

FELRA & UFCW

Active Health and Welfare Plan

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

PLAN XXX



SUMMARY PLAN DESCRIPTION

January 2025

The Administrative Manager:

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

**The Administrative Manager is
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 medical 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 Active 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.

DEAR PARTICIPANT,

The FELRA & UFCW Active Health and Welfare Plan (“Plan”), a plan of the Food Employers 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 Employers*. 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 book. Any decision made by the *Trustees* is binding upon *Participating Employers*, 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 book) 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 provided under the Plan.

- 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 book--which is intended as an explanation of your benefits--and the formal agreements between the *Fund* and any insurance carriers, 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 delay or disrupt 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'll share with us the satisfaction of knowing you have the protection of this Plan.

Sincerely,

BOARD OF TRUSTEES

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Covered Employment with Participating Employers

Facts about the Plan

Health and Welfare Board of Trustees

Summary of Benefits for Full Time Participants

Summary of Benefits for Part Time Participants

Notice – No Fund Liability

Health Care Cost Containment Corporation

Repaying the Fund/Overpayment of Benefits

Definitions

COVERED EMPLOYMENT WITH PARTICIPATING EMPLOYERS

UFCW Local 27

The benefits outlined in this book apply to employees of the *Participating Employers* as described below, **hired on or after January 1, 2014**, who are in Plan XXX and are covered by a current *Collective Bargaining Agreement* with UFCW Local 27 requiring contributions to the *Fund* on their behalf. Employees must meet the eligibility requirements in the “Employee Eligibility” section beginning on page 35 in order to be eligible for benefits under Plan XXX.

1. Giant
2. Giant Super G Delaware
3. Safeway
4. Safeway Dover and Delaware

UFCW Local 400

The benefits outlined in this book apply to employees of the *Participating Employers* as described below, **hired on or after January 1, 2014**, who are in Plan XXX and are covered by a current *Collective Bargaining Agreement* with UFCW Local 400 requiring contributions to the *Fund* on their behalf. Employees must meet the eligibility requirements in the “Employee Eligibility” section beginning on page 35 in order to be eligible for benefits under Plan XXX.

1. Giant
2. Safeway
3. Safeway Culpeper
4. Giant Valley

FACTS ABOUT THE PLAN

Plan Name

FELRA & UFCW Active 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: life, accidental death and dismemberment, hospitalization, medical, surgical, mental health, accident and sickness, 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 of the Fund at this address:

FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

Sources of Contribution

Sources of contributions to the *Fund* are *Participating Employers* pursuant to the terms of their *Collective Bargaining Agreements* or participation agreements 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 accumulated assets of 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, Suite 200
Landover, MD 20785

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

Michael Wilson
UFCW Local 400
8400 Corporate Drive, Suite 200
Landover, MD 20785

Javiel Nazario
UFCW Local 27
3 Mason Drive
Selbyville, DE 19975

Employer Trustees

Chairman:

Jason Paradis
25 Charles Street
Wrentham, MA 02093

Daniel Dosenbach
Albertsons Companies
75 Valley Stream Parkway
Malvern, PA 19355

Michael Goble
Giant Food
8301 Professional Place, Suite 115
Landover, MD 20785

SCHEDULE OF BENEFITS FOR FULL TIME PARTICIPANTS

Full Time Group A benefits includes Hospitalization, Medical/Surgical, and Prescription Drug.

<p>Hospitalization</p> <p>Participant and Eligible Dependent(s).</p>	<p>All emergency <i>Inpatient Hospital</i> stays must be certified within 48 hours of admission and all non-emergency <i>Inpatient</i> stays must be pre-certified with Conifer Health Solutions, to the extent consistent with applicable law. Emergency room service is a \$75 <i>Co-payment</i>, then covered at 70%, up to the <i>Allowable Charge</i>. <i>Co-payment</i> is waived if admitted. In-network <i>Hospital</i> room and miscellaneous <i>Hospital</i> charges are covered at 70%, up to the <i>Allowable Charge</i> under Comprehensive Medical Benefits, after you pay a \$500 <i>Deductible</i> (per person, per year). You must use an in-network CareFirst PPO provider (with the exception of (1) <i>No Surprises Services</i> and (2) emergency <i>Ambulance Service</i>).</p>
<p>Medical/Surgical</p> <p>Participant and Eligible Dependent(s).</p>	<p>Comprehensive Medical Benefits are covered at 70% up to the <i>Allowable Charge</i> after you pay an in-network <i>Deductible</i> of \$500 per person, per year. The annual out-of-pocket maximum is \$5,000 per person and \$10,000 per family. You must use a CareFirst PPO participating provider (with the exception of (1) <i>No Surprises Services</i> and (2) emergency <i>Ambulance Service</i>). You must pre-certify all non-emergency <i>Inpatient Hospital</i> stays with Conifer</p>

	<p>Health Solutions. You must use LabCorp or Quest facilities in order to be covered for laboratory services, <u>except</u> that laboratory services performed by out-of-network providers at in-network facilities also are covered.</p>
<p>Prescription Drug</p> <p>Participant and Eligible Dependent(s).</p>	<p>Prescription Drug Benefits are provided through Express Scripts, Inc. Generic drugs are mandatory, if available, and you must use an in-network pharmacy. Annual out-of-pocket maximum is \$1,600 per person and \$3,200 per family.</p> <ul style="list-style-type: none"> ▪ Generic drugs are 5% <i>Co-payment</i> (with a \$5 minimum); 15% co-pay (with a \$15 minimum) for brand name drugs on the preferred formulary list; 25% co-pay (with a \$25 minimum) for brand name drugs not on the preferred formulary list. Brand name is covered only if there is no generic equivalent. Limited to 34-day supply, 100-day supply for approved maintenance; some additional quantity limits apply. ▪ Certain specialty medications require prior authorization and must be ordered by phone through Accredo Specialty Pharmacy with the same <i>Co-payments</i> as specified above. However, if a specialty drug is covered by the Fund’s SaveonSP program and you enroll and participate in the program, your <i>Co-payment</i> will be paid through the drug manufacturer’s co-pay assistance program and you will pay nothing (\$0). If

	<p>you do not participate in the SaveonSP program, the specialty drug will be subject to a 30% <i>Co-payment</i> for any specialty drug listed on the SaveonSP program’s current Non-Essential Health Benefit Specialty Drug List, and the <i>Co-payment</i> will not count towards your deductible or out-of-pocket maximums. See the “Prescription Drug Benefit” Section of the SPD for more information.</p>
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Full Time Group B benefits include Life Insurance and Accidental Death and Dismemberment.

Life Insurance Participant only.	\$5,000
Accidental Death And Dismemberment Participant only.	\$5,000

Full Time Group C benefits include Accident and Sickness, Dental, and Optical Benefits

Accident & Sickness Participant only.	50% of gross straight time pay for first 8 weeks and 40% of gross straight time pay for next 4 weeks, depending on length of employment. First day for accident or hospitalization, and 4 th day for sickness. Eligibility for all benefits is continued during sick pay. See page 104 for more detailed information regarding your Accident & Sickness benefits.
Dental Participant and Eligible Dependent(s).	Routine cleanings, exams, x-rays and fillings covered at no charge when using a Dentegra provider. Other services covered with <i>Co-payments</i> .
Optical Participant and Eligible Dependent(s).	Exam, frames, and lenses once every two years through Superior Vision.

SCHEDULE OF BENEFITS FOR PART TIME PARTICIPANTS

Part Time Group A benefits includes Hospitalization, Medical/Surgical, and Prescription Drug.

<p>Hospitalization</p> <p>Participant and Eligible Dependent Children.</p>	<p>All emergency <i>Inpatient Hospital</i> stays must be certified within 24 hours of admission and all non-emergency <i>Inpatient</i> stays must be pre-certified with Conifer Health Solutions, to the extent consistent with applicable law. Emergency room service is \$75 <i>Co-payment</i>, then coverage at 70%, up to the <i>Allowable Charge</i>. <i>Co-payment</i> is waived if admitted. In-network <i>Hospital</i> room and miscellaneous <i>Hospital</i> charges are covered at 70%, up to the <i>Allowable Charge</i> under Comprehensive Medical Benefits, after you pay a \$500 <i>Deductible</i> (per person, per year). You must use an in-network CareFirst PPO provider (with the exception of (1) <i>No Surprises Services</i> and (2) emergency <i>Ambulance Service</i>).</p>
<p>Medical/Surgical</p> <p>Participant and Eligible Dependent Children.</p>	<p>Comprehensive Medical Benefits are covered at 70% up to the <i>Allowable Charge</i> after you pay an in-network <i>Deductible</i> of \$500 per person, per year. The annual out-of-pocket maximum is \$5,000 per person and \$10,000 per family. You must use a CareFirst PPO participating provider (with the exception of (1) <i>No Surprises Services</i> and (2) emergency <i>Ambulance Service</i>). You must pre-certify all non- emergency <i>Inpatient Hospital</i> stays with Conifer Health Solutions. You must use</p>

	<p>LabCorp or Quest facilities in order to be covered for laboratory services, <u>except</u> that laboratory services performed by out-of-network providers at in-network facilities also are covered.</p>
<p>Prescription Drug</p> <p>Participant and Eligible Dependent Children.</p>	<p>Prescription Drug Benefits are provided through Express Scripts, Inc. Generic drugs are mandatory, if available, and you must use an in-network pharmacy. Annual out-of-pocket maximum is \$1,600 per person and \$3,200 per family.</p> <ul style="list-style-type: none"> ▪ Generic drugs are 5% <i>Co-payment</i> (with a \$5 minimum); 15% co-pay (with a \$15 minimum) for brand name drugs on the preferred formulary list; 25% co-pay (with a \$25 minimum) for brand name drugs not on the preferred formulary list. Brand name is covered only if there is no generic equivalent. Limited to 34-day supply, 100-day supply for approved maintenance; some additional quantity limits apply. ▪ Certain specialty medications require prior authorization and must be ordered by phone through Accredo Specialty Pharmacy with the same <i>Co-payments</i> as specified above. However, if a specialty drug is covered by the Fund’s SaveonSP program and you enroll and participate in the program, your <i>Co-payment</i> will be paid through the drug manufacturer’s co-pay assistance program and you will pay nothing (\$0). If you do not participate in the SaveonSP program, the specialty drug will be subject to a 30% Co-payment for

	<p>any specialty drug listed on the SaveonSP program’s current Non-Essential Health Benefit Specialty Drug List, and the <i>Co-payment</i> will not count towards your deductible or out-of-pocket maximums. See the “Prescription Drug Benefit” Section of the SPD for more information.</p>
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Part Time Group B benefits include *Accidental Death and Dismemberment.*

Life Insurance Participant only.	\$2,500
Accidental Death And Dismemberment Participant only.	\$2,500

Part Time Group C benefits include *Accident and Sickness, Dental, and Optical.*

Accident & Sickness Participant only.	40% of gross straight time pay for first 8 weeks and 30% gross straight time pay for next 4 weeks, depending on length of employment. First day for accident or hospitalization, 7 th day for sickness. Eligibility for all benefits is continued during sick pay. See page 104 for more detailed information regarding your Accident & Sickness benefits.
Dental Participant and Eligible Dependent Children.	Routine cleanings, exams, x-rays and fillings covered at no charge when using a Dentegra provider. Other services covered with <i>Co-payments</i> .
Optical Participant and Eligible Dependent Children.	Exam, frames, and lenses once every two years, through Superior Vision.

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 either because, for example, you have a compensable Workers' Compensation claim or have received a third party recovery (see "Subrogation" and "Advance Benefits for Workers'")

Compensation Claims”), 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 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*. 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 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 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 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’ future benefit payments payable by the *Fund*

under the Plan, including but not limited to benefits payable under this Plan, the FELRA & UFCW Retiree Health and Welfare Plan, and the UFCW & FELRA Severance Plan, a program of the *Fund*. 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. If the overpayment or advancement was made to or on behalf of your dependent, the *Fund* may offset the future benefits payable by the *Fund* to you and any of your dependents.

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 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 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.

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.

PROHIBITION OF ASSIGNMENT OF BENEFITS

No benefit under the Plan or right under ERISA may be assigned or transferred to another party by a participant, dependent, spouse or beneficiary. The *Fund* will not recognize any attempted assignment. Nothing in this SPD or the *Fund's* Trust Agreement shall be construed to make the *Fund*, the *Trustees*, UFCW Locals 27 or 400, or any *Participating Employer* liable to any third-party to whom a participant, dependent, spouse or beneficiary may be liable for medical care, treatment, or services. The *Fund* may make direct payments to a medical provider. A direct payment by the *Fund* to a medical provider does not make the provider an assignee, and in no way confers upon the provider any rights that a participant has under the Plan or ERISA.

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).

ACTIVE WORK/ACTIVELY WORKING/ACTIVE AT WORK. Your attendance in-person at your usual and customary place of business (outside your residence), acting in the regular performance of the duties of your occupation for wages or profit.

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.

ALLOWABLE CHARGE. The fee, as determined by the *Fund*, that is the lowest of: (1) the health care provider’s actual charge; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the maximum amount that the *Fund* has determined it will pay for the service or supply; or (4) the amount that is reasonable and customary for the locality in which incurred. Notwithstanding the above, for CareFirst in-network claims, the *Allowable Charge* is the CareFirst allowed amount.

AMBULANCE SERVICE. A licensed private professional ambulance service providing local ground/surface transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

ANCILLARY SERVICES. With respect to an in-network *Health Care*

Facility, (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; and (4) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

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

CARDIAC REHABILITATION. Health care specializing in the rehabilitation of persons suffering from angina pectoris or persons who have recently undergone cardiac *Surgery* or who have suffered a heart attack.

COBRA. Consolidated Omnibus Budget Reconciliation Act of 1985, and all related regulations, as amended from time to time. Provides for continuation of benefits under certain circumstances for participants and their eligible dependent(s) when benefits are lost.

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 FELRA & UFCW VEBA Fund.

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

CONTINUING CARE PATIENT. An individual who is: (1) receiving a course of treatment for a *Serious and Complex Condition*; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment

for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

CO-PAYMENT OR CO-INSURANCE. The out-of-pocket amount of the *Allowable Charge* that a participant or dependent is responsible for paying when receiving benefits after paying any applicable *Deductible* amount for that year. Effective January 1, 2022, the *Co-insurance* or *Co-payment* applicable to *No Surprises Services* is based on the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the “Qualifying Payment Amount” (“QPA”), or the amount billed by the provider.

DEDUCTIBLE. The out-of-pocket amount a participant or dependent must pay prior to receiving benefits from the *Fund*. The per person *Deductible* is the first \$500 of covered medical expenses *Incurred* in a *Calendar Year* for *Sickness* or *Injury*.

DIAGNOSTIC (PROCEDURE, TEST, SERVICE, OR STUDY). 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 participant or dependent begins.

EMERGENCY MEDICAL CONDITION. A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES. Any of the following, with respect to an *Emergency Medical Condition*:

- An appropriate medical screening examination that is within the capability of the emergency department of a *Hospital* or *Independent Freestanding Emergency Department*, including *Ancillary Services* routinely available to the emergency department to evaluate such *Emergency Medical Condition*;
- Such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and
- Services provided by an out-of-network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:
 - The attending emergency physician or treating provider determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an in-network provider or facility located within a reasonable travel distance, taking into account the patient's medical condition;
 - The patient is supplied with a written *Notice*, as required by federal law, that the provider is an out-of-network

provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and

- The patient gives informed *Consent* to continued treatment by the nonparticipating provider, acknowledging that she or he understands that continued treatment by the out-of-network provider may result in greater cost to the patient.

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:

1. 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;
2. 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;
3. 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
4. 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.

FMLA. The Family Medical Leave Act of 1993, and any regulations, as amended from time to time.

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*.”

HEALTH CARE FACILITY. For non-*Emergency Services*, a: (1) hospital; (2) hospital outpatient department; (3) critical access hospital; or (4) ambulatory surgical center.

HOSPICE CARE. Care designed for meeting the special physical, spiritual, psychological and social needs of dying individuals and their families.

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.

HOSPITAL CONFINEMENT. Confinement for which a daily *Hospital* room and board charge is made, except that a daily *Hospital* room and board charge is not required if a surgical procedure is performed or if emergency treatment is rendered within 48 hours after an *Accidental Injury*.

One period of *Hospital Confinement* includes successive periods of *Hospital Confinement* resulting from the same or related causes *unless* they are: 1) with respect to a participant, two or more unrelated conditions which are separated by your return to *Active Work* on a full time basis for one full day, or for related conditions, separated by your return to *Active Work* on a full time basis for 60 full days; 2) with respect to eligible dependents, the confinements must be separated by at least three months.

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.

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT. A facility that is geographically separate and distinct from a *Hospital* under applicable state law and provides, and is licensed under state law to provide, *Emergency Services*.

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 alone does not 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.

NO SURPRISES ACT. The No Surprises Act enacted under the federal Consolidated Appropriations Act of 2021.

NO SURPRISES SERVICES. The following services, to the extent covered under the Plan: (1) out-of-network *Emergency Services*; (2) out-of-network air ambulance services; (3) non-emergency *Ancillary Services* (such as anesthesiology, pathology, radiology, neonatology and diagnostic services and other services defined as ancillary under the *No Surprises Act* and its implementing regulations) when performed by out-of-network providers at in-network *Health Care Facilities*; and (4) other out-of-network non-*Emergency Services* performed by an out-of-network provider at in-network *Health Care Facilities* with respect to which the provider does not comply with federal *Notice and Consent* requirements.

NOTICE AND CONSENT. With respect to out-of-network services provided at an in-network *Health Care Facility*, *Notice and Consent* means: (1) that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and (2) you give informed consent to continued treatment by the out-of-network provider, acknowledging that you understand that continued

treatment by the out-of-network provider may result in greater cost to you.

NURSE MIDWIFE. A licensed registered nurse, certified by the American College of Midwives as qualified to render non-surgical obstetrical care.

OPTOMETRIST. *Physicians* 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 Dentegra 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*.

PEDODONTIA. Dental treatment of children under the age of 4.

PERIODONTIA. Dental treatment for gum disease.

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.

SERIOUS AND COMPLEX CONDITION. A condition, (1) in the case of an acute illness, that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

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 FELRA & UFCW VEBA 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.

USERRA. The Uniformed Services Employment and Re-employment Rights Act of 1994 (“*USERRA*”), which provides for the continuation of benefits for participants and their eligible dependent(s) who are absent from work due to military service.

EMPLOYEE ELIGIBILITY

Employee Eligibility

Special Enrollment Provisions

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Enrolling New Dependents

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Medicaid and Children’s Health Insurance Program

EMPLOYEE ELIGIBILITY

Plan XXX – Initial Eligibility for Full-Time Employees

If you were hired as a “full-time” employee (as defined under the *Collective Bargaining Agreement* applicable to your employment), you will be eligible for benefits under Plan XXX as follows, subject to the *Fund’s* receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the *Fund Office* the necessary enrollment forms, including any payroll deduction forms:

Type of Benefit	Enrollment Date
▪ Hospital, Medical, Prescription Drug	First of the month following 90 days of employment.
▪ Life, Accidental Death & Dismemberment	First of the month following 90 days of employment.
▪ Accident & Sickness, Dental, Vision	First of the month following 90 days of employment.

For example, if you were hired as a full-time employee on April 15, 2024, you would become eligible for all benefits on August 1, 2024.

Plan XXX – Initial Eligibility for Part-Time Employees

If you were hired to work an undetermined number of hours per week, and you were entitled to be paid for an average of at least 28 hours per week (30 hours per week if you are a Giant employee hired after 11/16/16) during your first 12 months of employment, you will be eligible for Hospital, Medical and Prescription Drug benefits under Plan XXX on the first day of the month after you have worked for 13 months, and you will be eligible for Life and Accidental Death and Dismemberment benefits on the first day of the month after you have worked 18 months, subject to the *Fund’s* receipt of contributions, when contractually required, made on

your behalf by your participating employer, and subject to you completing and filing with the *Fund Office* the necessary enrollment forms, including any payroll deduction forms. For example, if you start work on May 15, 2024 and you are entitled to payment for an average of 28 hours a week (or 30 hours per week if you are a Giant employee hired after 11/16/16) through May 14, 2025, you will be covered under Plan XXX as of July 1, 2025.

If you are covered under Plan XXX, you will become eligible to receive Accident & Sickness benefits, Dental benefits and Vision benefits on the first day of the month after you have worked in covered employment for 30 months. For example, if you begin work on May 15, 2024 and you continue to be eligible for payment for covered employment for 30 months, you will be eligible for Accident & Sickness, Dental and Vision benefits on December 1, 2026.

Plan XXX – Continued Eligibility for Full-Time and Part-Time Employees

As long as you are employed by a *Participating Employer* making contributions to the Fund on your behalf pursuant to a *Collective Bargaining Agreement* with a participating *Union* or a Participation Agreement with the *Fund*, you will continue to be eligible for the above-described benefits under Plan XXX for a period of 12 months from the date that your coverage begins. For example, if you first become covered on April 1, 2024, you will continue to be covered at least until March 31, 2025, provided you continue to work in covered employment. (There is a limited exception to the above described rule for participants who are hired between October 16th – November 1st of any calendar year and first become eligible for coverage under Plan XXX on December 1 of the following year. If this applies to you, your initial eligibility period will continue for 13 months, until the next December 31, provided you continue in

covered employment. For example, if you first become covered on December 1, 2024, you will continue to be covered until at least December 31, 2025).

After your first period of coverage ends, your continuing eligibility for benefits under Plan XXX each calendar year will depend on the average number of hours per week for which you were entitled to payment for covered employment in each 12-month period ending October 14th of the prior year. For example, if your first coverage period ends on March 31, 2025, your eligibility for continued coverage through December 31, 2025 will depend on the average number of hours per week for which you were entitled to payment during the period of October 15, 2023 – October 14, 2024. If you were entitled to payment for an average of at least 28 hours per week (30 hours per week if you are a Giant employee hired after 11/16/16) during this period, you will be eligible for benefits under Plan XXX until at least December 31, 2025. If you continued to be employed in covered employment but were entitled to payment for an average of less than 28 (hours per week or 30 hours per week if you are a Giant employee hired after 11/16/16) during this period, you will be eligible for benefits under Plan XL until at least December 31, 2025. There is a separate Summary Plan Description for Plan XL. If Plan XL applies to you, please contact the *Fund Office*.

For purposes of the above, a participant is considered to be employed:

1. during periods of *Active Work*,
2. during paid vacations,
3. while on jury duty,
4. while collecting Accident and Sickness benefits from this Plan*,
5. while collecting Workers' Compensation benefits from a *Participating Employer*, not to exceed your Accident and Sickness entitlement*, and

6. during periods of leave covered under the Family and Medical Leave Act (“FMLA”) as described on page 71.

* No Contributions are required if there is no compensation in the month.

Delay in Eligibility

If you are absent from work on the day your eligibility for any group of benefits would otherwise begin, you will not be eligible for those benefits until the day you actually return to work with a *Participating Employer*. However, if you have actually begun work covered by the *Fund*, but you are not *actively at work* on the date your eligibility would otherwise begin due to *Sickness or Injury*, you will be treated as being *actively at work* for purposes of eligibility for all benefits under the *Fund* except Life benefits, Accidental Death and Dismemberment benefits and Accident and Sickness Benefits.

Transfers

Any employee of a *Participating Employer* who comes into the jurisdiction of a participating *Union* because of a geographical transfer or change in job classification will have the initial eligibility requirements waived, provided:

1. the *Participating Employer* agrees to make contributions to the *Fund* beginning with the first month following the date of the transfer or change of job classification; and
2. the length of the employee’s non-covered employment was sufficient to otherwise satisfy the Plan’s initial eligibility requirements.

You are eligible for all benefits on the first day of the calendar month following the date of transfer or reclassification. If you are re-employed by a *Participating Employer* within 30 days of termination of coverage under this *Fund* or the UFCW Unions and Participating

Employers Health and Welfare Fund (“UFCW Unions Fund”), you will be eligible for benefits under this *Fund* according to your total length of covered employment under both Plans.

If, within the same company, you are transferred from a food to a non-food classification or from a non-food to a food classification, you will be entitled to immediate benefits. The level of benefits is determined by the contribution rate.

Annual Open Enrollment

If you do not timely enroll yourself and/or your dependent(s) upon initial eligibility for coverage, you generally must wait until the next applicable Open Enrollment period to enroll or make changes to coverage for yourself and/or your dependent(s), as described below. There is an exception to this rule if you qualify for a special enrollment period, as described in the section entitled “Special Enrollment Provisions” under “Employee Eligibility.”

Enrolling in Coverage under the *Fund* and Adding or Dropping Dependents.

