UFCW UNIONS AND PARTICIPATING EMPLOYERS HEALTH AND WELFARE FUND

UFCW Unions and Participating Employers
Active Health and Welfare Plan

PLAN JSS2

SUMMARY PLAN DESCRIPTION

November 2023

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
Check the status of your medical claims 24 hours a day, 7 days a week by using the automated phone system and calling (800) 638-2972. Press "1" at the prompt.

With respect to all uninsured benefits described herein, this Summary Plan Description for the UFCW Unions and Participating Employers 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, as amended ("ERISA"), 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 United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund (referred to as "UFCW Unions and Participating Employers Health and Welfare Fund" or the "*Fund*") was established as a result of collective bargaining between your *Union* and your *Participating Employer*. The contribution rate paid by your *Participating Employer* determines the level of benefits you receive. An equal number of *Trustees* have been appointed by the *Union* and the *Participating Employer*s. The *Trustees* administer the *Fund* and serve without compensation. Their authority, established under the *Fund's* Trust Agreement, includes the right to make rules about your eligibility for benefits and the level of benefits available. The *Trustees* have the power to interpret, apply and construe the terms of the Plan and make factual determinations regarding the Plan's construction, interpretation and application. Further, the *Trustees* may amend the rules and benefit levels at any time and may terminate the Plan. If the *Trustees* terminate the Plan, your rights and the distribution of assets will be determined under the terms of the Trust and applicable law. Participants and beneficiaries have no vested rights to the benefits described in this book. Any decision made by the *Trustees* is binding upon *Participating Employer*s, 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*.

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

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

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

Sincerely,

BOARD OF TRUSTEES

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Note: Certain terms in this book are defined under the "Definitions" section on page 17. Such terms will appear in *italics* and *Capitalized* throughout this book.

The benefits outlined in this book apply to employees of the *Participating Employers* as described below who are in Plan JSS2 and are covered by a participation agreement with the *Fund*, or 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 26 in order to be eligible for benefits under Plan JSS2.

Safeway (Valley)

Shoppers Food Warehouse

UFCW Local 400 Temporary Employees

FACTS ABOUT THE PLAN

Plan Name
UFCW Unions and Participating Employers Active Health and Welfare Plan, a plan of the UFCW Unions and Participating Employers Health and Welfare Fund.

Plan Sponsor
Board of Trustees of the UFCW Unions and Participating Employers Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451, (410) 683-6500.

Employer Identification Number	**Plan Number**
52-6044428	502

Type of Plan
This is a welfare plan designed to provide health and welfare benefits such as: life, accidental death and dismemberment, hospitalization, medical, surgical, mental health, weekly disability, 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 UFCW Unions and Participating Employers Health and Welfare Fund

Agent for Service of Legal Process

Associated Administrators, LLC or any Trustee at this address:
UFCW Unions and Participating Employers
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(410) 683-6500

Sources of Contribution
Sources of contributions to the *Fund* are from the *Participating Employer*s pursuant to the terms of their *Collective Bargaining Agreements* or participation agreements and self-payments made by participants and/or dependents.

***Fund*ing Medium**

All assets are held in trust by the *Board of Trustees*. Insurance premiums are paid by the *Fund*, and insurance companies pay part of the benefits. Benefits are also partially paid from the accumulated assets of the Trust. For benefits provided by insurance companies, the benefits are guaranteed by and paid under the insurance contract and the insurance company 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

UFCW UNIONS AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

BOARD OF TRUSTEES

UNION TRUSTEES	EMPLOYER TRUSTEES
Mark Federici - Chair President UFCW Local 400 8400 Corporate Drive Suite 200 Landover, MD 20785	William Seehafer – Secretary Consultant 1270 Northland Drive, Suite 150 St. Paul, MN 55120
Jason Chorpenning - President UFCW Local 27 21 West Road, Second Floor Towson, Md. 21204	Margaret Lin Associate General Counsel, Benefits UNFI 11840 Valley View Road Eden Prairie, MN 55344
Thomas Hipkins Secretary - Treasurer UFCW Local 27 21 West Road, Second Floor Towson, MD 21204	Valerie Marsh SVP, Labor Relations and Strategy UNFI 313 Iron Horse Way Providence, RI 02908
Michael Wilson UFCW Local 400 8400 Corporate Drive, Ste. 200 Landover, MD 20785	Elizabeth Fiergola Manager, Labor Relations UNFI 313 Iron Horse Way Providence, RI 02908

SCHEDULE OF BENEFITS - SUMMARY

GROUP A BENEFITS

Group A benefits include Hospitalization, Medical and Surgical, Life and Accidental Death and Dismemberment.

Hospitalization Participant and Eligible Dependent(s).	Hospital charges are covered at 80% up to the *Allowable Charge* fees under Comprehensive Medical Benefits, after you pay a $200 *Deductible* (per person, per year). Emergency room service has a $75 *Co-payment*, then covered at 80% of the *Allowable Charge*. *Co-payment* is waived if admitted. **You must pre-certify all non-emergency *Inpatient Hospital* stays with Conifer Health Solutions ("Conifer")** (see section on Conifer Health Solutions for details)
Medical/Surgical Participant and Eligible Dependent(s).	Comprehensive Medical Benefits are covered at 80% up to the *Allowable Charge* after you pay a *Deductible* of $200 per person per *Calendar Year*. The annual out-of-pocket maximum for covered medical expenses for essential health benefits is $4,000 per person and $8,000 per family. Essential health benefits are covered at 100% for the remainder of the *Calendar Year* after a participant or dependent has met the per-person or per-family out-of-pocket maximum.
Life Insurance Participant only.	$20,000 for *Full Time* participants $10,000 for *Part Time* participants
Accidental Death & Dismemberment Participant only.	$20,000 for *Full Time* participants $10,000 for *Part Time* participants

GROUP B BENEFITS

Group B benefits include Weekly Disability and Prescription Drug.

Weekly Disability *Participant only*	66 2/3% of gross straight time pay up to a maximum of 26 weeks per disability. Benefits generally begin on the 3rd day of the disability. See page 71 for more detailed information regarding your Weekly Disability benefits.
Prescription Drug *Participant & Eligible Dependent(s)*	Prescription Drug Benefits are provided through OptumRx. **Generic drugs are mandatory, if available, and you must use an in-network pharmacy.** The annual out-of-pocket limit for prescription drugs is $2,600 per covered person, per *Calendar Year* and $5,200 per family per *Calendar Year*. Generic drugs and brand name drugs are covered with a 5% *Co-payment* at a Shopper's, Giant or Safeway pharmacy or 10% at any other in-network pharmacy; brand name drugs are covered only if there is no generic equivalent. Specialty drugs must be ordered by phone through OptumRx Specialty Services with a 5% *Co-Payment*.

GROUP C BENEFITS

Group C benefits include Vision and Dental.

Vision *Participant and Eligible Dependent(s)*	Exam, frames, and lenses covered once every two years through Group Vision Service ("GVS"). Contacts may be chosen in lieu of glasses.
Dental *Participant and Eligible Dependent(s)*	Benefits are provided through Dentegra Insurance Company. Some services are provided at no charge; others are provided with a *Co-payment* payable by you to the *Participating Dentist*.

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 *Fund*. 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.

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, and the UFCW Unions and Participating Employers Retiree Health and Welfare Plan. For example, if the overpayment or advancement was made to you or on your behalf as the *Fund* participant, the *Fund* may offset the future benefits payable by the *Fund* to you and any of your dependents. 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.

HEALTH CARE COST CONTAINMENT CORPORATION

The UFCW Unions and Participating Employers Health and Welfare *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. The HCCCC is able to achieve significant cost savings because of increased bargaining power in the health care marketplace.

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 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, 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.

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.

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

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

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 400, which require contributions to the UFCW Unions and Participating Employers Health and Welfare 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-INSURANCE OR CO-PAYMENT. 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 $200 of covered medical expenses *Incurred* in a *Calendar Year* for *Sickness* or *Injury*.

DENTAL EMERGENCY. An unforeseen situation requiring dental treatment to relieve a condition necessitating immediate care. Includes accidental injuries requiring immediate treatment.

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 provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;
    - 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 (or "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.

FULL TIME. You are considered "*Full Time*" if you are classified as full time under the *Collective Bargaining Agreement* applicable to your employment.

FUND. The United Food and Commercial Workers Unions and Participating Employers Health and Welfare *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 health and substance use 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*.

MEDICAL EMERGENCY. A situation which arises suddenly and which poses a serious threat to life or health. *Medical Emergencies* include heart attack, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and other acute conditions. The diagnosis or the symptoms, and the degree of severity, must be such that immediate *Medical Care* would normally be required.

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.

NO SURPRISES ACT. The No Surprises Act enacted under the federal Consolidated Appropriations Act of 2021, Public Law 116-260.

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.

PART TIME. You are considered "*Part Time*" if you are classified as part time under the *Collective Bargaining Agreement* applicable to your employment.

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 Insurance Company 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 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.

SICKNESS. Any physical sickness or mental health or substance use disorder. Pregnancy is not automatically considered to be a *Sickness*. There must be a medical reason for pregnancy to be considered a *Sickness*.

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.

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 UFCW Unions and Participating Employers Health and Welfare *Fund*.

UNION. The United Food and Commercial Workers International Union, Local 400 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 Agreement* or other agreement with an employer requiring contributions to the trust establishing the UFCW Unions and Participating Employers Health and Welfare *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 CARE 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

Initial Eligibility

Both *Full Time* and *Part Time* employees are eligible to participate in this Plan if you are employed by a *Participating Employer* and covered by a *Collective Bargaining Agreement* between that employer and United Food and Commercial Workers Union Local 400 which provides for contributions to the *Fund* for coverage under this Plan. You will be eligible for benefits under the Plan as follows, subject to the *Fund's* receipt of contributions, when contractually required, made on your behalf by your *Participating Employer*, and subject to your completing and filing with the *Fund Office* the necessary enrollment forms, including any payroll deduction forms:

- **Group A Benefits (Hospitalization, Medical/Surgical, Life, and Accidental Death and Dismemberment):** You will become eligible for Group A benefits on the first day of the calendar month following the month in which your employer is required to make the first contribution to the *Fund* on your behalf.

