UFCW Unions and Participating Employers Health and Welfare Fund

PLAN Y40

SUMMARY PLAN DESCRIPTION

September 2017

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 (ERISA), as amended, and the terms contained herein constitute the terms of the Plan. With respect to all fully insured benefits described herein, the terms of the Fund's formal agreement or policy with the applicable insurer and, to the extent not inconsistent with such agreement or policy, this Summary Plan Description, constitute the terms of the Plan.

DEAR PARTICIPANT,

The 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 Employers*, employees, participants, beneficiaries and all other persons who may be involved with, or affected by, the Plan. You will be notified of any material modifications (changes) to this Summary Plan Description (SPD) as required by federal law.

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

- An ***Administrative Manager*** (referred to as the "*Fund Office*" in this book) receives *Participating Employer* contributions, keeps eligibility records, pays claims, and assists Plan participants with their benefits. Some benefits are paid directly by the *Fund*; others are provided by insurance carriers or other providers and the *Fund* pays premiums. Benefits are limited to Plan assets for all benefits

provided under the Plan.

- An ***Investment Manager*** invests the *Fund*'s assets to achieve a reasonable rate of investment return.
- ***Fund Counsel*** provides legal advice.
- An independent ***Certified Public Accountant*** audits the *Fund* each year. Periodic payroll audits are also performed for each *Participating Employer*.

It is important that you verify coverage with the *Fund Office* before incurring expenses under the *Plan* so that you can confirm that you 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 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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THE PLAN

COVERED EMPLOYMENT WITH PARTICIPATING EMPLOYERS

The benefits outlined in this book apply to employees of the *Participating Employers* as described below who are in Plan Y40 and are covered by a participation agreement with the *Fund*, or a current *Collective Bargaining Agreement* with UFCW Local 27 or 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 19 in order to be eligible for benefits under Plan Y40.

Shoppers Food & Pharmacy
Metro/Basics
UFCW Local 27 (temporary employees)
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: 52-6044428

Plan Number: 502

Type of Plan
This is a welfare plan designed to provide health and welfare benefits such as: life insurance, accidental death and dismemberment, weekly disability, 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 *Participating Employer*s pursuant to the terms of their *Collective Bargaining Agreements* or participation agreements and self-payments made by participants and/or dependents.

Funding Medium

All assets are held in trust by the Board of Trustees. Insurance premiums are paid by the *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 - Chairman President UFCW Local 400 8400 Corporate Drive, Suite 200 Landover, MD 20785	Steven J. Loeffler, Secretary Regional Vice President of Labor Relations The Kroger Company 4111 Executive Parkway Westerville, OH 43081-3800
Thomas Hipkins Secretary-Treasurer UFCW Local 27 21 West Road, Second Floor Towson, MD 21204	Jon Born Director, Health and Benefits SuperValu, Inc. 11840 Valley View Road Eden Prairie, MN 55344
George Murphy UFCW Local 27 21 West Road, Second Floor Towson, MD 21204	Donna Gwin Director, Associate Relations and Labor Relations Shoppers Food and Pharmacy 16901 Melford Boulevard Bowie, MD 20715
Yolanda Anwar UFCW Local 400 8400 Corporate Drive Suite 200 Landover, MD 20785	

SUMMARY OF BENEFITS

Part Time Group A benefits include Life Insurance and Accidental Death and Dismemberment.

Life Insurance	$10,000
Accidental Death & Dismemberment	$10,000

Part Time Group B benefits include Weekly Disability, Dental and Optical benefits.

Weekly Disability	40% of average weekly straight time pay for first 8 weeks and 30% average weekly straight time pay for next 4 weeks, depending on length of employment. First day for accident or hospitalization, 7th day for sickness. Eligibility for all benefits is continued during sick pay. See page 59 for more detailed information regarding your Weekly Disability benefits.
Dental	Exams, x-rays, cleanings, amalgam fillings, and simple extractions covered at no charge when using a Group Dental Service (GDS) provider.
Optical	Exam, frames, and glasses once every 2 years through Group Vision Service (GVS).

