneficiaries have no vested rights to the benefits described in this booklet. Any decision made by the *Trustees* is binding upon *Participating Employers*, retirees, employees, participants, beneficiaries and all other persons who may be involved with, or affected by, the Plan. You will be notified of any material modifications (changes) to this Summary Plan Description (SPD) as required by federal law.

The *Trustees* delegate authority to professionals who help them manage the Plan:

- An ***Administrative Manager*** (referred to as the "*Fund Office*" in this booklet) receives *Participating Employer* contributions, keeps eligibility records, pays claims, and assists Plan participants with their benefits. Some benefits are paid directly by the *Fund*; others are provided by insurance carriers or other providers and the *Fund* pays premiums. Benefits are limited to Plan assets for all benefits.
- An ***Investment Manager*** invests the *Fund's* assets to achieve a reasonable rate of investment return.
- ***Fund Counsel*** provides legal advice.
- An independent ***Certified Public Accountant*** audits the *Fund* each year. Periodic payroll audits are also performed for each *Participating Employer*.

If there are any differences between this booklet, which is intended as an explanation of your benefits, and the formal agreements between the *Fund* and any insurance carriers that provide benefits described herein, the formal agreements will govern.

It is important that you verify coverage with the *Fund Office* before incurring expenses under the *Plan* so that you can confirm that you or your dependents are covered under the *Plan* for the services you are seeking. Please remember that no one other than the *Fund Office* can verify your coverage. Do not rely upon any statement regarding coverage or benefits under the *Plan* made by your *Participating Employer* or *Union* representative.

It is also extremely important that you keep the *Fund Office* informed of any change in address or desired changes in dependents and/or beneficiary. This is your obligation and you could lose benefits if you fail to do so. The importance of a current, correct address on file in the *Fund Office* cannot be overstated. **It is the ONLY way the *Trustees* can keep in touch with you regarding *Plan* changes and other developments affecting your interests under the *Plan*.**

We hope you always enjoy good health. However, if the need for coverage arises, we believe you will share with us the satisfaction of knowing you have the protection of this *Plan*.

Sincerely,

Board of Trustees

FACTS ABOUT THE PLAN

Plan Name
FELRA & UFCW Retiree Health and Welfare Plan, a plan of the Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund ("FELRA & UFCW VEBA Fund").

Plan Sponsor
Board of Trustees of the FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

Employer Identification Number
52-1036978

Plan Number
501

Type of Plan
This is a welfare plan designed to provide health care benefits such as hospitalization, medical, surgical, mental health, prescription drug, dental, and optical benefits.

Type of Administration
Contract Administration–The Board of *Trustees* has contracted with Associated Administrators, LLC to provide administrative management services.

Name of Plan Administrator
Board of Trustees of the FELRA & UFCW VEBA Fund

Agent for Service of Legal Process
Associated Administrators, LLC or any *Trustee* at this address:
FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500 or (800) 638-2972

Sources of Contribution
Sources of contributions to the Fund are *Participating Employers* pursuant to the terms of their *Collective Bargaining Agreement*s and self-payments made by participants and/or dependents.

Funding Medium
All assets are held in trust by the Board of *Trustees*. Insurance premiums are paid by the Trust Fund, and insurance companies or HMOs pay part of the benefits. Benefits are also partially paid from the Plan's accumulated assets held in the Trust. For benefits provided by insurance

companies or HMOs, the benefits are guaranteed by and paid under the insurance or HMO contract and the insurance company or HMO provides claims processing and administrative services related to such benefits. A current Summary Annual Report (available from the Plan Administrator) gives details of Plan funding of benefits. The *Fund's* assets are held by PNC Bank.

Plan Year and Fiscal Plan Year
January 1 - December 31.

FELRA & UFCW VEBA Fund
Board of Trustees

Union Trustees

Secretary:
Mark Federici, President
UFCW Local 400
8400 Corporate Drive, Ste. 200
Landover, MD 20785

Jason Chorpenning, President
UFCW Local 27
21 West Road, Second Floor
Towson, MD 21204

Alan Hanson
UFCW Local 400
8400 Corporate Drive, Ste. 200
Landover, MD 20785

Eric Masten
UFCW Local 27
21 West Road, Second Floor
Towson, MD 21204

Employer Trustees

Chairman:
Jason Paradis
25 Charles Street
Wrentham, MA 02093

Daniel Dosenbach
Human Resources & Labor Relations
New Albertsons Inc.
75 Valley Stream Parkway
Malvern, PA 19355

Michael Goble
Giant Food, LLC
8301 Professional Place, Ste. 115
Landover, MD 20785

NOTICE – NO FUND LIABILITY

Use of the services of any *Hospital*, clinic, doctor, or other provider rendering health care, whether designated by the *Fund* or otherwise, is the voluntary act of the participant or dependent. Some benefits may only be obtained from providers designated by the *Fund*. This is not meant to be a recommendation or instruction to use the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the *Fund*. Providers are independent contractors, not employees of the Plan. The *Fund* makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with *Fund* coverage. The provider is solely responsible for the services and treatments rendered.

HEALTH CARE COST CONTAINMENT CORPORATION

The FELRA & UFCW VEBA Fund, along with many other funds, participates in the Health Care Cost Containment Corporation of the Mid-Atlantic Region, Inc. (HCCCC). It is designed to benefit participating funds by reducing health care costs for participants and their families. Through bargaining, the HCCCC is able to achieve greater economies of scale and significant cost savings because of increased bargaining power in the health care marketplace.

REPAYING THE FUND/OVERPAYMENT OF BENEFITS

If the *Fund* pays benefits in error, such as when the *Fund* pays you or your dependent more benefits than you are entitled to, or if the *Fund* advances benefits that you or your dependent are required to reimburse because, for example, you have received a third party recovery (see "Subrogation"), you are required to reimburse the *Fund* in full and the *Fund* shall be entitled to recover any such benefits.

The *Fund* shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the *Fund* on any overpaid or advanced benefits received by you, your dependent or your or your dependent's representative (including an attorney) that is due to the *Fund*, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the *Fund* until paid to the *Fund*. By accepting benefits from the *Fund*, you and your dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the *Fund* in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your dependent or beneficiary to reimburse the *Fund* for an overpaid amount will be considered a breach of your agreement with the *Fund* that the *Fund* will provide the benefits available under the Plan and you will comply with the rules of the *Fund.* Further, by accepting benefits from the *Fund,* you and your dependent or beneficiary affirmatively waive any

defenses you may have in any action by the *Fund* to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your dependent or beneficiary refuse to reimburse the *Fund* for any overpaid amount, the *Fund* has the right to recover the full amount by any and all methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your dependents' or beneficiaries' future benefit payments payable by the *Fund* under the Plan. For example, if the overpayment or advancement was made to you or on your behalf as the *Fund* participant, the *Fund* may offset the future benefits payable by the *Fund* to you and any of your dependents or beneficiaries. If the overpayment or advancement was made to or on behalf of your dependent or beneficiary, the *Fund* may offset the future benefits payable by the *Fund* to you and any of your dependents or beneficiaries.

The *Fund* also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the *Fund* is required to pursue legal action against you or your dependent or beneficiary to obtain repayment of the benefits advanced by the *Fund*, you or your dependent or beneficiary shall pay all costs and expenses, including attorneys' fees and costs, incurred by the *Fund* in connection with the collection of any amounts owed the *Fund* or the enforcement of any of the *Fund's* rights to reimbursement. In the event of legal action, you or your dependent or beneficiary shall also be required to pay interest at the rate determined by the *Trustees* from time to time from the date you become obligated to repay the *Fund* through the date that the *Fund* is paid the full amount owed. The *Fund* has the right to file suit against you in any state or federal court that has jurisdiction over the *Fund's* claim.

SCHEDULE OF BENEFITS

Only Medicare-eligible retirees, and Medicare-eligible dependents of retirees, who enroll in Part B of Medicare are eligible for benefits under the Plan. See the Medicare Supplemental Benefit chart below. If you do not live in the Kaiser Permanente Medicare HMO area, see Schedule 1 or Schedule 2 on the next pages for the benefits that apply to you. ***In determining whether a retiree is part-time or full-time for purposes of the type of coverage available, status is determined based on a majority of service***.

If you live within the Kaiser Permanente *Medicare* HMO area, you must enroll in Kaiser to maintain your *Fund* benefits. Retirees and dependents in the Kaiser *Medicare* HMO have medical and prescription coverage through Kaiser. See your Kaiser Certificate of Coverage for details about your medical and prescription Drug benefits. Your optical and dental benefits are through the Fund (not through Kaiser) – see pages 48 and 57 for descriptions of these benefits.

If you do NOT live within the Kaiser area, the medical and prescription drug benefits described in Schedule 1 and Schedule 2 on the next pages are provided as an additional supplement to *Medicare* benefits. **Retirees and their eligible dependents must be *Medicare*-eligible and must enroll in Part B of *Medicare* to be eligible for any *Plan* benefits.** The *Plan* will not supplement charges not covered by *Medicare.*

The *Plan* covers the *Medicare* supplemental *Deductibles* and *Co-Insurance* amounts shown in the Medicare Supplemental Benefit chart below for **all eligible retirees and dependents**, regardless of whether they live within the Kaiser area. The amounts covered beginning January 1, 2019 are shown in the column on the right. These amounts may change***.***

Medicare Supplemental Benefit	**2019**
Medicare* Part A *Deductible *Medicare* Part A pays for *Inpatient Hospital*, skilled nursing facility, and some home health care. For each benefit period, *Medicare* pays (1) all covered costs, except the *Medicare* Part A deductible during the first 60 days; and (2) coinsurance amounts for *Hospital* stays that last between 61 days to 150 days.	$1,364.00
***Co-Insurance* for days 61-90** of an *Inpatient Hospital* stay.	$341 per day
***Co-Insurance* for days 91-150** of an *Inpatient Hospital* stay (days in an *Inpatient Hospital* after 90 days in a benefit period are called “lifetime reserve days”)	$682 per “lifetime reserve day” after day 90 for each benefit period (60 day lifetime maximum)

Skilled Nursing *Co-Insurance* for days 21-100 of a skilled nursing facility stay.	$170.50 per day
Medicare* Part B *Deductible *Medicare* Part B covers eligible *Physician* services, *Outpatient Hospital* services, *Durable Medical Equipment*, and certain home health services. After you meet the *Deductible*, **you pay 20% of the *Medicare*-approved amount for services.**	$185.00

Schedule 1

Schedule 1 Applies to the following eligible Retirees:

- **Full Time Retirees and Part Time Retirees who retired before October 1, 1992 and their eligible dependents; and**
- **Full Time Retirees who retired 10/1/92 and after and their eligible dependents**

Dependents of Retirees are not eligible for optical or dental benefits through the Fund.

Medical and Mental Health & Substance Abuse Benefits Retiree and Eligible Dependents who do not live within the Kaiser Permanente Medicare HMO area	In addition to covering the *Medicare* Part B deductible, the *Plan* will cover the *Medicare* co-insurance due for eligible *Physician* services, *Outpatient Hospital* services, *Durable Medical Equipment* and certain home health services that are covered by *Medicare*, subject to a $15 *Co-Payment* per office and/or urgent care center visit. This $15 *Co-Payment* will be deducted from whatever the *Fund's* payment amount would have been. There is a $50 emergency room *Co-Payment*, which will be waived if you are admitted to the *Hospital*. For balances remaining after *Medicare* has paid its portion, the Fund will deduct the above *Co-Payments* ***before processing the balance for secondary payment***. This does not change Medicare's primary payment of your claim.
Optical Benefit Retiree Only	Provided through and insured by Advantica. Exams, frames and lenses covered once every two years. See page 57 for details.
Dental Benefit Retiree Only	Provided through and insured by Group Dental Service of Maryland ("GDS"). Exams, frames and lenses are covered once every two years. See page 48 for details.
Prescription Drug Benefit Retiree and Eligible Spouse not living within the Kaiser Permanente Medicare HMO area.	Provided through Express Scripts, Inc. ("ESI"). Retiree benefit is 11% *Co-Payment* if you use a Giant or Safeway pharmacy; 18% if you use any other in-network pharmacy ("in-network" meaning a pharmacy which accepts your ESI card for benefits). If you live outside the geographic area of a Giant or Safeway pharmacy, you will pay an 11% *Co-Payment* at any in-network pharmacy. **The Fund does not cover prescriptions filled at Wal Mart, Walgreens, Rite Aid, or CVS.** **Generic drugs are mandatory if available.** Covered dependent's benefit is 75% (25% *Co-Payment* by the dependent) after satisfying the $200 prescription *Deductible* per *Calendar Year.*

Schedule 2

Schedule 2 applies to eligible Part Time Retirees Who Retired <u>on or after October 1, 1992</u> and their eligible dependents ("Part Time Comprehensive" Retirees)

Dependents of Retirees are not eligible for optical or dental benefits through the Fund.

Medical and Mental Health & Substance Abuse Benefits Retiree and Eligible Dependents who do not live within the Kaiser Permanente Medicare HMO area	In addition to covering the *Medicare* Part B deductible, the *Plan* will cover the *Medicare* co-insurance due for eligible *Physician* services, *Outpatient Hospital* services, *Durable Medical Equipment* and certain home health services that are covered by *Medicare*, subject to a $15 *Co-Payment* per office and/or urgent care center visit. This $15 *Co-Payment* will be deducted from whatever the *Fund's* payment amount would have been. There is a $50 emergency room *Co-Payment*, which will be waived if you are admitted to the *Hospital*. For balances remaining after *Medicare* has paid its portion, the Fund will deduct the above *Co-Payments* ***before processing the balance for secondary payment***. This does not change Medicare's primary payment of your claim.
Optical Benefit Retiree Only	Provided through and insured by Advantica. Exams, frames and lenses covered once every two years. See page 57 for details.
Dental Benefit Retiree Only	Provided through and insured by Group Dental Service. Fillings, exams, and routine services are covered. See page 48 for details.
Prescription Drug Benefit Retiree and Eligible Spouse who do not live within the Kaiser Permanente Medicare HMO area.	Provided through Express Scripts, Inc. ("ESI"). Retiree benefit is 11% *Co-Payment* if you use a Giant or Safeway pharmacy; 18% if you use any other in-network pharmacy ("in-network" meaning a pharmacy which accepts your ESI card for benefits). If you live outside the geographic area of a Giant or Safeway pharmacy, you will pay an 11% *Co-Payment* at any in-network pharmacy. ***Generic drugs are mandatory, if available.*** **The Fund does not cover prescriptions filled at Wal Mart, Walgreens, Rite Aid, or CVS.** Covered Dependent's benefit is 75% (25% *Co-Payment* by the dependent) after satisfying the $200 prescription *Deductible* per *Calendar Year*.

RETIREE ELIGIBILITY

Initial Eligibility

To be eligible for benefits, you must be *Medicare*-eligible and, on the date of your retirement, you must:

1. Be an active participant in the FELRA & UFCW Active Health and Welfare Plan, **Plan I,** when you retire (unless the circumstances described on page 19 of this SPD, under the heading "Eligibility under the FELRA & UFCW VEBA Fund and the UFCW Unions & Participating Employers Health and Welfare Fund" are applicable). You are considered active if you are working on the day before you retire; if you retire immediately after collecting Accident & Sickness Benefits; if you retire based on a workers' compensation injury; or if you are on a medical leave of absence and self-paying to maintain your benefits through the Fund or through *COBRA*;
2. Waive your right to *COBRA* continuation coverage as a retiree for any period for which you are Medicare-eligible.
3. Have the majority of your pension service under Tier I. If you have service as both a Tier I and a Tier II employee, your status for the purpose of determining eligibility for Retiree Plan benefits is based on a majority of service (Tier I and Tier II are terms used to describe your pension service as determined under your *Collective Bargaining Agreement*.);
4. Work less than 40 hours per month in the retail food industry–in the same geographical areas as the *Fund*–during your retirement;
5. Your employer must continue to be a *Participating Employer* under the *Fund*, unless your employer withdraws;
6. If you retired on or after January 1, 1990 but before October 1, 1992, to be eligible for health and welfare benefits as a retiree (apart from *COBRA*), you must have earned at least 10 years of Credited Service as defined in the FELRA & UFCW Pension Plan. If you retired on or after October 1, 1992, to be eligible for health and welfare benefits as a retiree (apart from *COBRA*) you must have earned at least 20 years of Credited Service as defined in the FELRA & UFCW Pension Plan;
7. If you retire on a disability pension (meaning you have been certified as being totally disabled and unable to work) and you are *Medicare*-eligible, you may be eligible for retiree health and welfare benefits. However, if you lose your disability status under Social Security, the regular eligibility rules of the *Plan* apply (meaning you must have 20 years of service to be eligible for Retiree Plan benefits).
8. *Medicare*-eligible retirees and *Medicare*-eligible dependents must enroll in Kaiser Permanente *Medicare* HMO if it is available in the area where you live. The *Medicare* HMO will provide ***medical and prescription*** benefits. Optical and Dental benefits will be provided through the *Fund* for eligible retirees only (not dependents). Retirees out of the service area of a Kaiser Permanente *Medicare* HMO will keep *Fund Medicare* Supplemental coverage as described in this booklet. ***Those who are in-area for part of the year must join the HMO while they are living in-area.***

When you become *Medicare*-eligible, the *Fund* will give you a one-time opportunity to enroll in coverage under the Retiree Plan. The *Fund Office* will send you a letter prior to the date you become *Medicare*-eligible due to age. You will then have a 60-day opportunity to enroll in coverage under the Retiree Plan. If you do not enroll within 60 days, you will no longer be eligible to enroll in coverage under the Retiree Plan. If you become eligible for *Medicare* for any reason except age, it is your responsibility to notify the *Fund Office* as soon as you become eligible for *Medicare*. You must enroll in Part B of *Medicare* to be eligible for benefits under the Retiree Plan.