- **Group B Benefits (Weekly Disability and Prescription Drug):** You will become eligible for Group B benefits on the first of the month following three months of eligibility for Group A benefits.

- **Group C Benefits (Vision and Dental):** You will become eligible for Group C benefits on the first of the month following three months of eligibility for Group B benefits.

Check your *Collective Bargaining Agreement* for the specifics about any applicable waiting period that must be completed before your employer is required to make contributions to the *Fund* on your behalf.

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 Weekly Disability 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 FELRA & UFCW VEBA *Fund*, you will be eligible for benefits under this *Fund* according to your total length of covered employment under both plans.

Annual Open Enrollment

After you enroll for coverage following your initial eligibility for benefits, or 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 as described below 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 from November 1st-30th each year for coverage effective January 1st.

Choosing How You Would Like Your Medical Benefit to Be Provided

If you live in the geographic 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) coverage under an HMO offered by the *Fund* instead of receiving traditional *Fund* medical coverage. This Open Enrollment period is from March 15th – May 15th for coverage effective June 1st each year. For more information, please refer to the "HMO Option" section of your SPD.

Enrollment Form

In order to enroll for benefits, you must complete a *Fund* enrollment form and file it with the *Fund Office*. You can get an enrollment form from your *Participating Employer*, the *Fund Office*, or your *Union* representative. Failure to enroll promptly will cause a delay in the start of your benefits. If you have dependent coverage, you must list those dependents on your enrollment form.

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

Continued Eligibility

Once you are initially eligible, you become and remain a participant as long as you are employed by a *Participating Employer* making contributions to the *Fund* on your behalf and covered by a *Collective Bargaining Agreement* with a participating *Union* or a participation agreement with the *Fund*.

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 Weekly Disability benefits from this Plan*,
5. while collecting Workers' Compensation benefits from a *Participating Employer*, not to exceed your Weekly Disability entitlement*, and
6. during periods of leave covered under the Family and Medical Leave Act ("*FMLA*") as described on page 48.

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

Special Enrollment Provisions

If you do not elect coverage for either yourself or for your dependents because you have access to 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 your 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:

UFCW Unions and Participating Employers Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: Special Enrollment
Telephone No. 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 49,
5. leave of absence, unless your eligibility is extended due to a provision in your *Collective Bargaining Agreement*,
6. unpaid vacation for which no contributions are made to the *Fund,*
7. exhaustion of Weekly Disability benefits provided by this Plan,
8. absence because of an accident or *Sickness* compensable under Workers' Compensation exceeding your Weekly Disability 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 JSS2 if you fail to satisfy the requirements for continued eligibility for Plan JSS2 benefits, as described under "Continued Eligibility" on page 28.

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 39. 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 49. Further, you may be entitled to continue your eligibility by making self-payments. See the "Self-Payments" section on page 51 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.

The following cost for coverage will be deducted from your payroll:
- $7 per week for individual only coverage,
- $13 per week for the participant plus one dependent,
- $18 per week for family coverage (participant plus two or more dependents),
- An additional $20 per week spousal surcharge may apply (see section below).

Spousal Surcharge
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-premium payroll deductions. 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 this Plan.

Retirees
If you are an *Actively Working* participant covered by this Plan and you 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 39 of this book.

The *Fund* has a separate retiree plan of benefits, known as the UFCW Unions and Participating Employers Retiree Health and Welfare Plan ("Retiree Plan"), under which certain retirees of this Plan are eligible to receive benefits. Please contact the *Fund Office* for more information regarding your eligibility for benefits under the Retiree Plan.

Pre-Existing Condition Exclusions
There are no pre-existing condition exclusions on any benefits except insured dental benefits.

Date Benefits Terminate
If you lose your eligibility, your benefits terminate as follows:

- **Accidental Death and Dismemberment benefits:** Terminate on the same day your loss of eligibility occurs.
- **Hospital and Medical benefits:** Terminate on the last day of the calendar month in which you lose eligibility or the first day of the month in which your ***Participating Employer*** fails to make a contribution on your behalf, whichever occurs first. However, if you are in the *Hospital* when loss of

eligibility occurs, these benefits will continue until you are discharged or until the benefits are exhausted, whichever occurs first.

- **Life benefits:** Terminate 31 days following the loss of eligibility. See page 69 for information about the Life Conversion privilege which allows you to convert Life Benefits to an individual policy.
- **Weekly Disability, Dental, Vision, or Prescription Drug benefits:** Terminate on the same day your loss of eligibility occurs. However, Weekly Disability 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 but do not terminate employment, you will be eligible for benefits on the first day of the month in which your *Participating Employer* again makes a contribution to the *Fund* on your behalf.
- If you lose eligibility due to termination of employment with a *Participating Employer*, 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 you lose eligibility due to a layoff, military service, or a leave of absence approved by your *Participating Employer*, and you return to active employment, your eligibility will be reinstated on the first day of the month in which your *Participating Employer* makes a contribution on your behalf.
- If you lose eligibility for any reason *other than* layoff, military service, or approved leave of absence, and the period of separation is 31 days or longer, you must again meet the Plan's initial eligibility requirements.

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 JSS2 benefits.

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

Full Time

In general, *Full Time* participants are eligible to add dependents to their coverage after completing a year or more of continuous service. However, some groups may have a different waiting period – check your *Collective Bargaining Agreement* to determine the length of the waiting period applicable to you.

Part Time

In general, *Part Time* participants who have completed one year of continuous service are eligible to add dependents to their coverage.

Who Is an Eligible Dependent?

Eligible dependents include your spouse and children only, as defined below. The children covered are your biological children, stepchildren, legally adopted children, or children placed with you for adoption.

Biological Children, Adopted Children and Children Placed for Adoption

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

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, optical, dental, 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.*

Children under age four are not eligible for dental benefits.

Full Time Student Coverage

Dependent stepchildren and children for whom you have legal custody may continue to receive **medical, optical, dental and prescription drug 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 <u>not</u> 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, without charge, 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.

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 birth. For adopted children or children placed with you for adoption other than newborns, when you apply within 30 days of the date of adoption or placement with you for adoption, the child(ren) 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.

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 35.

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 *Trustees*; for your spouse: a marriage license. In the case of a stepchild, a copy of the divorce decree or other documents indicating custody is required as evidence.

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 53 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, and the participant **must enroll the newborn child within 30 days of the child's birth or adoption to be eligible for this 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 date the child turns age 26.
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, at the end of the month in which the child no longer resides with you.

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 39.

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*," on page 54.

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 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:

Fund Office
UFCW Unions and Participating Employers
Health and Welfare Fund
Attention: COBRA Department
911 Ridgebrook Road
Sparks, MD 21152-9451

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 30 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 dependents keep the *Fund* informed of their current addresses. If you or a covered family member experiences a change of address, immediately inform the *Fund Office*.

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*, UFCW Unions and Participating Employers Health and Welfare Fund, Attention: COBRA Department, 911 Ridgebrook Road, Sparks, Maryland 21152-9451. 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, Prescription Drug, Optical, and Dental Benefits** (you cannot continue the Life Benefit, the Accidental Death and Dismemberment Benefit, or the Weekly Disability 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 besides COBRA Coverage

Instead of enrolling in *COBRA* coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, *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 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:

UFCW Unions and Participating Employers Health and Welfare Fund
COBRA Department
911 Ridgebrook Road
Sparks, MD 21152-9451

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

The Family and Medical Leave Act of 1993 *("FMLA"*) requires *Participating Employer*s 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 *USERRA* by the same method that the *Fund* uses to determine the cost of *COBRA* continuation coverage. See page 39.

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 coverage for yourself and for your eligible dependents by making self-payments directly to the Fund. If you choose to self-pay, coverage will be continued for all the 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 Time* 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:

   Fund Office
   UFCW Unions and Participating Employers
   Health and Welfare Fund
   911 Ridgebrook Road
   Sparks, MD 21152-9451

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 12 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. If you return to work in the middle of a month, your employer will not begin contributions until the following month; therefore, you still must self-pay for the month in which you return to work.

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.

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

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.**

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 dependent is eligible for *Medicare* and then elects *COBRA*

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

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

You and/or your dependent are required to notify the *Fund* within 10 days of any accident or *Injury* for which someone else may be liable. Further, the *Fund* must be notified within 10 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* shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the *Fund* on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the *Fund* under this Section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the *Fund* until paid to the *Fund*. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the *Fund* in reimbursing it for *Fund* costs and expenses.

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

subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the *Fund* arose, and your or your dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* on any payment amount or recovery that you or your dependent recovers from a third party.

Any refusal by you or your dependent to allow the *Fund* a right to subrogation or to reimburse the *Fund* from any recovery you receive, no matter how characterized, up to the full amount paid by the *Fund* on your or your dependent's behalf relating to the applicable *Injury* or *Sickness*, will be considered a breach of the agreement between the *Fund* and you that the *Fund* will provide the benefits available under the Plan and you will comply with the rules of the *Fund*. Further, by accepting benefits from the *Fund*, you and your dependent affirmatively waive any defenses you may have in any action by the *Fund* to recover amounts due under this Section or any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

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

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

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

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

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

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

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 Weekly Disability 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 related 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, we 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, we 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). We'll give you half of what we recover to a maximum of $1,000.

LIFE BENEFIT
Insured by MetLife
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
(Participant Only)

If you die while covered under the Plan, the amount of 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* within 30 days of the date you sign the form.

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 MetLife
P.O. Box 6100
Scranton, PA 18505-6100

(Participant Only)

This benefit is payable if you suffer any of the losses below as a direct result of, and within 12 months from, the date of an accidental injury 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.
One Hand, One Foot, or Sight of One Eye	Half the amount paid to you.
One Arm or One Leg	75% the amount paid to you.
One Thumb and Index Finger of Same Hand	25% the amount paid to you.
Speech and Hearing	Full amount paid to you.
Speech or Hearing	Half the amount paid to you.

For a description of additional benefits, you should refer to the MetLife group policy.