NOTICE – NO FUND LIABILITY

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

REPAYING THE FUND/OVERPAYMENT OF BENEFITS

If the *Fund* pays benefits in error, such as when the *Fund* pays you more benefits than you are entitled to, or if the *Fund* advances benefits that you 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 or your representative (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 for the benefit of the *Fund* until paid to the *Fund*. By accepting benefits from the *Fund*, you 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 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 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 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 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 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 as the *Fund* participant, the *Fund* may offset the future benefits payable by the *Fund* to you.

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 beneficiary to obtain repayment of the benefits advanced by the *Fund*, you or your 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 beneficiary shall also be required to pay interest at the rate determined by the *Trustees* from time to time from the date you become obligated to repay the *Fund* through the date that the *Fund* is paid the full amount owed. The *Fund* has the right to file suit against you in any state or federal court that has jurisdiction over the *Fund's* claim.

RETROACTIVE TERMINATION OF COVERAGE

The Fund reserves the right to retroactively terminate your coverage under the Plan if you 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 accepting benefits in excess of what is covered under the Plan and accepting benefits after you 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.

DEFINITIONS

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

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

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

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 when benefits are lost.

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

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

EFFECTIVE/ELIGIBILITY DATE. According to the Eligibility Rules, the date on which coverage begins.

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

EXPERIMENTAL. A drug, device, 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, treatment, or *procedure*, or the patient informed consent document utilized with the drug, device, 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, 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, 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, treatment, or *procedure*; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, treatment, or *procedure*.

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

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

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

FUND. The 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*.”

HOSPITAL. A legally constituted general hospital which provides diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons, and which is not, other than incidentally, a nursing home or a place for rest, the aged, substance abusers, or alcoholics. The definition specifically includes institutions which provide treatment for pulmonary tuberculosis or for mental disorders.

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

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

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. 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.

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 who receives covered services in a *Hospital*, but for whom an overnight room and board charge is not made.

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

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

400; or (2) Participation Agreement with the *Fund* which requires contributions to the *Fund*.

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

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*.

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

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

TRUSTEES. Members of the Board of Trustees of the UFCW Unions and Participating Employers Health and Welfare Fund.

UNION. The United Food and Commercial Workers International Union, Locals 400 and 27 or any successor by combination, consolidation, or merger, or any other local union affiliated with the United Food and Commercial Workers International Union that: 1) has a *Collective Bargaining 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*.

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

EMPLOYEE ELIGIBILITY

Initial Eligibility for Part-Time Employees

If you were hired to work an undetermined number of hours per week and you were entitled to be paid for an average of less than 28 hours per week during your first 12 months of employment (your "initial measurement period"), you will be eligible for Life, Accidental Death & Dismemberment, Dental, Optical, and Weekly Disability benefits on the first day of the month after you have worked for 18 months, subject to the *Fund's* receipt of contributions, when contractually required, made on your behalf by your *Participating Employer*, and subject to you completing and filing with the *Fund Office* the necessary enrollment forms, including any payroll deduction forms. For example, if you started work on May 15, 2016 and you were entitled to be paid for an average of 1 hour a week through May 14, 2017, you will be covered under the Plan Y40 as of December 1, 2017.

Plan Y40 – Continued Eligibility

As long as you are employed by a *Participating Employer* making contributions to the *Fund* on your behalf pursuant to a *Collective Bargaining Agreement* with a participating *Union* or participation agreement with the *Fund,* you will continue to be eligible for the above-described benefits under Plan Y40 for a period of one calendar year from the date that your coverage begins. For example, if you first become covered on June 1, 2017, you will continue to be covered at least until May 31, 2018, provided you continue to work in covered employment. (There is a limited exception to the above described rule for participants who are hired between October 16th – November 1st of any calendar year and first become eligible for coverage under Plan Y40 on December 1 of the following year. If this applies to you, your initial eligibility period will continue for 13 months, until the next December 31, provided you continue in covered employment.

For example, if you first become covered on December 1, 2017, you will continue to be covered until at least December 31, 2018).

After your first period of coverage ends, your continuing eligibility for benefits under Plan Y40 each calendar year will depend on the average number of hours per week for which you were entitled to payment for covered employment in each 12-month period ending October 14th of the prior year. For example, if your first coverage period ends on May 31, 2018, your eligibility for continued coverage through December 31, 2018 will depend on the average number of hours per week for which you were entitled to payment during the period of October 15, 2016 – October 14, 2017. If you continued to be employed in covered employment but were entitled to payment for an average of less than 28 hours per week during this period, you will be eligible for benefits under Plan Y40 until at least December 31, 2018.