If you enroll under the Plan you will receive benefits under the Fund's Kaiser Permanente Medicare HMO program if you live in the Kaiser Permanente service area. If you do not live in the Kaiser Permanente service area, you will be covered under the *Fund's Medicare* Supplemental Benefit. Prescription benefits are included through the Kaiser Permanente *Medicare* HMO, administered through Kaiser Permanente. Prescription benefits for those not in the Kaiser service area who are covered by the Fund's *Medicare* Supplemental Benefit are through Express Scripts, Inc. ("ESI").

If you join a Medicare Part D prescription program, your Fund prescription benefits will be terminated.

Retirees must meet all qualifications to be eligible for Retiree Plan benefits.

Former participants of Plan I who retire on a deferred vested pension are not eligible for retiree health and welfare benefits under the *Fund*. Former participants who retire from management may be eligible for Retiree Plan benefits if they have 20 years or more of Benefit Service. Contact the *Fund Office* for more information if this applies to you. If you are a pension beneficiary other than an eligible dependent, you are not eligible for benefits under the Retiree Plan.

The benefit levels described in this booklet are not guaranteed. To continue receiving these benefits, the employer you worked for when you retired must continue to be a *Participating Employer* in the *Fund* (except as described on page 19). The *Trustees* may terminate or change the level of benefits or may change the *Co-Payment* applicable to your benefits.

Co-Payments

Retirees and eligible dependents pay a monthly *Co-Payment* to maintain eligibility for Retiree Plan benefits. The rates are subject to change, based on your age at retirement, your years of service, and your number of dependents.

***Very important! If you do not make the monthly Co-Payment on time and by the due date, you will immediately lose your eligibility for all Plan benefits, including medical*, for a 12 month period.**

After 12 months, you can choose to make the *Co-Payments* to resume prospective health and welfare coverage. For example, if you do not timely make the *Co-Payment* for the month of June, you will not be eligible to receive benefits or make *Co-Payments* for benefits again until the

following May, for coverage effective in the month of June. Claims will only be covered if they are *incurred* in a month for which you have made the *Co-Payment*.

If you choose to drop dependent coverage and go to individual coverage, you generally may not elect coverage for your eligible spouse again until 12 months following the date you originally changed the coverage. There may be special enrollment circumstances; contact the *Fund office* for information if you are considering dropping dependent coverage.

Changes in status that affect your *Co-Payment* will result in a different *Co-Payment* as of the first of the month following the change. You must notify the *Fund Office* of changes affecting your *Co-Payment* by the 20th of the month preceding the *Effective Date* of the change in *Co-Payment*.

Following is the Co-Pay Category Chart. Your ***categor***y will always remain the same but your rate may change each year. The *Fund Office* will notify you of your rate and any changes.

If you are not eligible for coverage under the Retiree Plan **solely** because you are not *Medicare*-eligible, your *Medicare*-eligible dependents who otherwise meet the eligibility requirements under the Retiree Plan are eligible to elect individual dependent coverage under the Retiree Plan. The retiree will be charged the applicable *Co-Payment* for such *Medicare*-eligible dependent(s).

FELRA & UFCW Retiree Health and Welfare Plan
Retiree Co-Pay Chart as of January 1, 2019

Category	Age at Retirement	Service at Retirement	Family or Individual	Out Of Area	HMO Rate
A	At Least 60	At Least 30 Years	Individual	$59	$21
			Family	$88	$42
B	Less Than 60	At Least 30 Years	Individual	$113	$68
			Family	$180	$111
C	At Least 60	At Least 25 Years	Individual	$113	$68
			Family	$180	$111
D	At Least 55	At Least 20 Years	Individual	$233	$86
			Family	$359	$124
E	Retired @ 9/1/92	Less Than 20 Years	Individual	$288	$102
			Family	$448	$143
F	Disability Retiree	At Least 10 Years	Individual	$113	$68
			Family	$180	$111

WORK RULES

Retirees who work after retiring will have their health and welfare benefits coordinated with benefits available where they work, with the *Plan*'s benefits being secondary. Benefits are considered to be "available" if the employer pays 80% or more of the premium cost per month for the benefits. If the retiree chooses not to take the available benefits where he or she works, there will be **no benefits** (including optical, dental, and prescription drug) available through the *Plan*.

If you go back to work for 40 hours or more per month for an employer in the retail food industry that does not participate in the *Fund*, the *Fund* will not provide benefits to you or your dependents.

If you go back to work for a *Participating Employer* and again become eligible for FELRA & UFCW Active Health and Welfare Plan ("Active Plan") coverage under the Fund, you have two choices: (1) you may elect to receive Active Plan coverage, or (2) you may choose to waive your Active Plan coverage and continue to receive your Retiree Plan coverage instead. If you elect to receive Active Plan coverage, your Retiree Plan coverage will continue until your Active Plan coverage begins, as long as you otherwise meet the eligibility requirements for Retiree Plan coverage.

Eligibility under the FELRA & UFCW Retiree Health and Welfare Plan and the UFCW Unions & Participating Employers Health and Welfare Fund

- If you are eligible for retiree benefits from the FELRA & UFCW Retiree Health and Welfare Plan, and after you begin to receive those retiree benefits, you subsequently go to work for an employer that participates in the UFCW Unions & Participating Employers Health and Welfare Fund ("Non-Food Health and Welfare Fund"), your Retiree Plan benefits will be suspended when you become eligible for benefits under the Non-Food Health and Welfare Fund as an active employee. If you subsequently retire and are eligible for retiree welfare benefits from the Non-Food Health and Welfare Fund, you may elect benefits under either that Fund or the FELRA & UFCW Retiree Health and Welfare Plan. Your election, once made, cannot be changed.
- If you are eligible to retire from the FELRA & UFCW Pension Fund and are eligible for retiree health and welfare benefits from the FELRA & UFCW Retiree Health and Welfare Plan, and instead of retiring and receiving pension from the FELRA and UFCW Pension Fund, you go to work for a participating employer of the Non-Food Health and Welfare Fund, you will be eligible for Non-Food Health and Welfare Fund benefits only.

  If, when you retire from employment covered by the UFCW Unions & Participating Employers Pension Fund ("Non-Food Pension Fund") you are eligible for retiree health benefits under the Non-Food Health and Welfare Fund, you may elect health benefits from either the Non-Food Health and Welfare Fund or the FELRA & UFCW Retiree Health and Welfare Plan. Your election, once made, cannot be changed. The election is irrevocable.

- If you are eligible for retiree benefits under the FELRA and UFCW Retiree Health and Welfare Plan and, after you begin to receive those benefits:
  1. You become employed by an employer that does not participate in the FELRA and UFCW VEBA Fund or the Non-Food Health & Welfare Fund;
  2. You retire from that employment and are eligible for a pension under a plan that has a reciprocal agreement with the FELRA and UFCW Pension Fund; and
  3. You are eligible for retiree health and welfare benefits under a plan ***other than*** the FELRA & UFCW Retiree Health and Welfare Plan,

  you will no longer be eligible for retiree health benefits under the FELRA & UFCW Retiree Health & Welfare Plan.
- In no event are you entitled to retiree welfare benefits from both the FELRA & UFCW VEBA Fund and the Non-Food Health & Welfare Fund.

Loss of Eligibility

A retiree will cease to be eligible for benefits:

- Upon death.
- If your former employer files for bankruptcy under Chapter 11 of the United States Bankruptcy Code.
- If your former employer no longer participates in the *Fund* and, within 90 days of the last day of the month for which contributions are due from your employer, the succeeding employers do not agree to contribute to the *Fund* on behalf of at least 65% of the number of your former employer's covered employees for the previous month. The 65% contribution obligation will be at contribution rates that will, in the aggregate, fund both active participants' benefits and retiree benefits at the same or higher active rate as is being provided by the remaining employers' collective contributions.
- If you are no longer *Medicare*-eligible or no longer enrolled in *Medicare* Part B.
- When eligibility is otherwise lost under the rules of the *Fund*.

Enrollment Form

In order to enroll for benefits under the Plan you must complete a Retiree Enrollment Form and file it with the *Fund Office*. You can get an enrollment form from the *Fund Office*. Failure to enroll promptly may cause a delay in the start of your benefits. If you become eligible for *Medicare* after you retire, you must enroll in retiree coverage under the Plan within 60 days after you become eligible for *Medicare*. If you do not enroll within 60 days after you become eligible for *Medicare*, you will no longer be eligible for retiree coverage under the Plan. If you have dependent coverage, you must list those dependents on your enrollment form.

Only eligible dependents listed on the enrollment form will be entitled to dependent coverage.

Dependent Eligibility

For Medicare supplemental benefits and medical benefits, eligible dependents include your *Medicare*-eligible spouse and *Medicare*-eligible children, as defined below. For prescription drug benefits, eligible dependents include your *Medicare*-eligible spouse. Your dependents are not eligible for the dental or optical benefits. If you are not eligible for coverage under the Retiree Plan solely because you are not *Medicare*-eligible, your *Medicare*-eligible dependents who otherwise meet the eligibility requirements under the Retiree Plan will remain eligible for dependent coverage under the Retiree Plan.

Eligible dependents include only your spouse and children who were eligible dependents under your Active Plan on the day you retired. For example, if you divorce and subsequently re-marry, your new spouse may not be added as a dependent.

When Your Dependent Becomes Eligible for *Medicare*

When your dependent becomes *Medicare*-eligible, the *Fund* will offer a one-time opportunity to enroll your eligible dependent in coverage under the Retiree Plan.

The *Fund Office* will send you a letter prior to the date your dependent becomes *Medicare*-eligible due to age. You will then have a 60-day opportunity to enroll your dependent in coverage under the Retiree Plan. If you do not enroll your dependent within 60 days, your dependent will no longer be eligible to enroll in coverage under the Retiree Plan. If your dependent becomes eligible for *Medicare* for any reason except age, it is your and your dependent's responsibility to notify the *Fund Office* as soon as your dependent becomes eligible for *Medicare*. Your dependent must enroll in Part B of *Medicare* to be eligible for benefits under the Retiree Plan.

This is a one-time opportunity for enrollment.

Medicare-eligible dependents who enroll under the Plan will receive benefits under the Fund's Kaiser Permanente Medicare HMO program if you live in the Kaiser Permanente service area. If you do not live in the Kaiser Permanente service area, your dependent will be covered under the *Fund's Medicare* Supplemental Benefit. Prescription benefits are included through the Kaiser Permanente *Medicare* HMO, administered through Kaiser Permanente. Prescription benefits for those not in the Kaiser service area who are covered by the Fund's *Medicare* Supplemental Benefit are through Express Scripts, Inc. ("ESI").

If your dependent joins a Medicare Part D prescription program, your dependent's Fund prescription benefits will be terminated.

<u>Medical Benefit Eligibility</u>

Generally, your biological children, adopted children and children placed with you for adoption are eligible for medical benefit coverage as your dependents if they are under age 26.

Stepchildren* and children over whom you have legal custody,** as well as biological children, adopted children, and children placed with you for adoption, who do not meet the above criteria, are eligible for medical benefit coverage as your dependents if they are:

- Under age 19 (unless eligible for student coverage),
- Not married,
- Not employed on a regular full time basis, and
- Dependent on you for financial support.

* To be eligible for coverage, stepchildren must reside with you.

**** You must submit a notarized letter to the *Fund Office* every six months, confirming the continuation of custody.

In order to ensure continued coverage under the Plan, dependents and/or retirees (as applicable) must complete any request for information issued by the *Fund* for the purpose of confirming continued eligibility for benefits. Failure to respond to any such requests may result in the suspension or termination of coverage.

Only your dependents who are covered as your dependents under the FELRA & UFCW Active Health and Welfare Plan at the time of your retirement will have coverage. You may not add dependents after retirement except as a result of life changes such as marriage, the birth of a child, or the adoption or placement for adoption of a child.

A retiree who goes ***back to work*** for a *Participating Employer* may add dependents to his/her coverage. If you didn't choose to cover your dependents while you were actively working (or if you didn't have eligible dependents while you were actively working, but you do now), you may add him/her after returning to work provided you are working for a *Participating Employer.* If you continue to work for a *Participating Employer* after retirement for a minimum of 24 months, you may continue to cover those dependents when you again retire (the second time).

Qualified Medical Child Support Order (QMCSO)

The *Fund* will provide dependent coverage to a child if it is required to do so under the terms of a *Qualified Medical Child Support Order* ("*QMCSO"*). The *Fund* will provide coverage to a child under a *QMCSO* even if the retiree does not have legal custody of the child, and the child is not dependent upon the retiree for support, and regardless of enrollment season restrictions which otherwise may exist for dependent coverage. If the *Fund* receives a *QMCSO* and the participant does not enroll the affected child, the *Fund* will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. You can request a copy of the *Fund's* procedures for determining whether an order is a *QMCSO* by calling or writing to the *Fund Office*.

Reinstatement for Coverage

If a retiree elects to exclude a Medicare-eligible dependent child from coverage, the dependent child may not be reinstated at a later date. If a retiree elects to exclude his/her Medicare-eligible dependent spouse, the dependent spouse may only be reinstated under the following conditions:

- The Medicare-eligible spouse must have been excluded from Fund coverage originally because a benefit plan was available to him/her from another employer.
- The retiree and spouse must attest that another benefit plan was available to the spouse from his/her employer by submitting a signed statement that the spouse was employed and other coverage was available, but is **no longer** available, and must provide a description of the other coverage (a Summary Plan Description of the other coverage will satisfy this requirement).
- The retiree and spouse must also submit a statement from the spouse's employer that the spouse is no longer eligible for coverage due to termination or another specific reason. The statement must include the date eligibility for coverage was lost.

The retiree must also provide the *Fund Office* a written statement specifying the date on which he/she would like coverage for the spouse to be reinstated. Both the retiree and spouse must sign the statement.

The *Fund Office* must be notified of changes in coverage by the 20th of the month **preceding** the month for which reinstatement is requested. Otherwise, the reinstatement will be effective on the first day of the following month.

Loss of Dependent Eligibility

Your dependents cease to be eligible for benefits when:

- You lose your own eligibility (unless your loss of eligibility is due to you not being eligible for *Medicare* and you otherwise meet the Retiree Plan's eligibility requirements).
- The dependent becomes eligible as an employee of a *Participating Employer*.
- The dependent is a spouse and is divorced or legally separated from you. If you and your spouse are physically separated, but not legally separated, your spouse may remain a dependent until the earlier of three years from the date of physical separation or the date of divorce or legal separation.
- In the case of a biological child, adopted child, or child placed with you for adoption, the date the child turns age 26.
- In the case of a stepchild or child over whom you have legal custody, upon the occurrence of the earliest of:
  - The end of the *Calendar Year* in which the child has his or her 19th birthday;
  - The end of the month in which the child begins regular full-time employment;
  - The end of the *Calendar Year* in which the child ceases to be dependent on you for support; and
  - The end of the month in which the child is married.
- In the case of a child placed with you for adoption, when you no longer have a legal obligation to support the child.

Dependents of an eligible participant who will lose eligibility under the Plan may be entitled to continue coverage under the provisions of *COBRA*. See page 27 for more information.

Full Time Student Coverage

Applies to Medicare-eligible Stepchildren and Children over Whom You Have Legal Custody
Student coverage includes medical benefits only.

If an otherwise eligible *Medicare*-eligible dependent child will lose eligibility due to age and the child is not eligible for *COBRA* rights or, if eligible, elects to waive *COBRA* rights, **medical** benefits may continue without additional cost to him or her, provided that he or she:

a. Is enrolled as a full-time student in an accredited school;
b. is unmarried;
c. is financially dependent on you for support; and
d. if eligible, rejects his/her option to elect *COBRA* coverage under the *Fund.*

You must complete a student certification form and return it to the *Fund Office* **before** the child's 20th birthday and annually thereafter for coverage to be continued. Students are eligible for coverage only through the *Calendar Year* in which they become 23. Coverage will terminate on the earliest of the last day of the calendar month in which he/she marries, ceases to be financially dependent on you for support, ceases to be a full-time student, or the end of the *Calendar Year* in which he/she turns age 23.

If you do not complete a student certification form or the child is not enrolled in school at the time he/she loses eligibility for benefits under the *Plan*, the child's coverage under this *Plan* will cease. However, you may submit a subsequent student certification form and obtain coverage from the *Plan* after the applicable waiting period. Contact the *Fund Office* for details concerning student coverage.

Important: In order to receive student coverage for a dependent who is over age 18, he/she must have been your covered dependent under the Plan BEFORE he/she turned age 19.

Student coverage is considered alternative coverage in lieu of *COBRA* continuation coverage. You do not have to pay for student coverage, but you do have to pay for *COBRA* continuation coverage. Because student coverage is offered as an alternative to *COBRA* coverage, when student coverage ends (for whatever reason), the student will not be eligible for *COBRA* coverage.