If you sustain more than one covered loss due to an accidental injury, the amount payable will not exceed the full benefit amount as stated in the Schedule of Benefits. The benefit for accidental death is in addition to the life insurance benefit.

Not Covered

MetLife does not pay benefits for any loss caused or contributed to by:

- Physical illness or the diagnosis or treatment of such illness;
- Infection, other than infection occurring in an external wound or from food poisoning or an infection which results from a crime unless the crime was a felony which you committed or attempted to commit;
- Suicide or attempted suicide;
- Self-inflicted injury by an insane person;
- Service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
- Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
- Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
- Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
- Travel in an aircraft or device used: for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the earth's atmosphere;
- In the case of a loss sustained by you, your committing or attempting to commit a felony;
- In the case of a loss sustained by you, your being under the influence of a narcotic; or
- War, whether declared or undeclared, or act of war.

DEFAULT PAYMENT FORM FOR LIFE INSURANCE BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

- If your payment is less than $5,000, or you are not a United States citizen for tax purposes, MetLife will automatically pay you by check.
- Beneficiaries who are eligible to receive a life benefit or accidental death & dismemberment benefit of $5,000 or greater have the option of requesting payment by check, or having the payment made into a Total Control Account.
- If you do not select a payment option, you will receive a Total Control Account ("TCA"), unless MetLife is required by state law, rule or regulation to pay you by check.
- A TCA is a draft account in the Beneficiary's name, established and maintained by MetLife that works like a checking account. The proceeds in the account earn interest at a guaranteed minimum rate, and the Beneficiary may write drafts against the Account of at least $250 at a time, up to the full amount of the Account.
- MetLife will send you a statement each month there is activity in your account. If there is no activity, MetLife will send a statement once every three months.
- You can name a beneficiary for the TCA by completing and submitting a beneficiary form provided by MetLife when you open your Account.
- There are no monthly maintenance fees on your TCA, no charges for making withdrawals or writing drafts, and no charge for ordering additional drafts. MetLife may charge you for special services or an overdrawn TCA.

For more information about your benefit payment options, contact MetLife at (800) 638-6420, then press 2.

LIFE CONVERSION PRIVILEGE
UPON TERMINATION OF COVERAGE

If your insurance is reduced or terminated because of loss of eligibility, you may convert your group life insurance without medical examination or other evidence of insurability to a life insurance policy customarily issued by MetLife, except term insurance, by applying to MetLife at this address:

MetLife
P.O. Box 6100
Scranton, PA 18505-6100

You can get a conversion form from the *Fund Office*. After your loss of eligibility, you must submit a completed conversion form to MetLife within the time limits set forth in the life insurance group policy. You will pay the premium applicable to the form and amount of the policy at your age and class of risk, based on MetLife's rates then in use.

If your insurance is terminated due to discontinuance of the Plan, you have the same conversion privilege if insured under this Plan for five years or longer, except that the amount of life insurance will be reduced (1) by the amount of any life insurance you are eligible for under any new plan within 31 days of termination or (2) to $2,000, whichever is less. Your group life insurance is payable if you die within 31 days after your insurance is reduced or terminated period allowed for conversion whether or not you have applied for an individual policy, at the full amount you were entitled to convert

Claims Procedure

Life and AD&D
Notice of a Life Insurance and/or Accidental Death and Dismemberment claim should be submitted in writing to the *Fund Office* as soon as reasonably possible, and within 20 days after the date of loss upon which the claim is based in the case of an Accidental Death and Dismemberment claim, 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. MetLife 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.

Group Policy Information – Life and AD&D

The group policy has been issued to the UFCW Unions and Participating Employers Health and Welfare 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 526044-1-G.**

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.

WEEKLY DISABILITY BENEFITS

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

Weekly Disability Benefits (sometimes called "accident and sickness" 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:

You must be seen by a *Physician* IN PERSON.

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 Weekly Disability 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. 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 **IN-PERSON** by a *Physician* either in his/her office, at your home, or at the *Hospital*. Telephone consultations do not satisfy this requirement, except as follows. **Effective through December 31, 2022, this requirement that you be seen in-person by a *Physician* may be satisfied by a visit with the *Physician* through 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. No copies or fax transmissions will be accepted. The *Fund Office* must receive an original claim form.

6. No disability will be considered as beginning more than three days prior to the first visit to a *Physician* during the disability period. Telephone consultations will <u>not</u> be accepted, except as provided in paragraph 3

above. This rule will be waived if your *Physician* provides documentationthat 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. No supplemental benefit will be paid for the waiting period before benefits begin or to supplement the difference between what you receive from a Workers' Compensation award and what you would have been paid under the Weekly Disability benefit from this Plan.

9. 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*.

10. 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).

11. 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 96),
    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 Behavioral Health at the time of the *Injury* or *Sickness* and the Weekly Disability (accident and sickness) form is completed by a Carelon Behavioral Health *Physician,* or, if your medical benefits are provided through an HMO, under the treatment of a certified psychologist or psychiatrist, or a Certified Alcohol Counselor or a Master's Level Social Worker who has been approved by your HMO and the Weekly Disability form is completed by a Carelon Behavioral Health *Physician*, or
    f. Once you have retired or are receiving Social Security or permanent disability benefits from the Social Security Administration.

12. 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 Weekly Disability benefits.

13. Benefits will not be payable for days used as vacation days or other time paid by the *Participating Employer*.

14. 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*.

15. 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.

16. 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.

17. Lack of knowledge of coverage does not excuse these requirements.

18. 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 Weekly Disability or Medical benefits may be deducted from amounts owed.

19. If the *Fund* receives a *QMCSO* directing that Weekly Disability 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.

20. You must actively be receiving treatment from a *Physician* to improve the condition which is causing your disability.

21. There is no supplemental benefit paid during the three-day waiting period.

Benefit Amount

The weekly benefit amount up to a maximum of 26 weeks of disability will be 66 2/3% of your gross regular weekly straight time pay. Benefits begin on the third day of disability. The daily benefit amount will be 1/7 of the weekly benefit amount. Premium hours will not be counted in determining the benefit amount, but shift premiums will be counted.

Example of benefit amount computation:

First 26 Weeks	
Hourly Rate =	$10.00
$10.00 x 40 =	$400.00 gross straight time pay
$400.00 x 2/3 =	$266.66 weekly benefit amount

Nervous and Mental Claims

Disabilities arising from a nervous condition or mental health or substance abuse disorder 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 at (800) 454-8329 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 Behavioral Health refers you to another provider (such as a Master's Level social worker or a Certified Alcohol Counselor), 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. 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 Behavioral Health (such as a Master's Level social worker, for example).

Benefit Exhaustion

Your eligibility status for other health benefits will be maintained while you are receiving Weekly Disability benefits. But if you exhaust your Weekly Disability Benefits and do not return to active employment, you will lose eligibility and all benefits will terminate as described on page 29. If you secure a leave of absence from your *Participating Employer*, benefits may be continued under the provisions of *COBRA* as described on page 39. If you waive your *COBRA* election rights, you can continue benefits by making self-payments as discussed on page 51.

You have 90 days from the first date of disability to file a Weekly Disability claim.

Claims Procedure

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

1. Get a "Weekly Disability 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:

   UFCW Unions and Participating Employers
   Health and Welfare 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 Weekly Disability" 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.

Weekly Disability Benefit Claims Review and Appeal Procedures

The Plan's claims review and appeal procedures for Weekly Disability, benefit claims that are denied in whole or in part are described beginning under "If Your Weekly Disability Claim Is Denied" in the Claims Filing and Review Procedure section on page 142 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 the *Fund Office*'s Accident & Sickness Department by calling toll free at (800) 638-2972, by 4:30 p.m. on Wednesday. **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 Weekly Disability benefits and forwarded to the federal government. Your *Participating Employer* also pays FICA on your Weekly Disability 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 Weekly Disability benefits and forwarded to the federal government. Your *Participating Employer* pays FUTA on your Weekly Disability benefit payments. There are no forms necessary for you to fill out for FUTA withholding.

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 Weekly Disability Benefits. See the "Advance Benefits for Workers' Compensation Claims" section (page 61) for the conditions of payment.

Modified/Light Duty

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

CAREFIRST PPO

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. Although you are not ***required*** to use a CareFirst provider in order to be covered, you will receive the best discounts if you use a CareFirst provider.

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

ID Card
Each active participant will receive a white colored *Fund* identification ("ID") card showing CareFirst BlueCross BlueShield and his/her name and ID#. Depending on where you live, your ID card will have either blue writing (a "Net Lease" or "Local Lease" ID card) or black writing (a "Flexlink" ID card). If you have dependent coverage, you will receive two cards. Separate cards are not sent for each covered dependent child. **Always show the *Physician, Hospital* or other health care provider your *Fund* ID card.**

To Locate a CareFirst Provider
To locate a CareFirst provider, contact CareFirst at the telephone number listed on your ID card.

- If your ID card has blue writing ("Net Lease" or "Local Lease"), call (800) 235-5160.
- If your ID card has black writing ("Flexlink"), call (800) 810-2583.

Verify that the health care provider you selected participates with CareFirst when you make your appointment, as provider information is subject to change. At your appointment, show your *Fund* ID card and tell the *Physician* or facility that you participate with CareFirst. If you have a white ID card with blue writing ("Net Lease" or "Local Lease"), make sure your provider participates ***in CareFirst's Net Lease, Local Lease network***. If your Local Lease/Net Lease provider does not file electronically, you or the provider should send such claims to:

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

Provider Directory
The provider directory listing those providers that are in-network because they participate in CareFirst's network 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 in a current provider directory, then the services provided by that out-of-network provider will be covered as if the provider was in-network.

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

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 *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 "UFCW Unions and Participating Employers *Fund*," followed by "UFCW Unions and Participating Employers Health & Welfare *Fund*," to be directed to the *Fund's* homepage. From there, under "Important Notices," click on "UFCW Unions and Participating Employers 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.*

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 80, these expenses are paid at 80% (up to the *Allowable Charge*) after you have satisfied the annual *Deductible*.

The Deductible

The annual *Deductible* is the first $200 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 80% (up to the *Allowable Charge*) of your eligible medical expenses.