Switching from Plan Y40 to Plan Y30 after Your Initial Eligibility Determination

If you first become eligible to participate in Plan Y40 because you were entitled to payment for an average of less than 28 hours per week during your first 12 months of covered employment, but you later become entitled to payment for at least 28 hours per week, you may be eligible to move from Plan Y40 to Plan Y30. Your eligibility to switch from Plan Y40 to Plan Y30 on January 1st of any given year will depend on your average hours in Covered Employment during the preceding October 15 – October 14. For example, assume you were hired on January 15, 2017 and you are entitled to payment for an average of 27 hours per week from January 15, 2017 – January 14, 2018. You would become eligible for Plan Y40 on March 1, 2018. However, if your average hours for the period of October 15, 2017 – October 14, 2018 increase to 29 hours per week, you would become eligible for Plan Y30 on January 1, 2019.

(There is a separate Summary Plan Description for Plan Y30. If Plan Y30 applies to you, please contact the *Fund Office*).

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

1. during periods of *Active Work,*
2. during paid vacations,
3. while on jury duty,
4. while collecting 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 34.

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

Delay in Eligibility

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

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.

Special Enrollment Provisions

If you turned down coverage for yourself because of other health insurance or group health plan coverage, and then that other coverage ends, you may be able to enroll yourself 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. 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 36),
5. leave of absence,
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 PlanY40 if you fail to satisfy the requirements for continued eligibility for Plan Y40 benefits, as described under "Plan Y40 – Continued Eligibility."

If loss of eligibility occurs due to your termination of employment or a reduction in your hours of employment, you may be entitled to

continue your coverage under *COBRA*, as explained on page 26. 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 36. Further, you may be entitled to continue your eligibility by making self-payments. See the "Self-Payments" section on page 38 for complete details of this provision.

Retirees

If you are an *Actively Working* participant covered by this Plan and retire, you will no longer be eligible for health and welfare benefits under this *Plan*. However, you can exercise your rights to continue your benefits under this Plan for a limited period under the provisions of the Consolidated Omnibus Budget Reconciliation Act (*COBRA*) as described on pages 26-33 of this book.

Pre-Existing Condition Exclusions

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

Date Benefits Terminate

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

- **Life** benefits terminate 31 days following the loss of eligibility, but **Accidental Death and Dismemberment** benefits terminate on the day loss of eligibility occurs. See page 53 for the Life Conversion Privilege.

- **All Other** benefits terminate on the day you lose your eligibility. 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 because of layoff, or a leave of absence approved by your *Participating Employer*, and you return to active employment, you will be reinstated to eligibility status on the first day of the month in which your *Participating Employer* makes a contribution on your behalf. If you lose your eligibility because of military service, you will be reinstated as provided under the provisions of *USERRA* (see page 36). If you lose your eligibility for any other reason, but become actively employed again by the same or another *Participating Employer* within 30 days, your eligibility will automatically be reinstated on the day you return to active employment. If the separation is 31 days or longer, you must again meet the initial eligibility requirements. The contribution rate paid by the *Participating Employer* will determine the level of benefits you receive.

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.

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 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.

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.

If you are determined to have been disabled at the time of, or within the first 60 days of, continuation coverage, you must notify the *Fund Office* within 60 days of the date that the Social Security Administration determines that you are disabled and within 30 days of any final determination that you are 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, generally you will be entitled to continue your COBRA Continuation Coverage for up to 18 months, subject to the limitations described in this book.

All notifications under *COBRA* must comply with these provisions. You are 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, 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, if applicable.

Once the *Fund* receives timely notification that a qualifying event has occurred, *COBRA* coverage will be offered to the participant, as applicable.

Participants covered under *COBRA* Continuation Coverage must provide notice of a disability to the *Fund* within 60 days of 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 disability (for example: a copy of the SSA disability determination).