The *Fund* has a single annual Open Enrollment period during which you may enroll in or drop coverage as a participant under the Plan and add or drop coverage for your eligible dependents. This annual Open Enrollment period is during the month of December each year, for coverage effective January 1.

Enrolling in Medical Benefit Coverage through the Fund’s HMO Option.

If you are a participant in Plan XXX and you live in the geographical area of the HMO offered by the *Fund*, there is a separate annual opportunity to choose whether you want to receive your, and your enrolled dependents’ (if any), medical coverage under an HMO offered by the *Fund* instead of receiving traditional *Fund* medical coverage. This period is from July 15 – September 15 for coverage

effective October 1 each year. For more information, please refer to the “HMO Option” section of your SPD.

Other Enrollment Changes.

You may also drop coverage for your dependent children if the cost for dependent child coverage that must be deducted from your paycheck increases significantly, as determined in the sole discretion of the *Fund's* Trustees, provided you timely drop the dependent child coverage by submitting a new enrollment form within 30 days from the date you receive notice of the new rates.

Enrollment and Payroll Deduction Forms

In order to enroll for benefits you must complete a *Fund* enrollment form and payroll deduction form and file them with the *Fund Office*. You can get enrollment and payroll deduction forms from the *Fund Office*. Failure to enroll promptly will cause a delay in the start of your benefits

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

Special Enrollment Provisions

If you turned down coverage for either yourself or for your dependents because of other health insurance or group health plan coverage, and then that other coverage ends, you may be able to enroll yourself and your dependents under the *Fund*, **provided you do so within 30 days from the date the other coverage ended.** However, there are only a limited number of circumstances when you can enroll when you lose coverage. If the other coverage was COBRA coverage, you may request enrollment under this *Fund* only if the COBRA coverage is exhausted. For other coverage, you may request enrollment under this *Fund* if the other coverage was lost as a result of loss of eligibility or because employer contributions toward the other coverage ceased. You are not eligible to enroll

under this provision if the other coverage was lost because you stopped paying premiums.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days from the date of marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the *Fund Office* at:

FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (410) 683-6500

Loss of Eligibility

A participant will cease to be eligible for benefits upon:

1. termination of employment,
2. transfer to a job classification outside the jurisdiction of the *Collective Bargaining Agreement*,
3. layoff,
4. military service, except as provided under *USERRA* (see page 73),
5. leave of absence,
6. unpaid vacation for which no contributions are made to the *Fund*,
7. exhaustion of Accident and Sickness benefits provided by this Plan,
8. absence because of an accident or *Sickness* compensable under *Workers' Compensation* exceeding your Accident and Sickness Benefit entitlement,

9. the end of the *Participating Employer's* obligation to make contributions pursuant to a *Collective Bargaining Agreement*,
10. your *Participating Employer's* failure to make the required contributions to the *Fund* on your behalf,
11. death, or
12. your failure to remit any applicable weekly co-premium payroll deductions required by your *Collective Bargaining Agreement*.

In addition, you will cease to be eligible for benefits under Plan XXX if you fail to satisfy the requirements for continued eligibility for Plan XXX benefits, as described under “Plan XXX – Continued Eligibility for Full-Time and Part-Time Employees” on page 36.

If loss of eligibility occurs due to your termination of employment, a reduction in your hours of employment, or death, you and your eligible dependent(s) may be entitled to continue your coverage under *COBRA*, as explained on page 58. In addition, if loss of eligibility occurs due to military service, you may be entitled to continue your coverage under “*USERRA*” as explained on page 73. Further, you may be entitled to continue your eligibility by making self-payments. See the “Self-Payments” section on page 75 for complete details of this provision.

Payroll Deduction

You are responsible for paying a small portion of the cost for your health coverage through the *Fund* by deduction from your payroll.

Full Time Participants

If you are a full time participant, the cost for coverage that will be deducted from your payroll is:

- \$13 per week for individual only coverage,
- \$18 per week for the participant plus dependent child(ren) coverage,

- \$23 per week for the participant plus spouse coverage*
- \$28 per week for family coverage (participant plus two or more dependents). *

If you elect coverage under the Fund for your dependent spouse and your spouse is also eligible for health coverage through his or her employer, a \$20 per week surcharge will apply in addition to the above-described co-premiums. This surcharge will apply even if your spouse has not elected to participate in that other coverage. However, the \$20 per week surcharge is waived for any participant whose spouse also is a participant in the Plan.

Part Time Participants

If you are a part time participant, the cost for coverage that will be deducted from your payroll is:

- \$13 per week for individual only coverage,
- \$13 per week for individual coverage plus \$146.72 per month for coverage of one dependent child,
- \$13 per week for individual coverage plus \$293.44 per month for coverage of two dependent children, and
- \$13 per week for individual coverage plus \$440.16 per month for coverage of three or more dependent children.

Plan XXX part time participants are not eligible for dependent spouse coverage.

Retirees

If you are an *Actively Working* participant covered by this Plan and retire, you will no longer be eligible for health and welfare benefits under this *Plan*. However, you can exercise your rights to continue your benefits under this Plan for a limited period under the provisions of the Consolidated Omnibus Budget Reconciliation Act (*COBRA*) as described on pages 58-68 of this book.

Pre-Existing Condition Exclusions

There are no pre-existing condition exclusions on any benefits except insured dental benefits.

Date Benefits Terminate

If you terminate your employment or otherwise lose your eligibility on the first day of the month, eligibility for all benefits terminates on that day. If you lose your eligibility on any other day of the month, your benefits terminate as follows:

- **Medical** benefits terminate at the end of the calendar month in which you lose eligibility. However, if you or your eligible dependent is in the *Hospital* when loss of eligibility occurs, these benefits will continue for the hospitalized person until he or she is discharged or until the benefits are exhausted, whichever occurs first.
- **Life** benefits terminate 31 days following the loss of eligibility, but **Accidental Death and Dismemberment** benefits terminate on the day loss of eligibility occurs. See page 102 for the Life Conversion Privilege.
- **All Other** benefits terminate on the day you lose your eligibility. However, Accident and Sickness benefits will be continued to a participant who is disabled and receiving such benefits when loss of eligibility occurs, until the end of the disability or until this benefit is exhausted, whichever occurs first.

Reinstatement of Eligibility

If you lose your eligibility because of layoff, or a leave of absence approved by your *Participating Employer*, and you return to active employment, you will be reinstated to eligibility status on the first day of the month in which your *Participating Employer* makes a contribution on your behalf. If you lose your eligibility because of

military service, you will be reinstated as provided under the provisions of *USERRA* (see page 73). If you lose your eligibility for any other reason, but become actively employed again by the same or another *Participating Employer* within 30 days, your eligibility will automatically be reinstated on the day you return to active employment. If the separation is 31 days or longer, you must again meet the initial eligibility requirements. The contribution rate paid by the *Participating Employer* will determine the level of benefits you receive.

Change of Status

A full time participant who met the initial full time eligibility requirements and was reduced to part time status will be eligible for the part time schedule of benefits beginning the first day of the calendar month following the month in which he or she was reduced, provided the participant continues to meet the eligibility requirements for Plan XXX benefits. However, if the reduction to part time is involuntary, the *Participating Employer* will continue full time contributions and you will continue to be eligible for full time benefits until the first of the calendar month following the period determined by your *Collective Bargaining Agreement*.

A part time participant who met the initial part time eligibility requirements and is later reclassified to full time status will be eligible for the full time schedule of benefits only after satisfying the initial full time eligibility requirements. During the period before you satisfy those full time requirements, you will remain eligible for the part time schedule. However, if you had previously satisfied the full time eligibility requirements and are reclassified to full time status, you will be eligible for the full time schedule of benefits on the first of the calendar month following the month you are reclassified.

Courtesy Clerks

An eligible courtesy clerk promoted to either a full time or part time clerk will have his or her total length of employment counted toward the initial eligibility requirements of a full time or part time clerk.

DEPENDENT ELIGIBILITY

Only full time participants are eligible for dependent spouse coverage. Part time participants are not eligible for dependent spouse coverage.

Eligible dependents include your spouse (full time participants only) and children, as defined below.

Biological Children, Adopted Children and Children Placed for Adoption

Medical and Prescription Drug Benefit Eligibility

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

Optical Benefit Eligibility

Generally, your biological children, adopted children and children placed with you for adoption are eligible for optical benefit coverage as your dependents through the end of the *Calendar Year* in which the dependent turns age 23.

Dental Benefit Eligibility

Subject to the requirements described in the Dental Benefit section of this SPD, your biological children, adopted children, and children placed with you for adoption are eligible for dental benefit coverage as your dependents through the end of the *Calendar Year* in which the dependent turns age 19, if they are:

- Not married,
- Not employed on a regular full time basis, and
- Dependent on you for financial support.

* Children under age four are not eligible for dental benefits.

The *Fund* will provide dependent coverage for a child who is placed for adoption with a participant regardless of whether the adoption is finalized. A child will be considered to be placed for adoption with a participant if the participant assumes a legal obligation for the total or partial support of a child in anticipation of the adoption of that child. The child's placement with the participant will be considered terminated when the participant no longer has a legal obligation to support the child.

Stepchildren and Children over Whom You Have Legal Custody

Stepchildren* and children for whom you have legal custody** are eligible for medical, dental, optical and prescription drug coverage as your dependents through the end of the *Calendar Year* in which the dependent turns age 19 (unless eligible for student coverage—see “Full Time Student Coverage” below), if they are:

- 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 the eligible participant.

** You must have had court-awarded legal custody of a child for at least six months to enroll that child as your dependent. You must submit a copy of the court-entered custody order along with the applicable enrollment form. Further, you must submit a notarized letter to the *Fund Office* every six months, confirming the continuation of custody.

Full Time Student Coverage – For Dependent Stepchildren and Children For Whom You Have Legal Custody

Dependent stepchildren and children for whom you have legal custody may continue to receive **medical and optical benefits**

under the *Fund* on and after their 19th birthday if they are a full-time student at an accredited college or university, and they elect to waive any rights to elect *COBRA* that they may have. In such case the above-referenced coverage may be continued until 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.

You must complete a student certification form and return it to the *Fund Office* before the child's 20th birthday and annually thereafter in order for coverage to be continued.

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 19, 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.

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 participant does not have legal custody of the child, the child is not dependent upon the participant 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*.

A QMCSO may require that weekly disability benefits payable by the *Fund* be paid to satisfy child support obligations with respect to a child of a participant. If the *Fund* receives such an order/notice, the

order/notice meets the requirements of a *QMCSO*, and benefits are currently payable or become payable in the future while the order/notice is in effect, the *Fund* will make payments either to the Child Support Agency or to the recipient listed in the order/notice.

Full Time Participants: Waiting Period For Dependent Eligibility

Dependents of full time participants are eligible for benefits on the same date as the participant.

Part Time Participants: Waiting Period for Dependent Child Eligibility

Dependent children of part time participants are eligible for benefits on the same date as the participant. Dependent spouses of Part Time participants are not eligible for coverage.

Enrolling New Dependents

Once you have satisfied the waiting period for dependent coverage, if any, a newly eligible dependent can be included for benefit coverage by notifying the *Fund Office* and completing an enrollment form. You must apply for dependent coverage within 30 days of the date your family member becomes your dependent. If you apply for dependent coverage within 30 days from your date of marriage, your eligible spouse may be included for benefit coverage on the first day of the calendar month following the date of marriage. When you apply within 30 days of the date of a child's birth, the biological child(ren) and/or newborn child(ren) adopted or placed for adoption with you may be added as of the date of adoption or placement for adoption. When you apply within 30 days of the date of your marriage, stepchildren may be added on the first of the month following your date of marriage. If you do not enroll your dependent spouse or child within 30 days of the applicable date described above, you must wait until the next Open Enrollment period to add him or her, unless you qualify for a special enrollment event as described in this SPD.

Part Time Participants: You may enroll eligible dependent children as described above, but you are required to pay the full cost of the dependent coverage via payroll deduction. If you enroll your child/ren, your employer will set up payroll deductions to begin with the first month you are eligible for dependent coverage. Dependent coverage will not begin until the month in which your first payroll deductions are made.

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 *QMCSO*, see page 50.

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 of the stepchild is required as evidence, and evidence that the stepchild resides with the participant,.

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

Do You Already Have Coverage on a Dependent?

See "Coordination of Benefits" on pages 79-83 for the rules governing availability of dependent coverage when more than one group plan is available.

Newborn Children

Benefits begin at birth for any eligible newborn children or newborn children adopted or placed for adoption with a participant, provided the participant has timely added the child(ren) by submitting a new enrollment form within 30 days of the child's birth or adoption.

A baby born to a female participant without dependent coverage or a newborn baby adopted or placed for adoption with a female participant without dependent coverage will be eligible for medical benefits only from the date of birth until the end of the month following the date of birth. For example, if a baby is born on April 15th, he/she will be covered through May 31st.

This extension of coverage only applies if the female participant is not entitled to dependent coverage. If a participant is eligible for dependent coverage, the newborn, the newly born child placed for adoption, or newly born adopted child must be enrolled in the Plan within 30 days of the child's birth or adoption in order to be covered.

Loss of Dependent Eligibility

Your dependents cease to be eligible for benefits when:

1. You lose your own eligibility.
2. 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 3 years from the date of physical separation or the date of divorce or legal separation.

3. In the case of a biological child, adopted child, or child placed with you for adoption, the child will cease to be eligible for benefits as follows:
 - Medical and prescription drug benefits: the date the child turns age 26;
 - Dental benefits: the earliest of (a) the end of the *Calendar Year* in which the child turns age 19, (b) the end of the month in which the child begins regular full time employment, (c) the end of the *Calendar Year* in which the child ceases to be dependent on you for financial support, or (d) the end of the month in which the child is married;
 - Optical benefits: the end of the *Calendar Year* in which the child turns age 23.
4. In the case of a stepchild or child over whom you have legal custody, on the earliest of:
 - a. the end of the *Calendar Year* in which the child turns age 19 (unless he or she is eligible for student coverage);
 - b. the end of the month in which the child begins regular full time employment;
 - c. the end of the *Calendar Year* in which the child ceases to be dependent on you for financial support; or
 - d. the end of the month in which the child is married.
5. In the case of a child placed with you for adoption, when you no longer have a legal obligation to support the child.
6. In the case of a stepchild, when the child no longer resides with you.
7. You are reclassified from full time to part time status and do not meet the dependent coverage requirements for part time employees, which includes a required payroll deduction.

Dependents of an eligible participant who will lose eligibility under the Plan may be entitled to continue coverage under the provisions of *COBRA* as described on page 58.

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 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*. See also "*Medicare--Coordination of Benefits for Participants Who Are Actively Working,*" sections 1. and 2. on pages 80 and 81.

SPECIAL ENROLLMENT—MEDICAID AND CHILDREN’S HEALTH INSURANCE PROGRAM (“CHIP”)

If you turned down coverage for either yourself or your dependents when you were first eligible and, later, you or your dependents lose eligibility for financial assistance under Medicaid or the State Children’s Health Insurance Program (“CHIP”), you may be able to enroll yourself or your dependents for coverage under the *Fund*. However, you must request enrollment under the *Fund* within 60 days of the date that CHIP or Medicaid assistance terminates for you or your dependent.

In addition, you may be able to enroll yourself and your dependents in this Plan if you or your dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. Again, you must request enrollment within 60 days of the date you or your dependent becomes eligible for premium assistance through Medicaid or CHIP, in order to be covered under the *Fund*.

CONTINUATION OF COVERAGE

Continuation of Coverage under the Consolidated Omnibus
Budget Reconciliation Act of 1985 (“COBRA”)

Continuation of Coverage under the Family and Medical Leave Act
 (“FMLA”)

Continuation of Coverage under the Uniformed Services
Employment and Re-Employment Act of 1994 (“USERRA”)

Self-Payments

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 eligible participants and their eligible dependents 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 doesn’t accept late enrollees.

Participant’s Rights

Eligible participants who lose eligibility or who experience an increase in premiums for either of the following reasons, also referred to as “qualifying events,” may continue coverage:

1. Termination of employment (except for gross misconduct)
2. Reduction in hours of employment

The *Fund* offers *COBRA* coverage to qualified beneficiaries even when the beneficiary has other coverage at the time the *COBRA* election is made. However, if a participant obtains coverage, including *Medicare*, after he or she has elected *COBRA* under the *Fund*, such *COBRA* coverage may be terminated.

Spousal Rights

The dependent spouse of an eligible participant may continue coverage for himself or herself if he or she loses coverage under the Plan or experiences an increase in premiums for any of the following reasons, also referred to as “qualifying events”:

1. The death of the participant,
2. Termination of the participant’s employment, other than for gross misconduct, or reduction in the participant’s hours of employment,
3. Divorce or legal separation from the participant, or
4. The participant becomes eligible for *Medicare*.

Dependent Children’s Rights

The dependent child of an eligible participant may continue coverage for himself or herself if he or she loses coverage under the Plan or experiences an increase in premiums for any of the following reasons, also referred to as “qualifying events”:

1. The death of the participant,
2. Termination of the participant’s employment, other than for gross misconduct, or reduction in the participant’s hours of employment,
3. Divorce or legal separation of the participant
4. The participant becomes eligible for *Medicare*, or
5. The dependent child ceases to satisfy the *Fund’s* eligibility rules for dependent coverage.

Coverage may be continued for any eligible dependent that is properly enrolled on the day before the event resulting in loss of eligibility (listed above). Even if the participant rejects *COBRA* continuation coverage, each eligible dependent has the **independent** right to elect or reject *COBRA* continuation coverage. An election on behalf of a minor dependent child can be made by the child’s parent or legal guardian.

Newborn or Adopted Children

If you or your eligible dependent spouse gives birth to a child, or if a child is placed for adoption with you, you may elect *COBRA* continuation coverage for that child provided you first complete a *Fund* enrollment form and file it with the *Fund Office*. Coverage for the newborn or adopted child will continue until such time as coverage for dependent children who were properly enrolled in the *Fund* on the date before the event resulting in loss of eligibility would otherwise end.

Notification Requirements

The *Participating Employer* must notify the *Fund*, in writing, within 30 days of the participant's death, termination of the participant's employment, reduction in working hours, the participant's entitlement to *Medicare*, or the *Participating Employer's* initiation of bankruptcy proceedings. The *Participating Employer's* failure to provide timely notice may subject the *Participating Employer* to federal excise taxes.

The participant or eligible dependent must inform the *Fund*, in writing, within 60 days of a divorce or legal separation, or a dependent child's loss of dependent status under the *Fund*. If the participant or eligible dependent fails to notify the *Fund Office* within 60 days of such an event, the right to elect *COBRA* continuation coverage will be forfeited.

The participant or eligible dependent who is determined to have been disabled at the time of, or within the first 60 days of, continuation coverage must notify the *Fund Office* within 60 days of the date that the Social Security Administration determines that he or she is disabled and within 30 days of any final determination that he or she is no longer disabled.

If you become eligible for COBRA Continuation Coverage under the Plan as a result of your termination of employment or a reduction in your hours, and you elect to receive COBRA Continuation Coverage for yourself and your dependents, generally you and your dependents will be entitled to continue your COBRA Continuation Coverage for up to 18 months, subject to the limitations described in this book. If, during that 18-month Coverage period, a second qualifying event (described below) occurs, your dependents may be eligible to receive an additional 18 months of COBRA Continuation Coverage, for a total of 36 months of Coverage. Under no circumstances will COBRA Continuation Coverage extend beyond 36 months.

Second qualifying events include the death of the Participant, divorce or separation from the Participant or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund. However, since the Plan's eligibility rules permit active Participants and their dependents to remain covered after the Participant becomes eligible for Medicare, eligibility for Medicare is not a second qualifying event (it does not extend COBRA). In addition, the events described in this paragraph are second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred.

Here are some examples of how these rules work:

1. You and your dependents are currently receiving COBRA Continuation Coverage under the Plan for an 18-month period as a result of your termination of employment. If you and your spouse are divorced during that 18-month period, your dependents would be entitled to extend their COBRA Continuation Period for an additional 18 months.

2. You and your dependents are receiving COBRA Continuation Coverage under the Plan for an 18-month period as a result of your termination of employment and, during that 18-month period, you become eligible for Medicare because you have attained age 65. Your dependents will not be entitled to extend their period of COBRA Continuation Coverage under the Plan because your eligibility for Medicare would not have caused you to lose coverage under the Plan if you were still an active Participant under the Plan on your 65th birthday.

Your dependents must notify the Fund Office in writing and in accordance with the notification procedures described below in order to extend their period of COBRA Continuation Coverage upon the occurrence of a second qualifying event.

All notifications under *COBRA* must comply with these provisions. Both the participant 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 participant and/or beneficiary, participant's Social Security Number, date of occurrence of the qualifying event, and the nature of the qualifying event. In addition, you must enclose evidence of the occurrence of the qualifying event (for example: a copy of the divorce decree, separation agreement, death certificate, or dependent's birth certificate). Once the *Fund* receives timely notification that a

qualifying event has occurred, *COBRA* coverage will be offered to the participant and dependents, as applicable.

Participants and beneficiaries covered under *COBRA* Continuation Coverage must provide notice of a second qualifying event or Disability to the *Fund* within 60 days of the date of occurrence of the second qualifying event or the date of disability determination, and before the end of the 18-month *COBRA* Continuation Coverage period. The written notice must conform to the requirements for providing notices described above. The notice must include evidence of the second qualifying event or disability (for example: a copy of the divorce decree, separation agreement, death certificate, *Medicare* eligibility or enrollment, dependent's birth certificate or SSA disability determination).

Failure to provide the *Fund* notice of a disability or second qualifying event within 60 days will result in the loss of the right to extend coverage.

The *Fund Office* will notify the participant or eligible dependent within 14 days of receipt of notification of any of these events of the right to continue coverage. The participant or eligible dependent must elect *COBRA* continuation coverage within 60 days of the date that coverage would otherwise end, or if later, within 60 days from the date that the *Fund Office* first sent notice of the right to elect *COBRA* continuation coverage to the participant or eligible dependent. This election must be made in writing and returned to the *Fund Office* within the 60-day election period. Failure to notify the *Fund* on time will result in forfeiture of *COBRA* rights.

Financial Responsibility for Failure to Give Notice

If a participant or dependent does not give written notice within 60 days of the date of the qualifying event, or a *Participating Employer* within thirty days of the 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 or the *Participating Employer*, as applicable, 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 Participant, if the person was his or her dependent.

Notification Regarding Change of Address

It is very important that participants and beneficiaries 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*.

Length of Coverage

Coverage may continue under *COBRA* as follows:

1. Coverage for you and your dependent(s) may be continued for up to 18 months, if coverage is terminated due to the participant's:
 - a) Termination of employment, other than for gross misconduct; or
 - b) Reduced work hours

The 18-month period of continuation coverage may be extended an additional 11 months for you and your eligible dependent(s) if, within 60 days from the date of the event described in (a) or (b) above, the Social Security Administration determines that you were disabled. The self-pay premium for the 11 month extension will be increased by about 50%. Proof of disability must be provided to the *Fund* within 60 days from the date the Social Security Administration makes the determination and within the initial 18-month period of continuation coverage. If, during the initial 18-month period, the Social Security Administration determines that the person is

no longer disabled, the 11 month extension does not apply. If the Social Security Administration determines that the person is no longer disabled after the initial 18 month period, the period of continuation coverage ends with the first month that begins more than 30 days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed 29 months.

Other NON-DISABLED family members are also eligible for the 11 month extension. Newborn children, children placed for adoption, and newly adopted children will be treated as individual qualified beneficiaries.

2. Coverage for your eligible dependent may be continued up to a maximum of 36 months, if coverage terminated due to:
 - a) The participant's death
 - b) The participant's divorce or legal separation; or
 - c) A dependent child's ceasing to satisfy the *Fund's* rules for dependent status.
3. If a participant becomes entitled to *Medicare*, and within 18 months of becoming entitled to *Medicare*, he/she becomes entitled to *COBRA* due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the participant's dependent may be continued for up to 36 months from the date the participant became entitled to *Medicare*.

To get an extension of *COBRA* continuation coverage as described above, you must notify the *Fund Office*.

Termination of Coverage

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

1. The date a required premium is due and is not paid on time by you;
2. The date you or your eligible dependent becomes covered by another group health plan other than TRICARE (as an employee or otherwise) that does not contain any pre-existing exclusion or limitation affecting you or your eligible dependent;
3. You become covered by *Medicare* benefits;
4. In the event of divorce, you re-marry and are enrolled for coverage under your spouse's plan;
5. The *Fund* no longer provides group health plan coverage for similarly situated participants or dependents;
6. If your *Participating Employer* stops participating in the Plan, your continuation coverage will end on the date your employer establishes a new plan, or joins an existing plan, that makes health coverage available to a class of employees formerly covered under this Plan.
7. The date your eligible dependent becomes covered by *Medicare*.
8. The date the applicable period of continuation coverage is exhausted; or
9. The first month that begins more than 30 days after the date of the Social Security Administration's determination that you or your eligible dependent are no longer disabled, in situations where coverage was being extended for 11 months, provided the period of continuation coverage does not exceed 29 months.