Out-of-Pocket Maximum

When a participant or dependent has *Incurred* covered medical expenses for essential health benefits which result in $4,000 per person 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 $8,000 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 80%, 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* 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

You must contact *Conifer for pre-authorization for all Hospital admissions*, except that there is no prior authorization requirement for *Emergency Services*. Contact Conifer toll free at (833) 778-9806. Fax number is (410) 972-2044.

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 80% 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.

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 the provider leaves the network.

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.

Ambulatory Center Benefit

In place of a *Hospital*, you may use an ambulatory surgical facility which has permanent facilities and equipment for performing surgical *procedure*s 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 80%, 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 *procedure*s. **All rehabilitative care must be approved by Conifer.**

Coverage includes 30 days of *Inpatient* rehabilitation or 60 *Outpatient* visits when the visits are determined by Conifer 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 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 50 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*.

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.

Durable Medical Equipment ("DME")

Durable Medical Equipment ("DME") is covered by the *Fund* through the DME program administered by Conifer. *DME* over $750 generally must be pre-certified by Conifer and if $750 or under, the *Fund Office* must receive a letter of *Medical Necessity* from your *Physician*.

You or your *Physician's* representative should call the *Fund Office* at (800) 638-2972 for information regarding the pre-authorization requirements and contact Conifer, as soon as you know you need *DME*. Conifer will oversee the appropriateness and quality of the equipment you need, coordinate delivery and set-up or installation, and perform any necessary follow-up.

DME coverage includes rental and/or sale of equipment for:

- Respiratory Therapy;
- Monitoring (fetal, uterine, other);
- Rehabilitation;
- Total Parenteral Nutrition and intravenous supplies and pumps;
- Standard in-home medical equipment; or
- Pediatric equipment/services.

DME is covered under your Comprehensive Medical Benefits at 80%, so the lower the total cost, the less your 20% out-of-pocket expense will be.

Flu Shots

Immunizations for influenza (flu shots) are covered under the ACA Preventive Services Benefit section on page 80. There is no charge if you get the flu shot at any Shoppers, Giant, or Safeway pharmacy using your OptumRx prescription ID card. If you prefer to get your flu shot from your doctor or don't live near a Shoppers, 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) may only be covered under your medical benefit at 80% up to the *Allowable Charge* (see "Office Visit Coverage" under the ACA Preventive Services Benefit section).

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 any Shoppers, Giant or Safeway pharmacy at no cost to you using your OptumRx 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 80% up to the *Allowable Charge*, after satisfying the *Deductible* (see "Office Visit Coverage" under the ACA Preventive Services Benefit section).

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

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. 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.**

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 80.**

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 *procedure*s may be covered under your Dental Benefits through Dentegra Insurance Company—see page 88 of this booklet.

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 119). 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 Use Disorders

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. To qualify for coverage for a condition with a psychiatric diagnosis, all treatment must be *Medically Necessary* and rendered by a properly licensed practitioner or facility. Properly licensed practitioners include the following:

- Psychiatrist (MD or DO)
- Psychologist (Ph.D. EdD or PsyD)
- Licensed Social Worker/Masters Level (LMSW/LCSW)
- Licensed Mental Health Counselor or Professional Counselor (LMHC/PC)
- Psychiatric Nurse/Masters Level (MS/RN/NP)
- Credentialed Alcoholism and Substance Use Disorder Counselor (CASAC)

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 80% under the Comprehensive Medical Benefit up to the *Allowable Charge* and subject to the other limits of the Plan. To authorize treatment or to receive assistance in locating an in-network provider, contact Carelon at (800) 454-8329. For additional information, see page 90.

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 80.

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, 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 80% 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 *procedure*s, the reduction of fractures and dislocations, as well as major endoscopic and other surgical-*Diagnostic Procedure*s.

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, and
- 80% of the lesser of the *Allowable Charge* or allowed charge that is payable by the Plan for the procedure with the next highest cost.

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, endosseus 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 *procedure*s 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. Surgical services - payments are based on the Health Insurance Association of America schedule, using the 80th percentile;

3. 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;

4. Use of operating or treatment rooms;

5. Anesthesia and its administration;

6. X-ray laboratory procedures, examination, or analysis made for *Diagnostic* or treatment purposes;

7. X-ray, radon, radium, and radioactive isotope treatments or therapy;

8. Oxygen and its administration;

9. Blood transfusions, including the cost of blood and blood plasma (except when donated or replaced);

10. Services of an actively practicing nurse;
    a) in a hospital, services of a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.);
    b) outside a hospital, services of a registered professional nurse (R.N.) except in cases where an R.N. is not available and the physician provides certification that the services of a nurse are essential, the services of a licensed practical nurse (L.P.N.) will be considered covered medical expenses.

11. All drugs, medicines, and dressings used in the *Hospital;*

12. 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 84);

13. 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.

14. 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 86). Replacement batteries for electric wheelchairs will be covered once every two years.

15. 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);

16. Services for cosmetic purposes for the correction of congenital defects or conditions resulting from traumatic injuries;

17. 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);

18. Allergy shots and allergy testing, when *Medically Necessary* and administered by a *Physician;*

19. Any services rendered by a chiropractor, up to an annual limit of $1,000 for you and $1,000 for each eligible dependent;

20. Routine annual mammograms are covered for participants and eligible dependents ***age 40 and over.***
21. One annual PAP smear for each participant and eligible dependent.

22. *Sclerotherapy* (treatment of varicose veins) as follows:
    a) Treatment must be pre-approved by Conifer (see section on Conifer 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.

c) Your *Physician* must send a letter of *Medical Necessity*, pre-operative photographs, and a patient history indicating the need for testing to Conifer 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 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 57.
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 119.
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. Eyeglasses and the examination for prescription or fitting other than as provided in the Optical Benefits section on pages 134 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.
9. Services for cosmetic purposes except those previously specified as covered, unless necessary to correct conditions resulting from traumatic injuries.
10. Hearing aids and the examination for them.
11. 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).

12. Travel, whether or not recommended by a *Physician*.
13. Convalescent, milieu, custodial care, sanitaria care, or rest cures.
14. Services or supplies for treatment of infertility or contraception.
15. Services or supplies related to sterilization reversal.
16. Trans-sexual operations or any care or services associated with this type of operation.
17. 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.
18. Services, supplies, or medications rendered in a nursing home or extended care facility.
19. Supplies and medications primarily for dietary control.
20. 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.
21. Air conditioners, humidifiers, dehumidifiers, purifiers, and all similar equipment.
22. Care for nervous and mental conditions, including drug addiction and alcoholism except as specified in the "Mental Health/Substance Abuse Benefit" section (see page 99).
23. Care for quarantinable diseases in special institutions.
24. All drugs and medicines other than those provided in the *Hospital*.
25. Services or supplies which are in excess of the *Allowable Charge*.
26. Any service which is made available without charges, not including Medicaid or services provided only to insured persons.
27. Services rendered by a provider who is a member of the participant's or dependent's immediate family (parent, spouse, brother, sister, children).
28. Telephone consultations with patients, charges for failure to keep a scheduled visit, or charges for completion of forms. However, effective through December 31, 2023, the Plan will cover medical benefit claims for otherwise covered services provided by telephone conference, video conference, or similar technology, subject to any applicable Plan rules and cost-sharing requirements (*e.g.*, deductible, pre-authorization) that would apply to an in-person visit for the same service.
29. Pre-admission *Diagnostic Testing* relating to an *Inpatient* admission which is not covered under the Plan.
30. Administration of oral chemotherapeutic agents, except as provided in the Chemotherapy section on page 85.
31. Domestic or housekeeping services other than those specifically provided under the HomeCare program.

32. Treatment of autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation.
33. Meals-on-wheels and similar food arrangements.
34. 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.
35. Treatment, care, or services through a medical department or clinic or similar services provided or maintained by a *Participating Employer*.
36. Injections of varicose veins, except as provided in the section on *Sclerotherapy*.
37. Injections for treatment of hemorrhoids or hernias.
38. Injection of cortisone or other preparations, except for trauma or acute suppurative infections, except as provided under the Comprehensive Medical section.
39. 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.
40. 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).
41. 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*.
42. 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.
43. Complications resulting from cosmetic *Surgery* are not covered.
44. 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 119.
45. Services or care of any kind other than those defined and limited in this Plan.

Extension of Benefits

Comprehensive Medical Benefits will be payable if you or your eligible dependent are an inpatient in a hospital at any time within 90 days after your coverage under the Plan has been terminated, provided you or your eligible dependent has been totally and continuously disabled and under the regular care of a legally qualified physician from the date your coverage terminates to the date the hospital confinement begins.

MENTAL HEALTH/SUBSTANCE ABUSE BENEFIT

Benefits are provided through the Fund, not insured.
Closed Panel Services provided through Carelon Behavioral Health

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.

Mental health and substance abuse treatment is covered at 80% under Comprehensive Medical Benefits up to the *Allowable Charge* and subject to the other limits of the Plan. To receive assistance in locating an in-network provider, contact Carelon toll free at (800) 454-8329.

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 Behavioral Health panel of therapists is available by calling the Carelon 24-hour, 7-day-a-week referral service at (800) 454-8329. Referrals are available for both emergency/*Hospital* care and for non-emergency/*Outpatient* referrals. In an emergency, you or your therapist must call Carelon within 24 hours after admission to the *Hospital*.

You are encouraged to use a therapist or facility from the Carelon Behavioral Health panel for your mental health care or substance abuse care. 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.

You are free to use any therapist or *Hospital* you wish. **However, by using the panel, you will receive a higher benefit level coverage.** If you do not use a panel provider, you will be responsible for any uncovered charges. You may call Carelon at (800) 454-8329 any day, any time for referral to a participating provider and to get certification for treatment.

Whether you use a panel therapist or a therapist who is not on the panel, **all mental health and substance abuse services must be certified by Carelon in order to be paid**. Certification means that Carelon has determined the services proposed by the provider are both *Medically Necessary* and medically appropriate. If services are not certified by Carelon, they may not be covered.