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

The *Fund Office* will notify the participant within 14 days of receipt of notification of a disability of the right to continue coverage. The participant 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. 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 does not give written notice within 60 days of the date of the qualifying event, or a *Participating Employer* within thirty days of the qualifying event, and as a result, the Plan pays a claim for a person whose coverage terminated due to a qualifying event, then that person or the *Participating Employer*, as applicable, must reimburse the Plan for any claims that should not have been paid. If the person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual.

Notification Regarding Change of Address

It is very important that participants and beneficiaries keep the *Fund* informed of their current addresses. If you experience a change of address, immediately inform the *Fund Office*.

Length of Coverage

Your coverage may be continued under *COBRA* for up to 18 months, if coverage is terminated due to your:

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 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 you are no longer disabled, the 11 month extension does not apply. If the Social Security Administration determines that you are 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.

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 become 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;
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;
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 the applicable period of continuation coverage is exhausted; or
8. The first month that begins more than 30 days after the date of the Social Security Administration's determination that you 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 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*, you may continue coverage for **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 or only dental). 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 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 send 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 has elected continuation coverage, will be held until the election has been made and premiums have been paid in full. If the participant 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.

Other Coverage Options besides COBRA Coverage

Instead of enrolling in *COBRA* coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan

coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than *COBRA* coverage. You can learn more about many of these options at www.healthcare.gov.

Contact for Additional Information

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

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* leave for impermissible reasons, the *Fund* may offset payment of outstanding 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 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 under the provisions of *USERRA*. The period of coverage for you ends on the earlier of:

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

After 31 days, you must pay the cost of the coverage unless your *Participating Employer* elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in accordance with the provisions of the *USERRA* by the same method that the *Fund* uses to determine the cost of *COBRA* continuation coverage. See page 26.

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 under the provisions of *USERRA* within 60 days

after your military service begins. Payment of the *USERRA* premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of election of your *USERRA* coverage.

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

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

SELF-PAYMENTS

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

If you choose to self-pay, you may continue:
1. Life and Accidental Death and Dismemberment benefits **ONLY**;
2. Optical and Dental benefits **ONLY**; <u>or</u>
3. Life, Accidental Death and Dismemberment, Optical and Dental benefits.

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

1. You must elect to continue eligibility by making self-payments **within 30 days** following your loss of eligibility. The self-payment period must start with the month immediately following the month in which eligibility was lost. Failure to elect to make self-payments on time will cause a loss of eligibility and benefits will terminate.

2. Self-payments must be made monthly in an amount determined by the Board of *Trustees*. Amounts depend on your status 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:

UFCW Unions and Participating Employers
Health and Welfare Fund
Attn: Eligibility Department
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 18 months following your loss of eligibility. You will not be entitled to *COBRA* continuation coverage when your self-pay coverage ends.

5. Self-payments will no longer be necessary when you return to work and your *Participating Employer* resumes contributions on your behalf.

Military Personnel

Participants who are retired from active military service are entitled to benefits from this Plan for themselves 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. Notwithstanding the foregoing, benefits will be provided to participants as required under federal law.

COORDINATION OF BENEFITS

Coordination of Benefits applies when a participant 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.

If a participant 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.

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.

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

Medicare - Coordination of Benefits for Participants Who Are "*Actively Working*"

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

All active participants over age 65 will be entitled to receive coverage under this Plan under the same conditions as a participant under age 65. The Plan cannot be "secondary" to *Medicare* for employees 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, 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.

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 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 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 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 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*, **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.**

Important: To ensure that the *Fund* coordinates and pays your benefits properly, you must keep the *Fund* informed of any and all coverage.

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

SUBROGATION

Were you 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 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 benefits based on the requirement that you reimburse the *Fund* in full from any recovery you 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. 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 injuries.

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

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

Also, if you receive any benefit payments from the *Fund* for any *Injury* or *Sickness*, the *Fund* is subrogated to all rights of recovery available to you 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 behalf. This means that the *Fund* has an independent right to bring an action in connection with such *Injury* or *Sickness* in your name and also has a right to intervene in any action brought by you, 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 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 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 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 or a representative of you (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 for the benefit of the *Fund* until paid to the *Fund*. You 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 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 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 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 attorney, if applicable. However, even if you or your representative (including your attorney) do not execute the required Subrogation Agreement and the *Fund* nevertheless pays benefits to or on behalf of you, your acceptance of such benefits shall constitute your agreement to the *Fund's* right to subrogation or reimbursement from any recovery by you from a third party that is based on the circumstance from which the expense or benefit paid by the *Fund* arose, and your 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 recover from a third party.