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

You or your eligible dependent must notify the *Fund Office* immediately if you become covered by any other plan of group health benefits. Notice should be mailed or hand delivered to the

Fund Office, FELRA & UFCW VEBA Fund, Attention: COBRA Department, 8400 Corporate Drive, Suite 430, Landover, MD 20785-2361. You must repay the *Fund* for any claims paid in error as a result of your failure to notify the *Fund Office* of any other health coverage.

Under *COBRA*, the participant or eligible dependent may continue coverage for **Medical, Drug, Optical, and Dental Benefits** (you cannot continue the Life Benefit, the Accidental Death and Dismemberment Benefit, or the Accident and Sickness Benefit). You must continue every one of those benefits for which you were eligible prior to your loss of coverage (in other words, you cannot choose to continue only optical and medical, for example, or any other combination). You may **only** elect to continue benefits which were already in place at the time of the event resulting in the loss of eligibility. The cost that you must pay to continue benefits is determined annually and will be contained in the notice of right to elect continuation of coverage sent to you by the *Fund Office*.

The cost that you must pay to continue benefits is 102% of the cost of coverage, as determined annually by the *Fund*. The cost will be specified in the notice of right to elect continuation of coverage sent to you by the *Fund Office*. However, the *COBRA* premium for the 11-month disability extension period (if applicable) is increased to 150% of the cost of coverage. If your former *Participating Employer* alters the level of benefits provided through the *Fund* to similarly situated active employees, your coverage and cost will also 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 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

You must make the initial payment either at the time of your election of continuation coverage or within 45 days of the election. **Ongoing payments are due the first day of the month for which coverage is to be continued** (for example, if you want coverage for October, payment is due on October 1st). If you fail to make your premium payment within 30 days of the due date, *COBRA* coverage will be terminated.

You will not be billed; it is your responsibility to remit payments to the Fund Office. Late payments can result in termination of coverage. You are responsible for the payment of required premiums.

Important! Timely retroactive payments must be made to the date of loss of eligibility.

Claims *Incurred* following the date of the event which resulted in the loss of eligibility, but before the eligible participant or dependent has elected continuation coverage, will be held until the election has been made and premiums have been paid in full. If the participant or 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.

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.

Coverage Options Other than COBRA Coverage

Instead of enrolling in *COBRA* coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, *Medicare*, Medicaid, Children’s Health Insurance Program (CHIP), 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* continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Enrollment in Medicare Instead of COBRA Coverage after Coverage under the Plan Ends

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period (<https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>) to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare and elect *COBRA* continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect *COBRA* continuation coverage and later enroll in Medicare Part A or B before the *COBRA* continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or Part B is effective on or before the date of the *COBRA* election, *COBRA* coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of *COBRA* coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second.

For more information visit:

<https://www.medicare.gov/medicare-and-you>.

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, Suite 430
Landover, MD 20785-2361
301-459-3020

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 (“*FMLA*”) requires *Participating Employers* with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee’s child, for the employee to care for his/her own *Sickness* or to care for a seriously ill child, spouse, or parent, or for a qualifying exigency that arises in connection with the active military service of the employee’s child, spouse, or parent. You may be entitled to up to 26 weeks of *FMLA* leave if you are injured in military service, or to care for a family member who is injured in military service. Contact the *Fund Office* for more information.

In compliance with the provisions of the *FMLA*, your *Participating Employer* is required to maintain pre-existing coverage under the Plan during your period of leave under the *FMLA* just as if you were actively employed. Your coverage under the *FMLA* will cease once the *Fund Office* is notified or otherwise determines that you have terminated employment, exhausted your 12 or 26 week *FMLA* leave entitlement, or do not intend to return from leave. Your coverage will also cease if your *Participating Employer* fails to maintain coverage on your behalf by making the required contribution to the *Fund*.

Once the *Fund Office* is notified or otherwise determines that you are not returning to employment following a period of *FMLA* leave, you may elect to continue your coverage under the *COBRA* continuation rules, as described in the previous section. The qualifying event entitling you to *COBRA* continuation coverage is the last day of your *FMLA* leave.

If you fail to return to covered employment following your leave, the *Fund* may recover the value of benefits it paid to maintain your health coverage during the period of *FMLA* leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the *FMLA*. If you fail to return from *FMLA* for impermissible reasons, the *Fund* may offset payment of outstanding medical claims *Incurred* prior to the period of *FMLA* leave against the value of benefits paid on your behalf during the period of *FMLA* leave.

CONTINUATION OF COVERAGE UNDER USERRA

As required by the *Uniformed Services Employment and Re-Employment Rights Act of 1994* (“*USERRA*”), the *Fund* provides you with the right to elect continuous health coverage for you and your eligible dependent(s) for up to 24 months, beginning on the date your absence begins from employment due to military service, including Reserve and National Guard Duty, as described below. Contact the *Fund Office* for more information if this may apply to you.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible dependent(s) under the provisions of *USERRA*. The period of coverage for you and your eligible dependent ends on the earlier of:

1. The end of the 24-month period beginning on the date on which your absence begins; or
2. The day after the date on which you are required but fail to apply under *USERRA* for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

After 31 days, you must pay the cost of the coverage unless your *Participating Employer* elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in accordance with the provisions of the *USERRA* by the same method that the *Fund* uses to determine the cost of *COBRA* continuation coverage. See page 58.

You must notify your *Participating Employer* or the *Fund Office* that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under

all relevant circumstances, notice is impossible or unreasonable. You also must contact the *Fund Office* and elect continuation coverage for yourself or your eligible dependent(s) under the provisions of *USERRA* within 60 days after your military service begins. Payment of the *USERRA* premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of election of your *USERRA* coverage.

Ongoing payments must be made by the last day of the month for which coverage is to be provided. **You will not be billed; it is your responsibility to remit payments to the *Fund Office*. Late payments can result in termination of coverage.** You are responsible for the payment of required premiums.

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under *USERRA*.

SELF-PAYMENTS

A participant who is granted a leave of absence in writing by a *Participating Employer* may elect to continue coverage by making self-payments directly to the *Fund*. If you are eligible for benefits under *COBRA* or *USERRA*, or both, and you waive such coverage, you may also choose to continue your eligibility status by making self-payments directly to the *Fund*.

If you choose to self-pay, you may continue:

1. Medical benefits **ONLY**;
2. Life and Accidental Death and Dismemberment benefits **ONLY**;
3. Drug, Optical and Dental benefits **ONLY**; or
4. Any combination of these three groups.

You may make self-payments only for those benefits for which you were eligible as of the last day **prior** to your loss of eligibility. If you elect to continue eligibility by making self-payments, you must meet the following conditions:

1. You must elect to continue eligibility by making self-payments **within 30 days** following your loss of eligibility. The self-payment period must start with the month immediately following the month in which eligibility was lost. Failure to elect to make self-payments on time will cause a loss of eligibility and benefits will terminate.
2. Self-payments must be made monthly in an amount determined by the Board of *Trustees*. Amounts depend on your status (full or part time, individual or family coverage) as of your last day worked. Self-payments must be received by the *Fund Office* **on or before the first day of each month for which continued eligibility is desired**. Failure to make payments on time will terminate your eligibility for benefits as of the last day

of the most recent calendar month for which a self-payment was accepted.

3. To begin this procedure, call the *Fund Office* to find out the amount of the payment required. Mail your check or money order and a copy of your written leave of absence, if applicable, to:

FELRA & UFCW VEBA Fund
Attn: Eligibility Dept.
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361

4. Timely self-payments will be accepted until you return to active employment covered by the Plan or until your leave of absence expires, but in no case more than 18 months following your loss of eligibility. You will not be entitled to *COBRA* continuation coverage when your self-pay coverage ends.
5. Self-payments will no longer be necessary when you return to work and your *Participating Employer* resumes contributions on your behalf.

Military Personnel

Participants who are retired from active military service are entitled to benefits from this Plan for themselves and their eligible dependents even though they may be provided benefits under the TRICARE Program. Participants married to active duty military personnel are entitled to benefits from this Plan for themselves and any eligible dependents not in active military service. Notwithstanding the foregoing, benefits will be provided to participants and eligible dependents as required under federal law.

COST CONTAINMENT

Coordination of Benefits

Subrogation

Advance Benefits for Workers' Compensation Claims

Cost Awareness Reward Program

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 Allowable Charge.**

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.

Example: Suppose your spouse has a medical claim of \$500, and your spouse's primary carrier paid 80% of the claim (\$400). If the *Fund* had paid this medical claim as primary, the payment would have been 80% of approved charges, meaning the *Fund* would have paid a maximum of \$400. The *Fund* would not make any payment on this claim as secondary because the primary coverage already has paid the maximum amount the *Fund* would have paid as primary.

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.

If one plan does not have a coordination of benefits rule, it will be primary. Otherwise, the plan which covers the person as an

employee is the primary plan. The plan which 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 primary financial responsibility for a child's health care expenses, the plan of the parent having that responsibility, or the plan of the stepparent married to 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 primary custody pays before the plan of the other parent. The plan of the stepparent married to the parent with primary custody of the child pays before the plan of the parent who does not have primary custody.
3. If both parents have equal custody and financial responsibility for health care expenses, the "birthday rule" described above will apply.

Important Notice – 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.**

Rule For Part Time Participants

Coverage for part time employees **shall be secondary if the employee is covered under another plan.**

Medicare - Coordination of Benefits for Participants Who Are “Actively Working”

If you work for an employer with fewer than 20 employees, and the *Fund* has obtained an exception from the Centers for Medicare & Medicaid Services (“CMS”) for you, then *Medicare* is primary for you and your dependents. Otherwise, the following rules apply.

All active participants over age 65 and spouses over age 65 of active participants of any age will be entitled to receive coverage under this Plan under the same conditions as a participant or participant’s spouse under age 65. The Plan cannot be “secondary” to *Medicare* for employees and spouses over age 65 by paying only those medical expenses *Medicare* does not cover.

Absent an election (described below), the Plan will be the primary payor of medical costs for active participants, and spouses over age 65 of active participants of any age, with *Medicare* providing secondary coverage. This means you will be reimbursed first under

this Plan (except in the case of End Stage Renal Disease “ESRD,” as set forth below). If there are covered expenses not paid by the Plan, *Medicare* may reimburse you—if the expenses are covered by *Medicare*. To get reimbursement from *Medicare*, you must enroll for *Medicare*. In addition, to get coverage under Part B of *Medicare*, you must enroll and pay a monthly premium.

Medicare – Coordination of Benefits for Participants Who Are on COBRA

If you or your eligible dependent is eligible for *Medicare* and then elects COBRA continuation coverage, *Medicare* will be primary to *Fund’s* benefits (except in the case of End Stage Renal Disease (“ESRD”) as set forth below.)

1. Election of Medicare

If you are age 65 or older you are still entitled to elect *Medicare* as your primary coverage in lieu of the Plan. However, an active participant over age 65 or an active participant’s spouse over age 65 will automatically continue to be covered by this Plan as the primary plan unless you a) notify the *Fund Office*, in writing, that you do not want coverage under this Plan or b) you cease to be eligible for coverage under this Plan. If you elect your coverage under *Medicare* to be primary, the Plan cannot, under law, pay benefits secondary to *Medicare*. If you have any questions about the coordination of benefits under this Plan with *Medicare* benefits, contact the *Fund Office*.

2. Disability

If you are actively employed and you or your eligible dependent(s) are under age 65 and are entitled to *Medicare* due to disability (other than ESRD), the Plan will pay benefits as primary.

3. End Stage Renal Disease (ESRD)

If you or your eligible dependent(s) are entitled to *Medicare* on the basis of age or disability and you become entitled to *Medicare* based on ESRD, and the Plan is currently paying benefits as primary or you or your eligible dependent(s) are receiving COBRA continuation coverage under the Plan, the Plan will remain primary for the first 30 months of your entitlement to *Medicare* due to ESRD. If the Plan is currently paying benefits secondary to *Medicare*, the Plan will remain secondary upon your entitlement to *Medicare* due to ESRD (unless you are receiving COBRA continuation coverage).

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 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 for you and your eligible dependent.

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

SUBROGATION

Were you or your 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 and Accident & Sickness 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 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* or its designated representative of any accident or *Injury* for which someone else may be liable. You also must promptly respond to any questionnaire or inquiry sent from the *Fund's* subrogation provider. Further, you must notify the *Fund* or its designated representative 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.

You or your dependent's acceptance of *Fund* 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.

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* or its designated representative 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* or its designated representative 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 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* or its designated representative 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 fails 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 respond to the *Fund's* or its designated representative'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.

ADVANCE BENEFITS FOR WORKERS' COMPENSATION CLAIMS

The Plan does not cover claims arising from a work-related *Injury* or *Sickness*. If you suffer an *Injury* or *Sickness* that is work-related, you must file a claim for Workers' Compensation benefits with your employer. If you apply for Workers' Compensation and your claim is denied by either your employer or your employer's insurance carrier, you may apply to this Plan for Accident and Sickness or medical benefits.

Carrier vs. Commission

Your employer or your employer's Workers' Compensation *carrier* is the entity that provides work-related *Injury* or *Sickness* benefits to you and other employees of your employer. You will be sent a letter from your employer or its claims adjuster after the carrier reviews your claim, stating their decision. You must send a copy of this letter to the *Fund Office*.

If your employer or the carrier denies your claim for Workers' Compensation, you must appeal that denial to the Workers' Compensation Commission in order to receive benefits from the *Fund* related to your work-related *Injury* or *Sickness*. In order for the Fund to consider your work-related claim, your case must be heard before the Commission. When you receive a copy of the Commission's decision, you must forward it to the *Fund Office*.

The Plan will pay benefits provided that:

1. You file a claim with the *Fund* on time.
2. You submit a copy of the written denial from your employer or your employer's Workers' Compensation carrier. The denial must state that the claim is denied because it is not compensable, meaning that it is not work-related. If the claim is denied for any other reason, the *Fund* will not cover it.

3. You appeal the denial of your Workers' Compensation claim to the Workers' Compensation Commission for final adjudication within 30 days from the date the claim is denied by your employer.
4. You take all procedural action necessary to pursue your appeal with the Workers' Compensation Commission.
5. If you fail to file an appeal with the Commission within 30 days from the date the claim is denied by your employer, all benefits terminate and you must immediately repay to the *Fund* payments made by the Plan to you and/or your provider relating to your *Injury or Sickness*.
6. You notify the *Fund Office* of the date of your Workers' Compensation Commission hearing (when scheduled), and you attend the hearing.
7. You obtain approval from the *Fund* prior to any settlement of your appeal. If you accept a settlement in connection with your Workers' Compensation claim, the *Fund* will consider this an indication that your claim is work-related and will require that you reimburse the *Fund*, in full, for any benefits it has paid on your behalf relating to your Workers' Compensation claim.
8. If the Workers' Compensation Commission determines that your claim is compensable, all benefits terminate and you must immediately repay to the *Fund* payments made by the Plan to you and/or your provider relating to your *Injury or Sickness*.
9. If the Workers' Compensation Commission denies your claim for ***any reason OTHER than being non-compensable under the Workers' Compensation laws of that state, you must immediately repay to the Fund payments made by the Plan to you and/or your provider relating to your Injury or Sickness.*** If the Commission denies your claim as being non-compensable and you don't appeal that denial, you may keep any payments the

Fund has advanced to you. However, if you decide to pursue your claim after that denial and you receive any recovery, whether by judgment, settlement, or compromise, you must repay the *Fund* the payments advanced to you.

10. You must sign the *Fund's* forms agreeing to comply with these procedures.

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 advancement of benefits, 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 *all of its* costs and expenses related to the collection of those benefits.

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 attorney's 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 or your dependent 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.

COST AWARENESS (“AMATEUR AUDIT”) REWARD PROGRAM

The *Fund* wants to catch not just billing mistakes, but bills for services that are unnecessary. If you help the *Fund* find a mistake, you may get half of what is recovered--up to \$1,000. In order to receive your money, you must submit documentation that your action *resulted in the correction of the bill*. This does not apply to processing errors by the *Fund*, CareFirst PPO discount changes, or coordination of benefits in progress.

Medical, Surgical, and *Hospital* bills are open to this “amateur auditor” reward. Day-to-day *Hospital*, medical, and surgical billings, for such things as the scheduling of tests, surgical assistants, administration of prescriptions, etc., can lead to costs which you--and the *Fund*--might consider avoidable. Take your complaint to the provider, and if the provider agrees, *the Fund* can eliminate some unnecessary expenses.

Here’s what to do:

1. Try to keep track of medical services rendered to you (tests, medication, etc.). Always ask that a copy of an itemized bill be sent directly to you.
2. If there is an error on your bill, or if you believe you’ve been charged for anything you consider unnecessary, ask for an explanation from the provider. If the provider agrees, have the provider’s office correct your bill.
3. In order to receive the award, **you must contact the provider and initiate the correction. Be sure to note the names of everyone you speak with and the date you contacted him or her.** If you call the *Fund Office* about an error, the *Fund Office* will attempt to have it corrected, but it will not count for an amateur audit award.
4. Send the original bill and the corrected bill to the *Fund Office* with an explanation of your “audit.” You must submit documentation

that ***your audit*** resulted in correction of the billing error (for example, send a copy of the old bill containing the error along with the corrected bill with the name of the person you spoke with to initiate the correction). The *Fund* will give you half of what the *Fund* recovers, up to \$1,000.

Conifer Health Solutions also helps the *Fund* recover money by checking *hospital* bills to be sure they are correct. When Conifer Health Solutions discovers an error on a bill, they will contact the *hospital* to have the bill corrected, saving you and the *Fund* money. When the *Fund* saves money by not paying for incorrect charges, there is more money available for your benefits. Also, if your total bill is lower, any amount for which you are responsible is also lower.

In order for Conifer Health Solutions to review your bill, it must obtain your records from the *hospital*. If the *hospital* requires your authorization before releasing your records, Conifer Health Solutions will send you an authorization form to sign and return, giving the hospital permission to release your records to Conifer Health Solutions. Please complete and return this form promptly.

YOUR BENEFITS

Life Benefit

Accidental Death and Dismemberment Benefit

Life Conversion Privilege upon Termination of Coverage

Accident and Sickness Benefits

CareFirst PPO

ACA Preventive Services Benefit

Comprehensive Medical Benefits

Exclusions and Limitations

Mental Health/Substance Abuse Benefit

Conifer Health Solutions

Mandatory Second Surgical Opinion

Home Healthcare

Hospice Care Services

Prescription Drug Benefit

Mandatory Formulary for Prescription Drugs

Specialty Medications/Accredo Specialty Pharmacy

Prior Authorization

Step Therapy Program

Dental Benefits

Optical Benefits

Women's Health and Cancer Rights Act ("WHCRA")

HMO Option

LIFE BENEFIT

Insured by Symetra Life Insurance Company
777 108TH Ave NE, Ste. 1200
Bellevue, WA 98004
(Participant Only)

If you die while covered under the Plan, the amount of the Life Benefit in the schedule of benefits is payable to the person you have named as your beneficiary.

There are different benefit amounts in the schedule of benefits, depending on your status (full time or part time). A part time participant who has satisfied the initial eligibility requirement and is later promoted to full time will continue to be eligible for the part time life benefit until eligible for full time benefits. A participant is never eligible for both a part time and a full time life benefit.

Beneficiary

You may name any person you choose to be your beneficiary. You may change the named beneficiary at any time.

1. Contact the *Fund Office* for an enrollment form.
2. Complete and sign the form.
3. Return the form to the *Fund Office*.

Only enrollment forms which are properly completed, signed, and received by the *Fund Office* prior to a participant's death will be honored.

If the beneficiary you designate dies before you and/or you fail to designate a beneficiary, the life benefits will be paid to the first survivor in the following order:

1. Your spouse
2. Your children
3. Your parents
4. Your brothers and sisters
5. Your estate

If you and your spouse or designated beneficiary die at the same time, or simultaneously as determined by relevant state law, as a result of injuries sustained or resulting from the same accident or event, your spouse or designated beneficiary will be deemed to have pre-deceased you for purposes of this life benefit.

A beneficiary may be designated in an entered court order, provided that such order contains a clear designation of rights. The designation will become *effective* only when it is received by the *Fund* and will be *effective* only if the *Fund* has not made payment or taken other action before the designation was entered. A beneficiary designation in a court order meeting the above requirements will supersede any prior or subsequent conflicting beneficiary designation that is filed with the *Fund Office*.

Waiver of Rights

A beneficiary may waive his or her rights as a beneficiary under the Plan in an entered court order, provided that such order contains a clear waiver of rights. The waiver will become *effective* only when it is received by the *Fund* and will be *effective* only if the *Fund* has not made payment or taken other action before the waiver was entered. A waiver in a court order meeting the above requirements will supersede any prior conflicting beneficiary designation that has been filed with the *Fund Office*. If a court order contains a waiver of rights by the beneficiary on file with the *Fund Office*, and you subsequently die without naming a new beneficiary, then the *Fund*

may pay the death benefit to the first survivor in the following order:

1. Your surviving spouse
2. Your surviving children
3. Your surviving parents
4. Your surviving brothers and sisters
5. Your estate

* These same beneficiary designation procedures apply to Accidental Death and Dismemberment benefits payable on your behalf under the Plan.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Insured by Symetra Life Insurance Company

777 108TH Ave NE, Ste. 1200

Bellevue, WA 98004

(Participant Only)

This benefit is payable if you suffer any of the losses below as a result of, and within 365 days from the date of, an accident occurring while you are covered by the Plan.

For Loss of:	Benefit Amount is as stated in the “Schedule of Benefits”
Life	Full amount paid to your beneficiary.
Both Hands or Both Feet or Sight of Both Eyes	Full amount paid to you.
Any Combination of Foot, Hand, or Sight of One Eye	Full amount paid to you.
Speech and Hearing in Both Ears	Full amount paid to you.
Movement of Both Upper and Lower Limbs (Quadriplegia)	Full amount paid to you.
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters of the amount paid to you.
Movement of Three Limbs (Triplegia)	Three-Quarters of the amount paid to you.

Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	Half the amount paid to you.
One Hand, One Foot, or Sight of One Eye	Half the amount paid to you.
Speech or Hearing in Both Ears	Half the amount paid to you.
Movement of One Limb (Uniplegia)	One-Quarter of the amount paid to you.
Thumb and Index Finger of Either Hand	One-Quarter of the amount paid to you.

Benefits for the insured during all periods of coverage under the policy will not be paid for more than the full amount for all losses that are due to the same accident.

The benefit for accidental death is in addition to the life insurance benefit.

Not Covered

Symetra does not pay benefits for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury.
- *Injury* sustained while riding or driving in a scheduled race or testing any motor vehicle on tracks, speedways or proving grounds.
- *Injury* due to intoxication or being under the influence of any narcotic.
- On any aircraft except a civil or public aircraft, or military transport aircraft.
- Riding in or descending from an aircraft:

- as a pilot, crew member, student pilot, or flight instructor or examiner; or
- Being used for tests, experimental purposes, stunt flying, racing or endurance tests.
- An act of war.
- *Injury* suffered while in the military service for any country.
- *Injury* which occurs during a felony crime you commit or try to commit.

Beneficiary Designation

Your beneficiary for Life Insurance and for the Accidental Death portion of Accidental Death and Dismemberment Insurance is the person last designated by you as shown by the record on file with the *Fund Office* unless a beneficiary has been designated or waived in a court order as explained below. In accordance with the terms of the group policy, you may change your beneficiary at any time by notifying the insurance company through the *Fund Office*.

A beneficiary also may be designated in an entered court order, provided that such order contains a clear designation of rights. The designation in a court order will only be effective when it reaches the *Fund Office* and provided that the Fund has not made payment or taken other action before the designation was received. A beneficiary designation in a court order that meets these requirements will supersede any prior or subsequent conflicting beneficiary designation that is filed with the *Fund Office*.

A beneficiary may waive his/her rights to a benefit in an entered court order, provided the court order contains a clear waiver of rights. The waiver will become effective only when it reaches the *Fund Office* and provided that the Fund has not made payment or taken other action before the designation was received. A waiver in a court order that meets these requirements will supersede any

prior conflicting beneficiary designation that is filed with the *Fund Office*.