Benefits described in this summary are provided pursuant to the contract issued by Carelon Behavioral Health. 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, regardless of whether you use a Carelon panel provider or another provider.**

When You Use a Panel Therapist

Call the Carelon Clinical Referral Line at (800) 454-8329 (or go to https://www.carelonbehavioralhealth.com, click on "Find Services," and then on "Providers") to locate a Carelon Behavioral Health panel provider. In an emergency situation, go to your nearest emergency room. In emergencies, the in-network benefits will be available for *Emergency Services* and until stabilization and a transfer can be made to a participating facility. For less urgent referrals, you will receive the names of one or two psychologists or independently licensed psychiatric social workers.

If You Do Not Use A Carelon Panel Therapist

If you do not use a Carelon provider, you may choose any licensed provider you wish. However, you still must certify the care with Carelon. Carelon will review the services to determine whether they are *Medically Necessary* and medically appropriate.

Benefit Payment

The *Fund* will pay 80% 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 Behavioral Health 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 Level II 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 142 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.

Participants and providers can request and receive, at no cost, the following information by calling Carelon at (800) 204-5581:

- Any internal rules, guidelines, protocols, or other criteria (including clinical review criteria) used by Carelon to make its preliminary assessment decision; and
- An explanation of the scientific or clinical judgment for the preliminary assessment decision/determination (applying the terms of the plan to the claimant's medical circumstances) in cases where the decision is based on a Medical Necessity, Experimental treatment or similar exclusion or limit;
- The Carelon clinical criteria are also available at https://www.carelonbehavioralhealth.com;
- The American Society of Addiction Medicine criteria (if applicable).

The treating provider may request a consultation with the Carelon Peer Advisor by calling (800) 204-5581.

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 request and receive, at no cost, additional information or a review of the preliminary assessment regarding your claim for services by either calling Carelon Service Department at (800) 454-8329, 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 Behavioral Health 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 30 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 30-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 30-day period.

See the "Claims Filing and Review Procedures" and the "Claims Review – Types of Claims" sections beginning on page 142 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 Carelon – Denial of Claims

When your claim has been denied by Carelon, you can appeal the denial directly to the Board of Trustees. If you decide to appeal the Carelon 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 Carelon. See the "Review of a Denied Claim" section on page 150 for specific instructions.

CONIFER HEALTH SOLUTIONS

Conifer Health Solutions ("Conifer"), the *Fund*'s disease management provider, provides medical management services to participants and dependents. If you or a covered family member are living with a chronic or complex medical condition, a personal nurse may be assigned to help coordinate and address your or your loved one's health care needs.

Conifer offers 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. If you fail to do this, 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 (866) 290-8147. Fax number (410) 972-2044
   - 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 80% 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 Out-Patient 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 80% after the *Deductible*. Coverage includes a maximum of 30 days of *Inpatient* rehabilitation or 60 *Outpatient* visits per year, and 90 days of cardiac rehabilitation per occurrence, 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 150, for more information.

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, Diskectomy, 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 total amount considered by the *Fund Office* in processing your claim will be limited to 75% of the allowable charge of your surgeon's bill. In other words, instead of considering the entire bill and processing under the rules of the Plan, the *Fund* will only consider 75% of the bill, and then pay the appropriate percentage from there. Thus, you will be responsible for at least 25% 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 (866) 290-8147.

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 Solutions 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 80%, 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. Additionally, some other Home Healthcare services (not in lieu of *Inpatient* hospitalization) may be covered under your Comprehensive Medical Benefits, **provided that they have been approved by Conifer**.

If you believe you need Home Healthcare, have your *Physician* contact Conifer. Conifer 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 (866) 290-8147.

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 80% of 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, subject to the other limits of the Plan. 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 (866) 290-8147.

PRESCRIPTION DRUG BENEFIT

Benefits are provided through the Fund, not insured.
Closed Panel Services are provided through OptumRx Specialty Services.

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 and brand name drugs have a five percent (5%) *Co-payment* when purchased at a Shopper's, Giant or Safeway pharmacy, and ten percent (10%) at other participating OptumRx pharmacies. If you live outside the geographic area in which *Participating Employers* operate pharmacies, the 5% *Co-Payment* will apply. Brand name drugs are covered only if there is no generic 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 OptumRx Specialty Services by calling (855-427-4682). Specialty drugs have a five percent (5%) *Co-payment* when ordered through OptumRx.
- The out-of-pocket maximum per calendar year for prescription drug benefits is $2,600 per individual and $5,200 per family. After the out-of-pocket maximum is reached, benefits for covered prescription drugs are paid at 100% of covered charges.

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

1. The prescription is filled by a pharmacy in the OptumRx network.
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 $1,800 is approved by OptumRx.
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 80. (Syringes and needles are covered 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 and not for cosmetic purposes.

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 OptumRx 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.

If you have questions or need assistance in locating the nearest in-network pharmacy, please contact OptumRx toll-free at 877-645-1282.

Preventive Medications

As provided under the ACA Preventive Services Benefit section on page 80, 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 "UFCW Unions and Participating Employers Health and Welfare *Fund*" to be directed to the *Fund's* homepage. From there, under "Important Notices," click on the "UFCW Unions and Participating Employers List of ACA Preventive Services" to view the complete list.

Claims Procedure

1. Upon becoming eligible for benefits, a participant will receive *Fund* ID cards which show 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. Contact the *Fund Office* for the proper forms to complete. 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 <u>within one year</u> 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 and you do not obtain prior authorization for the brand name drug, in most cases 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. The Fund uses OptumRx's Select Standard Formulary, which is updated periodically and subject to change. To get the most up-to-date list of drugs on the formulary, visit Optumrx.com or call the toll-free OptumRx phone number on the back of your ID card.

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 <u>are</u> 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

- Certain acne medications, such as Retin-A, are covered through age 26. After age 26, a prescription for an acne medication such as Retin-A requires prior authorization and must be accompanied by a written diagnosis from your *Physician* of acne vulgaris or another medical condition in order to be covered. For a prescription after age 26, contact OptumRx to initiate the prior authorization process.

- Erectile dysfunction medications such as **Viagra and Cialis** will be covered to a maximum of 8 tablets per month. Contact OptumRx at (866) 290-8147 to initiate the prior authorization process. OptumRx will fax your *Physician* a form to indicate your diagnosis which will reflect your approval or denial of your prescription.

Specialty Medications/OptumRx Specialty Services

Prescriptions for specialty medications are provided through Optum Specialty Pharmacy, and not through your local pharmacy. Specialty medications are generally high cost medications used to treat complex and/or rare diseases and conditions, such as Crohn's disease, multiple sclerosis, hepatitis, organ transplant, and cancer. Specialty medications may be self-injectable or oral, have special dosage, storage handling and administration requirements, and require high touch patient care and monitoring.

If you are prescribed a specialty medication, you must order them through Optum Specialty Pharmacy by calling (855) 427-4682 or logging onto specialty.optumrx.com. The medication will be mailed by priority overnight mail directly to your door. OptumRx also has a pharmaceutical consulting staff available to answer any questions you may have about your medication. Contact OptumRx if you are prescribed a specialty drug and need information about ordering, shipment, etc.

Note: Since the specialty drugs available through OptumRx Specialty Services are subject to change, please refer to OptumRx Specialty Services' website: specialty.optumrx.com for a list of available specialty drugs.

Quantity Limits/Prior Authorization

In addition to the specific drug restrictions described above, there are dispensing or quantity limits ("QL") and prior authorization ("PA") requirements on certain medications, such as drugs used to treat migraines, nausea and vomiting, erectile disorder, hepatitis, and narcotic pain medications. The *Fund's* prescription drug manager, OptumRx, developed

these guidelines based on the FDA's and the manufacturers' recommended dosages. They were established to help ensure the safe and effective use of these medications. For information on the medications currently subject to the Fund's QL and/or PA requirements, contact OptumRx at (866) 290-8147 or visit www.optumrx.com.

For medications requiring a PA, either you, your *Physician* or your pharmacist will need to contact OptumRx's customer service help to initiate the prior authorization process. For prior authorizations, please call OptumRx Customer Service at (877-645-1282). 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 80% after the $200 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. Send your **paid, itemized** receipts to the ***Fund Office.***

Over-the-Counter COVID-19 Test Coverage
The Plan will cover up to 2 over-the-counter (OTC) COVID-19 diagnostic tests per covered Participant and Dependent per 30-day period, provided those tests are purchased at a participating pharmacy in the OptumRx network. 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 under the applicable FDA authorization, clearance, or approval. Generally, at-home OTC tests that are available for purchase in participating pharmacies in the OptumRx network will meet this standard.

To find a retail pharmacy in your network, visit www.optumrx.com or call the phone number for OptumRx on the back of your Plan ID card for an updated list of participating pharmacies before you purchase any OTC Tests. If you prefer to order your OTC Tests online at $0 copay and have them delivered to your home, visit www.optumrx.com. Please note that a shipping fee will likely apply.

Regardless of whether you obtain the OTC Tests at a Participating Pharmacy or from the Optum Store online, coverage is limited to two (2) tests per covered participant

or dependent per calendar month. Please note, COVID-19 diagnostic tests performed at a provider's office, hospital, or clinic do not count toward this limit.

DENTAL BENEFITS

Benefits are provided through Dentegra Insurance Company ("Dentegra") and are insured. Covered services are exams, x-rays, cleaning, amalgam fillings, and simple extractions.

The Plan provides benefits for the dental services described below only when performed by a *Participating Dentist*. Except as otherwise provided below, any services rendered by a non-*Participating Dentist* will NOT be covered by this Plan. Children under four 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 or visit Dentegra's website at dentegra.com/UFCWUPE-Shoppers. When calling Dentegra, 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 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
Except as provided below, 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*;

2. When authorized in advance by Dentegra;
3. In the case of an emergency which occurs more than 50 miles from the participant's primary dentist if the participant or eligible dependent is temporarily away from home. "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*.
5. If the participant lives or works in Georgia, Florida, Mississippi, Montana, or Texas.