If a dependent child enrolled in Full Time Student Coverage ceases to be a full-time student at an accredited school because of a *Medically Necessary* leave of absence resulting from a serious

Injury or illness, coverage under this Plan will be extended to the dependent during his or her leave of absence until the earlier of:

1. the one-year anniversary of the date on which the dependent child's leave of absence began; or
2. the date on which the dependent child's coverage under the Plan would otherwise terminate in accordance with this subsection.

To be eligible for this extended coverage, you must provide the Plan with written certification from the dependent child's treating *Physician* that his or her leave of absence from school is *Medically Necessary* and is as a result of a serious illness or *Injury*. The extended coverage will not be provided until the date such certification is received by the *Fund*, but will be retroactive to the date on which his/her leave of absence began.

Coverage for Disabled Dependents

Any unmarried child who otherwise would not be eligible for dependent coverage due to age and who is incapable of self-support because of a physical or mental disability which began **before** he or she exceeded the maximum age for dependent eligibility may continue to be covered as an eligible dependent for all dependent child benefits offered by the Plan, provided that the child elects to waive *COBRA* rights. The child must be dependent upon the participant for support. You must complete a disability certificate annually and return it to the *Fund Office.*

Proof of Eligibility for Dependents

The participant must submit evidence acceptable to the *Fund Office* to certify the eligibility status for each dependent. Only eligible dependents listed on the most recent enrollment form will be entitled to dependent benefit coverage. However, if the *Fund* receives a *QMCSO* and the participant fails to enroll the child covered under the *QMCSO*, the *Fund* will allow the custodial parent or state agency to complete the enrollment form. For more information on *QMCSOs*, see page 22.

The Plan requires you to submit evidence of your dependent(s)' eligibility status – for your children: a birth certificate, adoption papers, or other proof of adoption or placement for adoption acceptable to the *Fund*; for your spouse: a marriage license. In the case of a stepchild, a copy of the divorce decree or other documents indicating custody is required as evidence.

Conversion Option for Dependents

If the retiree dies, the *Medicare*-eligible spouse may continue benefits by self-paying to the Fund under the *Fund's* rules for self-payment. This option, called a "conversion," does not apply to any dependent other than the retiree's *Medicare*-eligible spouse at the time of the retiree's death. The request for conversion coverage must be made within 30 days from the date of the retiree's death.

Call the *Fund Office* for the current rates. Rates are subject to change as the cost of benefits changes. Self-payments must be made by the 25th day of the month before the month for which coverage is desired.

Send your payment to FELRA & UFCW VEBA Fund, 8400 Corporate Drive, Ste. 430, Landover, MD 20785. Write "Retiree Self-Payment" on the front of the envelope. If you do not make payments on time, you will immediately lose the coverage and it will not be reinstated. ***You must contact the Fund Office and elect this conversion option within 30 days from the date of the retiree's death.***

When Two Retirees Are Married

In the case of two retirees who are married, and both are eligible for coverage under the Fund, benefits will be considered separate for each retiree. However, if you elect it, one retiree may be covered as the eligible dependent of the other, when the other is entitled to dependent benefits. (You must have been married before retirement.) Only one *Co-Payment* will then be necessary; however the dependent will not be entitled to optical and dental benefits, (and will receive a lesser prescription drug benefit) and will only receive the coverage available to a retiree's dependent spouse. If two participants are married, one retires, and the other remains active, the retiree may elect coverage as the dependent of the active participant. If the active participant loses eligibility and the retired dependent is *Medicare*-eligible and otherwise meets the eligibility requirements for retiree coverage, the retired dependent can elect to begin coverage as a retiree by making the necessary *Co-Payments.*

Date Benefits Terminate

If you lose your eligibility, benefits terminate as follows:

- The Medicare Supplemental Benefit, including medical benefits, terminate at the end of the calendar month in which you lose eligibility. However, if you are in the *Hospital* when loss of eligibility occurs, these benefits will continue until you are discharged or until the benefits are exhausted, whichever occurs first.
- Dental, optical, and prescription drug benefits terminate on the day you lose your eligibility.

Does Your Dependent Already Have Other Coverage?

See the "Coordination of Benefits" section beginning on page 32 for the rules governing availability of dependent coverage when more than one group plan is available.

RETROACTIVE TERMINATION OF COVERAGE

The *Fund* reserves the right to retroactively terminate your and your dependents' coverage under the Plan if you or any of your dependents engage in fraud and/or intentionally misrepresent or omit a material fact relevant to your Plan coverage, or if you or your *Participating Employer* fail to timely pay any applicable premium or contribution to the *Fund* relating to your benefits. Failure to follow the terms of the Plan, including but not limited to failing to notify the *Fund* of a change in dependent status, accepting benefits in excess of what is covered under the Plan, and accepting benefits after you or your dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having full knowledge of all the eligibility terms of this Plan.

CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (*"COBRA"*) requires that the Plan offer the eligible dependents of retirees the opportunity to pay for a temporary extension of health coverage at group rates in instances where coverage under the Plan would otherwise end, in accordance with the provisions of federal law.

You may have other options available to you if you lose coverage under the Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

Your eligible dependent spouse and children may have an independent right to elect *COBRA* continuation coverage, if any of the following qualifying events result in a loss of dependent coverage or an increase in premiums:

1. Death of the retiree;
2. Divorce or legal separation from the retiree; or
3. A dependent ceasing to be an eligible dependent under the rules of the Plan.

Sometimes, an employer's filing of a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer for whom a retiree worked while covered as an active employee under the Fund, and that bankruptcy results in the loss of retiree health coverage under the Plan, the retiree's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. The retiree will not be eligible for COBRA, based on his or her prior waiver of COBRA coverage as a condition of accepting retiree coverage under this Plan. The retiree's former employer must notify the *Fund* within 30 days of the employer's initiation of bankruptcy proceedings.

Notification Requirements

The covered dependent (spouse or child) must notify the *Administrative Manager* in writing of the following qualifying events within 60 days after the later of (a) the date of the qualifying event; or (b) the date the covered dependent would lose coverage or experience an increase in premiums due to one of the following qualifying events:

- Divorce or legal separation of the retiree from the dependent spouse;
- A dependent child ceasing to be a covered dependent under the rules of the Plan; or
- The death of a retiree.

If the covered dependent fails to notify the *Administrative Manager* of any of these specific qualifying events within the time period set forth above, the dependent will not be eligible to elect *COBRA* continuation coverage. All notifications under *COBRA* must comply with these

provisions. Both the retiree and the affected dependent are jointly responsible for this notice. Notice should be mailed or hand delivered to:

FELRA & UFCW VEBA Fund
Attention: COBRA Department
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361.

The written notice of a qualifying event must include the following information; name and address of affected dependent, retiree's Social Security number, date of occurrence of the qualifying event, and the nature of the qualifying event. In addition, the *Fund* must receive evidence of the occurrence of the qualifying event (for example: a copy of the divorce decree, legal separation agreement, death certificate, or the dependent's birth certificate). Once the *Fund* receives timely notification that a qualifying event has occurred, *COBRA* coverage will be offered to the dependents, as applicable.

Financial Responsibility for Failure to Give Notice

If a retiree or dependent does not give written notice within 60 days of the date of the dependent's qualifying event, and as a result, the Plan pays a claim for a person whose coverage terminated due to a qualifying event, then that person must reimburse the Plan for any claims that should not have been paid. If the person fails 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 retiree, if the person was his or her dependent.

Within 14 days after the *Fund* receives notice of a qualifying event, it will notify the eligible dependent of the right to continuation coverage and the procedures that must be followed to elect such coverage. An Election Form must be completed, signed and returned to the *Administrative Manager* within 60 days of the date that the covered dependent would lose coverage or experience an increase in premiums due to a qualifying event, or if later, within 60 days of the date the *Fund* sent notice of the qualifying event to the dependent. Failure to return the election form on time will terminate the eligible dependent's right to continue coverage.

Coverage may be continued for any eligible dependent properly enrolled on the day before the qualifying event. Each eligible dependent has the opportunity to make an independent election to accept or reject *COBRA* continuation coverage. A child's parents or legal guardian may make an election on behalf of a minor dependent child. Dependent *COBRA* continuation coverage will include only Medicare Supplemental Benefits and medical benefits, and the prescription benefit for an eligible spouse of a retiree. These benefits are described in the "Schedule of Benefits" section starting beginning on page 12.

Each eligible dependent electing continuation coverage will be responsible for making the required premium payments. The cost that the dependent must pay to continue benefits is 102% of the cost of coverage, as determined annually by the *Fund*. The cost is specified in the notice of right to elect continuation coverage sent to the dependent by the *Administrative Manager*. If

your former *Participating Employer* alters the level of benefits provided through the *Fund* to similarly situated active employees, your dependents' coverage and cost also will change.

The *Trustees* will determine the premium for the continued coverage. The premium will not necessarily be the same as the amount of the monthly contribution that a *Participating Employer* makes on the behalf of a covered employee. The premium will be fixed, in advance, for a 12-month period. The *COBRA* premium will be changed at the same time every year for all *COBRA* beneficiaries. Therefore, the premium may change for an individual beneficiary before he or she has received 12 months of *COBRA* coverage.

Payment of Premiums

COBRA premiums must be paid on time. Failure to pay on time will cause a termination of benefits. The first premium must be paid within 45 days of the date that the dependent elects *COBRA* coverage by returning the Election Form. The first payment must cover the period beginning with the first month following the date coverage was lost, to and including the month for which payment is being sent. The date coverage was lost is the last day of the month in which the dependent was actually eligible under the Plan. Subsequent premiums must be received by the *Administrative Manager* by the first day of the month for which coverage is to be continued. (For example, if a dependent wants coverage for October, payment must be submitted by October 1.) If payments are not received within 30 days of the due date, *COBRA* coverage will be terminated and the *Fund* will not accept any further payments. **Dependent(s) will not be billed for the *COBRA* premiums; it is their responsibility to remit the payments on time**.

Claims *Incurred* following the date of the qualifying event but before the eligible dependent has elected continuation coverage will be held until the election has been made and premiums have been paid in full. If the eligible dependent does not make a timely election and pay the premiums, no *Fund* coverage will be provided. Coverage under this Plan will remain in effect only while the monthly premiums are paid fully and on time.

Length of Coverage

Your dependents may receive *COBRA* coverage for a maximum of 36 months if their coverage under the Plan terminates due to:

- The retiree's death;
- The retiree's divorce or legal separation; or
- A dependent child's ceasing to satisfy the *Fund's* rules for dependent status.

Special rules apply in determining the maximum length of *COBRA* coverage if your and your dependents' coverage under the Plan terminates due to the bankruptcy of your former employer. Please refer to paragraph (g) below.

Termination of Coverage

Continuation coverage will terminate upon the earliest of the following events:

a. The *Fund* no longer provides group health coverage to any of its similarly situated dependents;
b. The dependent does not pay the premium due in full by the end of the grace period;
c. The dependent becomes covered under another group health plan other than TRICARE (as an employee or otherwise) and that group health plan does not exclude or limit coverage of pre-existing medical conditions of the dependent;
d. The dependent (spouse or child) becomes eligible for *Medicare*;
e. The dependent spouse is divorced from the retiree and subsequently remarries and is covered under the new spouse's health plan.
f. The retiree's former *Participating Employer* stops participating in the Plan and establishes a new plan, or joins an existing plan, that makes health coverage available to a class of retirees formerly covered under this Plan; and
g. The date that the applicable period of continuation coverage has been exhausted.
h. If the qualifying event giving rise to *COBRA* Coverage is the bankruptcy of the retiree's former employer, *COBRA* coverage for the retiree will terminate upon the earliest to occur of:
    1. Events (a), (b), (c), (e); or
    2. The retiree's death.

    Further, *COBRA* Coverage for the retiree's dependents will continue until the earliest of:
    1. Events (a) through (e);
    2. 36 months after the retiree's death; or
    3. The dependent's death.

If the retiree's former employer changes the level of coverage through this *Fund* for its similarly situated dependents, the dependent's coverage will also change. **It is crucial that dependents keep the *Fund* informed of their current addresses.** If you or a covered family member experiences a change of address, immediately inform the *Fund Office*.

Your dependent must notify the *Fund Office* immediately if he or she becomes covered by any other group health plan. Notice should be mailed or hand delivered to:

Fund Office
Attn: COBRA Department
FELRA & UFCW VEBA Fund
8400 Corporate Drive, Ste. 430
Landover, MD 20785-2361

Your dependent must repay the *Fund* for any claims paid in error do to the failure to notify the *Fund Office* of any other health coverage.

Other Rights

This notice describes your rights under *COBRA*. It is not intended to describe all of the rights available under *ERISA*, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws.

Other Coverage Options besides COBRA Coverage

Instead of enrolling in *COBRA* coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than *COBRA* coverage. You can learn more about many of these options at www.healthcare.gov.

Contact for Additional Information

If you have questions or wish to request additional information about *COBRA* coverage or the health plan, please contact the *Fund Office* as follows:

FELRA & UFCW VEBA Fund
COBRA Department
8400 Corporate Drive, Ste. 430
Landover, MD 20785-2361
301-459-3020

COORDINATION OF BENEFITS

Coordination of Benefits applies when a **participant or eligible dependent** is entitled to benefits under any other kind of group health coverage in addition to the *Fund*. When duplicate coverage exists, the primary plan normally pays benefits according to its Schedule of Benefits, and the secondary plan pays a reduced amount. **The *Fund* will never pay, either as the primary or secondary plan, benefits which, when added to the benefits payable by the other plan for the same service, exceed 100% of the *Usual, Customary, and Reasonable (UCR)* charge.** These provisions apply whether or not a claim is filed under *Medicare* or another plan. The *Fund* is authorized to obtain information about benefits and services available from *Medicare* or other plans to implement this rule.

The following rules apply:
If one plan does not have a coordination of benefits rule, it will be primary. Otherwise, the plan that covers the person as an employee is the primary plan. The plan that covers the person as a dependent is the secondary plan.

If a participant is covered as an employee under more than one plan, the plan with the earliest *Effective Date* of coverage is the primary plan.

Where both parents are covered by different plans, and the parents are not separated or divorced, and the claim is for a dependent child, the primary plan is the plan of the parent whose birthday falls earliest in the year. If both parents have the same birthday, the plan which has covered a parent longer pays first. However, if the other plan does not have a birthday rule and instead has a rule based on the gender of the parent and as a result of this, the two plans do not agree which is primary, the plan of the father will pay first.

If two or more plans cover a child whose parents are separated or divorced, benefits will be paid as follows:

1. If a court determines financial responsibility for a child's health care expenses, the plan of the parent having that responsibility pays first.
2. If a court determination has not been made or the court divides the financial responsibility equally, the plan of the parent with custody pays before the plan of the other parent. The plan of the step-parent married to the parent with custody of the child pays before the plan of the parent who does not have custody.

If a participant or dependent is covered under another health plan as primary and has secondary coverage under the Fund, the Fund will not supplement the primary coverage if that would result in an overall payment that is more than the Fund ***would have paid*** as primary.

Important Information—Read Below!

When an eligible dependent under the Plan is offered a program of health, dental, drug, and/or vision benefits by another employer as a result of his or her employment, and the dependent has the option of selecting the other employer's health coverage or receiving cash or other financial incentive, this Plan coordinates its benefits as if the other employer's health coverage were applicable. It does so even when the dependent **does not** elect the coverage under another employer-sponsored plan.

Before the *Fund* will pay benefits to an employed dependent, he or she must provide the *Fund Office* with information explaining the other employer's health coverage, if any.

Coordination of Benefits with an HMO or Any Other Health Plan

If you have primary coverage through your work under an HMO and secondary coverage under the *Fund* as a dependent, **you must follow the rules of the HMO in order to have remaining balances considered for payment by the *Fund* as secondary payer**. If you go outside of your HMO for services (or otherwise fail to follow the rules of the HMO), and then submit the bill to the *Fund* for secondary payment, it will be denied.

For purposes of coordinating benefits, an HMO is treated the same as any other plan. **If you fail to follow the rules of any primary plan, including an HMO, the *Fund* will not pay benefits as either primary or secondary.**

The *Fund* also has the right to collect any excess payment directly from the parties involved, from the other plan, **or by offset against any future benefit payment from the *Fund*** on the dependent's behalf, if he or she failed to notify the *Fund Office* of the availability of the other employer's health coverage. This right of offset does not keep the *Fund* from recovering erroneous payments in any other manner.

Important: To ensure that the *Fund* coordinates and pays your benefits properly, you must keep the *Fund* informed of any and all coverage available to you and/or your eligible dependent, regardless of whether the dependent elects to receive such coverage.

Coordination of benefits saves the *Fund* money by making sure other plans pay benefits where they are available.

SUBROGATION

Were you or your eligible dependent injured in a car accident or other accident for which someone else may be responsible? If so, that person (or his/her insurance) may be liable for paying your (or your eligible dependent's) Medical expenses and these expenses would not be covered under the *Fund*.