If you die without naming a beneficiary, or if your beneficiary predeceases you, the *Fund* will pay the death benefit in the following order:

1. Your surviving spouse
2. Your surviving children
3. Your surviving parents
4. Your surviving brothers and sisters
5. Your estate

Group Policy Information – Life and AD&D

The group policy has been issued to the FELRA and UFCW VEBA Fund. Life and Accidental Death and Dismemberment benefits are guaranteed pursuant to this group policy. The group policy is on file and may be examined at the *Fund Office*. **The policy number is 01 017797 00.**

This is a description of the insurance issued under, and subject to the terms, conditions, and provisions of the group policy. The group policy controls in all instances. This section merely summarizes and explains the pertinent provisions of the group policy, and it does not constitute a contract of insurance.

LIFE CONVERSION PRIVILEGE UPON TERMINATION OF COVERAGE

If your insurance is terminated because of loss of eligibility, you may convert your group life insurance without medical examination or other evidence of insurability to any life insurance policy then customarily issued by Symetra, except term insurance, by applying to Symetra Life Insurance Company at this address:

HRMP Life Conversion Facility
300 Rosewood Drive, Suite 250
Danvers, MA 01923

You can get a conversion form from the *Fund Office*. You may convert within 31 days after loss of eligibility and you will pay the premium applicable:

- To the form and amount of the policy at your age; and
- To the amount you select, up to the amount for which you were insured under the Plan.

If your insurance is terminated due to discontinuance of the Plan, you have the same conversion privilege if insured under this Plan for 5 years or longer, except that the amount of life insurance will be reduced by the amount of any life insurance you are eligible for under any new plan within 31 days of termination or \$10,000, whichever is less. Your group life insurance is payable if you die within the 31 day period allowed for conversion whether or not you have applied for an individual policy.

CLAIMS PROCEDURE

Life and AD&D

Notice of a Life and/or Accidental Death and Dismemberment Claim must be submitted in writing to the *Fund Office* within 20 days after

the date of loss upon which the claim is based, or as soon afterwards as reasonably possible.

The *Fund Office* will then provide the proper claim forms. Life Insurance claims must be accompanied by a Board of Health Certificate of Death certified by the proper authorities. Accidental Death and Dismemberment Claims must include a *Physician's* statement attesting to the loss. Symetra may, at its expense, examine the participant during the pendency of a claim. It may also, where not forbidden by law, conduct an autopsy in case of death.

For more about how to file a claim, see “Claims Filing and Review Procedure” on page 196.

ACCIDENT AND SICKNESS BENEFITS

Benefits are provided through the Fund, not insured. Benefit claims are processed by Associated Administrators, LLC (the Fund Office)

Accident and Sickness Benefits (sometimes called "weekly disability" benefits) are paid directly from the *Fund's* assets to an eligible participant who is actively at work and becomes disabled to the extent that he/she cannot perform any of the usual and customary duties with a *Participating Employer*, subject to the following conditions:

1. A completed initial claim form (one which has been approved by the Board of *Trustees*), must be received by the *Fund Office* within 90 days from the beginning of the disability. Continuation forms are sent to you every six weeks (or as needed) and must be returned within four (4) weeks of the date sent by the *Fund Office*. If your continuation form is not returned on time, you will not receive any additional Accident and Sickness benefits for that disability.
2. The disability must be verified in writing on the claim form by a *Physician* legally licensed to practice medicine, a Certified Alcohol Counselor, or a Master's Level Social Worker who is approved by Carelon Behavioral Health ("Carelon"). If you have chosen one of the HMOs to provide your medical benefits, a Certified Alcohol Counselor or Master's Level Social Worker who has been approved by your HMO may verify your disability in writing on the claim form. Your claim form may also be signed by a Certified Registered Nurse Practitioner (CRNP) or a Physician's Assistant (PA).
3. You must be seen by a *Physician* either in-person in his/her office, at your home, or at the *Hospital*, or by telephone conference, video conference, or similar technology.

4. Your *Participating Employer* must complete its section of the form.
5. All questions on the claim form must be answered. Incomplete forms will be returned for completion.
6. No disability will be considered as beginning more than three days prior to the first visit to a *Physician* during the disability period. This rule will be waived if your *Physician* provides documentation that he/she has been treating you on a regular basis for that same disability. The usual waiting periods for when benefits begin will apply.
7. No disability will be considered as beginning until after your last day worked.
8. Continuation forms must be returned within four weeks and requests for other information must be returned within two weeks from the date mailed by the *Fund Office*.
9. The fact that a claim for benefits from a source other than the *Fund* has been filed or is pending does not excuse these report requirements (e.g., *Workers' Compensation* or auto insurance).
10. Benefits are not payable if the disability is due to an *Injury* or *Sickness* which, as determined by the *Trustees*, is:
 - a) Compensable under *Workers' Compensation* legislation, occupational disease act legislation, employer's liability laws or other similar legislation, or your *Personal Injury Protection (PIP)* insurance for lost wages or sustained on a job outside the *Fund*, i.e. not a *Participating Employer*, (see "Exclusions and Limitations" on page 142),
 - b) Caused by an act of war,
 - c) Self-inflicted,

- d) The responsibility of some other person or entity,
 - e) Sustained in the commission of a felony or willful misconduct. If the felony or willful misconduct is the use of illegal substances, claims will be denied except when you are already in a treatment program approved by Carelon at the time of the *Injury* or *Sickness* and the Accident and Sickness form is completed by a Carelon *Physician*.
11. Benefits will not be payable for any period of time for which you have a compensable Workers' Compensation claim, even if the disability under your Workers' Compensation claim is different from the disability for which you seek accident and sickness benefits.
 12. Benefits will not be payable for days used as vacation days or other time paid by the *Participating Employer*.
 13. Successive periods of disability due to the same or related causes will be considered as one period of disability unless they are separated by a 60-day period during which you are not absent from work because of disability. Successive periods of disability due to entirely unrelated causes are considered one disability unless they are separated by complete recovery and return to *Active Work*.
 14. An initial claim form must be filed for any recurrence of a disability regardless of the length of time you returned to work. Continuation forms are not acceptable.
 15. The *Fund* reserves the right and opportunity to examine the person whose *Injury* or *Sickness* is the basis of a claim as often as the *Fund* may reasonably require during pendency of the claim.

16. Lack of knowledge of coverage does not excuse these requirements.
17. No benefits will be paid to any participant who owes money to the *Fund*. Failure to repay amounts owed may result in suspension of Optical, Dental and Prescription benefits. Subsequent amounts payable under the Accident and Sickness or Medical benefits may be deducted from amounts owed.
18. If the *Fund* receives a *QMCSO* directing that Accident and Sickness benefits be paid to satisfy a participant's child support obligations, and benefits are currently payable or become payable while the *QMCSO* is in effect, the *Fund* will make payment to either the state agency or alternate payee listed in the *QMCSO*.
19. You must actively be receiving treatment from a *Physician* to improve the condition which is causing your disability.

Benefit Amount – Full Time Participants

After 15 months continuous employment	Maximum Benefit – 50% of gross straight time pay for first 8 weeks plus 40% of gross straight time pay for the next 4 weeks.
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Benefits begin on the first day of disability if the disability is due to an accident. Benefits begin immediately upon hospitalization if it occurs any time during your waiting period. Hospitalization after your waiting period will not cause your waiting period to be waived. However, there are *Outpatient* medical procedures for which the *Fund* will pay benefits beginning on the first day of the disability if the procedure is performed on the first day of disability. Contact the Accident and Sickness Department to see if your planned *Surgery* is on this list.

Benefits begin on the fourth day of disability if it is because of *Sickness*. The daily benefit amount will be 1/5 of the weekly benefit amount. However, in the case of a work-related disability, where the *Fund* is providing a Supplemental benefit, the daily benefit amount will be 1/7 of the weekly benefit amount to conform with Workers' Compensation payments. Sundays or other premium days will not be counted in determining the benefit amount, but shift premiums will be counted. Benefits will not be paid for your regular day off.

Example of benefit amount computation (Full Time Participants):

First 8 weeks:

Hourly rate	= \$10.00
\$10.00 X 40	= \$400.00 gross straight time pay
\$400.00 X 50%	= \$200.00 weekly benefit amount
\$200.00 ÷ 5	= \$40 daily benefit amount

Next 4 weeks:

\$10.00 X 40	= \$400.00 gross straight time pay
\$400.00 X 40%	= \$160.00 weekly benefit amount
\$160.00 ÷ 5	= \$32.00 daily benefit amount

Benefit Amount -- Part Time Participants

After 30 months of continuous employment	Maximum Benefit – 40% of average weekly straight time pay for first 8 weeks plus 30% of average weekly straight time pay for the next 4 weeks.
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Your average weekly straight time pay is based on the average straight time hours worked in the five full pay weeks preceding the disability, as reported to the *Fund* by your *Participating Employer*.

Sundays or other premium days are not counted in determining the benefit amount, but shift premiums will be counted.

Benefits begin as of the first day of disability if it is due to an accident which immediately disables you from working. Benefits begin immediately upon hospitalization if it occurs at any time during your waiting period.

Hospitalization after your waiting period will not cause your original waiting period to be waived. However, there are *Outpatient* medical procedures for which the *Fund* will pay disability beginning on the first day. Contact the Accident and Sickness Department to see if your planned *surgery* is on this list.

Benefits begin on the seventh day of disability if it is due to *Sickness*. The daily benefit amount will be 1/7 of the weekly benefit amount.

Example of benefit amount computation (Part Time Participants):

First 8 weeks:

Hourly rate	= \$10.00
Average hours worked	= 25
$\$10.00 \times 25$	= \$250.00 gross straight time pay

$\$250.00 \times .40\%$	= \$100.00 weekly benefit amount
$\$100.00 \div 7$	= \$14.29 daily benefit amount

Next 4 weeks:

$\$10.00 \times 25$	= \$250.00 gross straight time pay
$\$250.00 \times 30\%$	= \$75.00 weekly benefit amount
$\$75.00 \div 7$	= \$10.71 daily benefit amount

Mental Health and Substance Use Disorder Claims

Disabilities arising from mental health and substance abuse disorders (which include those listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)) must be verified by a board eligible or board certified psychiatrist, a licensed or certified PhD psychologist, a Master's Level Social Worker or a Certified Alcohol Counselor. Contact Carelon Behavioral Health ("Carelon") at (800) 353-3572 for referral to an appropriate provider. The *Fund* will reimburse you for any uncovered balance you may owe for your initial visit upon receipt of an actual paid-in-full receipt from the psychiatrist or psychologist. Note: If Carelon refers you to another provider (such as a Master's Level social worker or a Certified Alcohol Counselor) or, if you have chosen one of the HMOs to provide your medical benefits and your HMO refers you to another type of provider, the *Fund Office* will accept such provider's signature on the claim form.

If an initial claim for a disability arising from a nervous or mental condition was certified by a medical *Physician* who is not a board eligible or board certified psychiatrist, only the first six days after the appropriate waiting period will be paid. Should you be hospitalized as a result of the condition, the six-day limit will be waived. Continuation forms for the initial disability claim, as well as subsequent claims due to the same disability, **must** be verified by a board eligible or board certified psychiatrist or a licensed or certified PhD psychologist or another type of provider approved by Carelon (such as a Master's Level social worker, for example).

Benefit Exhaustion

Your eligibility status for other benefits will be maintained while you are receiving Accident and Sickness benefits. But if you exhaust your Accident and Sickness Benefits and do not return to active employment, you will lose eligibility and all benefits will terminate as described on page 41. If you secure a leave of absence from your *Participating Employer*, benefits may be continued under the

provisions of *COBRA* as described on page 58. If you waive your *COBRA* election rights, you can continue benefits by making self-payments as discussed on page 75.

**You have 90 days from the first date of disability to file an
Accident and Sickness claim.**

Claims Procedure

To claim a benefit from the *Fund*, you must:

1. Get an “Accident and Sickness Claim Form” from your *Participating Employer* or the *Fund Office*.
2. Complete the participant section of the form and sign it.
3. Have your *Physician* complete the *Physician* section of the form. A certified *Nurse Midwife* may certify a disability for delivery only. If you are disabled prior to delivery, a *Physician* must complete the form and state the pregnancy-related disability. If the return to work date is unknown, your *Physician* should estimate a date. ONLY the treating *Physician*, Master’s Level social worker, certified alcohol counselor, physician’s assistant or certified registered nurse practitioner can complete this section. All questions must be answered completely.
4. Have your store manager or other authorized employer representative complete the employer section of the form. ONLY an authorized employer representative can complete it. All questions must be answered completely.
5. Corrections to the form **must be initialed** by the person making the change or the form will be returned. Improperly altered claim forms will be denied.
6. Mail the completed form to:
FELRA and UFCW VEBA Fund
P.O. Box 1064
Sparks, MD 21152-1064

Claims must be received in the *Fund Office* within 90 days from the beginning of the disability.

7. If you remain disabled you may be required to submit a “Notice of Continuation for Group Accident and Sickness” form periodically for the duration of your disability. If a Continuation Form is required, the *Fund Office* will send you one.
8. If you fail to return your Continuation Form on time, all future benefits related to that disability will terminate.

Accident and Sickness Benefit Claims Review and Appeal Procedures

The Plan’s claims review and appeal procedures for Accident and Sickness benefit claims that are denied in whole or in part are described beginning under “If Your Accident & Sickness Claim Is Denied” in the Claims Filing and Review Procedure section on page 211 of this book.

How to Pick Up Your Check

Disability claims are paid weekly and are not issued at any other time. Your check will be mailed to you each Friday unless you decide to pick it up yourself at the *Fund Office*. Checks may be picked up at any *Fund Office* location between 12:30 and 2:30 p.m. on Friday.

If you want to pick up your check at the Sparks or Landover offices, you must notify Participant Services in the Accident & Sickness Department by 4:30 p.m. on Wednesday. Call toll free at 1-800-638-2972. **Only the participant may pick up a check.** For your protection, photo identification is required. Your check will **not** be released if you do not have proof of identity. Holidays may cause a change in the check pick-up schedule.

Withholding Income Taxes

A form reporting the total benefits paid in a *Calendar Year* will be provided to you each year by your *Participating Employer*. A copy

will be sent to the Internal Revenue Service. You may request that taxes be withheld from your weekly benefit check provided:

1. You submit a signed IRS Form W-4S for federal withholding, or an Annuitant's Request for State Income Tax Withholding for state withholding, to the *Fund Office*; **and**
2. The amount to be withheld is not less than \$4.00 per day or \$20.00 per week.

Withholding will not take place if the amount you wish to have withheld will reduce the weekly benefit amount to \$10.00 or less. Withholding on partial weeks will be pro-rated.

Social Security

Federal law requires that Social Security and *Medicare* Tax (FICA) be withheld from your Accident and Sickness benefits and forwarded to the federal government. Your *Participating Employer* also pays FICA on your Accident and Sickness benefit payments. There are no forms necessary for you to fill out for FICA withholding.

Federal Unemployment Taxes

Federal law requires that federal unemployment taxes (FUTA) be withheld from your Accident and Sickness benefits and forwarded to the federal government. Your *Participating Employer* pays FUTA on your Accident and Sickness benefit payments. There are no forms necessary for you to fill out for FUTA withholding.

Workers' Compensation

If you become disabled as a result of an accident or illness related to your employment with a *Participating Employer* in this *Fund*, the *Fund* may supplement the benefits you receive under your *Participating Employer's* Workers' Compensation insurance. There are two types of additional benefits:

- **Waiting Periods.** Time lost without pay because of waiting periods imposed by State Workers' Compensation laws will be supplemented by the *Fund*.

Example: Workers' Compensation in Maryland begins on the fourth day of disability. If the disability lasts for more than 14 days, the Workers' Compensation benefit then pays the first three days. If the disability is 14 days or less, the *Fund* will pay for the first three days.

- **Supplemental Benefit.** If you are a **full time** participant, the *Fund* will pay you the difference between the weekly benefit amount you receive from Workers' Compensation and the amount you would have received from the *Fund* if the disability had **not** been work related.

Example: If the Plan's Accident and Sickness Benefit is \$266.66 per week and the Workers Compensation Benefit is \$250.00 per week, the *Fund* Supplemental Benefit would be \$16.66 per week. If the Workers' Compensation payment exceeds your Accident and Sickness Benefit amount, the *Fund* will make no supplemental payment. **Remember, this Supplemental Benefit is only available for full-time participants (not part-time).**

Workers' Compensation - Denied Claims

If you apply for Workers' Compensation and your claim is denied by either your *Participating Employer* or your *Participating Employer's* insurance carrier, you may apply to this *Fund* for Accident and Sickness Benefits. See the "Advance Benefits for Workers' Compensation Claims" section (page 90) for the conditions of payment.

Modified/Light Duty

The *Fund* does not pay Accident and Sickness benefits if you are partially disabled and return to work on modified or light duty.

CAREFIRST PPO

If You Have Chosen an HMO Option for Providing Your Medical Benefits, the CareFirst PPO Does Not Apply to You

CareFirst PPO is a network of *Hospitals, Physicians*, and other health care providers which offers medical and *Hospital* services at discounted rates that are generally lower than usual provider fees. **You must use a CareFirst provider to have coverage for *Hospital, medical, or surgical benefits under the Fund*** (with the exception of: (1) *No Surprises Services* and (2) emergency *Ambulance Service*). You are covered for *No Surprises Services* and emergency *Ambulance Service* provided by non-PPO network providers.

CareFirst *reprices* claims when you use a participating provider, but CareFirst is not your insurance carrier. Your coverage is provided through the *Fund*.

Provider Directory

The provider directory which lists providers that are in-network because they participate with CareFirst will be updated at least every ninety (90) days and will be available through the Fund's website. If you receive services from a provider that you thought was in-network, based on inaccurate information provided by the Fund in a provider directory stating that the provider was in-network, then the services provided by that out-of-network provider will be covered as if the provider was in-network.

ID Card

Each active participant who lives within the Baltimore, DC, Northern VA area will receive a green colored *Fund* identification ("ID") card from the Fund office showing his/her name, CareFirst ID number, as well as his/her CareFirst Group, Prefix and Plan. If you have dependent coverage, you will receive two cards. The CareFirst network applicable to participants receiving this ID card

is referred to as the ***Local Lease or Net Lease network with CareFirst***. ***If you are a Local Lease participant, you must use a Local Lease CareFirst provider in order for your provider to be considered in-network under the Plan! This is very important.***

If you live outside the Baltimore, DC, and Northern VA area, you will receive a white ID card directly from CareFirst showing your CareFirst ID number, CareFirst Group, and Plan. The CareFirst network applicable to participants receiving this ID card is referred to as the ***Flexlink network with CareFirst***.

Participants will not receive separate ID cards for each covered dependent child. ***Always show the Physician, Hospital or other health care provider your Fund ID card.***

CareFirst does not give out participating provider information over the phone! You must go online using the instructions below to locate a participating provider. If you don't have Internet access, call the Fund office for assistance in locating a participating provider.

To Locate a CareFirst Provider – Local Lease (blue ID card)

1. **Go online** to www.carefirst.com
2. Click on the “Find a Doctor” link (Bottom left of screen)
3. Click on the “Search for Care” link under the Find a Doctor” section.
4. Click on the “CareFirst – Network Leasing” link (bottom left of screen)
5. Type in the City, State or Zip in the “City, state or zip” line, then click on the desired choice OR click on “Use Current Location”, then choose:
 - a) “Browse by Category”
 - a. Medical - click on the blue arrow for additional sub-categories:

- i. Medical: Primary Care, OBGYN, Specialist, Urgent Care Center, Behavioral Health, Hospitals, Other Facilities, Other Medical Providers, All Specialties (A-Z)
- b. Urgent Care Centers - “Search for Names and Specialties”

To Locate a CareFirst Provider for Flexlink Participants (white ID card)

1. Type www.bcbs.com
2. Click on the “Find a Doctor” link (top right of screen)
3. Click on the “In the United States, Puerto Rico and US Virgin Islands” link OR the “Outside United States” link
4. Click on “Choose a location and plan”
5. Type in “Enter the address, city or zip code” OR click on the “Use my current location” link for the area you are searching.
6. Click on “Yes, this is correct”
7. Input the Fund prefix from your ID card under “Find your plan by prefix”, then click on “Continue”
8. Click on any of the following links: “Doctor by name”, “Doctor by specialty”, “Places by name”, or “Places by type”

Always verify that the provider participates with CareFirst when you arrive at your appointment. This is especially important for Local Lease participants.

CareFirst will reprice the claim and forward it to the *Fund Office* for processing.

For Local Lease participants, if your provider is not submitting your claim electronically, it should be mailed directly to CareFirst at:

CareFirst/Network Leasing
PO Box 981633
El Paso, TX 79998-1633

Flexlink providers should file claims electronically.

A CareFirst provider should **not** require payment for covered services at the time of service unless the service provided is a non-covered benefit or if your *Deductible* has not been met. If the provider attempts to collect payment for covered services at the time of your visit, remind the provider that payment will be made by the *Fund* after CareFirst reprints the billing. The amount of the reduced charge which the patient is responsible for paying will be shown on the *Explanation of Benefits (EOB)* which is sent to you and your provider after your claim has been processed.

Laboratory Services through LabCorp or Quest

Important: For laboratory services to be covered, you must use either LabCorp or Quest Diagnostic Laboratories for all laboratory services (except those performed when you are an *Inpatient* in the *Hospital* or by out-of-network providers at in-network facilities). Lab services performed in your doctor's office or other locations generally will not be covered. To find the nearest LabCorp location, call (888) 522-2677 or log onto their website at www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220 or go to their website at www.questdiagnostics.com/appointment.

ACA PREVENTIVE SERVICES BENEFIT

This Fund provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided on an in-network basis only, at 100% of the *Fund's Allowable Charge*, with no cost-sharing (for example, no *Deductibles*, *Co-insurance*, or *Co-payments*), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit.

The *Fund* will determine whether a particular benefit is covered under this Preventive Services benefit.

A complete list of preventive services covered under this Preventive Services benefit, with detailed descriptions of coverage limitations and exclusions, is available on the *Fund's* website at www.associated-admin.com. Click on "Your Benefits" and select "FELRA," followed by "FELRA & UFCW Health & Welfare Plan," to be directed to the *Fund's* homepage. From there, under "Important Notices," click on "FELRA and UFCW List of ACA

Preventive Services” to view the complete list. You also may request a paper copy of the complete preventive services list, including limitations and exclusions, by contacting the Fund Office.

Office Visit Coverage

Preventive Services are paid based on the *Fund’s* payment schedules for the individual services. However, there may be limited situations in which an in-network office visit also is payable under the Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition. The following conditions apply to payment for in-network office visits under the Preventive Services benefit.

- If a preventive item or service is billed separately from an office visit, then the *Fund* will impose cost-sharing with respect to the office visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the *Fund* will pay for the office visit without cost-sharing.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the *Fund* will impose cost-sharing with respect to the office visit.

For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the *Fund* will require a co-payment for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the *Fund* will charge a co-payment for the office visit because the blood pressure check was not the primary purpose of the office visit.

OTHER ROUTINE EXAMS/TESTS

Routine PSA Test

In addition to the routine tests and examinations covered under the ACA Preventive Services benefit referenced above and described in detail on the *Fund's* website, a routine PSA (prostate specific antigen) test for male participants and dependents age 50 and over is covered under your medical benefits at 100%, up to the *Allowable Charge*, with no *Deductible*, once every 12 months.

COMPREHENSIVE MEDICAL BENEFITS

Benefits are provided through the Fund, not insured.

Benefit claims are processed by Associated Administrators LLC (the Fund Office).

Notwithstanding anything in this Section to the contrary, no prior authorization requirement will apply to Emergency Services.

You Must Use a CareFirst Provider

Medical benefits will be covered ***only if services are performed by an in-network provider***, with the exception of: (1) *No Surprises Services* and (2) *emergency Ambulance Service*. When you need to use a provider (whether a *Hospital, Physician*, or other health care provider), be sure they are in the CareFirst network. Otherwise, your claim will be denied unless it fits into one of the specific exceptions mentioned above.

Benefit Amount

The following pages describe the services payable under the Comprehensive Medical Benefit. Covered services include *Hospital* services, medical surgical services, medical services and mental health and substance abuse benefits. Unless specified otherwise or covered under the ACA Preventive Services Benefit section on page 120, these expenses are paid at 70% (up to the *Allowable Charge*) after you have satisfied the annual *Deductible*.

The Deductible

The annual *Deductible* is the first \$500 per covered person, of covered medical expenses *Incurred* in a *Calendar Year* for an illness or *Injury*. In cases of a common accident in which two or more of your family members are involved, only one *Deductible* must be satisfied. After the *Deductible* is met, the Comprehensive Medical Benefit covers 70% (up to the *Allowable Charge*) of your eligible medical expenses.