For emergency services, Dentegra will reimburse the non-*Participating Provider* its billed fee minus any applicable *Co-payment* listed below. For non-emergency services, Dentegra will reimburse the non-*Participating Provider* Dentegra's network contracted fee minus any applicable *Co-payment* listed below. You will be responsible for paying any balance billing over Dentegra's network contracted fee for non-emergency services, and any applicable *Co-payment*.

Dental expenses *Incurred* in connection with any dental procedure started prior to a participant's or eligible dependent's *Effective Date* of coverage are excluded.

DESCRIPTION OF DENTAL SERVICES AND FEES

Procedure Code	**Description**	**Member Co-Pay**
Diagnostic & Preventive		
D0120	Periodic Oral Exam	No charge
D0140	Limited Oral Evaluation - Problem Focused	No charge
D0150	Comprehensive Oral Evaluation	No charge
D0170	Re-evaluation - Limited, Problem Focused	No charge
D0180	Comprehensive periodontal evaluation	No charge
D0210	Intraoral - Complete Series, Including Bitewings (once per 3 years)	No charge
D0220	Intraoral - Periapical - First Film	No charge
D0230	Intraoral - Periapical - Each Additional Film	No charge
D0240	Intraoral - Occlusal Film	No charge
D0270	Bitewings - Single Film	No charge
D0272	Bitewings - Two Films	No charge
D0273	Bitewings - Three Films	No charge
D0274	Bitewings - Four Films	No charge
D0277	Vertical Bitewings - 7 to 8 Films	No charge
D0330	Panoramic Film (once per 3 years)	No charge
D0340	Cephalometric Film	No charge*****
D0460	Pulp Vitality Tests	No charge*****

D1110	Prophylaxis - Adult (once per 6 months)	No charge
D1120	Prophylaxis - Child	No charge
D1208	Top Application of Fluoride (w/o Varnish)	No charge
D1510	Space Maintainer - Fixed - Unilateral	$10
D1550	Recementation of Space Maintainer	No charge
D1551	Recement/Rebond Space Maint. - Maxillary	No charge
D1552	Recement/Rebond Space Maint. - Mandibular	No charge
D1553	Recement/Rebond Space Maint. - Per Quadrant	No charge
D1516	Space Maintainer - Fixed - Bilateral, Maxillary	No charge
D1517	Space Maintainer - Fixed - Bilateral, Mandibular	No charge

*** Not benefited separately. Fee is included in another procedure's fee being performed**

Basic Restorative

D2140	Amalgam - One Surface, Permanent	No charge
D2150	Amalgam - Two Surfaces, Permanent	No charge
D2160	Amalgam - Three Surfaces, Permanent	No charge
D2161	Amalgam - Four or More Surfaces, Permanent	No charge
D2330	Resin - One Surface, Anterior	No charge
D2331	Resin - Two Surfaces, Anterior	No charge
D2332	Resin - Three Surfaces, Anterior	No charge
D2335	Resin - Four or More Surfaces or Incisal Angle	No charge
D2390	Resin - Crown, Anterior	No charge

***Dentegra pays up to the cost of Amalgam, patient pays the difference**

Single Restorations

D2740	Crown - Porcelain/Ceramic	$125
D2750	Crown - Porcelain fused to High Noble	$200
D2751	Crown - Porcelain Fused to Predominately Base Metal	$125
D2752	Crown - Porcelain Fused to Noble	$125
D2753	Crown - Porcelain Fused to titanium and titanium alloys	$200
D2790	Crown - Full Cast High Noble Metal	$200
D2791	Crown - Full Cast Predominately	$125
D2792	Crown - Full Cast Noble Metal	$125
D2920	Recement Crown	No charge
D2921		
D2930	Prefabricated Stainless Steel. Crown -Primary Tooth	$30
D2931	Prefabricated Stainless Steel. Crown -Permanent Tooth	$30
D2932	Prefabricated Resin Crown	$30
D2940	Protective Restoration	No charge
D2941	Interim therapeutic restoration – primary dentition	No charge
D2950	Core Buildup, Including Any Pins	No charge

D2951	Pin Retention - Per Tooth, In Addition	No charge
D2952	Cast Post & Core in Addition to	No charge
D2954	Prefabricated Post & Core in Addition	No charge
D2980	Crown Repair, by Report	No charge

Endodontic

D3110	Pulp Cap Direct (excluding final restoration)	No charge
D3120	Pulp Cap Indirect (excluding final restoration)	No charge
D3310	Endodontic Therapy – Anterior Tooth	$125***
D3320	Endodontic Therapy – Biscuspid Tooth	$125***
D3330	Endodontic Therapy – Molar (Excl Final Rest)	$250***
D3920	Hemisection – Include Root Removal – No Root Canal	$110***

***** Additional $100 fee applies if root canal is performed by a specialist.**

Periodontics

D0150	Comprehensive Oral Evaluation Performed by Periodontist	$30
D0210	Intraoral Complete Series, Including Bitewings (one per 3 yrs)	$30
D0220	Intraoral - Periapical First Film	$4
D0470	Diagnostic Casts	$20
D4210	Gingivectomy/Gingivoplasty , per Quad	$200
D4211	Gingivectomy/Gingivoplasty , per Tooth	$55/tooth
D4212	Gingivectomy/Gingivoplasty to allow access for restorative procedure, per Tooth	$19
D4240	Gingival Flap Procedure, Including Root Planing,	$200
D4241	Gingival Flap Procedure, Including Root Planing	$55/tooth
D4260	Osseous Surgery, Including Flap Entry/Closure,	$325
D4261	Osseous Surgery (Incl Flap Entry/Closure), 1-3 teeth per Quad	$100
D4277	Free Soft Tissue Graft Procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$200

D4278	Free Soft Tissue Graft Procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$100
D4341	Periodontal Scaling & Root Planing – four or more teeth per quadrant	$70
D4342	Periodontal Scaling & Root Planing – one to three teeth per quadrant	$35
D4355	Full Mouth Debridement	No charge
D4910	Periodontal Maintenance Procedures	$35

Removable Prosthetics

D5110	Complete Upper Denture (Includes adjustments)	$30
D5120	Complete Lower Denture (Includes adjustments)	$30
D5130	Immediate Upper Denture (Includes adjustments)	$30
D5140	Immediate Lower Denture (Includes adjustments)	$30
D5211	Upper Partial Resin Base (Includes adjustments)	$30
D5212	Lower Partial Resin Base (Includes adjustments)	$30
D5213	Upper Partial - Cast Metal Frame w/Resin Base	$30
D5214	Lower Partial - Cast Metal Frame w/Resin Base	$30
D5410	Adjust Complete Denture - Upper	No charge
D5411	Adjust Complete Denture - Lower	No charge
D5421	Adjust Partial Denture - Upper	No charge
D5422	Adjust Partial Denture - Lower	No charge
D5511	Repair broken complete denture base, mandibular	No charge
D5512	Repair broken complete denture base, maxillary	No charge
D5520	Replace Missing/Broken Tooth - Complete Denture -Ea. Tooth	No charge
D5611	Repair resin partial denture base, mandibular	No charge
D5612	Repair resin partial denture base, maxillary	No charge
D5621	Repair cast partial framework, mandibular	No charge
D5622	Repair cast partial framework, maxillary	No charge
D5630	Repair or Replace Broken Clasp	No charge
D5640	Partial Denture - Replace Broken Tooth - Per Tooth	No charge
D5650	AD0 Tooth to Existing Partial Denture	No charge
D5660	AD0 Clasp to Existing Partial Denture	No charge
D5670	Replace All Teeth & Acrylic - Cast Metal Frame	No charge
D5671	Replace All Teeth & Acrylic - Cast Metal Frame (Lower)	No charge
D5730	Reline Complete Upper Denture (Chairside)	No charge
D5731	Reline Complete Lower Denture (Chairside)	No charge
D5740	Reline Upper Partial (Chairside)	No charge
D5741	Reline Lower Partial (Chairside)	No charge
D5750	Reline Complete Upper Denture (Lab)	No charge
D5751	Reline Complete Lower Denture (Lab)	No charge
D5760	Reline Upper Partial (Lab)	No charge
D5761	Reline Lower Partial (Lab)	No charge

Fixed Prosthetics, per Unit (each retainer and each pontic constitutes a unit in a fixed partial denture)

D6210	Pontic - Cast High Noble Metal	$200
D6211	Pontic - Cast Predominately Base Metal	$125

D6212	Pontic - Cast Noble Metal	$125
D6240	Pontic - Porcelain to High Noble Metal	$200
D6241	Pontic - Porcelain to Predominately Base Metal	$125
D6242	Pontic - Porcelain Fused to Noble Metal	$125
D6243	Pontic – porcelain fused to titanium and titanium alloys	$125
D6245	Pontic - Porcelain/Ceramic	$125
D6545	Retainer - Cast Metal Resin Bonded Bridge	$50
D6740	Crown - Porcelain/Ceramic	$125
D6750	Bridge Crown - Porcelain to High Noble Metal	$200
D6751	Bridge Crown - Porcelain to Predominately Base Metal	$125
D6752	Bridge Crown - Porcelain Fused to Noble Metal	$125
D6753	Retainer crown – porcelain fused to titanium and titanium Alloys	$200
D6783	Bridge Crown - Porcelain/Ceramic	$125
D6784	Retainer crown ¾ – titanium and titanium alloys	$200
D6790	Bridge Crown - Full Cast High Noble Metal	$200
D6791	Bridge Crown - Full Cast Predominately Base Metal	$125
D6792	Bridge Crown - Full Cast Noble Metal	$125
D6930	Re-cement or re-bond fixed partial denture	No charge

Oral Surgery

D7111	Coronal Remnants- Deciduous Tooth	No charge
D7140	Extraction, Erupted Tooth or Exposed Root	No charge
D7210	Surgical Removal of Erupted Tooth	No charge
D7220	Remove Impacted Tooth - Soft Tissue	No charge
D7230	Remove Impacted Tooth - Partially Bony	No charge
D7240	Remove Impacted Tooth - Completely Bony	No charge
D7241	Remove Impacted Tooth - Compl Bony, Unusual	No charge
D7250	Surgical Removal of Residual Roots	No charge
D7251	Coronectomy – intentional partial tooth removal	No charge
D7310	Alveoplasty in Conjunction w/Extr, per Quad	No charge
D7510	Incision & Drainage of Abscess/Intraoral Soft Tissue	No charge