Waiting for a third party to pay for these *Injuries* may be difficult. Since recovery from a third party can take a long time (you may have to go to court) and your creditors will not wait patiently, as a service to you, the *Fund* will advance your (or your dependent's) benefits based on the requirement that **you reimburse the *Fund* in full** from **any** recovery you or your eligible dependent may receive, no matter how it is characterized. This means that you must reimburse the *Fund* if you obtain any recovery from any source, person or entity. This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the *Fund* money (which saves you money too) by making sure that the responsible party pays for claims incurred relating to your or your dependent's injuries.

You and/or your dependent are required to notify the *Fund* within ten days of any accident or *Injury* for which someone else may be liable. Further, the *Fund* must be notified within ten days of the initiation of any lawsuit or settlement negotiations relating to the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the *Fund's* claims.

If you or your dependent receive **any** benefit payments from the *Fund* for any *Injury* or *Sickness*, and you or your dependent recover any amount from any third party or parties in connection with that *Injury* or *Sickness*, you or your dependent must reimburse the *Fund* from that recovery the total amount of all benefit payments the *Fund* made or will make on your or your dependent's behalf in connection with such *Injury* or *Sickness.*

Also, if you or your dependent receive any benefit payments from the *Fund* for any *Injury* or *Sickness*, the *Fund* is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery that has accrued, may accrue or which is asserted in connection with such *Injury* or *Sickness*, to the extent of any and all related benefit payments made or to be made by the *Fund* on your or your dependent's behalf. This means that the *Fund* has an independent right to bring an action in connection with such *Injury* or *Sickness* in your or your dependent's name and also has a right to intervene in any action brought by you or your dependent, including any action against an insurance carrier including under any uninsured or underinsured motor vehicle policy.

The *Fund's* rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the *Injury* or *Sickness*, and regardless of whether you and/or your dependent actually receive the full amount of such judgment, award, settlement, compromise, insurance or order. The *Fund's* rights of

reimbursement and subrogation provide the *Fund* with first priority to any and all recovery in connection with the *Injury* and *Sickness,* whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. This recovery includes amounts payable under your or your dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the *Fund's* rights of reimbursement and subrogation. The *Fund's* rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery.

The *Fund* has a constructive trust, lien and/or an equitable lien by agreement in favor of the *Fund* on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the *Fund* under this Section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the *Fund* until paid to the *Fund*. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the *Fund* in reimbursing it for *Fund* costs and expenses.

Consistent with the *Fund's* rights set forth in this section, if you or your dependent submit claims for or receive any benefit payments from the *Fund* for an *Injury* or *Sickness* that may give rise to any claim against any third party, you and/or your dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" ("Subrogation Agreement") affirming the *Fund's* rights of reimbursement and subrogation with respect to such benefit payments and claims. This Subrogation Agreement also must be executed by your or your dependent's attorney, if applicable. However, even if you or your dependent or a representative of you or your dependent (including your or your dependent's attorney) do not execute the required Subrogation Agreement and the *Fund* nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute your or your dependent's agreement to the *Fund's* right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the *Fund* arose, and your or your dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* on any payment amount or recovery that you or your dependent recovers from a third party.

Any refusal by you or your dependent to allow the *Fund* a right to subrogation or to reimburse the Fund from any recovery you receive, no matter how characterized, up to the full amount paid by the *Fund* on your or your dependent's behalf relating to the applicable *Injury* or *Sickness,* will be considered a breach of the agreement between the *Fund* and you that the *Fund* will provide the benefits available under the Plan and you will comply with the rules of the *Fund.* Further, by accepting benefits from the *Fund*, you and your dependent affirmatively waive any defenses you may have in any action by the *Fund* to recover amounts due under this Section or any other rule

of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, you or your dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your dependent or your attorney may receive as a result of the accident or *Injury*, no matter how these amounts are characterized or who pays these amounts, are excluded from Plan coverage, as provided in this Section.

Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the *Fund* in its exercise of its rights of reimbursement and subrogation, including notifying the *Fund* of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery. If you are asked to do so, you must contact the *Fund Office* immediately. You or your dependent also must do nothing to impair or prejudice the *Fund*'s rights. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. Where you or your eligible dependent chooses not to pursue the liability of a third party, the acceptance of benefits from the *Fund* authorizes the *Fund* to litigate or settle your claims against the third party. If the *Fund* takes legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the *Fund* in seeking its recovery, and in providing relevant information with respect to the accident.

You or your dependent must also notify the *Fund* before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the *Fund* has advanced you, you will still be required to repay the *Fund*, in full, for any benefits it has paid. The *Fund* may withhold benefits if you or your dependent waives any of the *Fund's* rights to recovery or fail to cooperate with the *Fund* in any respect regarding the *Fund's* subrogation rights.

If you or your dependent refuse to reimburse the *Fund* from any recovery or refuse to cooperate with the *Fund* regarding its subrogation or reimbursement rights, the *Fund* has the right to recover the full amount of all benefits paid by any and all other methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party to respond to the *Fund's* inquiries concerning the status of any claim or any other inquiry relating to the *Fund's* rights of reimbursement and subrogation.

If the *Fund* is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the *Fund*, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, *Incurred* by the *Fund* in connection with the collection of any amounts owed the *Fund* or the enforcement of any of the *Fund's* rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the *Trustees* from time to time from the date you become obligated to repay the *Fund* through the date that the *Fund* is paid the full amount owed. The *Fund* has the right to file suit against you in any state or federal court that has jurisdiction over the *Fund's* claim.

MEDICAL BENEFIT

This benefit is only available to retirees and eligible spouses who are not living within the Kaiser Permanente *Medicare* HMO area.

The Fund will supplement payments made by *Medicare* to eligible retirees and dependents, as described in the charts under the Schedule of Benefits on pages 12-15. File your claim with *Medicare* and the *Fund Office* at the same time. When you receive your Explanation of Benefits from *Medicare*, send it to the *Fund Office.* The *Fund* will then process the balance remaining after Medicare has paid, up to the limits of the Plan (see the Schedule of Benefits).

PRESCRIPTION DRUG BENEFIT

This benefit is only available to retirees and eligible spouses who are not living within the Kaiser Permanente *Medicare* HMO area. Retirees and dependents whose medical coverage is provided through Kaiser Permanente also have their prescription coverage provided through Kaiser Permanente. If you are not living within the Kaiser Permanente Medicare HMO area, your Prescription Drug Coverage is provided through Express Scripts, Inc. ("Express Scripts").

NOTE: If you or your dependents join a Medicare Part D prescription program, your *Fund* prescription benefits will be terminated.

The Prescription Drug *Co-Payment* for **Retirees** is:

11% of the cost of the drug when you use a Giant or Safeway pharmacy.

18% of the cost of the drug if you use any other pharmacy in the Express Scripts network.

11% of the cost of the drug if you live outside the geographic area of a Giant or Safeway pharmacy.

The Prescription Drug *Co-Payment* for a **Spouse** is:

25% of the cost of the drug after the annual $200 *Deductible* has been paid.

The *Fund* will pay for *Medically Necessary* prescription drugs which require compounding, legend drugs, insulin, oral contraceptives and injectables, subject to the provisions below. The prescriptions must be written by a *Physician* legally licensed to practice medicine. If a generic drug is available and you receive the brand name drug instead, you will pay the entire cost of the brand name drug. If there is no generic equivalent, the brand name drug will be covered at the applicable *Co-Payment* level.

The *Fund* will pay the balance after you pay the *Co-Payment*, provided the following conditions are met:

1. The prescription is filled by a participating pharmacy. **Note: The *Fund* will not cover prescriptions filled at CVS, Walmart, Walgreens or Rite Aid pharmacies.**
2. You present your ID card with the prescription to the pharmacist.
3. The participating pharmacist fills the prescription to a maximum of 34 days supply, or up to 100 days for approved maintenance drugs.
4. The cost of ingredients exceeding $1000.00 is approved by Express Scripts, Inc.
5. The prescription is not for over-the-counter drugs, appliances, devices, or for legend drugs whose usage has not been pre-approved by the FDA.
6. Oral contraceptives are covered for the retiree or the retiree's spouse only if the retiree was hired before October 1, 1992 and the spouse is an eligible dependent. Oral contraceptives

are limited to three a month supply per prescription. Oral contraceptives for dependent daughters will not be covered unless they are *Medically Necessary* for reasons other than contraception. For approval of coverage of oral contraceptives for a dependent daughter, the participant should contact Express Scripts, Inc. to initiate the prior authorization process.
7. Refills must be authorized by your *Physician*.
8. Prescriptions will only be covered if they are prescribed to treat *Medically Necessary* conditions and are not for cosmetic purposes.
9. Injectables are covered with the regular *Co-Payment* applying. Office visits associated with an injectable are covered under your Comprehensive Medical Benefit.

Needles and syringes ***for administration of insulin only*** are covered under your prescription benefit. Other needles and syringes may be covered using your prescription card.

If you have questions or need assistance in locating the nearest in-network pharmacy, please contact Express Scripts toll free at (800) 903-8325.

Rules Concerning Your Prescription Benefit
1. Drugs for which a person is compensated under a Workers' Compensation law are not covered by the Plan.
2. ***CVS, Wal-Mart, Walgreens, and Rite Aid pharmacies are not part of the Plan's pharmacy network.***
3. No purchase should be made without your Express Scripts ID card.
4. The ID card is NOT TRANSFERABLE and may not be used by anyone other than the person to whom it has been issued.
5. The card is invalid and void if the cardholder loses eligibility under the Plan.
6. If you use your card after eligibility is terminated, you must reimburse the *Fund* for amounts paid.
7. The *Fund* reserves the right to suspend your benefit or to place you on the direct reimbursement program of claim payment when abuse of the benefit is suspected.

Compound Management Program
The Plan will not cover compounded medication products that have little or no proven clinical value and have not been evaluated or verified for safety or efficacy by the Food and Drug Administration ("FDA").

Compound medicines are custom prescriptions mixed by pharmacists based on the prescribing instructions provided by a doctor. In many cases, there are over-the-counter drugs or conventional prescription drugs that serve the same medical purpose as a compound drug. If you are prescribed a compound drug that is not covered under the Plan, ask your doctor if an FDA-approved drug is available and appropriate for your treatment.

Mandatory Formulary and Excluded Medications
The *Fund* maintains a mandatory formulary list for prescription drugs. Prescription drugs that are not on the formulary list will not be covered. If you get a prescription for a drug that is not

on the *Fund's* approved formulary list, the pharmacist will give you a notice showing the equivalent drugs that are on the formulary list.

If you have any questions regarding the *Fund's* approved formulary list, please call the number on your member ID card, or contact the *Fund Office*.

Claims Procedure

1. Upon becoming eligible for benefits, a retiree or dependent will receive a Plan ID card that shows his or her prescription Plan coverage. You should keep the cards in your wallet or purse so you have them with you at all times.
2. Take your *Physician's* prescription to a participating pharmacy.
3. Identify yourself by presenting your ID card.
4. Pay the pharmacist the *Co-Payment*.

If You Forget Your Card

If you forget your ID card when you have your prescription filled, you must pay the full cost of the prescription to the pharmacy and request a reimbursement. Contact the *Fund Office* for the proper forms to complete. You will be reimbursed for the amount that *would have been* reimbursed to the participating pharmacy. When your reimbursement is processed, the check will be made out to you. Claims for reimbursement will only be considered for prescriptions filled within one year of the date the claim was submitted.

Lost Card

If you lose your ID card you can get another, at a cost of $1.00, by contacting the *Fund Office*.

Generic Drugs

Generic drugs are drugs that go by their chemical names and are required to meet the same government standards as brand name drugs. Brand name drugs are much more expensive than generic drugs. Generic drugs are mandatory under the *Fund*, when they are available. If you fill a prescription for a brand name drug when there is a generic equivalent available, you will be responsible for the entire cost of the prescription. Generic drugs will be dispensed automatically (where there is a generic available).

Specific Drug Restrictions

- Prescriptions for drugs such as **Retin-A and Renova** are prescribed primarily for cosmetic reasons and are usually not *Medically Necessary*. They must be accompanied by a written diagnosis from your *Physician* of acne vulgaris or another medical condition in order to be covered. For *Medically Necessary* prescriptions of these drugs, contact Express Scripts to initiate the prior authorization process.
- Erectile dysfunction medications such as **Viagra and Cialis** will be covered to a maximum of 8 tablets per month. You must contact Express Scripts, Inc. at (800) 903-8325 in order to initiate the prior authorization process. Express Scripts will fax your *Physician* a form to indicate your diagnosis that will reflect the approval or denial of your prescription.
- Anti-Obesity drugs will be covered with prior authorization from Express Scripts, Inc. In order

to be approved, the patient must have a Body Mass Index (BMI) of 30 or greater, coupled with another disease indicator. If approved, medication is authorized for a three-month period. If, after three months, the patient has lost at least five pounds, the medication will be approved for up to another nine months. At the end of the first year, if the patient has maintained at least a 5% weight loss from his/her original weight, another year of medication will be approved. At no time will medication be covered for more than a two-year period.

Flu Shots

Immunizations for influenza (flu shots) are covered at any Giant or Safeway pharmacy at **no cost to you** using your Express Scripts prescription ID card. Simply go to your Giant or Safeway pharmacy, show your ESI card, and receive your flu shot.

If you prefer to get your flu shot from your doctor or don't live near a Giant or Safeway pharmacy, the flu shot will be covered under your medical benefits. For participants and dependents with Prescription Drug Benefit coverage, the injection itself is covered at 100% up to the *UCR* fee and the office visit charge is covered under the Medicare Supplemental and Medical benefit.

For participants in Kaiser Permanente HMO, the flu shot is covered in full, with no co-pay if you use a Kaiser *Physician*.

Gardasil Vaccine

The HPV vaccine Gardasil is covered under the Plan for dependent daughters. The vaccine is available as described below.

The shot is available at a Giant or Safeway pharmacy at no cost to you using your Express Scripts ID pharmacy card, provided certain dosage requirements are met, or your dependents may receive the injection at the doctor's office. If the vaccine is administered at the doctor's office, the injection will be covered in full with no *Deductible*, up to the *UCR* charge, and the office visit charge is covered under the Medicare Supplemental and Medical benefit.

You also have the choice of picking up the vaccine at the pharmacy at no charge, and bringing it to the *Physician's* office for administration. If you do that, the office visit charge may be paid under medical, as described above.

SPECIALTY MEDICATIONS/ACCREDO SPECIALTY PHARMACY

Prescriptions for specialty medications are provided through Express Scripts's Accredo Specialty Pharmacy, and not through your local pharmacy. Specialty medications are generally self-injectable medications (excluding insulin) and oral medications for a variety of conditions as such as oncology or transplants.

Specialty Drugs Available through the Accredo Specialty Pharmacy Include but Are Not Limited to:

1. HPN-100 (Ravicti, glycerol phenylbutyrate) – Used to treat urea cycle disorder (UCD). Also known as hyperammonemia.
2. Cysteamine Delayed-Release (DR) – Used to treat Nephropathic cystinosis.
3. Metreleptin – Used to treat diabetes and/or hypertriglycemia in patients with rare forms of lipodystrophy unresponsive to conventional therapies.
4. Tofacitinib – Used to treat moderate to severe rheumatoid arthritis (RA).
5. Lixivaptan – Used to treat hyponatremia.
6. Bosutinib – Used for previously treated Philadelphia chromosome positive (Ph+) chronic myeloid
7. BG-12 (dimethyl fumarate) – Used to treat relapsing-remitting multiple sclerosis (MS).

There are many other specialty medications available through Accredo. If you are prescribed a specialty medication, you must use the Accredo Mail Order Specialty Pharmacy (through Express Scripts). You can order your specialty drugs over the phone by calling (800) 803-2523. If you have a new prescription, you can contact Express Scripts, Inc. for further instructions. The medication will be mailed by priority overnight mail directly to your door. Express Scripts also has a pharmaceutical consulting staff available to answer any questions you may have about your medication.

QUANTITY LIMITS/PRIOR AUTHORIZATION

There are dispensing limits and prior authorization requirements on the following medications. The *Fund's* prescription drug manager, Express Scripts, Inc., developed these guidelines based on the FDA's and the manufacturers' recommended dosages. They were established to help ensure the safe and effective use of these medications.

Nausea and Vomiting Medication	**Dispensing Limit—30 days**
Anzemet	5 tablets
Kytril	10 tablets
Zofran 4 mg, 8 mg and ODT	15 tablets
Emend Pak	12 capsules
Emend 80 mg	8 capsules
Emend 125 mg	4 capsules

Migraine Medication	Dispensing Limit—30 days	
Amerge	9 tablets	
Axert	12 tablets	
Frova	12 tablets	
Imitrex Tablets	9 tablets	
Imitrex Nasal Spray	12 sprays	
Imitrex Injectable	10 syringes	
Imitrex Injectable Kit	4 boxes/8 syringes	
Maxalt	12 tablets	
Zomig	6 tablets	
Relpax	6 tablets	
Anti-Inflammatory Medication	**Dispensing Limit per Rx**	
Toradol	20 tablets per 5 days	
Anti-Inflammatory Cox-2 Inhibitors	**Dispensing Limit per Rx**	
Celebrex 100 mg	30 capsules/30 days	
Celebrex 200 mg	30 capsules/30 days–Prior Authorization Required for Higher Doses	
Celebrex 400 mg	Prior Authorization Required	
Narcolepsy Medications	**Dispensing Limit per Rx**	
Nuvigil	Prior Authorization Required	
Provigil	Prior Authorization Required	
Sleeping Medication	**Dispensing Limit—30 days**	**Annual Limits**
Ambien and Sonata	15 tablets	120 tablets/year

For medications requiring a prior authorization, either you, your *Physician* or your pharmacist will need to contact Express Scripts' customer service help to initiate the prior authorization process. These medications will have specific criteria forms that will be sent to your *Physician* to complete and return. Based on the information that is provided, a determination will be made as to whether or not it has met the approval criteria. Once the determination has been made, both the pharmacy and your *Physician* will be notified.