When a participant or dependent has *Incurred* covered medical expenses for essential health benefits which result in \$5,000 being paid out-of-pocket in a *Calendar Year*, reimbursement for essential health benefits will be increased to 100% of covered charges for the remainder of that *Calendar Year*. In addition, when a family (the participant and all covered dependents) has *Incurred* covered medical expenses for essential health benefits which result in \$10,000 being paid out-of-pocket in a *Calendar Year*, reimbursement for essential health benefits will be increased to 100% of covered charges for the remainder of that *Calendar Year*.

Payment of Benefits

When the professional services described below are rendered by a *Physician*, physician's assistant, nurse practitioner or certified surgical assistant, the Plan will provide benefit payment at 70%, up to the *Allowable Charge*. The annual *Deductible* applies, except as may otherwise be provided here or under applicable law. Payment by the *Fund* will constitute full and final payment, except as may otherwise be provided or limited here or under applicable law. Charges made in excess of these amounts are the responsibility of the patient, **except** in the case of *No Surprises Services*. Your only financial responsibility for any *No Surprises Service* is any applicable *Deductible*, *Co-Insurance* and/or *Co-Payment* amount, up to the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider. You will not be responsible for any other amount relating to *No Surprises Services*, even if the provider does not accept the *Allowable Charge*.

Hospital Services

Conifer Health Solutions pre-authorization is required for all *Hospital* admissions, except that there is no prior authorization requirement for *Emergency Services*. Contact Conifer Health Solutions at (833) 778-9806.

Extent and Duration

When you or your eligible dependent are admitted to a *Hospital* as a registered *Inpatient*, you are eligible for benefits for the following *Hospital* services when the services are furnished and billed as *Hospital* services, and when consistent with the diagnosis and treatment of the condition for which hospitalization is required:

1. Room and board in semi-private accommodations and special care units is covered at 70% up to the semi-private room rate.
2. General nursing care;
3. Use of the operating, delivery, recovery, or treatment room;
4. Anesthesia, radiation, and x-ray therapy when administered by an employee of the *Hospital*;
5. Dressings, plaster casts, and splints provided by the *Hospital*;
6. Laboratory examinations;
7. Basal metabolism tests;
8. X-ray examinations;
9. Electrocardiograms and electroencephalograms;
10. Physiotherapy and hydrotherapy;
11. Oxygen provided by the *Hospital*;
12. Drugs and medicines in general use;
13. Administration of blood and blood plasma and intravenous injections and solutions; and
14. Special Care Units.

If you request a private room, you are eligible for all the benefits above, but you must pay the *Hospital* the difference between its

actual charge for the private room and its average charge for semi-private rooms.

Air Ambulance Services

Under applicable law, the cost-sharing requirement applicable to out-of-network air ambulance services must be no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider. In general, you cannot be balance billed for these air ambulance services, in excess of the Plan's applicable in-network cost-sharing requirements.

Ambulance Service

Benefits are provided for emergency *Ambulance Service* up to \$200 per trip. The patient's condition must be such that use of any other method of transportation is not medically advisable.

Ambulatory Center Benefit

In place of a *Hospital*, you may use an ambulatory surgical facility which has permanent facilities and equipment for performing surgical procedures on an *Outpatient* basis. This facility must provide treatment by or under the supervision of *Physicians* and nursing services whenever the patient is in the facility, but it cannot provide *Inpatient* accommodations. It must not, other than incidentally, be used as an office or clinic for the private practice of a *Physician* or another provider. The facility must be approved by the Plan.

Anesthesia Services

The Fund covers the services of a Certified Registered Nurse Anesthetist ("CRNA") when administering anesthesia, but **only** if an anesthesiologist is not also administering anesthesia.

If you receive anesthesia and the Fund is billed for the services of both a CRNA and an anesthesiologist for the same operation, the Fund will pay only the anesthesiologist, not the CRNA. Services of a CRNA are only covered if an anesthesiologist has not billed the Fund.

Cardiac And Rehabilitation Benefit

Cardiac and Rehabilitation charges are covered at 70% up to the *Allowable Charge*, after the *Deductible*.

Rehabilitation benefits are available for participants and eligible dependents who have had cardiovascular or cerebrovascular accidents, closed head injuries, spinal cord injuries, neurological disorders, and major joint procedures. **All rehabilitative care must be approved by Conifer Health Solutions.** Coverage includes 30 days of *Inpatient* rehabilitation or 60 *Outpatient* visits when the visits are determined by Conifer Health Solutions to be in lieu of *Inpatient* treatment. Speech and occupational therapy services are covered when provided as part of the approved rehabilitation program.

To be eligible as a patient for the Cardiac Rehabilitation Program (CRP), you or your eligible dependent must have angina pectoris, or must have previously had a myocardial infarction or undergone coronary *surgery*. Benefits are based on the number of visits you make. This is because the services and supplies available to each patient will vary with the choice of *Cardiac Rehabilitation* provider. The program provides benefits for expenses for up to a maximum of 90 visits under any one course of treatment; however, benefits can be renewed for recurring heart problems, such as a *Hospital* stay for a heart attack or heart *surgery*, or as a result of a diagnosis of angina pectoris (chest pain).

The program must include planned exercise under guidelines set by the American Heart Association. Approved programs also must include educational sessions on topics such as diet and personal health behavior, as well as individual, family, and group counseling

to aid mental and social adjustment to heart disease. The Cardiac Rehabilitation Program must be conducted under the direction of a *Physician* in a *Hospital Outpatient* setting.

Only those services or supplies provided at the direction of or through the coordination of CRP Providers are covered. Your CRP benefits are renewed for another 90 visits by another *Hospital* admission for a diagnosed myocardial infarction or coronary *surgery* or, in the case of diagnosed angina pectoris, by satisfying a given set of criteria. Unused visits from one CRP course of treatment may NOT be carried over to a subsequent CRP course of treatment.

Send your treatment plan to the *Fund Office* to see if it meets the above requirements.

Chemotherapy

Benefits for chemotherapy services shall be available to you or your eligible dependent(s) for the reasonable cost for the administration of anticancer chemotherapeutic agents when provided in the *Physician's* office or an outpatient facility. Benefits shall include the cost of chemotherapy materials used.

Cleft Lip or Palate Conditions

Benefits are available to cover medical expenses for the treatment of cleft lip and cleft palate conditions. The various covered services include: expenses arising from orthodontics; oral *surgery*; otologic, audiological, and speech/language treatment.

Cologuard – Colorectal Cancer Screening

Cologuard colorectal cancer screening tests are covered under the Plan, subject to the same guidelines followed by Medicare Part B for coverage of such tests. Under the current Medicare guidelines, the test is covered once every three years for participants and eligible dependents who are ages 45 to 85 years old, have no signs or

symptoms of colorectal disease (i.e., lower gastrointestinal pain, blood in stool, etc.), and are at average risk of developing colorectal cancer.

Consultation Services

Benefits for consultation services, except staff consultation required by *Hospital* rules or regulations, are available to you or your eligible dependent when you are admitted to a *Hospital* as an *Inpatient* in conjunction with surgical or medical services and when the consultation is requested by the attending *Physician*. Benefits will be provided for one consultation per consultant during any *Hospital confinement*.

Continuing Care Patients

If an in-network provider leaves the CareFirst network, a *Continuing Care Patient* who is receiving care with that provider will be notified, and may elect to continue to receive such care at the same in-network *Co-Payment* and *Co-Insurance* rate for up to 90 days after receiving the notification of the provider leaving the network.

Diagnostic Study (Admission)

Inpatient admissions for *Diagnostic Study* are covered when the study is directed toward the diagnosis of a definite condition of disease or *Injury*. Benefits are not provided for *Inpatient* admissions for:

- (1) audiometric testing; (2) eye refractions; (3) examinations for the fitting of eye glasses or hearing aids; (4) psychiatric examinations; (5) psychological testing; (6) dental examinations; (7) pre-marital examinations; (8) research studies; (9) allergy testing; (10) screening; (11) routine physical examinations or checkups; or (12) fluoroscopy without films.

Diagnostic X-Ray and Laboratory Services

Benefits for *Diagnostic* x-ray and laboratory services (including pathological examination of tissue, electrocardiograms, electroencephalograms, routine PAP smears, and basal metabolism tests) are available to you and your eligible dependent when treated in the *Outpatient* department of a *Hospital* or a *Physician's* office and such examinations are required for the diagnosis or treatment of *Sickness* or *Injury*.

Benefits do not include services for any examinations in connection with care of teeth, research studies, pre-marital examinations, fluoroscopy without films, or an examination not incidental to or necessary for the diagnosis of a disease or *Injury*. Payment will not be made to both a *Hospital* and *Physician* for the same service.

Important: For laboratory services to be covered, you must use either LabCorp or Quest Diagnostic Laboratories for all laboratory services (except those performed when you are an *Inpatient* in the *Hospital* or by out-of-network providers at in-network facilities). Lab services performed in your doctor's office or other locations generally will not be covered. To find the nearest LabCorp location, call (888) 522-2677 or log onto their website at www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220 or go to their website at www.questdiagnostics.com/appointment.

Durable Medical Equipment ("DME")

Durable Medical Equipment is covered by the *Fund*, subject to pre-authorization by Conifer.

For DME equipment, you or your *Physician's* representative should call Conifer Health Solutions at (833) 778-9806 for pre-authorization as soon as you know you will need *Durable Medical*

Equipment. Conifer Health Solutions will review for *Medical Necessity*.

Flu Shots

Immunizations for influenza (flu shots) are covered under the ACA Preventive Services Benefit section on page 120. There is no charge if you get the flu shot at any Giant or Safeway pharmacy using your Express Scripts prescription ID card. 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 Fund coverage, the injection itself is covered at 100% up to the *Allowable Charge*, but the office visit charge (if there is one) is covered under your medical benefit at 70% up to the *Allowable Charge* (see "Office Visit Coverage" under the ACA Preventive Services Benefit section). However, if you get the flu shot in a doctor's office, you **must** use a participating CareFirst provider in order to be covered.

Gardasil Vaccine

The HPV vaccine Gardasil is covered under the ACA Preventive Services Benefit. 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, or you 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 *Allowable Charge*, but the office visit charge (if there is one) may only be covered under your medical benefit at 70% up to the *Allowable Charge*, after satisfying the *Deductible* (see "Office Visit Coverage" under the ACA Preventive Services Benefit section).

Human Organ Transplants

Benefits are available for *Hospital* services and supplies and practitioner services for kidney, cornea, and bone marrow transplants. If you or your eligible dependent are the recipient of the transplant, benefits cover both you and the donor. If you are the donor, only you are covered, and only to the extent that the recipient does not cover you. Charges for procurement of major organs are not covered.

In addition, benefits are available for evaluation, room and board, *Hospital* services and supplies, and practitioner services for human heart, heart-lung, liver, and pancreas transplants. Charges for evaluation, room and board, *Hospital Services* and supplies, and practitioner *services* are covered up to the limits of the Plan and are subject to the Comprehensive Major Medical benefit of \$1 million for each different organ transplanted. There are other conditions and exclusions under this benefit. If you are a candidate for a transplant, you must contact the *Fund Office* at least 30 days prior to the proposed transplant for approval. **Pre-certification is required and services must be approved by Conifer Health Solutions.**

Replacement transplants are not covered, and services related to a second transplant (including complications from the second transplant) are not covered.

Inpatient Medical Services

Benefits for medical services are available to you when you or your eligible dependent are admitted to a *Hospital* as an *Inpatient*.

Maternity Benefits

A female participant or spouse entitled to dependent coverage is eligible to receive the *Hospital* services described above beginning on the date she is eligible for benefits. There is no **additional** waiting period for maternity benefits. Benefits are available for services rendered in a maternity center or by a registered *Nurse Midwife*

certified by the American College of Nurse Midwives. Midwives must meet the criteria required by law to be covered. Maternity benefits include nursery care of the newborn child or children while the mother is receiving benefits. **Dependent daughters of participants are not eligible for maternity benefits, except to the extent benefits are covered under the ACA Preventive Services Benefit section on page 120.**

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

Medical Conditions of the Mouth, Jaw, and Proximate Areas

Benefits are available to you for oral surgical services consisting of the reduction or manipulation of fractures or bones; excision of the mandible joints and lesions of the mandible, mouth, lip, or tongue; incision of the accessory sinuses, mouth, salivary glands, or ducts; manipulations of dislocations of the jaw; removal of impacted teeth only when *Hospital Confinement* is required or when rendered in the *Outpatient* department of a *Hospital*; plastic reconstruction or repair of the mouth or lips necessary to correct *Accidental Injury*. Charges *Incurred* for the treatment of the teeth, dental structures, alveolar processes, dental caries, extractions, corrections of impactions, gingivitis, orthodontia, or prostheses, or the professional fee for extraction of teeth will not be covered under the medical benefit;

but some of these procedures may be covered under your Dental Benefits through Dentegra—see page 178 of this book.

In general, services related to the mouth, jaw, and proximate areas are covered under the medical benefit when the clinical diagnosis and symptoms are medical in nature, not dental. See the exclusion for dental services under “Exclusions and Limitations” on page 181. Eligible services may be covered when there is a diagnosis of medical disease, skeletal deformity with actual or potential degeneration or skeletal discrepancy. The *Fund* may require radiological exams and a medical history and physical exam in order to determine whether the services are medical in nature. Please submit a treatment plan to the *Fund Office* so it may make this determination before claims are *Incurred*.

Mental Health And Substance Abuse

All inpatient care, partial hospitalization, intensive outpatient, residential care and other forms of treatment involving residential supervision **MUST** be pre-certified by Carelon Behavioral Health (“Carelon”) to be covered under the Plan, with the exception of *Emergency Services*. In addition, psychological testing (when conducted in connection with a diagnosed mental health disorder) must be pre-certified by Carelon, and all Electro-Convulsive Therapy (ECT) must be pre-certified by Carelon. Finally, Carelon will review all claims for behavioral health services under the Plan.

Mental health and substance abuse treatment is covered at 70% under Major Medical up to the *Allowable Charge* and subject to the other limits of the Plan. **You and your eligible dependent(s) must use a Carelon provider in order to be covered, with the exception of *Emergency Services* and *No Surprises Services*.** To authorize treatment or to receive assistance in locating an in-network provider, contact Carelon at (800) 353-3572. For additional information, see page 147.

Obstetrical Benefits

Benefits for obstetrical services are available to all female participants or spouses of full time participants entitled to dependent coverage. These benefits include prenatal and postnatal care. Care shall be provided to any properly enrolled eligible newborn child or children from birth or to any newborn child or children adopted or placed for adoption with a participant. In lieu of obstetrical services provided by a *Physician*, you may elect to receive benefits for non-surgical obstetrical care or services provided by a nurse-midwife who is a licensed registered nurse certified by the American College of Nurse Midwives. There is no waiting period for obstetrical benefits.

In addition, obstetrical services are available to all female dependent spouses and children of full time and part time participants to the extent the services are covered benefits under the ACA Preventive Services Benefit section on page 120.

Outpatient Emergency Care

Benefits are available to you or your eligible dependents for care received within 72 hours of an *Accidental Injury*, by a *Physician*, wherever it is performed, and for *Outpatient Emergency Services*.

Outpatient Treatment

Outpatient Hospital treatment will be covered when the treatment is for:

1. The performance by a *Physician* of minor surgical procedures required for treatment and not solely for diagnosis,
2. care rendered within 72 hours after a non-occupational *Accidental Injury*, or
3. *Emergency Services*.

Benefits for coverage of *Outpatient* radiation and radioactive isotope therapy will be provided when performed in the *Outpatient* department of a *Hospital* and billed as a *Hospital* service.

Pediatric Services

Benefits for pediatric services are available for any properly enrolled newborn child or children born to a full time participant or eligible dependent spouse or for any properly enrolled newborn child or children adopted or placed for adoption with a participant or eligible dependent spouse. These benefits will not be provided if the pediatric service is rendered by the same *Physician* who rendered obstetrical services. **Dependent daughters of participants are not eligible for pediatric benefits relating to the care of the dependent daughter's newborn or adopted child(ren).**

Physical Therapy

Like all medical services, physical therapy must be *Medically Necessary* to be covered. The *Fund's* medical adviser, Conifer Health Solutions, will determine how many treatments are necessary. It is wise to submit a treatment plan so that you are aware of any treatments which would be found not *Medically Necessary* before you *Incurred* them.

Pre-Admission Testing

Benefits are available to you and eligible dependents for pre-operative laboratory tests and x-ray examinations performed in the *Outpatient* department of a *Hospital* prior to your scheduled admission for an *Inpatient* stay, provided the tests would have been available under this program to a *Hospital Inpatient* and are *Medically Necessary* for the treatment of your condition.

Benefits will not be payable if those tests are not *Medically Necessary* at the time of the subsequent *Hospital* admission or if the admission is cancelled for non-medical conditions.

Radiation Therapy

Benefits shall be provided to you or your eligible dependent(s) for the reasonable cost for the following services wherever administered by a *Physician*.

1. Deep or superficial x-rays for the treatment of neoplasms, lymphoid hyperplasia of the nose and pharynx, and disorders of the female genital system and breasts.
2. The application or implantation of radium or radon.

Benefits are not provided for the cost of radiation therapy materials used.

Room and Board

Room and Board in the *Hospital* or in a special care unit is payable at 70% of the semi-private room rate up to the *Allowable Charge*.

Surgical Assistant Services

Benefits are available to you or your eligible dependents for the services of a *Physician*, certified surgical assistant, physician's assistant, or nurse practitioner who actively assists the operating surgeon in the performance of surgical services when the condition of the patient and type of surgical performance require assistance and when interns, residents, or house staff are not available.

When a certified surgical assistant submits a claim having performed services as an assistant at a *surgery*, the plan will determine if the *surgery* is a covered benefit and if the use of an assistant was *Medically Necessary*. If so, for services as an assistant at *surgery* the Plan will pay:

- For a certified surgical assistant, 16% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status.

- For a *physician*, 20% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status.

Surgical Services

Benefits for surgical services are available to you or your eligible dependent whenever performed by a *Physician* for operative and cutting procedures, the reduction of fractures and dislocations, as well as major endoscopic and other surgical-*Diagnostic Procedures*.

When two or more *Surgeries* are performed at the same time and in the same operative field, benefits are payable for the most expensive operation. Multiple unrelated surgical procedures performed during the same operative session will be as follows:

- The lesser of the *Allowable Charge* or allowed charge that is payable by the Plan for the most expensive procedure,
- 70% of the lesser of the *Allowable Charge* or allowed charge that is payable by the Plan for the procedure with the next highest cost, and
- 50% of the lesser of the *Allowable Charge* or allowed charge that is payable by the Plan for each additional procedure.

Temporomandibular Joint Disorder (TMJ)

The *Fund* will pay for the cost of *surgery* for TMJ disorder, but not for related services such as occlusal equilibration and physical therapy. Not covered, for example, are: isometric therapy, capping/crowning of teeth, subperiosteal implants, endosseous implants, mandibular staple implants, photographic records, intra-oral dental slides, dental x-rays, and dental tracings. Because TMJ treatment usually involves both covered and non-covered services, you should contact the *Fund Office* prior to treatment so that planned procedures may be reviewed and you may be advised of what will be covered.

Tonograms

Tonograms are covered whether rendered on an *Inpatient* or *Outpatient* basis provided they are performed by a *Physician* and directly related to a *Sickness*.

Other Medical Services

Covered medical expenses include charges for the services shown below which are *Incurred* during the treatment of a *Sickness* or *Injury* and which are performed or prescribed by a duly licensed *Physician*:

1. Services of *Physicians* (including specialists) provided in a *Hospital*, in the home, and in the *Physician's* office;
2. Room and board including special diets; general nursing services in a *Hospital* except for room and board charges in excess of the *Hospital's* average semi-private room rate;
3. Use of operating or treatment rooms;
4. Anesthesia and its administration;
5. X-ray, laboratory procedures, examination, or analysis made for *Diagnostic* or treatment purposes;
6. X-ray, radon, radium, and radioactive isotope treatments or therapy;
7. Oxygen and its administration;
8. Blood transfusions, including the cost of blood and blood plasma (except when donated or replaced);
9. All drugs, medicines, and dressings used in the *Hospital*;
10. Services of a licensed physical therapist when indicated for medical reasons but not as part of rehabilitative care (except when included in the rehabilitation benefit programs described on page 156);
11. Services of an actively practicing private duty nurse when *Medically Necessary* as follows:
 - a. In or out of the *Hospital*, the services of a registered professional nurse (R.N.) or licensed practical nurse (L.P.N.);

- b. The technical proficiency and scientific skills of an R.N. or L.P.N. are required and skilled services are actually rendered;
 - c. Services cannot be rendered by the *Hospital's* general nursing staff.
12. Rental or--at the discretion of the Plan--purchase of a wheelchair, *Hospital-type* bed, or other *Durable Medical Equipment* (DME) which is necessary for therapeutic use (see section on DME Network, page 130). Replacement batteries for electric wheelchairs will be covered once every two years;
 13. Professional *Ambulance Services* for *Outpatient Hospital* care for *Accidental Injury* and for *Inpatient* admissions (donations for the services of a volunteer ambulance are ineligible for coverage);
 14. *Services* for cosmetic purposes for the correction of congenital defects or conditions resulting from traumatic injuries;
 15. Services or appliances for dental care resulting from an accidental bodily *Injury*. (Services for the replacement or correction of false teeth as a result of *Accidental Injury* are ineligible for coverage);
 16. Allergy shots and allergy testing, when *Medically Necessary* and administered by a *Physician*;
 17. Any services rendered by a chiropractor, up to an annual limit of \$1,000 for you and \$1,000 for each eligible dependent;
 18. Routine annual mammograms are covered for participants and eligible dependents **age 40 and over**;
 19. One annual PAP smear for each participant and eligible dependent;
 20. *Sclerotherapy* (treatment of varicose veins) as follows:
 - a) Treatment must be pre-approved by Conifer Health Solutions (see section on Conifer Health Solutions for details on how to call for approval).
 - b) Benefits are provided on a “per treatment session” basis with the number and frequency of sessions and the amount

of benefit paid to be determined by Conifer Health Solutions.

- c) Your *Physician* must send a letter of *Medical Necessity*, pre-operative photographs, and a patient history indicating the need for testing to Conifer Health Solutions demonstrating the *Medical Necessity* of treatment (treatment for cosmetic purposes is not covered).
- d) Pre-operative testing will be approved only for those cases in which justification can be provided. Subsequent review will be required on any case which exceeds five treatments per area.
- e) Consecutive treatments must be separated by 6-8 weeks to evaluate the effectiveness of the treatment.
- f) Only the initial consultation will be covered as a separate office visit - charges for subsequent office visits during the course of treatment will not be covered.
- g) Surgical supplies over the *Allowable Charge* approved by Conifer Health Solutions will not be covered.
- h) Billing for laser treatment of varicose veins will be covered at the same level as *Sclerotherapy*.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to **all benefits** payable under the Plan, except as otherwise specifically provided under the Plan (including, but not limited to, under the ACA Preventive Services Benefit and Prescription Drug Benefit sections of this SPD) 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 which is 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" and "Advance Benefits for Workers' Compensation Claims" sections starting on page 84.
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 178.
6. Dental *surgery* or dental appliances to replace the natural teeth and gums unless such charges are made necessary by *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 178.
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 pages 185-190, 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.
15. Services or supplies related to sterilization reversal.
16. Sex reassignment surgery or any care or services associated with this type of operation.
17. Travel, whether or not recommended by a *Physician*.

18. Convalescent, milieu, custodial care, sanitaria care, or rest cures.
19. 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.
20. Services, supplies, or medications rendered in a nursing home or extended care facility.
21. Supplies and medications primarily for dietary control.
22. 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;
23. Air conditioners, humidifiers, dehumidifiers, purifiers, and all similar equipment.
24. Care for nervous and mental conditions, including drug addiction and alcoholism except as specified in the “Mental Health/Substance Abuse Benefit” section on page 134.
25. Care for quarantinable diseases in special institutions.
26. All drugs and medicines other than those provided in the *Hospital*.
27. Services or supplies which are in excess of the *Allowable Charge*.
28. Organ transplant expenses in excess of \$1 million for each different organ transplanted. Replacement transplants and related services following the replacement transplants, are not covered.
29. Any service which is made available without charges, not including Medicaid or services provided only to insured persons.
30. Services rendered by a provider who is a member of the participant’s or dependent’s immediate family (parent, spouse, brother, sister, or children).