Orthodontics

D8070	Comprehensive Orthodontic Treatment - Transitional Dentition - 2-year program	$425/year + $75 on completion
D8080	Comprehensive Orthodontic Treatment - Adolescent Dentition - 2-year program	$425/year + $75 on completion
D8090	Comprehensive Orthodontic Treatment - Adult Dentition - 2-year program	$425/year + $75 on completion

Miscellaneous

D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	No charge
D9215	Local Anesthesia	No charge
D9222	General Anesthesia - 1st 15 Minutes	No charge*
D9223	General Anesthesia - Each Additional 15 Minutes	No charge*

D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	No charge*
D9239	I.V. Sedation/Analgesia - 1st 15 Minutes	No charge*
D9243	I.V. Sedation/Analgesia – Each Additional 15 Minutes	No charge*
D9248	Non-Intravenous Conscious Sedation	No charge
D9310	Consultation (by dentist other than attending dentist) - per Session	No charge

- **Procedures not shown are not covered by the Plan.**
- **If a condition can be treated by more than one procedure, Dentegra will only cover the least costly professionally adequate service.**

Exclusions and Limitations

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

Limitations

1. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. Examples of Optional Services:

   - A composite restoration instead of an amalgam restoration on posterior teeth;
   - A crown where a filling would restore the tooth;
   - An inlay/onlay instead of an amalgam restoration; or
   - Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

   If a participant or covered dependent receives Optional Services, an alternate benefit will be allowed, which means Dentegra will base benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The participant or covered dependent will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

2. Dentegra will pay for oral examinations (except after-hour exams and exams for observation) and cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than twice in a calendar year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings, procedure codes that include periodontal cleanings and full mouth debridement are standardly

covered as a Basic benefit, and routine cleanings are standardly covered as a Diagnostic and Preventive benefit.

3. X-ray limitations:
    - Dentegra will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the accepted fee for a complete intraoral series.
    - When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series.
    - If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
    - A complete intraoral series and panoramic film are each limited to once every 60 months.
    - Bitewing x-rays are limited to two times in a calendar year when provided to participants and covered dependents under age 18 and one time each calendar year for participants and covered dependents age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
4. Topical application of fluoride solutions is limited to participants and covered dependents to age 19 and no more than twice in a calendar year.
5. Space maintainer limitations:
    - Space maintainers are limited to the initial appliance and are a benefit for a covered dependent to age 14.
    - Recementation of space maintainer is limited to once per lifetime.
    - The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different provider/provider's office.
6. Pulp vitality tests are allowed once per day when definitive treatment is not performed.
7. Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime only when orthodontic services are covered. If orthodontic services are covered, see limitations as age limits may apply.
8. Sealants are limited as follows:

- To permanent first molars through age eight and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
- Do not include repair or replacement of a sealant on any tooth within 24 months of its application.

9. Specialist consultations, screenings of patients, and assessments of patients are limited to once per lifetime per provider and count toward the oral exam frequency.
10. Dentegra will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated resin and stainless steel crowns within 24 months of treatment if the service is provided by the same provider/provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
11. Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16.
12. Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
13. Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same provider/provider office within 24 months is considered part of the original procedure.
14. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one initial visit, four interim visits and one final visit to age 19.
15. Retreatment of apical surgery by the same provider/provider office within 24 months is considered part of the original procedure.
16. Pin retention is covered not more than once in any 24-month period.
17. Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
18. Periodontal limitations:
    - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
    - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.

- Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
- If in the same quadrant, scaling and root planing must be performed at least six weeks prior to the periodontal surgery.
- Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same provider office.

19. Oral surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.
20. The following oral surgery procedure is limited to age 19: transseptal fiberotomy/supra crestal fiberotomy, by report.
21. The following oral surgery procedures are limited to age 19 (or orthodontic limiting age) provided orthodontic services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
22. Crowns and inlays/onlays are limited to participants and covered dependents age 12 and older and are covered not more often than once in any 60-month period except when Dentegra determines the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
23. When an alternate benefit of an amalgam is allowed for inlays/onlays, they are limited to participants and covered dependents age 12 and older and are covered not more than once in any 60-month period.
24. Core buildup, including any pins, are covered not more than once in any 60-month period.
25. Post and core services are covered not more than once in any 60-month period.
26. Crown repairs are covered not more than twice in any 60-month period.
27. Denture repairs are covered not more than once in any six-month period except for fixed denture repairs which are covered not more than twice in any 60-month period.
28. Prosthodontic appliances (including implants and/or implant supported prosthetics*) that were provided under any Dentegra plan will be

replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to participants and covered dependents age 16 and older. Replacement of a prosthodontic appliance (and/or implant supported prosthesis*) not provided under a Dentegra plan will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory.

*Applicable if implants are indicated as covered under the Plan: Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one for each implant during the participant's or covered dependent's lifetime whether provided under Dentegra or any other dental care plan.

29. When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a benefit.

30. Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same provider/provider office within six months of the initial placement. After six months, payment will be limited to one recementation in a lifetime by the same provider/provider office.

31. Dentegra limits payment for dentures to a standard partial or complete denture (applicable coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six months after placement.

    - Denture rebase is limited to one per arch in a 24-month period and includes any relining and adjustments for six months following placement.
    - Dentures, removable partial dentures and relines include adjustments for six months following installation. After the initial six months of an adjustment or reline, adjustments are limited to two per arch in a calendar year and relining is limited to one per arch in a six-month period.
    - Tissue conditioning is limited to two per arch in a 12-month period. However, tissue conditioning is not allowed as a separate benefit when performed on the same day as a denture, reline or rebase service.

Exclusions

1. Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
2. Cosmetic surgery or procedures for purely cosmetic reasons.
3. Maxillofacial prosthetics.
4. Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).
5. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
6. Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or night guards/occlusal guards and abfraction.
7. Any single procedure provided prior to the date the participant or covered dependent became eligible for services under this Plan.
8. Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
9. Charges for anesthesia, other than general anesthesia and IV sedation administered by a provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
10. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
11. Laboratory processed crowns for covered dependents under age 12.
12. Fixed bridges and removable partials for covered dependents under age 16.
13. Interim implants.
14. Indirectly fabricated resin-based inlays/onlays.
15. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the provider for treatment in any such facility.

16. Treatment by someone other than a provider or a person who by law may work under a provider's direct supervision.
17. Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
18. Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
19. Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
20. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Plan, will be the responsibility of the participant or covered dependent and not a covered benefit.
21. Deductibles, amounts over plan maximums and/or any service not covered under the Plan.
22. Services covered under the Plan that exceed benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
23. Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws), unless otherwise indicated as covered.
24. Services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues, unless otherwise indicated as covered.
25. Endodontic endosseous implant.
26. Implants and related services, unless otherwise indicated as covered.

Grievance Procedure

Grievances or complaints may be directed orally or in writing to the 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 1-877-280-4204 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 you, your 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.

You, your 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.

OPTICAL BENEFITS

Optical benefits under the Plan are provided by
Group Vision Service ("GVS")
6700 Alexander Bell Drive, Suite 200
Columbia, MD 21046
Customer Service – 866-265-4626

The *Fund* will provide optical benefits once every 24 months from the last date of service. Optical benefits include coverage for a vision examination, eyeglass lenses and frame. Optical benefits are available from an extensive national network of participating providers in the Group Vision Service network.

You have a choice of independent optometrists and ophthalmologists, as well as retail locations such as Lens Crafters, Sears Optical, Target Optical, JC Penney Optical and most Pearle Vision Centers. You will receive additional savings from GVS network providers for lens upgrades and additional pair purchases.

Locating an Optical Provider
To locate providers in the GVS network, log on to the GVS website at www.gvsmd.com. The names of the providers are updated regularly. You can also call GVS' Customer Service at the toll free number listed above to see if your provider participates with GVS.

The *Fund* will provide you and your eligible dependents with optical benefits once every two years. There will be no charge to you or your dependent when the services are rendered by Group Vision Service or an *Optometrist* participating in the Group Vision Service network. You have a choice of independent *Optometrists* and *Ophthalmologists*, as well as retail locations such as LensCrafters, Target Optical and participating Pearle Vision locations.

The following optical benefits are covered:
1. A complete eye examination by a licensed *Optometrist*
2. One pair of eyeglasses, if prescribed, including:
    a. A choice from a wide selection of frames
    b. Clear glass or plastic lenses: (1) Single vision, (2) Bifocal (TK, FT25, FT28, and Executive), (3) Trifocal (7x25 or 7x28).
3. Prescription and order for proper lenses.
4. Adjustments, not including breakage, made whenever necessary.
5. **Contact lenses:** Contact lens benefits are provided instead of the regular eye exam and eyeglasses benefits as described below:

a. One pair of spherical daily or extended wear (**not** disposable) contacts from GVS's covered selection.
b. Eye exam and follow-up visits.
c. One contact lens care kit.

When Using A GVS Network Provider:

- Schedule an exam with the provider of your choice. When scheduling your appointment, inform the provider that you are a GVS member and provide your name and date of birth. The provider will verify your eligibility and Plan benefits prior to your appointment.
- If you have already made an appointment, show your ID card at the time of service or provide your name and date of birth for quick verification of eligibility and Plan coverage.
- You are responsible for paying the provider at the time of service for co-payments/costs that exceed your Plan coverage.