For prior authorizations, please call Express Scripts's Customer Service at (800) 903-8235.

Diabetic Benefit

If you are *Medicare*-eligible and not in the Kaiser Permanente HMO, diabetic supplies such as glucometers, test strips, and accu-check will be processed through Medicare and the Fund will pay secondary through the Medicare Supplemental and Medical benefit. If you are enrolled in Kaiser Permanente, diabetic supplies are covered by Kaiser. Once you receive your Explanation of Benefits from *Medicare*, send it to the *Fund Office*. The Fund will then supplement Medicare's payment for diabetic supplies **not covered** under the prescription drug benefits with the Medicare Supplemental and Medical benefit.

STEP THERAPY PROGRAM

ONLY FOR RETIREES AND DEPENDENTS NOT ENROLLED IN THE KAISER HMO.

Express Scripts has developed the Step Therapy program based on the manufacturers' recommended guidelines and/or the Express Scripts National Pharmacy & Therapeutics Committee. The program was established to help ensure the safe and effective use of these medications along with promoting the most cost effective medications on the market.

Step Therapy is a process that requires the use of a preferred product or specific criteria to be met before a particular drug can be approved. If a prescription for a medication requiring Step Therapy is presented to the pharmacy, your prescription profile is instantly reviewed when the claim is electronically submitted to Express Scripts, Inc. Based on the history in your file, the prescription claim may be approved automatically. If the prescription is rejected, two options exist. The pharmacist may call the *Physician* to obtain a prescription for the preferred product, or you may pursue approval of the prescription through our prior authorization process. The preferred product must be used before a prescription requiring Step Therapy can be obtained.

Drug Description	Medications Affected	Program Involved
Proton Pump Inhibitors	Prilosec, Omeprazole, Nexium, Aciphex, Prevacid and Protonix	Step Therapy
Anti-Inflammatory Medications	Celebrex	Step Therapy
Asthma/Allergy Medication	Singulair	Step Therapy
NSAIDS	Mobic	Step Therapy

To avoid an extra trip to the pharmacy before filling a prescription for the four types of drugs described above, determine whether you need to try an alternative first or to obtain prior-authorization. If you are unsure or you need to request a prior-authorization, contact Express Scripts at (800) 903-8235.

Requirements for Select Medications

Proton Pump Inhibitor Step Therapy

Proton Pump Inhibitors are medications used to treat frequent heartburn and reflux disease. Prilosec has received FDA approval to be marketed as an over-the-counter (OTC) product at the same 20 mg strength as the prescription product. The prescription products (Aciphex, Nexium, Prevacid, Protonix, and Omeprazole) do not offer any additional benefits as compared to Prilosec OTC.

This program requires participants to try a 30-day trial of Prilosec OTC, prescribed by a *Physician*, ***prior*** to being able to receive any of the prescription products. A prescription from your *Physician* is required even though Prilosec OTC is an over-the-counter product. You will benefit by having a lower prescription co-pay.

When your pharmacy submits a prescription proton pump inhibitor medication to Express Scripts, Inc., the system will look back at your prescription profile to determine if Prilosec had been tried for 30 days. If the system finds that to be true, the claim will automatically be processed without any inconvenience to you. If that trial period is not found in your history, the claim will be rejected with a message to the pharmacy that Prilosec OTC must first be used. If you have used Prilosec OTC but did not submit the claim through Express Scripts, you will need to pursue approval through Express Scripts's Prior Authorization department by calling (800) 903-8325.

Therefore, for this drug class, if you have not done so before, either get a prescription from your doctor for OTC Prilosec or contact Express Scripts to request a prior-authorization.

Medication	Coverage Change
Prilosec OTC	Covered
Rx Prilosec 10, 20 and 40 mg	Not Covered
Omeprazole 10 mg	Covered
Omeprazole 20 mg	Not Covered
Nexium, Protonix Aciphex, Prevacid	Covered after a 30-day trial of any of the covered drugs listed above.

Anti-Inflammatory Medications (COX-2 Inhibitors) Step Therapy

This class of medication is comprised of one brand, Celebrex, with no available generics. This medication is indicated for the treatment of osteoarthritis, rheumatoid arthritis, Familial Adenomatous Polyposis (FAP), and acute pain including primary dysmenorrhea. Published literature states there is no clinical evidence that COX-2 Inhibitors are superior to NSAIDs (non-steroidal anti-inflammatory agents) in providing pain relief. The COX-2 inhibitors should be reserved for participants who have a compelling medical reason to obtain such a medication.

This program covers a COX-2 Inhibitor, without requiring a prior authorization, for participants identified as being at risk for a gastro-intestinal bleed due to age or concurrent drug therapies. If the conditions are not met, the pharmacy will be notified that prior authorization is required. A fax will be sent to the prescribing *Physician* requesting documentation of any of the above criteria. Once the form is returned from the *Physician*'s office, it will be reviewed by the Express Scripts Prior Authorization Department.

If you are not sure whether you qualify for this drug or you need to request a prior authorization, contact Express Scripts at (800) 903-8325.

Asthma / Allergy Medication Step Therapy (Singulair)

Singulair is a medication approved to treat asthma and allergic rhinitis. Allergic rhinitis describes the various symptoms, such as sneezing, itchy/tearing eyes, congestion, and runny nose that

people experience after exposure to dust, pollen, or other airborne particles. It is commonly known as “hay fever.” To treat this condition, several medication options exist. Steroid nasal sprays have been proven superior to Singulair, and antihistamines have been proven equally effective.

This program requires an adequate trial of a steroid nasal spray and antihistamine product in order to obtain a prescription for Singulair. Since Singulair is approved for use in asthma, patients who use Singulair for asthma control will be exempt from the trial of a steroid nasal spray and an antihistamine. If the system does not identify a member as having asthma by instantaneously reviewing the member’s claim history for other standard asthmatic medications, the Singulair claim will be rejected and the pharmacy will be notified that a prior authorization is required. A fax will be sent to the prescribing *Physician* requesting documentation of an asthmatic condition, or documentation of failure on an intranasal steroid and an antihistamine product. Once the form is returned from the *Physician*’s office, a clinician will review the form.

You can contact Express Scripts in advance if you are unsure whether you are identified as having asthma or you need to request a prior authorization.

NSAIDS Step Therapy (Mobic)
Mobic belongs to a class of medications known as the NSAIDs. This class of medications also includes common generic drugs such as ibuprofen, naproxen, and etodolac. Published literature states there is no clinical evidence that Mobic is superior or advantageous for patients requiring an NSAID.

This program requires that a participant has tried a minimum 14-day trial of any three other NSAIDs within the past year. If the system does not identify a member as having tried three NSAIDs, the claim will be rejected and the pharmacy will be notified that a prior authorization is necessary. You, your pharmacist, or *Physician* must then initiate this process by contacting our customer service department. A fax will then be sent to the prescribing *Physician* requesting documentation of the above criteria. Once the form is returned from the *Physician’s* office, it will be reviewed by the Express Scripts Prior Authorization Department. If you are not sure whether you qualify for this drug or you need to request a prior authorization, contact Express Scripts, Inc.

DENTAL BENEFITS

Benefits are provided through Group Dental Service of Maryland ("GDS") and are insured.

The Plan provides dental services to retirees only when performed by a *Participating Dentist*. **Dependents of retirees are not eligible.** Any services rendered by a non-*Participating Dentist*, periodontist, oral surgeon, or orthodontist will NOT be covered by the Plan, except under the circumstances mentioned below.

Claims Procedure
To request a participating provider in the Plan, call Group Dental Service at (800) 242-0450 between 8:00 a.m. – 6:00 p.m., Monday through Thursday and 8:00 a.m. – 5:00 p.m. on Friday. When calling Group Dental Service, please be ready to give your Social Security Number and to take down the name, address, and phone number of the dentist. There are no claim forms necessary when seeing an in-network provider.

Broken Appointments
Many participants need dental services, and broken appointments may keep another person from getting treatment due to scheduling limitations. Therefore, you will be charged ten dollars ($10) **per half-hour** of scheduled appointment time for any broken appointment unless you notified the dentist with whom you had the appointment at least 24 hours **prior to** the scheduled appointment. Until the broken appointment fee is paid, no further dental work will be done. You should plan to be at the dentist's office at least 10 minutes before your appointment time. If you arrive ten minutes late for an appointment, it will be considered a broken appointment and the broken appointment charge will apply.

Important: Any services you receive from a dentist who does not participate with Group Dental Service will NOT be covered under the *Fund*, except under the circumstances mentioned below. Coverage under the Plan is provided only for the least costly, professionally adequate procedure to treat a condition. If you elect a more costly procedure, the Plan will only cover the less costly procedure and you will be responsible for the difference in cost.

Covered services are limited to services provided by a *Participating Dentist* ***except*** under the following circumstances:

1. When referred by a *Participating Dentist* to a non-participating specialist;
2. When authorized in advance by GDS;
3. In the case of an emergency which occurs more than 50 miles from the participant's primary dentist if the participant or eligible dependent is temporarily away from home and outside the GDS service area, in which case GDS will reimburse the participant for dental expenses relating to minor procedures for the palliative relief of pain to a limit of $50 per occurrence. "Emergency" means an unforeseen situation requiring services necessary to treat a condition or illness that, without immediate dental attention, would result in unalleviated acute dental pain, dental infection, and/or dentally related bleeding;
4. When the participant does not live or work within 20 miles or 30 minutes of a *Participating Dentist*.

Dental expenses *Incurred* in connection with any dental procedure started prior to your *Effective Date* of coverage are excluded.

Schedule of Dental Benefits

Procedure Code	Description	Member Co-Pay
Diagnostic & Preventative		
D0120	Periodic Oral Exam	N/C
D0140	Limited Oral Evaluation–Problem Focused	N/C
D0150	Comprehensive Oral Evaluation	N/C
D0170	Re-evaluation–Limited, Problem Focused	N/C
D0210	Intraoral–Complete Series. Including Bitewings (once per three years)	N/C
D0220	Intraoral-Periapical-First Film	N/C
D0230	Intraoral-Periapical-Each Additional Film	N/C
D0240	Intraoral–Occlusal Film	N/C
D0270	Bitewings–Single Film	N/C
D0272	Bitewings–Two Films	N/C
D0273	Bitewings and Three Radiographic Images	N/C
D0274	Bitewings–Four Films	N/C
D0277	Vertical Bitewings–7 to 8 Films	N/C
D0330	Panoramic Film (once per three years)	N/C
D0340	Cephalometric Film	N/C
D0460	Pulp Vitality Tests	N/C
D1110	Prophylaxis–Adult (6 months)	N/C
Basic Restorative		
D2140	Amalgam–One Surface, Primary or Permanent	N/C
D2150	Amalgam–Two Surfaces, Primary or Permanent	N/C
D2160	Amalgam–Three Surfaces, Primary or Permanent	N/C
D2161	Amalgam–Four or More Surfaces, Primary or Permanent	N/C
D2330	Resin–One Surface, Anterior	N/C
D2331	Resin–Two Surfaces, Anterior	N/C
D2332	Resin–Three Surfaces, Anterior	N/C
D2335	Resin–Four or More Surfaces or Incisal Angle	N/C
D2390	Resin–Crown, Anterior	N/C
Procedure Code Description Member Co-Pay		
Basic Restorative		
D2391	Resin–One Surface, Posterior	N/C*
D2392	Resin–Two Surfaces, Posterior	N/C*
D2393	Resin–Three Surfaces, Posterior	N/C*
D2394	Resin–Four or More Surfaces, Posterior	N/C*
**GDS pays up to the cost of Amalgam, patient pays the difference.*		

Procedure Code	Description	Member Co-Pay
	Crowns (Single Restorations)	
D2740	Crown–Porcelain/Ceramic Substrate	$125
D2750	Crown–Porcelain fused to High Noble Metal	$125
D2751	Crown–Porcelain Fused to Predominately Base Metal	$125
D2752	Crown–Porcelain Fused to Noble Metal	$125
D2790	Crown–Full Cast High Noble Metal	$125
D2791	Crown–Full Cast Predominately Base Metal	$125
D2792	Crown–Full Cast Noble Metal	$125
D2920	Re-cement Crown	N/C
D2931	Prefabricated Stainless Steel Crown–Perm. Tooth	$30
D2932	Prefabricated Resin Crown	$30
D2940	Sedative Filling	N/C
D2950	Core Buildup, Including Any Pins	N/C
D2951	Pin Retention–Per Tooth, in Addition to Restoration	N/C
D2952	Cast Post & Core in Addition to Crown	N/C
D2954	Prefabricated Post & Core in Addition to Crown	N/C
D2980	Crown Repair, by Report	N/C
	Endodontics–Local 400 Retirees Only	
D3110	Pulp Cap Direct (excl. final restoration)	N/C
D3120	Pulp Cap Indirect (excl. final restoration)	N/C
D3220	Therapeutic Pulpotomy (excl. final restoration)	N/C
D3310	Anterior Root Canal Therapy (excl. final restoration)	N/C
D3320	Bicuspid Root Canal Therapy (excl. final restoration)	N/C
D3330	Molar Root Canal Therapy (excl. final restoration)	N/C
D3346	Re-treatment of Previous Root Canal, Anterior	*
D3347	Re-treatment of Previous Root Canal, Bicuspid	*
D3348	Re-treatment of Previous Root Canal, Molar	*
	Procedure Code Description Member Co-Pay	
	Endodontics–Local 400 Retirees Only	
D3410	Apicoectomy/Periradicular *Surgery*, Anterior	N/C
D3421	Apicoectomy/Periradicular *Surgery*, Bicuspid, 1st Root	N/C
D3425	Apicoectomy/Periradicular *Surgery*, Molar, 1st Root	N/C
D3426	Apicoectomy/Periradicular *Surgery* (each additional root)	N/C
D3430	Retrograde Filling (per root)	N/C
	N/C = No Charge	
	** GDS will pay up to the cost of root canal, patient pays the difference.*	
	Removable Prosthetics	
D5110	Complete Upper Denture (Includes adjustments)	$30
D5120	Complete Lower Denture (Includes adjustments)	$30

Procedure Code	Description	Member Co-Pay
D5130	Immediate Upper Denture (Includes adjustments)	$30
D5140	Immediate Lower Denture (Includes adjustments)	$30
D5211	Upper Partial Resin Base (Includes adjustments)	$30
D5212	Lower Partial Resin Base (Includes adjustments)	$30
D5213	Upper Partial–Cast Metal Frame w/Resin Base	$30
D5214	Lower Partial–Cast Metal Frame w/Resin Base	$30
D5410	Adjust Complete Denture–Upper	N/C
D5411	Adjust Complete Denture–Lower	N/C
D5421	Adjust Partial Denture–Upper	N/C
D5422	Adjust Partial Denture–Lower	N/C
D5510	Repair Broken Complete Denture Base	N/C
D5520	Replace Missing/Broken Tooth–Complete Denture–Each Tooth	N/C
D5610	Partial Denture–Repair Resin Sole/Base	N/C
D5620	Partial Denture–Repair Cast Framework	N/C
D5630	Repair or Replace Broken Clasp	N/C
D5640	Partial Denture–Replace Broken Tooth–Per Tooth	N/C
D5650	Add Tooth to Existing Partial Denture	N/C
D5660	Add Clasp to Existing Partial Denture	N/C
D5670	Replace All Teeth & Acrylic on Cast Metal Frame (Upper) Four or More	N/C
D5671	Replace All Teeth & Acrylic on Cast Metal Frame (Lower) Four or More	N/C
D5730	Reline Complete Upper Denture (Chairside)	N/C
D5731	Reline Complete Lower Denture (Chairside)	N/C
D5740	Reline Upper Partial (Chairside)	N/C
D5741	Reline Lower Partial (Chairside)	N/C
	Removable Prosthetics	
D5750	Reline Complete Upper Denture (Lab)	N/C
D5751	Reline Complete Lower Denture (Lab)	N/C
D5760	Reline Upper Partial (Lab)	N/C
D5761	Reline Lower Partial (Lab)	N/C
	Fixed Prosthetics, per Unit (each retainer and each pontic constitutes a unit in a fixed partial denture)	
D6210	Pontic–Cast High Noble Metal	$125
D6211	Pontic–Cast Predominately Base Metal	$125
D6212	Pontic–Cast Noble Metal	$125
D6240	Pontic–Porcelain to High Noble Metal	$125
D6241	Pontic–Porcelain to Predominately Base Metal	$125
D6242	Pontic–Porcelain Fused to Noble Metal	$125
D6245	Pontic–Porcelain/Ceramic	$125
D6545	Retainer–Cast Metal Resin Bonded Bridge	$50
D6740	Crown–Porcelain/Ceramic	$125