31. Charges for failure to keep a scheduled visit or charges for completion of forms.
32. Pre-admission *Diagnostic Testing* relating to an *Inpatient* admission which is not covered under the Plan.
33. Administration of oral chemotherapeutic agents, except as provided in the Chemotherapy section on page 128.
34. Domestic or housekeeping services other than those specifically provided under the HomeCare program.
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*.
39. Injections of varicose veins, except as provided in the section on *Sclerotherapy*.
40. Injections for treatment of hemorrhoids or hernias.
41. Injection of cortisone or other preparations, except for trauma or acute suppurative infections, except as provided under the Comprehensive Medical section.
42. Care of corns, bunions (except capsular or bone *surgery*), callouses, 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. 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).

44. Consultation services are not available with medical or surgical services when they are rendered by the same *Physician* during the same *Hospital* admission, except in the sole discretion of the Board of Trustees.
45. 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.
46. 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.

Closed Panel Services provided through Carelon Behavioral Health (Carelon).

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.

All Treatment Must Be Certified by Carelon

Mental health and substance abuse treatment is covered at 70% under Major Medical up to the *Allowable Charge* and subject to the other limits of the Plan. **You and your eligible dependent(s) must use a Carelon Behavioral Health (“Carelon”) provider in order to be covered, except in emergency situations as described below.** To authorize treatment or to receive assistance in locating an in-network provider, contact Carelon toll free at (800) 353-3572.

Carelon provides you and your eligible dependent(s) with in-network referrals to therapists and facilities for mental health and substance abuse services. Carelon reviews your treatment plan to make sure your care is *Medically Necessary* and appropriate. Services are completely confidential. No one has access to your clinical medical records without your written permission unless access is required by law.

Access to the Carelon panel of therapists is available by calling the Carelon 24-hour, 7-day-a-week referral service at (800) 353-3572. Referrals are available for both emergency/*Hospital* care and for

non-emergency/*Outpatient* care. In an emergency, you or your therapist should call Carelon within 24 hours after admission to the *Hospital*.

The psychiatrists, psychologists, licensed social workers, and facilities affiliated with Carelon have been selected and credentialed to participate in the program. The program is designed to provide you with a high level of benefits, minimum out-of-pocket costs, and no claims paperwork when you use one of the Carelon providers.

Benefits described in this summary are provided pursuant to the contract issued by Carelon. In the case of any inconsistencies between this summary and the contract, the contract will govern. **Remember, all mental health claims must be filed with Carelon and you must use a Carelon provider. Do NOT use CareFirst for mental health claims.**

When You Use a Panel Therapist

Call the Carelon Clinical Referral Line at (800) 353-3572 to locate a Carelon panel provider. In an emergency situation, go to your nearest emergency room. In emergencies, you should have your non-panel therapist call Carelon Case Registration Department at (800) 353-3572 at the time of admission or within 24 hours of hospitalization to begin the certification process. The in-network benefits will be available for all *Emergency Services* and *No Surprises Services* until the attending emergency physician or treating provider determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an in-network provider or facility located within a reasonable travel distance, taking into account the patient's medical condition. For less urgent referrals, you will receive the names of one or two psychologists or independently licensed psychiatric social workers.

The Fund will pay 70% for *Inpatient* and *Outpatient* care, up to the *Allowable Charge*. *Inpatient* treatment (including a drug and alcohol treatment facility) must be certified by Carelon prior to your admission, except in emergency situations as described above.

Exclusions

The types of treatment listed below are not covered under this benefit:

1. Psychological testing, except when pre-certified by Carelon and conducted in conjunction with a diagnosed mental health disorder when testing is not available through the local school system.
2. Marriage counseling.
3. Treatment for obesity and weight reduction.
4. Treatment for convalescent or custodial care.
5. Any medical or surgical services provided concurrently or in connection with the treatment of mental health or substance abuse condition. The ICD-10 classifications will generally be used to determine whether a condition is medical or psychiatric in nature. An ICD-10 classification means the comprehensive listing of diagnoses by category found in the International Classification of Diseases, 10th Ed.

I. Medical Necessity Review of Treatment by Carelon – Pre-Service Claims

Carelon will make a preliminary determination as to whether proposed treatment is *Medically Necessary* prior to treatment being provided. If, prior to treatment, Carelon determines that services are not covered based on any grounds other than *Medical Necessity*, Carelon will mail the participant a written notice of a claim denial in the form set forth in Section III. If a participant wishes to appeal such a denial to the Board of

Trustees, then he/she should follow the procedures set forth in Section IV below.

Carelon only certifies whether a covered service is *Medically Necessary* for purposes of deciding what benefit amount, if any, is payable under the Plan. Any decision regarding the need to obtain mental health or substance abuse care, like any other medical decision, is the responsibility of you or your treating provider. If Carelon determines that treatment is not *Medically Necessary*, it will mail the Participant a written claim denial in the form set forth in Section III. You or your treating provider, acting on your behalf, may request a Level I review of that determination by a Carelon Peer Advisor who was not involved in the earlier decision. A request for a Level I review should be made within two weeks of receiving the initial determination of *Medical Necessity* from Carelon. When contacting Carelon to initiate a review, you or your treating provider should identify the participant (and the patient if he or she is your dependent), state that the participant is a beneficiary under the Plan, and request a Level I review of the *Medical Necessity* determination. Carelon will notify you and your treating provider in writing of the outcome of the Level I review. While you are not obligated to follow Carelon's Level I or Level II review procedure prior to appealing the denial to the Board of Trustees, if you do choose to request a review by Carelon, you must do so **before** submitting your appeal to the Board of Trustees.

If you or your treating provider, acting on your behalf, are dissatisfied with the Level I review determination given by Carelon, you may request a review of the determination within two weeks from the date of the Level I review notification from Carelon. Call Carelon immediately after you receive a denial for details regarding further review procedures.

If you are dissatisfied with a Carelon preliminary determination or a Level I or Level II review determination that treatment is not *Medically Necessary*, you may appeal such denial to the Board of Trustees, following the procedures set forth in Section IV below. While you are not obligated to follow Carelon’s review procedures prior to appealing the claim denial directly to the Board of Trustees, if you choose to request a review of the claim by Carelon, you must do so before submitting your appeal to the Board of Trustees.

See the “Claims Filing and Review Procedures” and the “Claims Review – Types of Claims” sections beginning on page 196 for more information and provisions that apply to your claims.

II. Carelon Review Procedures as to Claims for Services Provided – Post Service Claims

Carelon will make a preliminary assessment as to whether services which have been provided are covered prior to issuing a denial of a claim for services provided. Examples of these claims include, but are not limited to, review of the Carelon preliminary assessment as to the proper amount to be paid for treatment already provided, the preliminary assessment by Carelon that no payment should be made to you or your provider for services rendered in cases where Carelon believes that either certification of *Medical Necessity* for that treatment has run out or treatment was never certified as *Medically Necessary*, that treatment was provided for a service pursuant to a diagnosis that Carelon believes to be excluded under the Plan, or that treatment was provided for a service despite the belief by Carelon that your benefits were exhausted prior to receiving such service.

After you receive the notice from Carelon of its preliminary assessment regarding your claim for services provided, you

may have it reviewed by Carelon, through one level of review. If you do not wish to use the Carelon review procedure, you may treat that notice of its preliminary assessment regarding your claim for services provided as a denial of the claim and appeal directly to the Board of Trustees under the procedures set out in Section IV, below. However, if you want to have your claim reviewed by Carelon, you must do so before appealing to the Board of Trustees.

You may ask Carelon for a review of the preliminary assessment regarding your claim for services provided by either calling the Carelon Service Operations Department at (800) 353-3572 or by writing to Carelon at: Carelon Behavioral Health Claims Department, P.O. Box 1854, Hicksville, NY 11802, within 60 days of receiving written notice from Carelon of the preliminary assessment that all or part of your claim should be denied. When contacting Carelon, you should state that you are a participant in the Plan and are seeking review of its preliminary assessment that all or part of your claim for services provided should be denied. In a case in which Carelon determines after its review that services are not covered, Carelon will mail you a written notice of a claim denial on an *EOB* in the form set forth in Section III. If the outcome of the review is unfavorable, you may appeal such denial to the Board of Trustees, follow the procedures set forth in Section IV, below.

If Carelon denies your claim, it will notify you in writing within 15 days of the day the claim was made, unless special circumstances beyond the control of Carelon require an extension of time for rendering a final decision on your claim. If such an extension of time is needed, Carelon will give you written notice of the extension prior to the termination of the initial 15-day period. Such notice will indicate the circumstances requiring an extension of time, and the date by which Carelon expects to render a final decision on the claim. In no event shall

extension exceed a period of 15 days from the end of the initial 15-day period.

See the “Claims Filing and Review Procedures” and the “Claims Review – Types of Claims” sections beginning on page 196 for more information and provisions that apply to your claims.

III. Carelon — Denial of Claims

A written notice of your claim denial will be mailed to you on an *Explanation of Benefits (EOB)* by Carelon.

This notice of claim denial will contain the following information, to the extent applicable, so you know why the claim was denied:

1. the claim involved (including the date of service, the provider involved, if applicable, and the claim amount),
2. the specific reason(s) for denial,
3. reference to the pertinent plan provision(s) on which the denial is based,
4. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request,
5. if the denial of your claim was based on a *Medical Necessity* or *Experimental* treatment or similar exclusion or limit, an explanation will be provided free of charge upon request;
6. a description of additional materials or information you would need to perfect your claim, and an explanation of why the material or information is necessary;
7. a description of your right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered an appeal or request for external review),

8. the steps to take if you want to appeal the denial of your claim to the Board of Trustees and the amount of time you have to do this,
9. a description of the external review process and applicable time limits, and
10. a notice of your right to bring suit under *ERISA* if you decide to appeal and your appeal is denied.

IV. Appeal to the Board of Trustees of Carelton – Denial of Claims

When your claim has been denied by Carelton, you can appeal the denial directly to the Board of Trustees. If you decide to appeal the Carelton denial, you or your representative must make a written request to the Board of Trustees to appeal the claim denial within 180 days from the date you receive the written claim denial from Carelton. See the “Review of a Denied Claim” section on page 207 for specific instructions.

**CONIFER HEALTH SOLUTIONS (“Conifer”)
(CERTIFIED ADMISSION REVIEW AND EVALUATION)**

Conifer provides a cost containment program designed to control *Inpatient Hospital* costs by reducing unnecessary admissions. Conifer helps you and your *Physician* find alternative treatment settings that are safe and effective.

All eligible participants and all eligible dependents are required to have *Hospital* admissions certified. You must contact Conifer before admission to a *Hospital* for elective *surgery* and within 48 hours after an emergency admission, to the extent consistent with applicable law. If you fail to do this, to the extent consistent with applicable law, the *Fund* will not pay for any of your stay or for any of the services related to your stay.

Conifer certification is required to determine the *Medical Necessity* of procedures. Conifer does NOT certify that you are eligible for benefits, that the procedure or *Hospital* stay is a covered service under this Plan, or the amount of coverage provided by this Plan. You must verify eligibility and coverage with the *Fund Office*. Conifer provides advisory opinions using medically recognized standards. At no time will Conifer interfere with the delivery of high quality care to you. You should contact Conifer when you need to be admitted or require services for:

1. Elective (Non-Emergency) Admission (Required Certification Prior to Admission)
 - Call Conifer toll-free at (833) 778-9806.
 - An approval letter will be sent to you prior to admission.
2. Emergency Admission (Requires Certification within 48 Hours of Admission)

- Be sure you or a member of your family advises the *Hospital* of your participation in the Conifer program and that Conifer is notified within 48 hours of admission.
 - *Hospital* stays are covered at 70% of the *Allowable Charge* after satisfying the *Deductible*. There is a \$75 *Co-payment* for Emergency Room visits. This co-pay will be waived if you are admitted to a *Hospital*.
 - Emergency room visits do not require certification and *Emergency Services* do not require prior authorization.
3. Ambulatory or *Outpatient Surgery*
- For surgical procedures performed at the *Outpatient* center of a *Hospital* or at an ambulatory surgical center, follow the steps for Elective (Non-Emergency) Admissions above.
4. Rehabilitation Benefits
- **All *Inpatient* and *Outpatient* rehabilitative care must be approved by Conifer.** Follow the steps for elective (Non-Emergency) Admissions above. Rehabilitation charges are covered at 70% of the *Allowable Charge*, after the *Deductible*. Coverage includes a maximum of 30 days of *Inpatient* rehabilitation or 60 *Outpatient* visits when the visits are determined by Conifer to be in lieu of *Inpatient* treatment.

Concurrent Care

Conifer will monitor your stay while in the *Hospital* to assure an appropriate length of confinement. Conifer acts in its position as advisor to the *Fund* to recommend the appropriate number of days for your *Hospital* stay. If your medical condition requires an extension of your *Hospital* stay, Conifer will authorize it.

Review Procedures

1. Reconsideration (Peer-to-Peer)

If a length of stay for a hospitalization, procedure, or treatment is not certified, you (or your *Physician* on your behalf) have the right to request a reconsideration. This service is offered to provide peer-to-peer telephone discussion between your *Physician* and a Conifer Medical Director regarding the *Medical Necessity* of the treatment or services being rendered.

2. Expedited Appeals

Your *Physician* may appeal Conifer's decisions on an expedited basis by calling Conifer's Utilization Review Department if your services meet the Department of Labor's definition of "urgent." How does the Department of Labor define "urgent?" The Department of Labor specifies that whether a claim is a "claim involving urgent care" is to be determined by an individual acting on behalf of the health benefits plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a *Physician* with knowledge of the claimant's medical condition determines is a "claim involving urgent care" shall be treated as a claim involving urgent care. A board certified *Physician* in the same specialty as the attending *Physician* will review the appeal. The consultant *Physician* will be made available to the attending *Physician* by phone and by fax to make the appeal process as efficient as possible. Your *Physician* will be notified of the decision (by telephone) within 24 hours. Written verification will be sent to the *Physician*, facility, patient, and the *Fund* within one business day of the decision.

If you or your attending *Physician* or facility disagrees with the outcome of an expedited appeal, he/she may initiate a standard appeal within 30 days from the date of Conifer's non-certification notification.

3. Standard Reviews

All requests for review to Conifer must be made within 180 days from the date you are notified of Conifer's decision. A written or verbal request for a standard review may be initiated by the patient or the attending *Physician* or facility on the patient's behalf and should be accompanied by any relevant medical information or records.

The request for review will be completed by a board certified *Physician* consultant in the same or similar specialty as your attending *Physician* who will render a decision. Notification of Conifer's decision will be sent to you, your *Physician*, the facility and the *Fund* within 30 days following the receipt of your request and all the necessary documentation. The clinical rationale, clinical criteria, and copies of any other documents relevant to your request for review will be made available to you, your attending *Physician* or the medical facility upon the patient's written request.

Appeal to the Board of Trustees

You have the right to appeal to the Board of Trustees if you are not satisfied after exhausting Conifer's internal review process. If you wish to do so, submit your appeal to the Board of Trustees within 180 days from the date you receive Conifer's decision to uphold its non-certification.

If you do not wish to go through Conifer's internal review procedure, you may appeal directly to the Board of Trustees. Write to the Board of Trustees stating the reason for your appeal within 180 days from the date of Conifer's original decision to deny your certification. See "Review of a Denied Claim," page 207, for more information.

CONIFER HEALTH SOLUTIONS (“Conifer”) (DISEASE MANAGEMENT)

Conifer provides case management and disease management programs. Conifer’s nurse case managers will assess any individual medical needs you or your covered dependents may have and provide education and resources to manage your health. They can also help coordinate care and advocate for services on your behalf that will assist you in achieving an optimal level of health and wellbeing.

If you have certain acute or chronic medical issues, a Conifer Personal Health Nurse (or “PHN”) can work with you to structure a disease management program with the goal of better managing your ongoing care needs and thereby improving your quality of life. The telephone number for Conifer case management and disease management is (800) 459-2110.

MANDATORY SECOND SURGICAL OPINION PROGRAM

For all participants and eligible dependents.

In addition to cost effectiveness, the Mandatory Second Surgical Opinion Program (MSSOP) offers you several important benefits. Beyond the possibility of avoiding unnecessary *surgery*, you gain the peace of mind that comes from a second or, if necessary a third, surgical consultation. A second opinion can also alert you to alternative forms of treatment.

The MSSOP covers in full the cost of a second or third opinion after your surgeon has recommended an elective surgical *procedure*. Related *Diagnostic Services*, like x-ray and pathology, are also covered up to the limits of your Plan. A second opinion is required of all participants for the following 11 procedures when performed on an elective, non-emergency basis:

1. Cholecystectomy (gallbladder removal)
2. Hysterectomy
3. Tonsillectomy/Adenoidectomy
4. Laminectomy, Discectomy, Spinal Fusion
5. *Diagnostic Arthroscopy* (endoscopic examination of joint interior)
6. Radical and Modified Radical Mastectomy
7. Ano-rectal *Surgery* - Hemorrhoidectomy
8. Coronary Artery By-Pass
9. Bunionectomy
10. Ligation and Stripping of Varicose Veins
11. Submucous Resection

If your surgeon performs any of these procedures, **and you don't get a second opinion prior to surgery**, the *Fund Office* will only consider 70% of the otherwise allowable charge of your surgeon's bill for processing. In other words, instead of considering the entire bill and

processing under the rules of the Plan, the *Fund* will only consider 70% of the bill, and then pay the appropriate percentage from there. Thus, you will be responsible for at least 30% of the total bill **if you don't obtain a second opinion.**

Remember, this program is in effect only for elective, non-emergency *surgery*. You don't need to have a second opinion under the following circumstances:

- When your *surgery* is an emergency or when you are admitted from the emergency room.
- When unplanned *surgery* becomes necessary during a *Hospital* stay.

You and your dependent(s) should seek a voluntary second surgical opinion for any elective *surgery*, as well as for the required procedures. Benefits are provided for second opinions for all elective *surgery*.

How MSSOP Works

Follow the same procedure for both mandatory and voluntary second surgical consultations.

For example, you consult your *Physician* about a stomach ailment. After an examination and *Diagnostic Testing*, he or she recommends gallbladder removal *surgery*. Because this is one of the 11 procedures, you must get a second opinion before the *surgery*. Call Conifer toll-free at (833) 778-9806.

Conifer provides *Physician* referrals and can answer any questions you have about the program. Tell the representative you would like to arrange a second opinion. Conifer will recommend you seek a *Physician* in the appropriate specialty. If you need the name of a

Physician, Conifer will suggest *Physicians* in the specialty that have offices in your area.

If the two consultations result in a difference of opinion, you may elect at that time whether or not to have the *surgery*. However, if you wish, the *Fund* will pay for a third opinion, arranged through Conifer.

Important

- You must request a second surgical opinion, mandatory and voluntary, WITHIN 90 DAYS of your initial consultation.
- *Surgery* must be performed within six months of the second opinion consultation to be eligible for full benefits.
- **If your primary insurance coverage is through *Medicare* or another health insurer, the program does not apply to you.**
- The *Physician* submitting the second opinion cannot be affiliated with the *Physician* who will perform the *surgery*.

HOME HEALTHCARE PROGRAM

Home Healthcare benefits are provided through the Fund, not insured. Benefit claims are administered by Conifer Health Solutions

Home Healthcare must be provided through a participating CareFirst provider. Home Healthcare services and supplies include:

Occupational and inhalation therapy, medical social services, nutritional guidance, home health aide visits, prescription drugs, medical-surgical supplies, x-ray and lab tests, *Durable Medical Equipment, Ambulance Services (when Medically Necessary)*. Conifer Health may authorize intermittent nursing care, physical therapy, speech therapy, and homemakers.

Home Healthcare extends *Hospital* services that would normally be provided on an *Inpatient* basis to the home. Home Healthcare services are covered as a Comprehensive Medical Benefit at 70%, up to the *Allowable Charge*. You and your eligible dependents are eligible to receive benefits through Home Healthcare after early discharge from the *Hospital* or in place of in-*Hospital* care if such treatment is deemed cost effective by Conifer.

If you believe you need Home Healthcare, have your *Physician* contact Conifer. They will discuss your treatment with the *Physician* and determine whether the services are *Medically Necessary*. Conifer's determination is also made based on whether the patient's condition is stabilized. Use of Home Healthcare benefits will not reduce the number of in-*Hospital* days available to you.

You and your eligible dependents are also eligible to receive benefits for *Physician* Home Healthcare visits not to exceed an average of one visit per day during the period Home Healthcare benefits are

provided. When you have *Physician* Home Healthcare visits, payment by the Plan is made in an amount up to but not exceeding the *Allowable Charge* for the treatment provided.

Exclusions

The Home Healthcare program will not cover the following:

1. Domestic or housekeeping services unrelated to patient care; home food service (meals-on-wheels); nursing home or skilled nursing facility care; any visits, services, medical equipment or supplies not approved as part of the plan of treatment;
2. *Physician* services if rendered to you or your eligible dependent as a *Hospital Inpatient*; *Physician* Home Healthcare visits for care normally considered as part of post-surgical care;
3. *Physician* Home Healthcare visits for care unrelated to the plan of treatment; and services for which the *Physician* does not customarily bill the patient.
4. Care provided by a relative.

For additional information about Home Healthcare, contact Conifer toll-free at (833) 778-9806.

HOSPICE CARE SERVICES

*Hospice Care benefits are provided through the Fund, not insured.
Benefit claims are administered by
Conifer Health Solutions.*

Hospice Care Services are covered at 70%, up to the Allowable Charge.

For terminally ill participants or eligible dependents whose prognosis of probable survival is six months or less and who are receiving palliative, not curative, care, covered services include intermittent nursing care by a registered or licensed practical nurse, physical therapy, speech therapy, occupational therapy, services of a licensed medical social worker, home health aide visits, prescription drugs, lab tests and x-ray services, medical-surgical supplies, oxygen, *Durable Medical Equipment*, *Physician* home visits, *ambulance* and wheelchair transportation to or from the *Hospital* for palliative treatment or admission as an *Inpatient*. Your family may receive counseling and submit a claim to the *Fund Office*. The *Fund* pays up to \$500 for family counseling prior to the participant's death and up to \$100 for bereavement visits to the family (parents, spouse, brothers, sisters, or children) within three months after the death of a participant or eligible dependent who received plan-approved *hospice* benefits.

Pre-certification is required and services must be approved by Conifer.

For additional information about *Hospice Care*, contact Conifer toll-free at (833) 778-9806.

PRESCRIPTION DRUG BENEFIT

Benefits are provided through the Fund, not insured.

*Closed Panel Services are provided through
Express Scripts, Inc. (“Express Scripts”)*

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.

Cost of Prescription Drugs

Generic drugs are mandatory, if available, and you must use an in-network pharmacy.

- Generic drugs have a five percent (5%) *Co-payment* (with a \$5 minimum). Brand name drugs on the preferred formulary list have a fifteen percent (15%) *Co-payment* (with a \$15 minimum) and brand name drugs not on the preferred formulary list have a twenty-five percent (25%) *Co-payment* (with a \$25 minimum). Brand name drugs are covered only if there is no generic drug equivalent. Limited to 34-day supply, 100-day supply for approved maintenance; some quantity limits apply.
- Certain specialty medications require prior authorization and must be ordered by phone through Accredo Specialty Pharmacy with the same *Co-payments* as specified above.

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, Wal-Mart, Walgreens and 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 \$1,500.00 is approved by Express Scripts.
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, except to the extent covered under the ACA Preventive Services Benefit section on page 120. Syringes and needles may be available if approved by the *Fund Office*.
6. Refills must be authorized by your *Physician*.
7. Prescriptions will only be covered if they are prescribed to treat *Medically Necessary* conditions. Prescriptions for cosmetic purposes are not covered.

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

Cost for Certain Specialty Drugs under SaveonSP Program

Certain specialty drugs are subject to the Fund's program through SaveonSP. The SaveonSP program saves you and the Fund money through manufacturer co-payment assistance programs. If you are prescribed a specialty drug that is part of the SaveonSP program (a "Participating Specialty Drug") and you have not yet enrolled in this program, SaveonSP will contact you with educational and enrollment information after your prescription is presented to Accredo Specialty Pharmacy. Enrollment in the SaveonSP program is voluntary, but if you do not enroll, your co-payment for any Participating Specialty Drug will increase significantly.

If you choose not to enroll and participate in the SaveonSP program, you will be charged a 30% *Co-payment* for any specialty drug listed on the SaveonSP program's current Non-Essential

Health Benefit Specialty Drug List for a Participating Specialty Drug. The *Co-payment* will not count towards your deductible or out-of-pocket maximums.

However, if you enroll in the SaveonSP program, your full *Co-payment* for the Participating Specialty Drug will be paid through the drug manufacturer's co-pay assistance program and you will pay nothing (\$0), for as long as that Participating Specialty Drug is part of the program.