In-Network Benefits

Benefits are payable as shown in the following Schedule of Benefits for services rendered by a provider in the GVS network:

Benefits from a GVS Network Provider* Primary Benefit		
Vision Examination - includes dilation as required	$0 Co-payment	Once every 24 months*
Eyeglass Lenses - single vision, bifocal, or trifocal in standard/basic plastic w/Standard Scratch Resistance	$0 Co-payment	Once every 24 months*
Eyeglass Frame	Covered in full up to a $100.00 retail value. 20% off balance in excess of $100.00.	Once every 24 months*

Contact Lenses – in lieu of eyeglasses benefits (does not include fitting and follow-up)	**Elective:** Disposable or conventional covered in full up to $60.00. Conventional lenses: 15% discount off the balance over the Plan allowance. **Medically Necessary:** covered in full up to $250.00.	Once every 24 months*
**Benefits are available 24 months from last date of service.*		

Additional Savings Program (GVS Network Providers Only) Pricing available in conjunction with primary benefits			
Lens Options	***Price***	***Other Options/ Services***	***Price***
Tint (solid and gradient)	$15.00	Other Lens Options and Services	20% off Retail
UV Coating	$15.00	Additional Complete Pair Frame and Lenses***	40% off Retail
Standard Scratch Resistance*	No charge	Conventional Contact Lenses	15% off Retail
Standard Polycarbonate: Adult Children	 $40.00 $40.00	Contact Lens Fitting and Follow-up Standard Premium	 $40.00 10% discount
Standard Anti-Reflective	$45.00	Retinal Imaging	$39.00 max
Standard Progressive Lens**	$65.00	Photo chromatic Lenses	20% discount
Premium Progressive Lens**	$65.00 + 80% of retail, less $120.00.		
**Covered by primary benefit. **Standard/Premium Progressive lenses are not covered benefits – however when upgrading in conjunction with your primary benefit, Progressive lenses will be covered as follows.*			

*The cost for Standard Progressive lenses is $65.00. The cost for Premium Progressive lenses is $65.00 plus 80% of the retail price, less $120.00. You are responsible for any applicable lens co-payment and any additional charges if you are not eligible for your primary benefit. *** Discount applies on complete pair purchase once primary benefit is used.*

Out-of-Network Benefits

If you choose to visit a provider who is not in the GVS network, you must pay the provider his or her full charges for the exam and any eyewear at the time of service. You must complete and submit a claim for reimbursement (an out of network claim form that you can obtain from the GVS website at www.gvsmd.com). Submit the out of network claim form and provider receipt to the claims address indicated on the form. The following amounts are the maximum reimbursable amounts that may

be paid to you after you file a claim for services from an out of network provider:

Out-of-Network Benefit Schedule		
Vision Examination	Up to $30.00	Once every 24 months*
Lenses		
➢ Single Vision	Up to $35.00	
➢ Bifocal	Up to $50.00	
➢ Trifocal	Up to $75.00	
➢ Scratch Resistance	Up to $12.00	
Frame	Up to $50.00	
Contact Lenses	N/A	

**Benefits are available 24 months from last date of service.*

Limitations and Exclusions

Any service that is not specifically listed above as a covered benefit is excluded. Benefit allowances provide no remaining balance for future use within the same benefit frequency. No benefits will be paid for services or materials connected with/or charges arising from:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Anisellkonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures.
- Any corrective eyewear required as a condition of employment, safety eyewear, services provided as a result of any Worker's Compensation law or similar legislation, or services required by any governmental agency or program whether federal, state or subdivision thereof.
- Plano (non-prescription) lenses or non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.

- Services or materials provided by another group benefit plan providing vision care.
- Services rendered after the date you cease to be covered under the Plan, except when vision materials ordered before coverage ended are delivered and the services rendered to you are within 31 days from the date of such order.
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next period when you next become eligible for benefits.
- Certain frame brands in which the manufacturer imposes a no-discount policy.
- Covered benefits may not be used in conjunction with coupons or other provider discount offers.

Order Glasses Online

You have the opportunity to order glasses online at Glasses.com. Glasses.com is in the GVS network. This allows you to go online to buy glasses anytime, from anywhere and use your in-network benefits. Visit Glasses.com to locate a pair of glasses from thousands of name-brand frames.

EPIC Hearing Savings Program

The optical benefits provided by GVS include a hearing aid discount benefit. For more details regarding this benefit, please visit www.gvsmd.com.

Personalized Member Website Access

For benefits specific to your Plan, log on to the GVS website and follow the steps mentioned below.

1. You must first register on the GVS website – www.gvsmd.com
2. Under the MEMBER tab, select "View Your Benefits."
3. Welcome to the GVS Member - Click *here* to Login/Register.
4. Select "Register for an account."
5. When you enter the Member Site to Register for an Account, use the last four digits of your Social Security Number and pick your own user ID.
6. The site will send you an email confirmation and password selection information.

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, Comprehensive Medical Benefits, and Mental Health/Substance Abuse Benefit sections 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 Group Vision Service, Dentegra, and OptumRx*** 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 as an option to specified participants during the "open enrollment" period. During open enrollment, from March 15 – May 15 for coverage effective June 1st each year, 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.** Each year thereafter, participants may choose to keep the HMO or return to benefits administered by the *Fund*.

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). 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 is typically a monthly co-premium for coverage through an HMO which you must send to the *Fund Office.* This monthly co-premium is in addition to the weekly payroll deduction co-premium you pay for *Fund* health coverage, as described in the Employee Eligibility section on page 25. You will receive a letter each year explaining the open enrollment options and the monthly co-premium, if any, for each choice. Missed co-premium payments will result in a loss of HMO coverage. **Once coverage through the HMO is terminated due to missed co-premium payments, medical coverage through the *Fund* may only be reinstated at the next HMO open enrollment period effective on the next June 1st – 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

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.

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

4. 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:

   UFCW Unions and Participating Employers
   Health and Welfare *Fund*
   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 Weekly Disability payments, see page 71 in the Weekly Disability Benefit section. Filing procedures for medical claims are listed on page 142. The section below summarizes the general rules which apply to **ALL** claims for benefits under the Plan.

When You File a Claim

1. Present your Plan identification card when seeking service from a *Hospital* or *Physician*.
2. The *Hospital* or *Physician* will submit a bill directly to 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*. Weekly Disability 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 Weekly Disability or Medical Benefits. See "Advance

Benefits for Workers' Compensation Claims" (page 61) 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 we have all the information necessary to process it, and it is covered under the Plan, it will be paid. If we don't pay promptly and an extension is required, you will be notified. This extension notice will tell you why the *Fund Office* requires extra time and the approximate date that a decision on your claim is expected.

You will know your claim has been paid in one of several ways. For example, you will receive your Weekly Disability 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 17-25.

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 optical benefits**,** 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 optical or dental benefit appeals for ***eligibility denials.*** Further, if you appeal a denial of dental benefits pursuant to the procedures provided by Dentegra, 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% of 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
UFCW Unions and Participating Employers
Health and Welfare 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, P.O. Box 1854, Hicksville, NY 11802.
- For denied prescription benefit claims, you may contact OptumRx, P.O. Box 2975, Mission, KS 66201-9375.
- For certification denials made by Conifer, you may contact Conifer, 1596 Whitehall Road, Annapolis, MD 21409. Telephone: (800) 459-2110.

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 Weekly Disability Claim Is Denied

If your Weekly Disability 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% of 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 – Weekly Disability 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
UFCW Unions and Participating Employers
Health and Welfare *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 we need this material;
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 MetLife.

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
UFCW Unions and Participating Employers
Health and Welfare *Fund*
911 Ridgebrook Road
Sparks, MD 21152-9451

How Long the Review Takes
If MetLife 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 MetLife 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 United Food and Commercial Workers Unions and Participating Employers Active Health and Welfare Plan (the "Plan") 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, Maryland 21152-9451
(410) 683-6500

DETAILED NOTICE OF THE PLAN'S PRIVACY POLICIES

THE PLAN'S USES AND DISCLOSURES

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

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

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

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

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

Uses and Disclosures to Business Associates

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

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

Uses and Disclosures to the Plan Sponsor

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

Other Uses and Disclosures That May Be Made Without Your Authorization

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

1. **Required by Law**. Your health information may be used or disclosed as required by law. For example, your health I 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 UFCW Unions and Participating Employers Health and Welfare *Fund*, 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
In order to 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.
- eEOB feature allows you to review and print your Explanations of Benefits.
- Benefit access which allows you to track your claims and view the following:
  - Health Claims – displays claims submitted to the Plan on your behalf
  - Eligibility – past and present eligibility for you and/or your eligible dependent(s)
- Dashboard – a landing page containing quick navigation to other benefit information.
- Demographics –a demographic page displaying address, phone number, and other information for you and/or your dependent(s).

How Does It Work?

- Log in to www.associated-admin.com, select *Your Benefits,* located at the left side of the page, and select *UFCW Unions and Participating Employers Health and Welfare Fund.* Click on *MemberXG* which will take you to Member XG's site.
- Select *Create Account,* located at the upper, right corner. You will be asked to create a username and password.
- If you 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. It is possible that the information shown is inaccurate or is not fully up to date.

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.

You'll need to have some information ready in order 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, someone born on June 1st would enter "0601" as his/her 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 are questioning. 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 161 for a full explanation of these rules.

PARTICIPATING EMPLOYERS AND UNIONS

Safeway (Valley)
4551 Forbes Boulevard
Lanham, MD 20706

Shoppers Food Warehouse
16901 Melford Blvd.
Bowie, MD 20715

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

Participants 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)**..... (410) 683-6500

(Landover Local Line)..... (301) 459-3020

CareFirst PPO
Cardholders who have White ID Cards with
Blue Writing call..... (800) 235-5160

White ID Cards with Black Writing call..... (800) 810-2583

OptumRx..... (877) 645-1282
Optum Rx Specialty Services ..... (855) 427-4682

Conifer (Utilization Review and Case Management) ..... (866) 290-8147

Dental Information & Provider Search
Dentegra Insurance Company ("Dentegra")..... (877) 280-4204

eGroup Vision Service ("GVS") ..... (866) 265-4626

Carelon Behavioral Health..... (800) 454-8329

ADDRESSES

UFCW Unions and Participating Employers
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Special P.O. Box for Claims--Both Local Unions
Send Weekly Disability claims to:

UFCW Unions and Participating Employers
Health and Welfare *Fund*
Attn: A&S Department
P.O. Box 1064
Sparks, MD 21152-1064

If you use a CareFirst provider, send your <u>medical</u> 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:

UFCW Unions and Participating Employers
Health and Welfare 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

Send requests for Carelon Behavioral Health reviews to:

Carelon Behavioral Health
Appeals Coordinator
P.O. Box 1854
Hicksville, NY 11802