Procedure Code	Description	Member Co-Pay
D6750	Bridge Crown–Porcelain to High Noble Metal	$125
D6751	Bridge Crown–Porcelain to Predominately Base Metal	$125
D6752	Bridge Crown–Porcelain Fused to Noble Metal	$125
D6783	Bridge Crown–Porcelain/Ceramic	$125
D6790	Bridge Crown–Full Cast High Noble Metal	$125
D6791	Bridge Crown–Full Cast Predominately Base Metal	$125
D6792	Bridge Crown–Full Cast Noble Metal	$125
D6930	Re-cement Bridge	N/C
	Oral Surgery	
D7111	Coronal Remants–Deciduous Tooth	N/C
D7140	Extraction, Erupted Tooth or Exposed Rood	N/C
D7210	Surgical Removal of Erupted Tooth (including removal of bone and/or section of tooth)	N/C
D7220	Remove Impacted Tooth–Soft Tissue	N/C
D7230	Remove Impacted Tooth–Partially Bony	N/C
D7240	Remove Impacted Tooth–Completely Bony	N/C
D7241	Remove Impacted Tooth–Completely Bony, Unusual	N/C
D7250	Surgical Removal of Residual Roots	N/C
D7310	Alveoplasty in Conjunction w/Extractions, per Quad	N/C
D7510	Incision & Drainage of Abscess–Intraoral Soft Tissue	N/C
	Orthodontics	
D8090	Comp. Orthodontic Treatment–Adult Dentition - 2 year program $425 per year, plus $75 on completion	
	Miscellaneous	
D9110	Palliative (Emergency) Treatment of Dental Plan–Minor Procedure	N/C
D9215	Local Anesthesia	N/C
D9220	General Anesthesia–1st 30 Min. (Extractions Only)	N/C*
D9221	General Anesthesia–Each additional 15 minutes (Extractions Only)	N/C*
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide (Extractions Only)	N/C*
D9241	IV Sedation/Analgesia–1st 30 Min. (Extractions Only)	N/C*
D9242	IV Sedation/Analgesia–Each additional 15 minutes (Extractions Only)	N/C*
D9248	Non-Intravenous Conscious Sedation	N/C
D9310	Consultation (by dentist other than attending dentist)–per Session	N/C
D9999	Broken Appointment Charge (per ½ hour)	$10

- See notes on next page

- Anesthesia and/or general anesthesia is covered only when administered in an oral surgeon's office for extractions and other related services.
- N/C–No Charge
- Procedures not shown are not covered by Dental Plan
- When gold is used, there will be a gold surcharge. Surcharges will depend on the market price. Patient will be advised of the surcharge before performance of procedure.
- If a condition can be treated by more than one procedure, GDS will only cover the least costly professionally adequate service.

Exclusions and Limitations

Any service that is not specifically listed above as a covered dental service is excluded. In addition, the following exclusions and limitations apply to the Dental Benefit:

1. Prophylaxis (cleaning), including scaling and polishing, is limited to once every six months.
2. Dentures are limited to one partial or complete denture per arch within a five-year period.
3. Orthodontia coverage, when provided, is limited to:
   a. Diagnosis, including models, photographs, x-rays, and tracings.
   b. Active fully banded treatment, including necessary appliances and progress x-rays.
   c. Retention treatment following active treatment (not to exceed 10 visits in any 18-month period).
   d. Phase I (interceptive orthodontic treatment) is not covered.
   e. Benefits will not be provided beyond a period of 24-consecutive months of active treatment, nor beyond a period of 18-consecutive months of retention treatment.
   f. The Plan will not be liable for the replacement and/or repair of any appliance that was not initially furnished by GDS.
   g. Benefits will be provided to a participant not more than once within a five-year period.
   h. Patients must be age 11 or older.
4. Cosmetic services are excluded. Cosmetic services are those which are elective and which are not necessary for good dental health. Cosmetic services include, but are not limited to:
   a. Alteration or extraction and replacement of sound teeth.
   b. Any treatment of the teeth to remove or lessen discoloration except in connection with endodontic treatment.
5. Examination, evaluation, and treatment of temporomandibular joint (TMJ) pain dysfunction are excluded.
6. Replacement of dentures, bridgework, or any other dental appliances previously supplied by GDS due to loss or theft is not covered unless the participant received such appliance before the immediately preceding five-year period.
7. Dental expenses *Incurred* in connection with any dental procedure stated before a participant's *Effective Date* of coverage under the *Fund* are excluded. Examples include orthodontic work in progress and teeth prepared for crowns.
8. Hospitalization for any dental procedure is not covered.
9. Drugs, whether prescribed or over-the-counter, are not covered through GDS.
10. Dental implants and any prosthesis, crown, bridge, or denture associated with a dental implant are excluded.

11. Services rendered by prosthodontic specialists are excluded.
12. Procedures requiring fixed prosthodontic restorations that are necessary for complete oral rehabilitation or reconstruction are excluded.
13. Procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion are excluded.
14. General anesthesia is covered only when administered in an oral surgeon's office for extractions.
15. Treatment for malignancies, cysts, neoplasms, or congenital malformations is excluded.
16. Services for *Injuries* or conditions that are covered under workers' compensation or employer's liability laws are not covered; services that are provided by any municipality, country, or other political subdivision without cost to the participant are not excluded.
17. There is a replacement limit of one **every five years** for crowns, bridges, and dentures.
18. New services performed after the last day of the month in which a participant ceases to be eligible under the Plan are excluded, except as provided under the Continuation of Coverage (*COBRA*) provision.
19. Any service that the appropriate regulatory board determines was provided as a result of a prohibited referral.
20. Bitewing x-rays are limited to once every twelve (12) months, and are limited to four (4) bitewings except for bitewing x-rays required under procedure code D0277. Vertical Bitewings (D0277) are limited to once per 3 year period and will not be covered if performed in conjunction with the benefits listed under procedure codes D0210, D0220, D0230, D270, D0272, D0273, D0274 or D0330.
21. Amalgams and Composites (listed under procedure codes D2140 to D2394) are limited to one restoration per surface every 2 year period, per tooth.
22. Post and Cores (procedure codes D2952, and D2954) are limited to one per 5 year period per tooth and will not be covered instead of, in addition to, or within 2 years of Amalgams and Composites (procedure codes D2140 to D2394).
23. Crowns are limited to one per tooth per five (5) years.
24. Root canals (procedure codes D3310, D3320, D3330) are limited to once per tooth per lifetime.
25. Core Buildup and Pin Retention (procedure codes D2950 and D2951) are limited to once per 5 year period, per tooth.
26. Relines and rebases of existing removable dentures are limited to once per twenty-four (24) month period.

Grievance Procedure

Grievances or complaints may be directed orally or in writing to the GDS Administrative Office at 111 Rockville Pike, Suite 950, Rockville, MD 20850, telephone number (800) 242-0450. A Member Services representative will personally handle your complaint and attempt to resolve it in an equitable and fair manner. You will be told, either verbally or in writing, about the outcome of your complaint within twenty (20) days of the date it was received by GDS, unless you agreed to extend this period.

Appeals Process

If your dental claim is denied by GDS and you are not satisfied with the result of the GDS Grievance Procedure, described above, or you do not wish to file a grievance, you have the right to appeal the denied claim within 180 days of the denial. GDS's Manager of Member Services will handle your complaint if it concerns administrative issues, fee disputes, communication of covered services, or a question of eligibility. If the complaint concerns quality of care, your appeal will be decided by GDS's Director of Quality Assurance. In either case, the appeal must be made by a written request to the Member Services representative. The Manager of Member Services or the Director of Quality Assurance will attempt to reach a fair and equitable decision within 14 days following receipt of all the pertinent information. The decision will be conveyed to you in writing. If you are dissatisfied with the result of the appeal, you may appeal the decision by writing to the Board of *Trustees* of the *Fund*. **These procedures in no way limit any rights you may have to appeal directly to the Board of *Trustees* as explained below.**

Appeals

If you have a dental claim denied by Group Dental Service of Maryland (GDS), you have the right to appeal within 180 days of the denial. If GDS denies your appeal, the *Fund* offers you an additional 45 days from the date of GDS's denial to appeal to the Board of Trustees. In this case, appealing to the Board of Trustees is entirely voluntary and will not affect your legal right to bring suit against GDS under ERISA. However, please note the following if you choose to take advantage of this option:

(1) Upon request and free of charge, the *Fund* will provide you with information relating to a voluntary level of appeal. This information will be sufficient to enable you to make an informed judgment about whether to submit your denied dental benefit claim to the Board of Trustees. It will also include a statement that your decision (as to whether to submit your dental benefit dispute to this voluntary level of appeal) will have no effect on your right to any other benefit under the Plan. Additionally, it will include information about applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker (such as financial or personal interests in the result of any past or present relationship to any party in the review process).
(2) You may elect to file a voluntary appeal to the Board of Trustees only after your appeal has been denied by GDS.
(3) The *Fund* will not impose any fees or costs on you as part of this voluntary appeal.
(4) The time it takes to decide your appeal under this voluntary appeal process will not be counted against you in determining whether any lawsuit you file afterward is brought in a timely manner.
(5) Your appeal to the Board of Trustees must be submitted in writing within 45 days of the date you receive your appeal denial from GDS.
(6) Unless received within 30 days of the meeting, the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal.
(7) If your appeal is received within 30 days of the Board of Trustees quarterly meeting, it will be

reviewed at the second quarterly meeting following receipt of the appeal.

(8) If special circumstances require an extension of time beyond the second quarterly meeting, you will be notified in writing of the circumstances and the date on which a decision is expected. In no event will the decision be made later than the third quarterly meeting after receipt of your appeal, and

(9) The Board of Trustees will send a written notice, approving or denying your appeal, within five days of its decision.

OPTICAL BENEFITS

Dependents of Retirees are not eligible for Optical Benefits.

Benefits are provided and guaranteed pursuant to an insurance contract with Advantica

Advantica is your optical provider. They have an expanded network with providers located in major malls and other convenient locations, such as Pearl Vision, Sears, and JC Penney, as well as many individual providers.

The *Fund* will provide optical benefits once every two years. There will be no charge to you when the services are rendered by an *Optometrist* participating in the Advantica network.

The following optical benefits are covered:

1. A complete eye examination by a licensed *Optometrist*, which includes the following:
   - Patient's personal and family history;
   - Visual acuity;
   - Manifest refraction;
   - Intraocular pressures;
   - Biomicroscopy findings; and
   - Fundus evaluation with pupil dilation on all initial examinations and subsequently based on *Medical Necessity* and participant request.
2. A pair of eyeglasses, if prescribed, including:
   a) An allowance of up to $100 toward the cost of frames, plus a discount of 15% on the cost that exceeds $100; and
   b) Clear glass or plastic lenses, either:
      Single vision,
      Bifocal: TK, FT22, FT25, FT28, or executive, or
      Trifocal: 7x25, 7x28
3. Minor repairs and adjustments to eyeglasses.
4. Scratch resistant coating available at discounted pricing.

Exclusions and Limitations

The following exclusions and limitations apply to the Optical Benefit:

1. Unless they are *Medically Necessary*, cosmetic items are not covered by the program, but they are available for purchase at a discount. Such items include, but are not limited to:
   a. Solid and gradient tints
   b. Photosensitive lenses
   c. Oversized and specialty lenses
   d. Cataract lenses
   e. Non-prescription lenses, including sunglasses
   f. Contact lenses
2. Medical and surgical treatment of the eyes.
3. Post cataract refraction .
4. Orthoptics or vision training.

5. Low-vision aids.
6. Services or materials provided as a result of any workers' compensation law or similar legislation.
7. Any eye examination required by an employer as a condition of employment.
8. Two separate pairs of glasses in lieu of bifocals or trifocals.
9. *Experimental* or non-conventional treatment or devices.

Non-Covered Optical Benefits

Please check with Advantica before purchasing any non-covered service or supply so that you know the cost that you will be responsible for ahead of time. Check with Advantica for possible discounts on non-covered items such as frames or upgrades including: Standard AR, Standard UV, Standard Scratch Coating, Standard Tint.

Locating an Advantica Provider

To locate the most current providers in the Advantica network, visit www.advanticabenefits.com/Members/Provider_Search. The names of providers are updated regularly. You can also call Advantica Customer Service toll free at (866) 425-2323.

Important

Any services you receive from an *Optometrist* who does NOT participate with Advantica will NOT be covered under the Plan.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to all benefits payable under the Plan, except as otherwise specifically provided under the Plan or by applicable law.

1. Work-related *Injuries* or *Sicknesses* that are generally compensable under workers' compensation legislation, occupational disease act legislation, employer's liability law or other similar legislation. If, *except for* your failure to follow the appropriate procedural requirements for filing a claim or to otherwise similarly act, your claim *would have been compensable by workers' compensation*, the *Fund* will treat the claim as compensable by *workers' compensation* and excluded from coverage under the Plan.
2. Care furnished to you or your eligible dependent under the laws of the United States or any political subdivision thereof.
3. Care provided to you or your eligible dependent(s) to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your eligible dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your dependent, or you or your dependent's attorney may receive as a result of the accident or *Injury*, no matter how these amounts are characterized or who pays these amounts, as provided in the "Subrogation" section on page 34.
4. Disease or *Injuries* resulting from any war, declared or undeclared.
5. Dental care and treatment to the natural teeth and gums except as provided in the "Dental Benefit" section starting on page 48.
6. Dental *Surgery* or dental appliances to replace the natural teeth and gums unless such charges are necessary due to *Accidental Injury* to physical organs or parts.
7. Appliances or treatment related to bite corrections.
8. Services incidental to dental *Surgery*, including care of the teeth, dental structures, alveolar processes, dental caries, extractions, corrections of impactions, gingivitis, orthodontia, and prostheses, except as provided under the "Dental Benefit" section on page 48.
9. Hearing aids and the examination for them.
10. Eyeglasses and the examination for prescription or fitting other than as provided in the "Optical Benefits" section on page 57 except when necessary as a result of eye *Surgery*; operations performed to correct vision when it is possible to correct vision by using lenses covered under the Optical Benefit of this Plan.
11. Services for cosmetic purposes except those previously specified as covered, unless necessary to correct conditions resulting from traumatic *Injuries*.
12. Complications resulting from cosmetic *Surgery* are not covered.

13. Services or supplies not *Medically Necessary* for the treatment of *Sickness* or *Injury* (e.g., routine immunizations, screening examinations including x-ray examinations made without film, routine or periodic physical examinations except where previously defined as covered).
14. Services or supplies for treatment of infertility or contraception except as specifically provided for in the "Prescription Drug Benefit" section on page 39. Surgical implantation of Norplant is not covered.
15. Services or supplies related to sterilization reversal.
16. Travel, whether or not recommended by a *Physician*.
17. Convalescent, milieu, custodial care, sanitaria care, or rest cures.
18. Services or supplies covered under any federal or state program of health care for the aged, including but not limited to *Medicare*, except to the extent required by federal law.
19. Services, supplies, or medications rendered in a nursing home or extended care facility.
20. Supplies and medications primarily for dietary control.
21. Rehabilitative therapy not specifically covered herein, including, but not limited to, speech, occupational, recreational, or educational therapy, or forms of non-medical self-care or self-help training; and any related *Diagnostic Testing* provided on an *Outpatient* basis;
22. Air conditioners, humidifiers, dehumidifiers, purifiers, and all similar equipment.
23. Care for nervous and mental conditions, including drug addiction and alcoholism.
24. Care for quarantinable diseases in special institutions.
25. Except as provided in the "Prescription Drug Benefit" section on page 39, all drugs and medicines other than those provided in the *Hospital*.
26. Services or supplies which are in excess of the *UCR* amount.
27. Organ transplant expenses in excess of $1 million for each different organ transplanted. Replacement transplants, and related services following the replacement transplant, are not covered.
28. Any service which is made available without charges, not including Medicaid or services provided only to insured persons.
29. Services rendered by a provider who is a member of the participant's or dependent's immediate family (parent, spouse, brother, sister, or children).
30. Telephone consultations with patients, charges for failure to keep a scheduled visit, or charges for completion of forms.
31. Pre-admission *Diagnostic Testing* relating to an *Inpatient* admission which is not covered under the Plan.
32. Administration of oral chemotherapeutic agents.
33. Well Baby Care and immunizations.
34. Domestic or housekeeping services.
35. Treatment of autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or mental retardation.
36. Meals-on-wheels and similar food arrangements.
37. Services performed by interns, residents, or *Physicians* who are employees of a *Hospital* and whose fees are charged for, by, or payable to, a *Hospital* or other institution.
38. Treatment, care, or services through a medical department or clinic, or similar services provided or maintained by a *Participating Employer* except standard pharmacy services provided by *Participating Employer* pharmacies;

39. Injections of varicose veins.
40. Injections for treatment of hemorrhoids or hernias.
41. Injection of cortisone or other preparations, except for trauma or acute suppurative infections.
42. Care of corns, bunions (except capsular or bone *Surgery* therefore), calluses, nails of the feet, fallen arches, weak feet, chronic foot strain, routine care for or symptomatic complaints of the feet, except when major *Surgery*, as defined by the *Trustees*, is performed, or in conjunction with the treatment of diabetes.
43. Routine or periodic physical examinations and screening examinations including x-ray examinations made without film except for PAP smears and mammograms, as previously described.
44. Services, supplies, drugs, devices, medical treatment, procedures or care of any kind which is *Experimental* in nature, or which is not accepted practice by the medical community practicing as determined by the *Fund* (see "*Experimental*" under "Definitions" section).
45. Consultation services are not available with medical or surgical services when they are performed by the same *Physician* during the same *Hospital* admission, except in the sole discretion of the Board of *Trustees*.
46. Unless otherwise stated, *Injuries* resulting from an act of domestic violence or from a medical condition (including a mental health condition), are not excluded solely because the source of *Injury* was an act of domestic violence or a medical condition.
47. Services or care of any kind other than those defined and limited in this Plan.