For a copy of the current Non-Essential Health Benefit Specialty Drug List of Participating Specialty Drugs, or if you have any questions regarding the SaveonSP program, please contact SaveonSP at (800) 683-1074.

Preventive Medications

As provided under the ACA Preventive Services Benefit section on page 120, the Plan covers a number of preventive medications, including FDA-approved oral contraceptives, with no co-pay or other cost sharing if the prescriptions are filled by a participating network pharmacy. **A complete list of preventive medications covered under this Preventive Services benefit, with detailed descriptions of coverage limitations and exclusions, is available on the *Fund's* website at www.associated-admin.com.** Click on "Your Benefits" and select "FELRA," followed by "FELRA & UFCW Health & Welfare Plan" to be directed to the *Fund's* homepage. From there, under "Important Notices," click on "FELRA and UFCW List of ACA Preventive Services" to view the complete list.

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. No purchase should be made without your Express Scripts ID card.

3. The ID card is NOT TRANSFERABLE and may not be used by anyone other than the person to whom it has been issued.
4. The card is invalid and void if you are no longer working for a *Participating Employer*, or otherwise lose eligibility under the Plan.
5. If you use your card after eligibility is terminated, you must reimburse the *Fund* for amounts paid.
6. 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.

Claims Procedure

1. Upon becoming eligible for benefits, a participant will receive *Fund* ID cards which shows his or her medical and prescription Plans. 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. You will be reimbursed for the amount which *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. 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).

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. You will not receive coverage under the Plan for prescription drugs that are not on the formulary list. 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*.

Specific Drug Restrictions

- Anti-Obesity drugs will be covered with prior authorization from Express Scripts. 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.
- 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 will be covered to a maximum of 8 tablets per month. You must contact Express Scripts at (800) 903-8325 in order to initiate the prior authorization process. Express Scripts will fax your *Physician* a form to indicate your diagnosis which will reflect your approval or denial of your prescription.

Shingles Zoster Vaccine

The shingles (zoster) vaccine is covered under the ACA Preventive Services Benefit at no cost as described on page 120 if you or your dependent(s) are **age 60** or over, including when you present your Express Scripts (ESI) ID card at any Giant or Safeway pharmacy.

Shingles Shingrix Vaccine

The shingles (shingrix) vaccine is covered under the ACA Preventive Services Benefit described on page 120 for participants and dependents **age 50 and over** and is available to those who have already received the Zoster vaccine.

Over-the-Counter COVID-19 Test Coverage

Certain at-home COVID-19 diagnostic tests purchased without a prescription (“over-the-counter” or “OTC Tests”) are covered under the Plan’s Prescription Drug Benefit.

The Plan will cover up to two (2) over-the-counter (OTC) COVID-19 diagnostic tests per covered Participant and Dependent per 30-day period, provided that those tests are purchased from an in-network participating pharmacy covered under the Plan’s Prescription Drug Benefit. These tests will be covered with no cost sharing (including deductibles, co-payments, and co-premiums) and no requirement of prior authorization.

The types of OTC Tests that are covered include at-home diagnostic tests approved, cleared, or authorized by the FDA for use without an order or individualized clinical assessment from a health care provider. Generally, at-home OTC tests that are available for purchase from participating pharmacies will meet this standard.

To find a retail pharmacy in your network, visit www.express-scripts.com and click “Find a Pharmacy” or use the Express Scripts mobile app. If you prefer to order your OTC Tests online at \$0 copay and have them delivered to your home, visit www.express-scripts.com/covid-19/resource-center to log in at the Express Scripts Pharmacy and place your order.

Regardless of whether you obtain the tests at a participating pharmacy or from Express Scripts online, coverage is limited to two

(2) tests per covered participant or dependent, per 30-day period. Please note, COVID-19 diagnostic tests performed at a provider's office, hospital, or clinic do not count toward this limit.

SPECIALTY MEDICATIONS/ACCREDO SPECIALTY PHARMACY

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

If you are prescribed medication that is considered specialty medication, you must use the Accredo Mail Order Specialty Pharmacy (through Express Scripts). Please visit Accredo online at www.accredo.com or contact Accredo by phone at (800) 803-2523 for the current list of specialty medications that must be obtained through Accredo Specialty Pharmacy. You can order your specialty drugs over the phone by calling Accredo at (866) 892-9976. If you have a new prescription, you can contact Express Scripts 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.

Limited Distribution Specialty Drugs

Certain "limited distribution" specialty drugs may not be available through the Accredo Mail Order Specialty Pharmacy. If such a specialty drug meets the Plan's requirements for coverage but is not available through Accredo or any other covered pharmacy, the Plan will cover prescriptions for the specialty drug ordered through CVS Specialty Pharmacy, subject to the same *Co-payment* that applies to specialty drugs ordered through Accredo.

PRIOR AUTHORIZATION

There are prior authorization requirements applicable to the coverage of certain medications under the Plan. If your prescription drug claim is denied based on the Fund's prior authorization requirements, please have your Physician or pharmacist contact Express Scripts and provide the appropriate documentation for review. Please go to www.express-scripts.com or contact Express Scripts by phone at (800) 903-8325 for the current list of drugs subject to prior authorization.

Drug Quantity Management

The Fund maintains a Drug Quantity Management program. Drug Quantity Management means that the Fund will only pay for a specific quantity at a particular strength for certain prescription drugs. Quantity limits are set in accordance with FDA approved prescribing limitations and standard medical practice. Please go to www.express-scripts.com or contact Express Scripts by phone at (800) 903-8325 for the current list of drugs subject to these rules. If your *Physician* wants to prescribe a particular strength or quantity of drug that does not fit within the limits of the Fund's Drug Quantity Management program, your Physician can request an exception by contacting Express Scripts.

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. For prior authorizations, please call Express Scripts Customer Service at (800) 753-2851. 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.

Diabetic Benefit

Diabetic supplies are covered at 70% after the \$500 annual *Deductible*.

If you or a covered dependent have Diabetes Mellitus, you may be reimbursed for the cost of blood sugar monitors (like Glucometer and Accu-Check) and other supplies, such as Chemstrips, purchased from a Giant or Safeway pharmacy or online from a medical supply or diabetic supply company that participates with CareFirst. Shipping is not covered for online purchases. **Send your paid, itemized receipts to the *Fund Office***, along with a note from your *Physician* verifying that you (or your eligible dependent) have Diabetes Mellitus, and that the supplies are related to the treatment of your illness.

STEP THERAPY PROGRAM

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. 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 the Fund’s 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, you should determine whether you need to try an alternative first or to obtain prior authorization. For information on the requirements under the Step Therapy program or to request a prior authorization, contact Express Scripts at (800) 753-2851.

PRESCRIPTION CARE MANAGEMENT

The Fund has adopted a prescription management program provided through Prescription Care Management, LLC (“PCM”). Under the program, PCM may contact you or your *Physician* to discuss lower cost alternatives to certain medications you are taking with the goal of achieving cost savings for both you and the Fund. Participation in the PCM program is completely voluntary and you will not be penalized if you decide not to participate.

DENTAL BENEFITS

Benefits are provided through Dentegra Insurance Company and are insured. Covered services are exams, x-rays, cleaning, amalgam fillings, and simple extractions. There are no Co-payments on covered benefits.

The Plan provides benefits for the dental services described below only when performed by a *Participating Dentist*. Any services rendered by a non-*Participating Dentist* will NOT be covered by this Plan. Children under four (4) years of age are not eligible for dental benefits.

Claims Procedure

To request a participating provider in the Plan, call Dentegra at 877-280-4204 between 8:00 a.m. – 8:00 p.m. EST. Monday through Friday. When calling Dentegra Service, please be ready to give the participant's 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 and dependents 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 one 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 ten minutes before your appointment time. If a patient arrives 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 Dentegra will NOT be covered under the *Fund*.

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. If the participant is diagnosed with a condition or disease that requires a specialist and no *Participating Dentist* has the specialized dental training and expertise to treat the condition or disease or Dentegra cannot provide reasonable access to a specialist who is a *Participating Dentist* without unreasonable delay or travel;
2. When authorized in advance by Dentegra;
3. In the case of a dental emergency which occurs more than 50 miles from the participant's primary dentist if the participant or eligible dependent is temporarily away from home. A dental "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;
or
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 a participant's or eligible dependent's *Effective Date* of coverage is excluded.

**D0100-D0999 I. DIAGNOSTIC
ENROLLEE PAYS**

PERIODIC ORAL EVALUATION – ESTABLISHED PATIENT	\$0.00
LIMITED ORAL EVALUATION – PROBLEM FOCUSED	\$0.00
COMPREHENSIVE ORAL EVALUATION – NEW OR ESTABLISHED PATIENT	\$0.00
RE-EVALUATION – LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)	\$0.00
INTRAORAL – COMPLETE SERIES OF RADIOGRAPHIC IMAGES	\$0.00
INTRAORAL – PERIAPICAL FIRST RADIOGRAPHIC IMAGE	\$0.00
INTRAORAL – PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	\$0.00
INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE	\$0.00
BITEWING – SINGLE RADIOGRAPHIC IMAGE	\$0.00
BITEWINGS – TWO RADIOGRAPHIC IMAGES	\$0.00
BITEWINGS – THREE RADIOGRAPHIC IMAGES	\$0.00
BITEWINGS – FOUR RADIOGRAPHIC IMAGES	\$0.00
VERTICAL BITEWINGS – 7 TO 8 RADIOGRAPHIC IMAGES	\$0.00
PANORAMIC RADIOGRAPHIC IMAGE	\$0.00
2D CEPHALOMETRIC RADIOGRAPHIC IMAGE – ACQUISITION, MEASUREMENT AND ANALYSIS	\$0.00
PULP VITALITY TESTS	\$0.00

**D1000-D1999 II. PREVENTIVE
ENROLLEE PAYS**

PROPHYLAXIS – ADULT	\$0.00
PROPHYLAXIS – CHILD	\$0.00
TOPICAL APPLICATION OF FLUORIDE VARNISH	\$0.00
TOPICAL APPLICATION OF FLUORIDE	\$0.00

**D2000-D2999 III. RESTORATIVE
ENROLLEE PAYS**

AMALGAM – ONE SURFACE, PRIMARY OR PERMANENT	\$0.00
AMALGAM – TWO SURFACES, PRIMARY OR PERMANENT	\$0.00
AMALGAM – THREE SURFACES, PRIMARY OR PERMANENT	\$0.00
AMALGAM – FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	\$0.00
RESIN-BASED COMPOSITE – ONE SURFACE, ANTERIOR	\$0.00
RESIN-BASED COMPOSITE – TWO SURFACES, ANTERIOR	\$0.00

RESIN-BASED COMPOSITE – THREE SURFACES, ANTERIOR	\$0.00
RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	\$0.00
RESIN-BASED COMPOSITE CROWN, ANTERIOR	\$0.00
PROTECTIVE RESTORATION	\$0.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

ENROLLEE PAYS

EXTRACTION, CORONAL REMNANTS – PRIMARY TOOTH	\$0.00
EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	\$0.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

ENROLLEE PAYS

PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR PROCEDURE	\$0.00
LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	\$0.00
UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT	\$10.00

NOTE: The procedures described and maximum allowances indicated on this table are subject to the terms of the contract and Dentegra processing policies. Any procedure not listed on this schedule is not covered.

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.
3. 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.
4. Examination, evaluation, and treatment of temporomandibular joint (TMJ) pain dysfunction are excluded.

5. Any service or treatment begun while the participant or eligible dependent was not covered by the Plan through Dentegra will not be covered.
6. Hospitalization for any dental procedure is excluded.
7. Drugs, whether prescribed or over-the-counter, are excluded.
8. Dental implants, and any prosthesis, crown, bridge, or denture associated with a dental implant are excluded.
9. Procedures requiring fixed prosthodontic restorations that are necessary for complete oral rehabilitation or reconstruction are excluded.
10. Procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion are excluded.
11. General anesthesia is covered only when administered in an oral surgeon's office for extractions.
12. Treatment of malignancies, cysts, neoplasms or congenital malformations is excluded.
13. Services for injuries or conditions which are covered under Workers' Compensation or employer's liability laws are excluded; services which are provided by any municipality, county, or other political subdivision are excluded.
14. Any service that the appropriate regulatory board determines was provided as a result of a prohibited referral. *Participating Dentists* are prohibited from referring you or your dependent to, or requesting reimbursement for, dental care services from a provider outside the *Participating Dentist's* office or group practice if:
 - a. The *Participating Dentist*, or the *Participating Dentist* in combination with his or her immediate family, owns a beneficial interest in that provider's business;
 - b. The *Participating Dentist's* immediate family owns a beneficial interest of three (3) percent or more in that provider's business; or
 - c. The *Participating Dentist*, his or her immediate family, or the *Participating Dentist* in combination with his or her immediate family has a compensation arrangement with that provider.

Grievance Procedure

Grievances or complaints may be directed orally or in writing to Dentegra Insurance Company, P.O. Box 1809, Alpharetta, GA 30023-1809, or telephone number 877-280-4204. A 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 disposition of your complaint within thirty (30) days of the date the grievance is filed for a prospective denial, and within forty-five (45) days of the date the grievance is filed for retrospective denials.

Appeals Process

If your dental claim is denied by Dentegra and you, your representative, or your provider want to appeal the denied claim, you, your Representative or the provider must write to Dentegra or call Dentegra at 1-800-932-0783 within one hundred eighty (180) days of receipt of the adverse decision. The request for appeal should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim should accompany the request for review. Written acknowledgement of the filing of the appeal will be provided to you, your representative, or the attending dentist within five (5) days of the filing of the appeal. You, your representative or the provider are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

The review of the appeal shall be conducted on behalf of Dentegra by a person who is neither the individual who made the coverage decision that is the subject of the review, nor the subordinate of such individual. Dentegra will render a final decision in writing to you, your representative, and/or provider acting on your behalf within 60

working days after the date on which the appeal is filed. Within 30 days after the Appeal Decision has been made, Dentegra will send to the Enrollee, the Enrollee's Representative, and the Provider a written notice of the Appeal Decision.

If in your opinion, or the opinion of your representative or the provider, the matter warrants further consideration, you, your representative, or the provider should advise Dentegra in writing as soon as possible. The matter shall then be immediately referred to Dentegra's Dental Affairs Committee. This stage can include a hearing before Dentegra's Dental Affairs Committee if requested by you, your representative, or the provider. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The notice of decision will state the specific factual bases for the decision. The decision of the Dental Affairs Committee shall be final insofar as Dentegra is concerned. Recourse thereafter would be to the Maryland Insurance Commissioner, or to the courts with an ERISA or other civil action.

An Enrollee, an Enrollee's Representative, or the Provider has a right to file a Complaint with the Maryland Insurance Commissioner within four (4) months after receipt of Dentegra's grievance or appeal decision. When filing a Complaint with the Commissioner, you or your representative will be required to authorize the release of any of your medical records that may be required to be reviewed for the purpose of reaching a decision on the complaint.

Please refer to your Dentegra Evidence of Coverage document for additional information on Dentegra's internal appeal and grievance procedures. A copy of this document can be found online at www.associated-admin.com.

OPTICAL BENEFITS

Benefits are provided and guaranteed pursuant to an insurance contract with Superior Vision.

Superior Vision is your optical provider. They have an expanded network (the Superior National Network) with providers located in major malls and other convenient locations including Lens Crafters, Pearl Vision, and JCPenney, as well as many individual providers and online retailers such as Glasses.com.

The *Fund* will provide the following optical benefits **once every 24 months**.

	In-Network Provider:	Out-of- Network Provider:
Vision Exam		
By Ophthalmologist	Covered in Full	\$40 Allowance*
By Optometrist	Covered in Full	\$40 Allowance*
Standard Eyeglass Lenses**		
Single Vision	Covered in Full	\$30 Allowance*
Bifocals	Covered in Full	\$46 Allowance*
Trifocals	Covered in Full	\$60 Allowance*
Progressives	Covered in Full after \$50 Co-pay in lieu of Standard Lenses	\$80 Allowance*
Lenticular	Covered in Full	\$100 Allowance*
Photochromic	Covered in Full after \$60 Co-pay in addition to Standard Lenses	\$70 Allowance*
Polycarbonate – only for persons under	Covered in Full	\$10 Allowance*

Factory Scratch Coat	Covered in Full	\$16 Allowance*
Frames:	\$100 Allowance*	\$50 Allowance*
Lens Add-Ons:	See list of covered lens add-ons below	

*Where an “Allowance” is shown, you are responsible for paying any charges in excess of the listed Allowance amount.

** A **Standard Eyeglass Lens** is a standard glass or plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size than 61mm in length. Standard multifocal lenses include segment through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

Covered Lens Add-Ons

Coverage for some lens add-on items is either in addition to or in lieu of the above coverage for standard lenses, as indicated below.

	In-Network Provider	Out-of-Network Provider
Polycarbonate upgrade	Covered in full for eligible dependent children under age 20	\$10 Allowance* for eligible dependent children under age 20
Factory Scratch Coat	Covered in full	\$16 Allowance*
Standard Progressives	Covered in full after \$50 <i>Co-payment</i> in lieu of standard lenses	\$80 Allowance* with \$50 <i>Co-payment</i> in lieu of standard lenses
Standard Photochromic	Covered in full after \$60 <i>Co-payment</i> in addition to standard lenses	\$70 Allowance* with \$60 <i>Co-payment</i> in addition to standard lenses

Exclusions and Limitations

No Optical Benefits are payable for any of the following conditions, procedures and/or materials, except to the extent they are covered as a lens add-on as described above or under the discount program described below:

1. Contact Lenses, and related materials; and services for the fitting thereof;
2. Plano or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or aniseikonic lenses;
6. Medical and surgical treatment of the eyes;
7. Experimental or non-conventional treatment or device;
8. Any eye examination or corrective eyewear required by an employer as a condition of employment;
9. Services for which benefits are paid by Workers' Compensation;
10. Blended bifocal lenses
11. Groove, Drill or Notch, and Roll and Polish;
12. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
13. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.);
14. Cosmetic items;
15. Faceted lenses;
16. High-Index Lenses;
17. Laminated Lenses;
18. Oversize Lenses – any lens with an eye size of 61mm or greater;
19. Photochromic (Transition) lenses;
20. Polaroid lenses;
21. Polished bevel lenses;
22. Prism lenses;
23. Slab-off lenses;
24. Tints (except Pink tint #1 and #2);
25. Ultra-violet tint or coating; and
26. Additional cost for a frame over the allowance.

In-Network Benefits

When benefits are payable for a covered vision exam or covered lenses and frames received from an in-network Superior Vision provider, Superior Vision will pay the in-network provider directly, based on the in-network benefits shown in the schedules above. You are responsible for paying any required *co-payment* and any charges above the covered benefits to the in-network provider.

Locating an In-Network Superior Vision Provider

To locate the most current providers in the Superior Vision network, visit www.superiorvision.com and search for providers in the Superior National Network. The names of providers are updated regularly. You can also call Superior Vision Customer Service toll free at (800) 507-3800.

Discount Features

Look for In-Network Providers in the provider directory who accept discounts, as some do not. You should verify the providers' services and discounts prior to service, as they vary. These discounts are separate from the Fund's insured optical benefits and are offered at the time of sale at the discretion of the In-Network Provider.

Discounts on covered materials may include:

Frames: 20% off amount over allowance

Lens options: 20% off retail

Progressives: 20% off amount over retail lined trifocal lens, including lens options

Specialty contact lens fit: 10% off retail, then apply allowance

Discounts on non-covered exam, services and materials may include:

Exams, frames, and prescription lenses: 30% off retail

Lens options, contacts, and miscellaneous options: 20% off retail

Disposable contact lenses: 10% off retail

Retinal imaging: \$39 maximum out-of-pocket

Discounts on standard (not premium, brand, or progressive) lens options may include:

	Single Vision	Bifocal & Trifocal
Ultraviolet Coat	\$15 out of pocket maximum	\$15 out of pocket maximum
Tints, Solid or Gradients	\$25 out of pocket maximum	\$25 out of pocket maximum
Anti-reflective Coat	\$50 out of pocket maximum	\$50 out of pocket maximum
Polycarbonate	\$40 out of pocket maximum	20% Off Retail
High Index 1.6	\$55 out of pocket maximum	20% Off Retail
Photochromics	\$80 out of pocket maximum	20% Off Retail

Refractive Surgery

Superior Vision has a nationwide network of independent refractive surgeons and partnerships with leading LASIK networks who offer members a discount. These discounts range from 10%-50%, and are the best possible discounts available to Superior Vision.

Out-of-Network Benefits

If you choose to use a provider that is not in the Superior Vision network, you must pay the provider in full. When benefits are payable, the Fund will reimburse you up to the amount of out-of-network benefits shown in the schedules above, less any *co-payment*. It is your responsibility to submit a claim for reimbursement to Superior Vision with the itemized invoice or receipt.

Claims must be submitted to Superior Vision within 90 days after the claim is incurred. However, Superior Vision will not deny any claim if it was not reasonably possible to submit the claim in the time required, provided the completed claim is submitted to Superior Vision within one year after the claim is incurred.

You may obtain a claim form at www.superiorvision.com or by contacting the Fund Office at (800) 638-2972.

WOMEN'S HEALTH AND CANCER RIGHTS ACT ("WHCRA")

The Women's Health and Cancer Rights Act ("WHCRA") provides protections for individuals who elect breast reconstruction after a mastectomy. Under federal law related to mastectomy benefits, the Plan is required to provide coverage for the following:

- All stages of reconstruction of the breast on which a mastectomy is performed;
- *surgery* and reconstruction of the other breast to produce a symmetrical appearance;
- prosthesis; and
- treatment of physical complications of all stages of mastectomy, including lymph edemas.

Such benefits are subject to the Plan's annual *Deductibles* and *Co-insurance* provisions.

HMO OPTION

Newly Eligible Participants

When you first become eligible for benefits under the *Fund*, you may choose whether your Medical and Mental Health/Substance Abuse Benefits will be provided under the *Fund* (as shown in the Schedule of Benefits section of this book), or by an HMO (Health Maintenance Organization) option. Prior to your initial *Eligibility Date*, the *Fund Office* will send you an enrollment packet containing information about these choices. **Before you enroll in an HMO, check to be sure there are participating providers in your area (some HMOs do not service all geographic areas).** Participants who elect an HMO will have their Medical and Mental Health/Substance Abuse Benefits provided by the HMO, using HMO *Physicians* and facilities. However, your Optical, Dental, and Prescription Drug Benefits will be provided by Superior Vision, Dentegra, and Express Scripts, Inc. as described in this book.

If you want your Medical and Mental Health/Substance Abuse Benefits provided through an HMO, you must complete and return the election form from the packet within 30 days from the date you first become eligible for benefits. **If you do not return an HMO enrollment form within 30 days from the date of your initial eligibility, you may enroll for Plan coverage for your Medical and Mental Health/Substance Abuse Benefits, subject to authorized salary deductions.** You may not change your election until the next open enrollment, unless permitted under applicable law.

All Participants

In any given Plan year, the *Fund* may enter into a contract with one or more Health Maintenance Organizations (HMOs). If you enroll in an HMO option, the benefits are guaranteed and paid through the HMO contract and the HMO provides claims processing and all administrative services related to the benefits provided by the HMO.

You should review the HMO materials for a detailed description of the benefits and administrative procedures.

Each year, the *Fund* may offer one or more HMOs (Health Maintenance Organizations) as an option to specified participants during the “open enrollment” period. During open enrollment, participants and their dependents may choose an HMO in lieu of the *Fund* Medical and Mental Health/Substance Abuse Benefits processed by Associated Administrators, LLC (the *Fund Office*). You will keep all your other existing *Fund* benefits, including Optical, Dental, and Prescription Drug. **This election must be for a full twelve months.** Thereafter, participants may keep the HMO or return to benefits administered by the *Fund*.

Under an HMO, participants must use HMO centers and *Physicians*, and *Hospital* admissions are arranged by the HMO. With the HMO, there are usually no *Deductibles* and minimal or no *Co-payments* required for each office visit. You are covered for *Hospital*, preventive, and routine office visits.

Cost

There may be a monthly co-premium for coverage through an HMO which you must submit directly to the Fund Office and not to the HMO. You will receive a letter each year explaining the Open Enrollment options and the monthly cost, if any, for each choice. Missed co-premium payments will result in a loss of medical coverage.

Monthly co-premium payments sent directly to the HMO may be lost or misapplied. Please send your HMO co-payments/premiums to the Fund Office. For your convenience, the Fund Office provides payment coupons and return envelopes pre-printed with the Fund Office’s address to all actively working participants enrolled in the HMO.

Once coverage through the HMO is lost, coverage through the *Fund* may only be reinstated at the next enrollment period – and it is up to you to contact the *Fund Office* during that open enrollment to let us know which option you are choosing for the next year.