Any refusal by you 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 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 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 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 treatment, service or supply to the extent that the cost of the services may be recovered by, or on behalf of you in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you 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 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 receipt of any recovery. If you are asked to do so, you must contact the *Fund Office* immediately. You also must do nothing to impair or prejudice the *Fund*'s rights. For example, if you choose not to pursue the liability of a third party, you may not waive any rights covering any conditions under which any recovery could be received. Where you choose 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 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 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 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 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 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 to obtain repayment of the benefits advanced by the *Fund*, you 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 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 other benefits.

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

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

The Plan will pay benefits provided that:

1. You file a claim with the *Fund* on time.

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

3. You appeal the denial of your Workers' Compensation claim to the Workers' Compensation Commission for final adjudication within 30 days from the date the claim is denied by your employer.

4. You take all procedural action necessary to pursue your appeal with the Workers' Compensation Commission.

5. If you fail to file an appeal with the Commission within 30 days from the date the claim is denied by your employer, all benefits terminate and you must immediately repay to the *Fund* payments made by the Plan to you and/or your provider relating to your *Injury* or *Sickness*.

6. You notify the *Fund Office* of the date of your Workers' Compensation Commission hearing (when scheduled), and you attend the hearing.

7. You obtain approval from the *Fund* prior to any settlement of your appeal. If you accept a settlement in connection with your Workers' Compensation claim, the *Fund* will consider this an indication that your claim is work-related and will require that you reimburse the *Fund*, in full, for any benefits it has paid on your behalf relating to your Workers' Compensation claim.

8. If the Workers' Compensation Commission determines that your claim is compensable, all benefits terminate and you must immediately repay to the *Fund* payments made by the Plan to you and/or your provider relating to your *Injury* or *Sickness*.

9. If the Workers' Compensation Commission denies your claim for ***any reason <u>OTHER</u> 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 or your representative (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 for the benefit of the *Fund* until paid to the *Fund*. You 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 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 to obtain repayment of the benefits advanced by the *Fund*, you 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 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.

LIFE BENEFIT

Insured by MetLife
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

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

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 Summary 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.
Paralysis of Both Arms and Both Legs	Full amount paid to you.
Paralysis of Both Legs	Half the amount paid to you.
Paralysis of the Arm and Leg on Either Side of the Body	Half the amount paid to you.
Paralysis of One Arm or One Leg	25% 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 Summary 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 1-800-638-6420, 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, 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).

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

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:

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 licensed or certified PhD psychologist, or a Certified Alcohol Counselor or Master's Level Social Worker who is under the supervision of a psychiatrist or a board certified psychologist. 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.

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. This rule will be waived if your *Physician* provides documentation that he/she has been treating you on a regular basis for that same disability. The usual waiting periods for when benefits begin will apply.

7. No disability will be considered as beginning until after your last day worked.

8. Continuation forms must be returned within four weeks and requests for other information must be returned within two weeks from the date mailed by the *Fund Office.*

9. The fact that a claim for benefits from a source other than the *Fund* has been filed or is pending does not excuse these report requirements (e.g., Workers' Compensation or auto insurance).

10. Benefits are not payable if the disability is due to an *Injury* or *Sickness* which, as determined by the *Trustees*, is:
    a) Compensable under Workers' Compensation legislation, occupational disease act legislation, employer's liability laws or other similar legislation, or your Personal Injury Protection (PIP) insurance for lost wages or sustained on a job outside the *Fund*, i.e. not a *Participating Employer*, (see "Exclusions and Limitations" on page 68),
    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.

11. Benefits will not be payable for any period of time for which you have a compensable Workers' Compensation claim, even if the disability under your Workers' Compensation claim is different from the disability for which you seek Weekly Disability benefits.

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

13. Successive periods of disability due to the same or related causes will be considered as one period of disability unless they are separated by a 60- day period during which you are not absent from work because of disability. Successive periods of disability due to entirely unrelated causes are considered one disability unless they are separated by complete recovery and return to *Active Work*.