MENTAL HEALTH/SUBSTANCE ABUSE BENEFIT

Benefits are provided through the Fund, not insured.
Claims are administered by Beacon Health Options.
This section does not apply to you if you are enrolled in Kaiser Permanente HMO.

Mental Health and Substance Abuse claims which have been paid in part by Medicare are eligible for supplemental payment under the Fund, as described on pages 14 and 15. See the "Claims Filing and Review Procedures" and the "Claims Review – Types of Claims" sections beginning on page 70 for more information and provisions that apply to your claims.

Note: The Plan does not impose on mental health or substance abuse benefits any financial requirements or treatment limits that are more stringent than those that apply to medical/surgical benefits in the same classification, as defined by applicable law and regulations. With respect to non-quantitative treatment limitations, the Plan applies criteria (including evidentiary standards, strategies and processes) that are comparable to, and no more stringent than, criteria for such limitations for medical/surgical benefits.

DEFINITIONS

ACCIDENTAL INJURY. Bodily *Injury* arising out of an accident. All *Injuries* sustained in connection with one accident will be considered one *Injury*. *Accidental Injury* does not include ptomaine poisoning, disease or infection (except pyogenic infection occurring through an accidental cut or wound).

ADMINISTRATIVE MANAGER. The company responsible for receiving *Participating Employer* contributions, keeping eligibility records, paying claims, and providing information to you about the *Fund*. The company is Associated Administrators, LLC, referred to as the "*Fund Office*" throughout this book.

CALENDAR YEAR. A calendar year from January 1st through December 31st.

COBRA. Consolidated Omnibus Budget Reconciliation Act of 1985. Provides for continuation of benefits under certain circumstances for participants and their eligible dependent(s) when benefits are lost. See page 27.

COLLECTIVE BARGAINING AGREEMENT. The agreement or agreements between a *Participating Employer* and the United Food and Commercial Workers Unions, Local 27 or Local 400, which require contributions to the *Fund*.

CONCURRENT CARE CLAIM. A *Pre-Service Claim* related to an ongoing course of treatment or a number of treatments over time.

CO-PAYMENT OR CO-INSURANCE. The out-of-pocket amount a participant or dependent is responsible for paying when receiving benefits.

DEDUCTIBLE. The out-of-pocket amount a participant or dependent must pay prior to receiving benefits from the *Fund*.

DIAGNOSTIC TEST. A medical procedure, test, service, or study for determining a *Sickness* or condition. Must be ordered by and performed by (or under the direction of) a *Physician* and may not be *Experimental* in nature.

DURABLE MEDICAL EQUIPMENT.
Equipment which:

1. Can withstand use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of a *Sickness* or *Injury*; and
4. Is appropriate for use in the home.

EFFECTIVE/ELIGIBILITY DATE. According to the Eligibility Rules, the date on which coverage for a retiree or dependent begins.

ERISA. The Employee Retirement Income Security Act of 1974, and regulations thereunder, as amended from time to time.

EXPERIMENTAL. A drug, device, medical treatment, or procedure is considered *Experimental* or investigative **unless**:

- The approval of the U.S. Food and Drug Administration and approval for marketing the drug or device has been given at the time the drug or device is furnished;
- The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other such body serving a similar function, if federal law requires such review or approval;
- Reliable evidence shows that the drug, device, medical treatment, or procedure is **not** the subject of on-going Phase I or Phase II clinical trials, or the research, experimental study, or investigational arm of ongoing Phase III clinical trials, or is **not** otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Notwithstanding the above, a drug, device, medical treatment, or procedure that is administered as part of a clinical trial is not considered *Experimental* to the extent the *Fund* is required by law to cover it.

EXPLANATION OF BENEFITS ("EOB"). A comprehensive statement of how a claim was processed.

FUND. The Food Employers Labor Relations Association & United Food and Commercial Workers VEBA Fund.

FUND OFFICE. The "*Administrative Manager*" of the *Fund* (as defined above) is also referred to as the "*Fund Office*." Associated Administrators, LLC is the *Administrative Manager* for this Plan, and acts as the "*Fund Office*."

HOSPITAL. A legally constituted general hospital which provides diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons,

and which is not, other than incidentally, a nursing home or a place for rest, the aged, substance abusers, or alcoholics. The definition specifically includes institutions which provide treatment for pulmonary tuberculosis or for mental disorders.

INCURRED. A charge will be considered "*Incurred*" on the date a participant or dependent receives the service or supply for which the charge is made.

INJURY. Bodily injury caused by an accident and resulting, directly and independently of all other causes, in loss which is covered by the Plan. All *Injuries* sustained in connection with one accident will be considered one *Injury*.

INPATIENT. A participant or eligible dependent who receives treatment while a registered bed patient in a *Hospital* or facility and for whom an overnight room and board charge is made.

MEDICAL CARE. Professional non-surgical services rendered by a *Physician* for the treatment of a *Sickness* or *Injury*.

MEDICALLY NECESSARY OR MEDICAL NECESSITY. Those services or supplies provided by a *Hospital*, *Physician*, or other provider of health care to identify or treat the *Sickness* or *Injury* which has been diagnosed or is reasonably suspected and which are 1) consistent with the diagnosis and treatment of your condition, 2) in accordance with standards of good medical practice, 3) required for reasons other than convenience to you, your *Physician*, your *Hospital*, or another provider and 4) the most appropriate supply or level of service which can safely be provided to you. When referring to *Inpatient* care, *Medically Necessary* means that your symptoms or condition require that those services or supplies cannot be safely provided to you on an *Outpatient* basis. The fact that a service or supply is prescribed by a *Physician* or another provider does not alone mean it is *Medically Necessary*.

MEDICARE. Benefits under Title XVIII of the Social Security Act of 1965, as amended from time to time.

MENTAL ILLNESS. Any emotional or mental disorder which, according to generally accepted medical professional standards, is amenable to significant improvement through short-term therapy and as further specified (or limited) in the Schedule of Benefits.

OPTOMETRIST. *Physician*s of Optometry who are registered and licensed in the respective states in which they practice and who are graduates of accredited Schools of Optometry.

OUTPATIENT. A participant or eligible dependent who receives covered services in a *Hospital*, but for whom an overnight room and board charge is not made.

PARTICIPATING DENTIST. A dentist who is duly licensed to practice as a dentist in the locality in which he or she performs a dental service and who has contracted with Group Dental Service of Maryland to provide dental services to participants and their eligible dependent(s).

PARTICIPATING EMPLOYER. An employer who is a party to a: (1) *Collective Bargaining Agreement* or other similar arrangement with the United Food and Commercial Workers Unions, Local 27 or Local 400; or (2) Participation Agreement with the *Fund* which requires contributions to the *Fund*.

PHYSICIAN. Any person, other than a close relative, who is licensed by the law of the state in which treatment is received to treat the type of *Sickness* or *Injury* causing the expenses, or loss, for which claim is made. A close relative is a spouse, brother, sister, parent or child of a participant or eligible dependent.

POST-SERVICE CLAIM. A claim for which the treatment or service has already been rendered.

PRE-SERVICE CLAIM. A claim which requires pre-authorization, such as a *Hospital* stay or a transplant procedure.

PROSTHETICS. Devices, such as artificial limbs, used to help compensate for a physical deficiency.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO"). A medical child support order which creates or recognizes the existence of an alternate payee's right to receive benefits from the Plan and which complies with the requirements for a *QMCSO* under *ERISA*.

SCLEROTHERAPY. Treatment of varicose veins in which a solution is injected directly into a blood vessel, causing it to shut down and disappear.

SICKNESS. Any physical sickness or *Mental Illness*. Pregnancy is not automatically considered to be a *Sickness*. There must be a medical reason for pregnancy to be considered a *Sickness*.

SURGERY. The performance of generally accepted operative and cutting procedures including endoscopic examinations and other invasive procedures, the correction of fractures/dislocations, the usual and related pre-operative and post-operative care, and other procedures approved by the Plan.

TRUSTEES. Members of the Board of Trustees of the *Fund*.

UNION. The United Food and Commercial Workers International Union, Locals 400 and 27 or any successor by combination, consolidation, or merger, or any other local union affiliated with the United Food and Commercial Workers International Union that: 1) has a *Collective Bargaining* or other Agreement with an employer requiring contributions to the trust establishing the FELRA & UFCW VEBA Fund ("Trust"); 2) has agreed in writing to participate in the Trust or has signed the Trust Agreement; and 3) is accepted for participation in the Plan by the *Trustees*.

URGENT CLAIM. A *Pre-Service Claim* for treatment of illness or *Injury* which involves imminent danger to life, health, or function or which causes the patient to be in extreme pain that, in the opinion of the patient's doctor, cannot be managed without the treatment requested in the claim.

URGENT CONCURRENT CARE CLAIM. An urgent *Pre-Service Claim* related to an ongoing course of treatment or a number of treatments over time.

USUAL, CUSTOMARY, AND REASONABLE, or UCR. The fee, as determined by the *Fund*, which is regularly charged and received for a given service by a health care provider which does not exceed the general level of charges being made by providers of similar training and experience when furnishing treatment for a similar *Sickness*, condition, or *Injury*. The locality where the charge is *Incurred* is also considered.

PARTICIPANT SERVICES HOTLINE

The *Fund* has a toll-free Participant Services telephone number you can call to obtain information about your eligibility and coverage under the Plan.

Call Participant Services at (800) 638-2972 and a representative can help you. When you call, please be ready to provide either your Social Security Number or your "Alternative ID" ("Alt/ID") number printed on your Plan ID card. Also, be ready to provide your union local number and company name.

You will be given an option to either access our system using the buttons on your touch-tone phone to check the status of your claim 24 hours a day, 7 days a week, or to speak with a representative directly (during office hours).

You may check the status of a claim, get information about payment amounts, dates paid, and more by accessing the "ABI" system.

MemberXG

Note: MemberXG does not apply to retirees and dependents whose claims are paid by Kaiser Permanente Medicare HMO.

MemberXG is an online access service that allows you to view your benefit claim information online and through your mobile device. It provides personal benefit information to you and your eligible dependents via the Internet in a safe, secure and HIPAA compliant environment.

MemberXG Offers the Following:

- Secure internet access to benefit information with assured privacy.
- Mobile-ready access allows you to view your benefit information 24 hours a day.
- eEOB feature allows you to review and print your Explanations of Benefits.
- Benefit access which allows you to track your claims and view the following:
  - Health Claims – displays claims submitted to the Plan on your behalf
  - Eligibility – past and present eligibility for you and/or your eligible dependent(s)
  - Dashboard – a landing page containing quick navigation to other benefit information.
  - Demographics –a demographic page displaying address, phone number, and other information for you and/or your dependent(s).

How Does It Work?

- Log in to www.associated-admin.com, select *Your Benefits,* located at the left side of the page, and select *FELRA & UFCW VEBA Fund.*
- Click on *MemberXG* which will take you to Member XG's site.
- Select *Create Account,* located at the upper, right corner. You will be asked to create a username and password.
- If you had a password for NETime, the online access service previously offered by the *Fund*, it **will not** apply to this site. You will need to create a new username and password for MemberXG.

If you have questions about a claim that you see on MemberXG, please call the Participant Services Department at (800) 638-2972.

Note: The information provided on the MemberXG website is not a guarantee of coverage. It is possible that information will not be fully up-to-date or could have been further revised.

CLAIMS FILING AND REVIEW PROCEDURES

Participants enrolled in Kaiser Permanente HMO should follow Kaiser's guidelines for filing medical or prescription drug claims. If you have medical coverage through the *Fund*, the procedures below apply to your supplemental medical and mental health & substance abuse benefits through the *Fund*.

If you want to file a claim for benefits, see "Claims Procedure"at the end of the section describing the particular benefit. The section below summarizes the general rules which apply to **ALL** claims for benefits under the Plan.

When You File a Claim

1. Present your Plan identification card when seeking service from a *Hospital* or *Physician*.
2. The *Hospital* or *Physician* will submit a bill directly to *Medicare*. Tell your provider to file a claim with the *Fund Office* at the same time. The Fund will deny the claim pending receipt of the *Medicare* Explanation of Benefits ("EOB"), but filing a claim with the *Fund* at the same time that you file a claim with *Medicare* will ensure that your claim is filed timely with the *Fund*. When the *Fund Office* receives the *Medicare* EOB, it will process your supplemental benefit. If you sign the "Assignment of Benefits" section on your claim form, the *Fund* will send payment directly to the *Hospital* or *Physician*.
3. You must either submit an itemized bill or file a claim to be eligible for benefits.
4. If your *Physician* or *Hospital* has not billed the *Fund* directly, you must submit an itemized bill to the *Fund Office*. Bills must be fully itemized and on the letterhead stationery of the provider of service. Bills must show the retiree's name and alternate ID number (as it appears on your ID card), patient's name, type of service, diagnosis, date(s) of service, provider's tax identification number, and charge per service. Cancelled checks, cash register receipts, and personal itemizations are not acceptable. Benefit payments will be sent directly to the provider unless they are unassigned and there is evidence of your payment on the bill.
5. If bills are submitted for more than one family member at a time, a separate itemized bill must be submitted for each individual.
6. Medical claims or itemized bills must be submitted within one year of the date of service. You have 45 days from the postmark date on a request from the *Fund* for additional information to return the information to the *Fund Office***.**
7. The fact that a claim for benefits from a source other than the *Fund* has been filed or is pending does not excuse these claims filing requirements. Further, lack of knowledge of coverage does not excuse these requirements.
8. If you receive *Hospital* care in a Veterans', Marine, or other federal *Hospital* or elsewhere at government (federal, state, or municipal) expense, no benefits are provided under this Plan. However, to the extent required by law, the *Fund* will reimburse the VA *Hospital* for care of a non-service related disability if the *Fund* would normally cover charges for such care and if the claim is properly filed within the appropriate *Fund* time periods.
9. The *Fund* reserves the right and opportunity to examine the person whose *Injury* or *Sickness* is the basis of a claim as often as it may reasonably require during pendency of the claim.

10. You will receive an *EOB* from the *Fund* when your medical claim is processed. Please keep the *EOB* and refer to it when you have questions regarding your claim and how it was processed.
11. Keep copies of all submitted bills for your records. Original bills will not be returned.

Payment of a Claim

When you submit itemized bills or file a claim using a claim form, the *Fund Office* begins to process it as soon as possible after receiving it. If your claim is valid, you have prepared the claim so we have all the information necessary to process it, and it is covered under the Plan, it will be paid. If we don't pay promptly and an extension is required, you will be notified. This extension notice will tell you why the *Fund Office* requires extra time and the approximate date that a decision on your claim is expected.

You will know your medical claim has been processed when you receive an *Explanation of Benefits.*

How Long the *Fund* Has to Respond/Process Your Claim

The Department of Labor has issued regulations regarding how long the *Fund* has to respond to your claim, make a decision, or process your claim. These time frames are described below. *Urgent Claims, Urgent Concurrent Care Claims, Pre-Service Claims, and Post-Service Claims* are defined in the "Definitions" section of this book on pages 63-67.

GENERAL INFORMATION REGARDING CLAIMS

For retirees and dependents not covered by an HMO, claims for hospital, medical, prescription drug, mental health and substance abuse benefits are provided directly by the *Fund*. The following procedures regarding claims and appeals apply to these benefits.

Claims for optical and dental benefits, as well as claims for benefits provided under an HMO, are provided under insurance agreements between the *Fund* and specific insurers. Please consult the information provided to you by the relevant insurer for a description of the applicable claims and appeals procedures for those benefits. However, because the *Fund* is still responsible for determining your eligibility for these benefits, you may follow the appeal procedures provided below for optical, dental or HMO benefit appeals for eligibility denials. Further, if you appeal a denial of dental benefits pursuant to the procedures provided by Group Dental Service, and that appeal is denied, please refer to the Appeal Procedure Section below for additional appeal rights relating to dental benefit claims.

You may name a representative to act on your behalf during the claims procedure. To do so, you must notify the *Fund* in writing of the representative's name, address, and telephone number and authorize the *Fund* to release information (which may include medical information) to your representative. Please contact the *Fund Office* for a form to designate a representative. In the case of an Urgent Care claim, defined below, a health care professional with knowledge of your medical condition will be permitted to act as your representative. The *Fund* does not impose any charges or costs to review a claim or appeal; however, regardless of the outcome of an appeal, neither the Board of *Trustees* nor the *Fund* will be responsible for paying any expenses that you might incur during the course of an appeal.

The *Fund* and Board of *Trustees*, in making decisions on claims and on appeal, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similarly situated claimants. Additionally, the *Fund* and *Trustees* will take into account all information you submit in making decisions on claims and on appeal.