Participants should receive a newsletter from the *Fund* and a brochure and application from each HMO being offered, explaining the options in greater detail. **Note: If you do not live within the service area of one of the HMOs, you will not receive an information brochure/enrollment application from that HMO.**

The HMO listed below is offered as an alternative to the *Fund* Medical and Mental Health/Substance Abuse Coverage as described in this book. The selection of HMOs offered is subject to change each year.

Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852

ADMINISTRATIVE PROCEDURES

Claims Filing and Review Procedures

Notice of Privacy Practices

Your Rights under ERISA

Member XG

Interactive Voice Response (IVR) System

Participating Employers and Unions

Telephone Numbers

Addresses

CLAIMS FILING AND REVIEW PROCEDURE

The following filing procedures apply to Comprehensive Medical Benefits:

Claims must be filed within one year from the date of service. If a claim is not filed within that time period, benefits will be denied. You have 45 days from the post mark date on a request from the *Fund Office* for additional information to return the information to the *Fund Office*. If your provider agrees to file the claim on your behalf but fails to submit the claim to the appropriate entity within the one-year deadline, causing the claim to be denied, the *Fund* will defend you against any attempts by the provider to collect payment from you. However, in order for the *Fund* to do so, you must notify the *Fund Office* within two weeks if you receive a bill from the provider for those services or if the provider takes any other action against you. Until the *Fund* receives such notice from you, it will not take action on your behalf. Further, in order for the *Fund* to defend you, you must notify the *Fund* when the provider first takes action against you. If you do not timely notify the *Fund*, you can be held responsible by the provider and the *Fund* will not defend you.

In order for the *Fund* to defend you, the following requirements must be satisfied:

If you receive a bill or lawsuit from the provider for services that were provided to you, and you believe these “hold harmless” rules apply, you must contact the *Fund Office* within two weeks to notify us that the provider is pursuing you and to request that the *Fund* defend you against attempts by the provider to collect payment for these services. If you don’t notify the *Fund Office* within this two-week period, the *Fund* cannot defend you and the provider can hold you responsible for the bill. You must also notify the *Fund Office* upon the first collection attempt by the provider.

If you receive a bill from a provider, it could be because the *Fund Office* has not received or paid it yet. The hold harmless protection applies when the *Fund* has denied the claim for lateness and the provider then attempts to collect the claim amount from you. In other words, just because you receive a bill, don't automatically apply for hold harmless protection. Contact the *Fund Office* to make sure we've received it.

Finally, please note that the *Fund* will not defend you against a provider's collection attempts if the reason for the provider's late filing of the claim was your failure to inform the provider of your *Fund* coverage.

1. Make sure your bills are fully itemized and on the letterhead stationery of the provider of service. Bills must show: ***Participant's name and alternate ID number (important)***, patient's name, type of service, diagnosis, date(s) of service, and charge per service. Cancelled checks, cash register receipts, and personal itemizations are not acceptable.
2. If you or your eligible dependent is enrolled in another group health plan, and that plan provides your primary coverage, include the "*Explanation of Benefits*" from your primary coverage along with copies of the itemized bills.
3. Benefit payments will be sent directly to the provider unless there is no payment direction and evidence of your payment is reflected. In that case, payment will be sent directly to you.
4. An *Explanation of Benefits* ("*EOB*") will be sent when your claim is processed or with the benefit payment. Please keep the *EOB* and refer to it if you have questions about your claim and how it was processed.

5. Always keep copies of bills for your records--originals will not be returned.

6. **You must use a CareFirst PPO participating provider** (with the exception of (1) *No Surprises Services* and (2) *emergency Ambulance Service*). If you used a CareFirst PPO participating provider, mail your claim for benefits/itemized bills to:

CareFirst/Network Leasing
PO Box 981633
El Paso, TX 79998-1633

If you did not use a CareFirst PPO participating provider, send your claim to the *Fund Office* at:

FELRA & UFCW VEBA Fund
Attn: Medical Claims Department
911 Ridgebrook Road
Sparks, MD 21152-9451

Claims Filing and Review Procedures

If you want to file a claim for benefits, see “Claims Procedure” at the end of the section describing the particular benefit. For example, if you want to file for Accident and Sickness payments, see page 111 in the Accident and Sickness Benefit section. The section below summarizes the general rules which apply to 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 CareFirst. This allows the *Fund* to pay the fee for covered services directly to the *Hospital or Physician*.

3. You must either submit an itemized bill or file a claim to CareFirst in order to be eligible for benefits. If you did not use a CareFirst provider, ask the provider to send the bill directly to the *Fund Office*.
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 participant'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 there is no payment direction 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 post mark date on a request from the *Fund* for additional information to return the information to the *Fund Office*.
Accident & Sickness claims must be filed within 90 days of the first date of disability.
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.

Advance Benefits for Workers' Compensation Claims

If you apply for Workers' Compensation and your claim is denied by either your *Participating Employer* or your *Participating Employer's* insurance carrier, you may apply to this Plan for Accident and Sickness or Medical Benefits. See "Advance Benefits for Workers' Compensation Claims" on page 90 for the conditions of payment.

Payment of a Claim

When you submit itemized bills to CareFirst, 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 the *Fund Office* has all the information necessary to process it, and it is covered under the Plan, it will be paid. If the *Fund Office* is unable to 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 claim has been paid in one of several ways. For example, you will receive your Accident and Sickness check in the mail, or, in the case of a medical claim, you will 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 all defined in the definitions section of this book on pages 22-33.

General Information Regarding Benefit Claims

Claims for *Hospital*, medical, prescription, 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 dental and vision 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 book 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 vision, 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 under Section 502(a) of the Employee Retirement Income Security Act (“ERISA”) 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, alternate payee 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* may also 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 fifteen 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 refile 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.

Notwithstanding the above, providers of *No Surprises Services* will receive payment, or a denial, of a *Post-Service Claim* for *No Surprises Services* within 30 days of the Fund's receipt of all information necessary to adjudicate the claim.

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) information regarding the claim involved (including the date of service, the provider involved, if applicable, and the claim amount); 2) the specific reason or reasons for denial; 3) reference to specific Plan provisions on which the denial is based; 4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; 5) an explanation of the Plan's claims review procedures and external review process and the time limits applicable to such

procedures, including the expedited review process applicable to Urgent Care claims; 6) a statement of your right to bring a civil action under Section 502(a) of *ERISA* following a denial of your appeal; 7) 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; 8) 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; and 9) a description of your right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered an appeal or request for external review). The written notice of denial also will include a description of any contractual limitations period that applies to your right to bring an action under ERISA if your appeal is denied.

If you live in a county in which 10% or more of the population in that county is literate only in a non-English language (as determined by the federal government) you may request to receive any adverse benefit determination or final adverse benefit determination in that non-English language. Please contact the *Fund Office* for more information.

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, on appeal, the Board of Trustees relies upon, considers or prepares new or additional evidence in connection with a claim, this evidence must be provided to you to the extent required by law.

If the Board of Trustees denies your claim on a basis other than what is originally stated in your initial claim denial, the *Fund* must provide this basis to you to the extent required by law.

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, please 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 Carelon Behavioral Health, c/o Utilization Review Manager, PO Box 1854, Hicksville, NY 11802.
- For denied prescription benefit claims, you may contact Express Scripts, P.O. Box 1179, Port Washington, NY 11050.
- For certification denials made by Conifer Health Solutions, you may contact Conifer at 1596 Whitehall Road, Annapolis, MD 21409.

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*.

If Your Accident & Sickness Claim Is Denied

If your Accident & Sickness claim is denied in whole or in part, you will be notified in writing within 45 days after your claim has been received by the *Fund Office*. The *Fund* may require an additional 30 days, and occasionally another 30 days beyond that, if extra time is needed for reasons beyond the control of the *Fund* (including if you fail to properly file the claim or do not submit sufficient information for the *Fund* to process it). If extra time is required, you will be notified in writing explaining the reasons for the delay, the standards for entitlement to a benefit, any unresolved issues and additional information required, and the date the *Fund* expects to issue a final decision. If the *Fund* requests additional information, you will have 45 days to respond. The *Fund* will not decide your claim until you respond or the 45 days expires, whichever comes first. If you do not submit the requested information, the *Fund* will deny your claim.

If your claim is denied, to the extent applicable, you will be advised of the claim involved (including the date of service, the provider involved, if applicable, and the claim amount), the specific reason for the denial, the specific Plan provision on which the denial is based, any additional information needed to reconsider the claim, a description of the Plan's appeal and external review procedures and time limits, a description of your right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered an appeal or request for external review), and your right to bring suit against the Plan under *ERISA* if your appeal is denied. If the *Fund* relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, etc., or a statement that it was relied upon and is available

upon request and free of charge. If the *Fund* based its decision on *Medical Necessity, Experimental* treatment or a similar exclusion or limit, you will receive either an explanation of the judgment related to your condition or a statement that such an explanation is available upon request and free of charge. If the *Fund* received the advice of any medical or vocational expert with respect to your claim, the *Fund* will identify the expert upon your request. The written notice of denial also will include a description of any contractual limitations period that applies to your right to bring an action under ERISA if your appeal is denied.

If you live in a county in which 10% or more of the population in that county is literate only in a non-English language (as determined by the federal government) you may request to receive any adverse benefit determination or final adverse benefit determination in that non-English language. Please contact the *Fund Office* for more information.

Initial Disability Claim Denial Involving Discretionary Determination of Disability by the Fund

In the case of a denial of your claim for disability benefits that is based on a determination by the *Fund* (and not by a third party acting independent of the *Fund* such as the Social Security Administration (“SSA”)) that you are not disabled under the Plan rules, the written notice of the denial also will include the following:

1. A discussion of the decision, including, if applicable, an explanation of the *Fund’s* basis for disagreeing with or not following:
 - (a) The views you presented to the *Fund* of health care professionals treating you and vocational professionals who evaluated you (if any);
 - (b) The views of any medical or vocational experts whose advice was obtained on behalf of the Fund in connection

- with the denial of your claim, even if the advice was not relied upon in making the determination; and
- (c) A disability determination made by the SSA, if you provided it to the Fund.
2. A copy of the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and
 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.

Appeal Procedures – Accident & Sickness Claims

You (or your authorized representative) may appeal the claim denial directly to the Board of Trustees. If you decide to appeal, you must make a written request for review within 180 days after you receive written notice that your claim has been denied. You must include in your written appeal all the facts relating to your claim as well as the reasons you feel the denial was incorrect. You (or your authorized representative) may receive, upon request and free of charge, reasonable access to and copies of any documents relevant to your claim. You may submit issues and comments in writing, and documents, relating to your claim.

You may name a representative to act on your behalf. To do so, you must notify the *Fund* in writing of the representative's name, address and telephone number. You may, at your own expense, have legal representation at any stage of these review procedures. Regardless of the outcome of your appeal, neither the Board of Trustees nor the *Fund* will be responsible for paying any legal expenses that you incur during the course of your appeal.

The Board of Trustees, in making its decisions on claims and appeals, will apply the terms of the Plan document and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, are applied consistently with respect to similarly situated claimants.

If, on appeal, the Board of Trustees relies upon, considers or prepares new or additional evidence in connection with a claim, this evidence must be provided to you to the extent required by law.

If the Board of Trustees denies your claim on a basis other than what is originally stated in your initial claim denial, the *Fund* must provide this basis to you to the extent required by law.

Disability Decision on Appeal Involving Discretionary Determination of Disability by the Fund

In the case of a denial of your appeal involving a claim for a disability benefit that is based on a determination by the *Fund* (and not by a third party acting independent of the *Fund* such as the SSA) that you are not disabled under the Plan rules, the written notice of denial also will include all of the information in the “Initial Disability Claim Denial Involving Discretionary Determination of Disability by the *Fund*” section above, as well as the calendar date on which the contractual limitations period expires for the claim.

Who Decides Appeals

You must send your request for review (appeal) to:

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

How Long the Review Takes

The Board of Trustees will make its decision at the next regularly scheduled meeting following receipt of your appeal, unless there are special circumstances, such as the need to hold a hearing, in which case the Board of Trustees will decide the appeal at its next regularly scheduled meeting. If you submit your appeal within 30 days of the next scheduled Board of Trustees meeting, the Board of Trustees will decide the appeal at the second scheduled meeting, or, if there are special circumstances, the third meeting after it receives your appeal. If the Board of Trustees requires a postponement of its decision to the next meeting, you will receive a notice describing the reason for the delay and an expected date of the decision.

The Board of Trustees will also take into account all information you submit. If the initial decision was based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination (or a subordinate of such person). The Board of Trustees did not initially review your claim, and will not give deference to the initial decision.

The Board of Trustees will send you a notice of its decision within five days of the date the decision is made. If the Board of Trustees denies your appeal, the notice will contain, to the extent applicable, the claim involved (including the date of service, the provider, and the claim amount), the specific reason or reasons for the denial, the specific Plan provisions on which the decision is based, a statement of your right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered a request for external review), notice of your right to receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to your claim, and a statement of your right to bring suit against the Plan under *ERISA*. If the *Fund* relied on an internal rule, guideline or protocol in making the decision, you

will receive a statement that it was relied upon and is available upon request and free of charge. If the *Fund* based its decision on *Medical Necessity*, *Experimental* treatment or a similar exclusion or limit, you will receive a statement that such an explanation is available upon request and free of charge. If the *Fund* received the advice of any medical or vocational expert with respect to your claim, the *Fund* will identify the expert upon your request.

The decision of the Board of Trustees is final and binding.

External Review of Claims for Uninsured Benefits – Comprehensive Medical and Prescription Drug

If your claim for uninsured benefits has been denied and if you have exhausted the *Fund's* internal claims and appeal procedures as described above, you may be entitled to appeal the decision to an external independent review organization (“IRO”). External review is limited to claims: (a) relating to a *No Surprises Service*; (b) involving medical judgment (e.g., lack of *Medical Necessity*, or a determination that a claim is *Experimental* or cosmetic); or (c) involving a retroactive rescission of coverage. No other denials will be reviewed by an IRO unless otherwise required by law.

A request for external review must be filed with the *Fund Office* within four months after you receive notice of the denial of your appeal (or if earlier, by the first day of the fifth month after receipt of the decision on your appeal).

Preliminary Review. Within five business days of receiving your request for an external review, the *Fund* will complete a preliminary review of your request to determine whether it is eligible for external review (e.g., whether you have exhausted the *Fund's* claims and appeals procedures and provided all the necessary information).

Within one business day after the preliminary review is completed, you will be notified whether the claim is eligible for external review,

except that to the extent required by law, the preliminary review may be referred to an IRO to determine whether the claim involves medical judgment. If your external review request is complete but your claim is not eligible for external review, you will receive a notice stating the reason(s) it is not eligible, and you will receive contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to make your request complete. You may submit additional required information within the original four-month filing period or within the 48-hour period following your receipt of the decision regarding your eligibility for external review, whichever is later.

Referral to Independent Review Organization. If your external review request is complete and your claim is eligible for external review, the *Fund* will forward your claim to an IRO for review. The IRO will notify you in writing that your claim has been accepted for external review.

You are permitted to submit in writing to the assigned IRO, within ten business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten business days. If you choose to submit such information, within one business day, the assigned IRO will forward the information to the *Fund*. Upon receipt of any such information, your claim that is subject to external review may be reconsidered. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the *Fund* decides, upon completion of its reconsideration, to reverse its denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

In making its decision, the IRO will review all of the information and documents it timely receives, and will not be bound by any decisions or conclusions reached during the *Fund's* internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it to be relevant.

The IRO will provide you with written notice of its decision within 45 days after it receives the request for review. The IRO's decision notice will contain:

- A general description of the claim and the reason for the external review request;
- The date the IRO received the external review assignment and the date of its decision;
- Reference to the evidence considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available to you; and
- Contact information for any applicable consumer assistance office.

Upon request, the IRO will make available to you its records relating to your request for external review, unless such disclosure would violate state or federal privacy laws.

Reversal of the Fund's decision. If the IRO issues a final decision that reverses the Fund's decision, the Fund will pay the claim.

Expedited External Review of Denied Claims. You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if the claimant has not yet been discharged from the facility. You may request an expedited external review at the same time an appeal is submitted to the Fund's Board of Trustees, if the claimant requires urgent care or is receiving an on-going course of treatment.

Immediately upon receiving your request for expedited external review, a determination will be made as to whether your request is eligible for external review as described above. The Fund will immediately send you a notice of its eligibility determination.

If your claim is determined to be subject to external review, the IRO will provide a decision as soon as possible under the circumstances but no more than 72 hours after receiving the expedited request for review.

Life Benefit and Accidental Death & Dismemberment Benefit Claims Procedures

Denial of a Claim

If your claim for benefits results in an adverse benefit determination, in whole or in part, you will receive a written explanation of the reason(s) it was denied usually within 90 days after your claim has been received by the Fund Office. If additional time of up to 90 days is required because of special circumstances, you will be notified in writing of the reason for the delay, and the date that the Fund expects to issue a final decision. A decision will be made with respect to your claim no more than 180 days from the date your claim is first filed with the Fund Office.

If your claim is denied, you will receive a written explanation that contains the following information:

1. the specific reason for the denial,
2. reference to the specific provision of the plan document or rule on which your denial is based,
3. a description of additional materials you would need to perfect your claim and an explanation of why this material is needed,
4. the steps you must take if you want to have your denied claim reviewed, including the amount of time you have to do this, and
5. your right to bring an action under *ERISA* if you decide to appeal and that appeal is denied.

Review of a Denied Claim

If you decide to appeal, you must make written request for a review within 60 days after you receive written notice your claim has been denied. You should include in your written appeal all the facts regarding your claim as well as the reason(s) you feel the denial was incorrect. You will receive, if you request it, reasonable access to and free copies of documents relevant to your claim. You may submit issues and comments in writing, and documents, relating to your claim.

The Board of Trustees will determine all requests for review for claims that were denied on the basis of the Plan's eligibility rules. Submit your appeal to the *Fund Office* address below. Life Benefit and Accidental Death and Dismemberment claims that are denied on the basis of the insurance contract are reviewed by Symetra.

You may name a representative to act on your behalf. To do so, you must notify the *Fund* in writing of the representative's name, address, and telephone number. You may, at your own expense, have legal representation at any stage of these review procedures. Regardless

of the outcome of your appeal, neither the Board of Trustees nor the *Fund* will be responsible for paying any legal expenses which you incur during the course of your appeal.

The Board of Trustees, in making its decisions on claims and on appeal, will apply the terms of the plan document 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.

Where to Send Your Appeal

You must send your request for review (appeal) to:

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

How Long the Review Takes

If Symetra reviews your claim, you will receive a written decision of the review of your claim denial within 60 days of the date they first receive your request for review. If special circumstances require a delay, you will receive a notice of the reason for the delay within those 60 days. The notice will describe the reason for the delay and the approximate date a decision will be made. The final decision on your claim will be issued no later than 120 days from the date they first receive your request for review. The review will take into account all information you submit relating to your claim. In the event your appeal is denied, you have the right to bring a civil action against Symetra under section 502(a) of *ERISA*.

If the Board of Trustees reviews your claim, it will take into account all information you submit in making its decision. The Board of Trustees will make its decision at the next regular meeting following receipt of your appeal, unless there are special circumstances, such as the need to hold a hearing, in which case the Board of Trustees will decide the case at its next regular meeting. If you submit your appeal less than 30 days before the next scheduled Board of Trustees meeting, the Board of Trustees will decide the case at the second scheduled meeting, or, if there are special circumstances, the third meeting after it receives your appeal. If the Board of Trustees requires a postponement of the decision to the next meeting, you will receive a notice describing the reason for the delay and an expected date of the decision.

The Board of Trustees will send you a notice of its decision within 5 days of the decision. If the Board of Trustees denies your appeal, the notice will contain the reasons for the decision, specific references to the plan provisions on which the decision was based, notice that you may receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to the claim, and a statement of your right to bring a lawsuit under *ERISA*.

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 Active Health and Welfare Plan (the “Plan”), a plan of the Food Employers Labor Relations Association and United Food and Commercial Workers VEBA 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.

SUMMARY OF THE PLAN'S PRIVACY PRACTICES

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, MD 21152-9451
(410) 683-6500
PrivacyOfficer@associated-admin.com

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 unemancipated 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 Active 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 as a result of a qualifying event, you or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

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.

MemberXG

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.
- Dashboard – a landing page containing quick navigation to other benefit information.
- Demographics – a demographic page displaying your address, phone number, and other information.
- Electronic EOB (“eEOB”) feature allows you to review and print your Explanations of Benefits.
- The dates of, and payments made to you for Accident and Sickness (Weekly Disability) 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)

How Does It Work?

- Log in to www.associated-admin.com, select “Your Benefits” located at the left side of the screen, and select *FELRA & UFCW Health and Welfare Plan*. Click on the MemberXG link which will take you to MemberXG site.
- Select “Create Account,” located at the upper, right corner. When you first access the MemberXG site, you will be asked to create a username and password.

- You and your dependent(s) (if age 18 or older) can each create your own username and password. Note: due to federal health privacy laws and the *Fund's* privacy rules, you will generally only have access to your own personal account information and may not be able to view your spouse's or non-minor child's personal data in your own MemberXG account.
- Once you have successfully logged in, you will be taken to the "Demographic" page, which displays your address, phone number, and certain dependent information.
- The menu selection screen appears in the left column of your screen. Here you can click on the category you wish to view (medical claims paid, Accident & Sickness benefits received, etc.).

If you have any 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. Information displayed when you log in to your Member XG account will not reflect data that has not yet been processed and may not yet reflect data that has recently been processed by the *Fund Office*.

INTERACTIVE VOICE RESPONSE (“IVR”) SYSTEM

Use the Interactive Voice Response (“IVR”) system to check on your medical claim 24 hours a day, seven days a week by calling (800) 638-2972.

To access your claim, you will need:

- The participant’s Social Security Number.
- The 4 digit PIN number. The default PIN is the participant’s month and date of birth (for example, if the participant was born on June 1st, you would enter "0601" as the PIN). However, you may change your PIN at any time by following the prompts in the system.
- The date of birth--month, day and year--of the patient.
- The date of service for the claim you wish to access. If you don't know the exact date, you can use the month and year in which the claim was *Incurred*.
- The billed amount of the claim.

Call the IVR system at (800) 638-2972 and follow the prompts, entering the information the system asks for. If your claim has been entered, the system will tell you its current status. If it has been processed, the system will tell you when, the dollar amount, and to whom the payment (if any) was made. It takes about three weeks from the date of service for a claim to be entered into our system (this allows time for the provider to bill us and for the claims adjustors to enter the claim). If there is "no record" of your claim, it means the claim has not yet been entered in our system. If your claim is not in the system and you think it should be, or if you need more information about a claim, simply call the same 800 number and follow the prompts to talk with a Participant Services representative. He or she will be happy to answer any questions you may have. Remember, because of the new Privacy Rules, the information you can receive on someone else’s claim (a spouse or a non-minor child) may be limited. See the *Fund’s* Notice of Privacy Practices on page 223 for a full explanation of these rules.

PARTICIPATING EMPLOYERS AND UNIONS

Giant Food, Inc.
8301 Professional Place, Suite 115
Landover, MD 20785-2351

Safeway, Inc.
4551 Forbes Boulevard
Lanham, MD 20706

United Food and Commercial Workers
Local 400
8400 Corporate Drive, Suite 200
Landover, MD 20785

United Food and Commercial Workers
Local 27
21 West Road
Baltimore, 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.

Fund Office Participant Services/Eligibility	(800) 638-2972
Fund Office (Sparks Local Line) (Landover Local Line)	(410) 683-6500 (301) 459-3020
Conifer Health Solutions	(800) 459-2110
Dental Information & Provider Search Dentegra Insurance Company	(877) 280-4204
Express Scripts (Prescription Claims)	(888) 903-8325
Prior Authorizations	(800) 753-2851
Accredo Specialty Pharmacy	(800) 850-9122
CareFirst PPO White ID card holders call Green ID card holders call	(800) 810-2583 (800) 235-5160
Superior Vision (Optical)	(800) 507-3800
Carelon Behavioral Health	(800) 353-3572

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

Special P.O. Box for Claims--Both Locals

Send Accident and Sickness claims to:

FELRA & UFCW VEBA Fund
Attn: A&S Department
P.O. Box 1064
Sparks, MD 21152-1064

If you use a CareFirst provider, send your medical claims to:

CareFirst PPO/Network Leasing
P.O. Box 981633
El Paso, TX 79998-1633

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

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

Send behavioral health claims to:

Carelon Behavioral Health Claims Department
P.O. Box 1854
Hicksville, NY 11802