14. An initial claim form must be filed for any recurrence of a disability regardless of the length of time you returned to work. Continuation forms are not acceptable.

15. The *Fund* reserves the right and opportunity to examine the person whose *Injury* or *Sickness* is the basis of a claim as often as the *Fund* may reasonably require during pendency of the claim.

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

17. No benefits will be paid to any participant who owes money to the *Fund*. Failure to repay amounts owed may result in suspension of Optical, Dental and Prescription benefits. Subsequent amounts payable under the Weekly Disability or Medical benefits may be deducted from amounts owed.

18. 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*.

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

Benefit Amount

First of the month following 18 months of employment	Maximum Benefit – 40% of average weekly straight time pay for first 8 weeks plus 30% of average weekly straight time pay for the next 4 weeks.

Your average weekly straight time pay is based on the average straight time hours worked in the five full pay weeks preceding the disability, as reported to the *Fund* by your *Participating Employer*. Sundays or other premium days are not counted in determining the benefit amount, but shift premiums will be counted.

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

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

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

Example of benefit amount computation:

First 8 weeks:

Hourly rate	= $15.00
Average hours worked	= 28
$15 x 28	= $420.00 average weekly straight time pay
$420.00 x .40%	= $168.00 weekly benefit amount
$168.00 ÷ 7	= $24.00 daily benefit amount

Next 4 weeks:

$15.00 x 28	= $420.00 average weekly straight time pay
$420.00 x 30%	= $126.00 weekly benefit amount
$126.00 ÷ 7	= $18.00 daily benefit amount

Nervous and Mental Claims

Disabilities arising from a nervous condition or mental illness must be verified by a board eligible or board certified psychiatrist, a licensed or certified PhD psychologist, or a Certified Alcohol Counselor or Master's Level Social Worker who is under the supervision of a psychiatrist or a board certified psychologist.

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, a licensed or certified

PhD psychologist, or a Certified Alcohol Counselor or Master's Level Social Worker who is under the supervision of a psychiatrist or a board certified psychologist.

Benefit Exhaustion

Your eligibility status for other 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 59. If you secure a leave of absence from your *Participating Employer*, benefits may be continued under the provisions of *COBRA* as described on page 26. If you waive your *COBRA* election rights, you can continue benefits by making self-payments as discussed on page 38.

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 91 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,* 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 – Supplemental Benefit for Waiting Periods

If you become disabled as a result of an accident or illness related to

your employment with a *Participating Employer* in this *Fund*, the *Fund* may supplement the benefits you receive under your *Participating Employer*'s Workers' Compensation insurance. Time lost without pay because of waiting periods imposed by State Workers' Compensation laws will be supplemented by the *Fund*.

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

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 48) 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.

EXCLUSIONS AND LIMITATIONS

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

1. Work-related *Injuries* or *Sicknesses* that are generally compensable under Workers' Compensation legislation, occupational disease act legislation, employer's liability law or other similar legislation. If, *except for* your failure to follow the appropriate procedural requirements for filing a claim or to otherwise similarly act, your claim *would have been compensable by Workers' Compensation*, the *Fund* will treat the claim as compensable by Workers' Compensation and excluded from coverage under the Plan.
2. Care which is furnished to you under the laws of the United States or any political subdivision thereof.
3. Care provided to you to the extent that the cost of the professional care may be recoverable by, or on behalf of, you in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you 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, as provided in the "Subrogation" and "Advance Benefits for Workers' Compensation Claims" sections starting on page 48.
4. Disease or injuries resulting from any war, declared or undeclared.
5. 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.
6. Services or care of any kind other than those defined and limited in this Plan.

DENTAL BENEFITS

Benefits are provided through Group Dental Service, Inc. (GDS) and are insured. Covered services are exams, x-rays, cleaning, amalgam fillings, and simple extractions. There are no Co-payments for covered benefits.