If your claim is denied in whole or in part, you are not required to appeal the decision. However, before you can file suit against the Fund under Section 502(a) of the Employee Retirement Income Security Act ("*ERISA*") relating to a claim decision made by the Fund on your claim for benefits, you must exhaust your administrative remedies by appealing the denial to the Board of *Trustees*. Failure to exhaust these administrative remedies will result in the loss of your right to file suit. If you wish to file suit for a denial of a claim for benefits, you must do so within three years of the date the *Trustees* denied your appeal. For all other actions, you must file suit within three years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Plan or the *Trustees*, you must file suit in the United States District Court for the District of Maryland. These rules apply to you, your spouse, dependent, or beneficiary, and any provider who provided services to you or your spouse,

dependent or beneficiary. The above paragraph applies to all litigation against the *Fund,* including litigation in which the *Fund* is named as a third party defendant.

The *Fund's* procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the *Fund* also may request that you voluntarily extend the period of time for the *Fund* to make a decision on your claim or your appeal.

Claims Review–Types of Claims

1. Pre-Service Claim

A *Pre-Service Claim* is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or part, on the *Fund's* approval of the benefit before you receive the *Medical Care*. For example, a request for services for which pre-certification is required, as described elsewhere in this book, would be a *Pre-Service Claim*.

If your *Pre-Service Claim* is filed improperly, the *Fund* will notify you of the problem (either orally or in writing, unless you request it in writing) within five days of the date you filed the claim. The *Fund* will notify you of its decision on your *Pre-Service Claim* (whether approved or denied) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claim is received by the *Fund*. The *Fund* may extend the period for a decision for up to 15 additional days due to matters beyond the control of the *Fund*, provided that the *Fund* gives you a written notice of such extension before the end of the initial 15-day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the *Fund* expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given 45 days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly refile the claim, the *Fund* will decide the claim based on the information it has available, and your claim may be denied.

2. Urgent Care Claim

An Urgent Care claim is a *Pre-Service Claim* that requires shortened time periods for making a determination where the longer time periods for making non-Urgent Care determinations 1) could seriously jeopardize your life or health or your ability to regain maximum function or 2) in the opinion of a *Physician* with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. It is important to note that the rules for an Urgent Care claim apply only when the Plan requires approval of the benefit *before* you receive the services; these rules do not apply if approval is not required before health care is provided, for example in the case of an emergency.

If your Urgent Care claim is filed improperly or is incomplete, the *Fund* will notify you of the problem (either orally or in writing, unless you request it in writing) within 24 hours of the date you filed the claim. The *Fund* will notify you of the decision on your Urgent Care claim (whether

approved or denied) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the claim is received by the *Fund*, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If the *Fund* needs more information, the *Fund* will notify you of the specific information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim by the *Fund*. You will be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the requested information. The *Fund* will notify you of its decision as soon as possible, but not later than 48 hours after the earlier of 1) the *Fund's* receipt of the specified information or 2) the end of the period given to you to provide the specified information. Due to the nature of an Urgent Care claim, you may be notified of a decision by telephone, which will be followed by a written notice of the same information within three days of the oral notice.

If you do not provide the information requested, or do not properly re-file the claim, the *Fund* will have to decide the claim based on the information it has available, and your claim may be denied.

3. Concurrent Care Claim

A *Concurrent Care Claim* is a request for the *Fund* to approve, or to extend, an ongoing course of treatment over a period of time or number of treatments, when such approval is required by the Plan. If you have been approved by the *Fund* for Concurrent Care treatment, any reduction or termination of such treatment (other than by Plan amendment or termination of the Plan) before the end of the period of time or number of treatments will be considered denial of a claim. The *Fund* will notify you of the denial of the claim at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on review of the denial of the claim before the benefit is reduced or terminated.

Urgent Concurrent Care Claim

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care claims (see above), except the *Fund* will notify you of the decision (whether approved or denied) within 24 hours after the *Fund's* receipt of the claim, provided that the claim is made to the *Fund* at least 24 hours before the end of the previously approved period of time or number of treatments.

4. Post-Service Claim

A *Post-Service Claim* is any claim under the Plan that is not a *Pre-Service Claim*. Typically, a *Post-Service Claim* is a request for payment by the *Fund* after you have received the services.

If the *Fund* denies your *Post-Service Claim*, in whole or in part, the *Fund* will send you a notice of the claim denial within a reasonable period of time, but not later than 30 days after the claim is received by the *Fund*. The *Fund* may extend the period for a decision for up to 15 additional days due to matters beyond the control of the *Fund*, provided that the *Fund* gives you a written notice of such extension before the end of the initial 30-day period. The notice of an extension will set

forth the circumstances requiring an extension of time and the date by which the *Fund* expects to make a decision. If your *Post-Service Claim* is incomplete, the *Fund* will deny the claim within the 30-day period mentioned above. You may resubmit the claim, with the necessary additional information, at any time within one year from the date of service.

Denial of a Claim

With respect to any claim relating to medical, *Hospital*, prescription, mental health and substance abuse benefits, if the *Fund* denies the claim, in whole or in part, the *Fund* will send you a written notice of the denial, unless, as noted above, your claim is for Urgent Care, then this notice may be oral, followed in writing. The notice will provide, to the extent applicable, 1) the specific reason or reasons for denial; 2) reference to specific Plan provisions on which the denial is based; 3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; 4) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures, including the expedited review process applicable to Urgent Care claims; 5) a statement of your right to bring a civil action under Section 502(a) of *ERISA* following a denial of your appeal; 6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and 7) if the denial is based on a determination of *Medical Necessity* or *Experimental* treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

Review of a Denied Claim

You have the right to appeal a denial of your benefit claim to the *Fund's* Board of *Trustees.* Your appeal must be in writing and must be sent to the Board of *Trustees* at the following address:

Board of Trustees
FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

An appeal of an Urgent Care claim (see above) may also be made by telephone by calling (800) 638-2972 or by faxing a letter to (877) 227-3536.

If your claim is denied, you (or your authorized representative) may, within 180 days from receipt of the denial, request a review by writing to the Board of *Trustees*. Pursuant to your right to appeal, you will have the right 1) to submit written comments, documents, records, and other information relating to your claim for benefits; and 2) upon request, to have reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits. In making a decision on review, the Board of *Trustees* or a committee of the Board of *Trustees* will review and consider all comments, documents, records, and all other information submitted by you or your duly authorized representative, without regard to whether such

information was submitted or considered in the initial claim determination. In reviewing your claim, the Board of *Trustees* will not automatically presume that the *Fund's* initial decision was correct, but will independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is *Experimental*, investigational, or not *Medically Necessary* or appropriate), the Board of *Trustees* will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the *Fund* on the initial claim.

In the case of an appeal of a claim involving Urgent Care as defined above, the Board of *Trustees* will notify you of the decision on your appeal as soon as possible, taking into account the applicable medical exigencies, but not later than 72 hours after the *Fund's* receipt of your appeal. In the case of an appeal of a *Pre-Service Claim*, the Board of *Trustees* will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the *Fund's* receipt of your appeal. The *Fund* may also request that you voluntarily extend the period of time for the Board of *Trustees* to make a decision on your appeal.

In the case of an appeal of a *Post-Service Claim*, the Board of *Trustees* or a committee of the Board of *Trustees* will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the *Fund* within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the *Trustees*, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The *Trustees* will send you a written notice of their decision (whether approved or denied) within five days of the decision.

If the Board of *Trustees* has denied your appeal, the notice will provide 1) the specific reason or reasons for the denial; 2) references to specific Plan provisions on which the denial is based; 3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and 4) a statement of your right to bring an action under Section 502(a) of *ERISA.* In addition, the notice will state that 1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and 2) if the denial of your appeal was based on a *Medical Necessity* or *Experimental* treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

The Board of *Trustees* has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of *Trustees* is final and binding.

For certain benefits, before filing an appeal with the Board of *Trustees* as described above, you may wish to contact the appropriate *Fund* provider identified below with any questions or concerns that you have regarding the claim denial. If you choose to do so, refer to the relevant section of this booklet, or contact the provider directly, for important information regarding the appropriate procedures, including any time limits.

For denied mental health and substance abuse claims, you may contact:

Beacon Health Options
c/o Utilization Review Manager
48561 Alpha Drive, Suite 150
Wixom, MI 48393

For denied prescription benefit claims, you may contact:

Express Scripts, Inc.
1 Express Way
St. Louis, MO 63121

Whether or not you choose to address your concerns to the provider, you have the right to appeal a benefit denial to the Board of *Trustees* as described above. However, if you choose to address your concerns to the provider, you must do so before you appeal to the Board of *Trustees* and, if you are not satisfied with the results through the provider and wish to file an appeal to the Board of *Trustees*, you must do so within 180 days from the day you received the claim denial from the *Fund Office* or other *Fund* provider. If you do not choose to address your concerns to the provider and wish to appeal directly to the Board of *Trustees*, you must do so within 180 days from the day you received the claim denial from the *Fund Office*. Please remember that if you are not able to resolve your concerns by contacting the appropriate provider named above, you must appeal to the Board of *Trustees* before filing a suit against the *Fund*.

Special Rule Regarding Appeals of Dental Benefit Claims

If you appeal your dental claim denial to GDS and GDS denies your appeal, the *Fund* offers an additional level of appeal by the Board of *Trustees* that is entirely voluntary. Please note the following about the *Fund's* voluntary level of appeal for dental claims:

- Upon request and free of charge, the *Fund* will provide you with sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a dental benefit dispute to the voluntary level of appeal, including a statement that your decision as to whether to submit your dental benefit dispute to the voluntary level of appeal will have no effect on your right to any other benefits under the Plan, information about the applicable rule, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision, such as financial or personal interests in the result or any past or present relationship to any party to the review process.
- You may elect to file a voluntary appeal to the Board of *Trustees* only after a denial of your appeal by GDS.

- During this voluntary appeal process, the time that it takes to decide your appeal will not be counted against you in determining whether any lawsuit that you file afterward is brought in a timely manner.

Your voluntary appeal must be submitted in writing to the Board of *Trustees* within 45 days of the date you receive your appeal denial from GDS. The Board of *Trustees* or a committee of the Board of *Trustees* will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the *Fund* within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the *Trustees*, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The *Trustees* will send you a written notice of their decision (whether approved or denied) within five days of the decision.

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you or your dependents may be used and disclosed and how you can get access to this information. Please review it carefully.

THE PLAN'S COMMITMENT TO PRIVACY

The FELRA & UFCW Retiree Health and Welfare Plan (the "Plan" or "Retiree Plan"), a plan of the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund, is committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Plan's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refers to participants and dependents who are eligible for benefits under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

The Plan collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Notice. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, Social Security Number, employment information, and medical and health claims information.

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Plan discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan may also disclose your health information to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Plan will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- Request access to your health information in an electronic format;
- Receive notice of a breach of unsecured protected health information if it affects you;
- File a complaint with the *Fund Office* or the Secretary of the Department of Health and Human
- Services if you believe that your privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Practices

The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or if you wish to obtain additional information about the Plan's privacy practices, please contact:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(410) 683-6500

DETAILED NOTICE OF THE PLAN'S PRIVACY POLICIES

THE PLAN'S USES AND DISCLOSURES

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Plan uses and discloses your health information only for the administration of the Plan and the processing of your health claims.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** Although the Plan does not anticipate making disclosures "for treatment," if necessary, the Plan may make such disclosures without your authorization. For example, the Plan may disclose your health information to a health care provider, such as a *Hospital* or *Physician*, to assist the provider in treating you.

2. **For Payment.** The Plan may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information with its third party administrator, Associated Administrators, LLC ("Associated"), so that it may process your claims. The Plan may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered under the Plan. Associated also may disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, Associated may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.

3. **For Health Care Operations**. The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Plan may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan.

Uses and Disclosures to Business Associates

The Plan shares health information about you with its "business associates," which are third parties that assist the Plan in its operations. The Plan discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Plan shares your health information with Associated so that it may process your claims. The Plan may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Plan may disclose your health information to a translator; and Associated may provide names and address information to mailing services.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected. Similarly, Associated contracts with the subcontractors it uses to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information to the Plan Sponsor, which is the Plan's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Plan, without your authorization. The Plan also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Plan that it will protect your health information and that it has amended the Plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Plan, may make without your authorization.

1. **Required by Law**. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:

- For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
- To report information related to victims of abuse, neglect, or domestic violence.
- To assist law enforcement officials in their law enforcement duties.
- To notify the appropriate authorities of a breach of unsecured protected health information.

2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.

3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

4. **Active Members of the Military and Veterans**. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

6. **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief

entity in the event of a disaster. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Notice.

7. **Others Involved In Your Care**. Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Plan). Also, upon request, Associated may advise a family member or close personal friend about your general condition, location (such as in the *Hospital*) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. **Personal Representatives**. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for un-emancipated minors and those who have Power of Attorney for adults.

9. **Treatment and Health-Related Benefits Information**. The Plan and its business associates, including Associated, may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.

10. **Research**. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

11. **Organ, Eye and Tissue Donation**. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

12. **Deceased Individuals**. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan and its business associates, including Associated, do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Plan will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the

disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(410) 683-6500

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records. For health records that the Plan keeps in electronic form, you may request to receive the records in an electronic format.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Plan will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, then the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment form and is not limited to a two year period, state that in your written request, and that request will be accommodated. If you request a paper copy of your underlying health record or a portion of your health record, the Plan will charge you a fee of $.25 per page for the cost of copying and mailing the response to your request. Records provided in electronic format also may be subject to a small charge.

In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request

if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for the Plan, unless you provide the *Fund* with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan, including disclosures by Associated to others. The accounting covers up to six years prior to the date of your request, except, in accordance with applicable law, the accounting will not include disclosures made before April 14, 2003. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. In response to your request for an accounting of disclosures, the Plan may provide you with a list of business associates who make such disclosures on behalf of the Plan, along with contact information so that you may request the accounting directly from each business associate. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, you will be charged for the cost of providing the accounting, but Associated will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that Associated discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is generally not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested. The Plan is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out of pocket.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Plan and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy of this Notice at Associated's website, www.Associated-Admin.com.

Right to Receive Notice of a Breach of Your Protected Health Information

You will be notified if your protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note

that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured—for example, computer data that is encrypted and inaccessible without a password—or if it is determined that there is a low probability that your health information has been compromised.

CHANGES IN THE PLAN'S PRIVACY POLICIES

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be posted for review near the front lobby of Associated's offices in Sparks, Maryland and Landover, Maryland. Any revised notice will also be available at Associated's website, www.Associated-Admin.com.

EFFECTIVE DATE

This Notice was first effective on April 14, 2003, and was revised, effective September 23, 2013, to reflect the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Notice will remain in effect unless and until the Plan publishes a revised Notice.

YOUR RIGHTS UNDER ERISA

As a participant of the FELRA & UFCW Retiree Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended *(ERISA).* The Board of *Trustees* complies fully with this law and encourages you to first seek assistance from the *Fund Office* when you have questions or problems that involve the Plan.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

This Plan is maintained pursuant to *Collective Bargaining Agreements*. A copy of these documents may be obtained by participants and beneficiaries upon written request to the *Fund Office.* The documents are also available for examination by participants and dependents.

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and *Collective Bargaining Agreements*, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the 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 this summary annual report.

Continue Group Health Plan Coverage

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

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. However, if you have a denied claim or disagree with the Plan's decision regarding an order, you must appeal these decisions within the plan's time limits before you can bring suit. 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 the 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.

PARTICIPATING EMPLOYERS and UNIONS

Giant Food, LLC
8301 Professional Place, Suite 115
Landover, MD 20785

Safeway, Inc.
4551 Forbes Boulevard
Lanham, MD 20706

UFCW Local 400
8400 Corporate Drive, Ste. 200
Landover, MD 20785

UFCW Local 27
21 West Road
Towson, MD 21204

Participants and beneficiaries may obtain a complete list of the *Participating Employers* and *Unions* sponsoring the *Fund* by making a written request to the *Fund Office,* and such list is available for examination by participants and beneficiaries.

TELEPHONE NUMBERS

Translation services are available when you call Participant Services if English is not your primary language.

Si ingles no es su lenguaje principal, servicios de traducción son disponibles cuando usted llame al Servicios Participantes al (800) 638-2972.

Fund Office

Participant Services/Eligibility..... (800) 638-2972
Sparks Local Line..... (410) 683-6500
Landover Local Line..... (301) 459-3020

Advantica EyeCare (Optical Appointments)..... (866) 425-2323

Beacon Health Options (Mental Health/Substance Abuse) ..... (800) 353-3572

Dental Information & Provider Search

Group Dental Service ..... (800) 242-0450

Express Scripts, Inc. ("ESI," Prescription Claims)..... (800) 903-8325
Accredo Specialty Drug Pharmacy ..... (800) 803-2523

Kaiser Permanente Medicare HMO Enrollment Information.....(301)-816-5690
Kaiser Permanente Medicare HMO Enrollment Fax.....(855) 454-8981

ADDRESSES

Local 27 Participants–Write:

FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Local 400 Participants–Write:

FELRA & UFCW VEBA Fund
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361

For claims or medical-claims-related correspondence, send to:

FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451