The Plan provides benefits for the dental services described below only when performed by a *Participating Dentist*. Any services rendered by a pedodontist (a dentist specializing in children's teeth) or a non-*Participating Dentist*, oral surgeon, periodontist, or orthodontist 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 Group Dental Service at (301) 770-1480 or toll free at (800) 242-0450 between 8:00 a.m. – 6:00 p.m. Monday through Thursday and 8:00 a.m. – 5:00 p.m. on Friday. When calling Group Dental Service, please be ready to give 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 need dental services, and broken appointments may keep another person from getting treatment due to scheduling limitations. Therefore, you will be charged ten dollars ($10) per one half hour of scheduled appointment time for any broken appointment unless you notified the dentist with whom you had the appointment at least 24 hours **prior** to the scheduled appointment. Until the broken appointment fee is paid, no further dental work will be done. You should plan to be at the dentist's office at least ten minutes before your appointment time. If a patient arrives ten minutes late for an appointment, it will be considered a broken appointment and the broken appointment charge will apply.

Important
Any services you receive from a dentist who does not participate with Group Dental Service 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. When referred by a *Participating Dentist* to a non-participating specialist;
2. When authorized in advance by GDS;
3. In the case of an emergency which occurs more than 50 miles from the participant's primary dentist if the participant 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*.

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

DESCRIPTION OF DENTAL SERVICES AND FEES

Procedure Code	Description	Member Co-Pay
	DIAGNOSTIC & PREVENTIVE	
00120	Periodic Oral Exam	No charge
00140	Limited Oral Evaluation – Problem Focused	No charge
00150	Comprehensive Oral Evaluation	No charge
00170	Re-evaluation – Limited, Problem Focused	No charge
00210	Intraoral – Complete Series, Including Bitewings (once per 3 years)	No charge
00220	Intraoral – Periapical – First Film	No charge
00230	Intraoral – Periapical – Each Additional Film	No charge
00240	Intraoral – Occlusal Film	No charge
00270	Bitewings – Single Film	No charge
00272	Bitewings – 2 Films	No charge
00273	Bitewings – 3 Films	No charge
00274	Bitewings – 4 Films	No charge
00277	Vertical Bitewings – 7 to 8 Films	No charge
00330	Panoramic Film (once per 3 years)	No charge
00340	Cephalometric Film	No charge
00460	Pulp Vitality Tests	No charge
01110	Prophylaxis – Adult (once per 6 months)	No charge

Procedure Code	Description	Member Co-Pay
	BASIC RESTORATIVE	
D2140	Amalgam – 1 Surface, Primary/ Permanent	No charge
D2150	Amalgam – 2 Surfaces, Primary/ Permanent	No charge
D2160	Amalgam – 3 Surfaces, Primary/ Permanent	No charge
D2161	Amalgam – 4 or More Surfaces, Primary/ Permanent	No charge
D2330	Resin – 1 Surface, Anterior	No charge
D2331	Resin – 2 Surfaces, Anterior	No charge
D2332	Resin – 3 Surfaces, Anterior	No charge
D2335	Resin – 4 or More Surfaces or Incisal Angle	No charge
D2390	Resin – Base Composite Crown, Anterior	No charge
	INLAYS/ONLAYS/CROWNS	
D2940	Sedative Filling	No charge
	ORAL SURGERY	
D7111	Extraction, Coronal Remnants, Deciduous Tooth	No charge
D7140	Extraction, Erupted Tooth or Exposed Root	No charge
	MISCELLANEOUS	
09110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	No charge
09215	Local Anesthesia (included in Procedure Fee)	No charge
09999	Broken Appointment Charge (per 1/2 hour)	$10

ENDODONTICS	Not Covered
PERIODONTICS	Not Covered
REMOVEABLE PROSTHETICS	Not Covered
FIXED PROSTHETICS	Not Covered
ORTHODONTICS	Not Covered

Procedures not shown are not covered by the Plan.

Exclusions and Limitations

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

1. Prophylaxis (cleaning), including scaling and polishing, is limited to once every six months.
2. Dentures are limited to one partial or complete denture per arch within a five-year period.
3. Cosmetic services are excluded. Cosmetic services are those which are elective and which are not necessary for good dental health. Cosmetic services include, but are not limited to:
    a. Alteration or extraction and replacement of sound teeth.
    b. Any treatment of the teeth to remove or lessen discoloration.
4. Examination, evaluation, and treatment of temporomandibular joint (TMJ) pain dysfunction are excluded.
5. Replacement of dentures, bridgework or any other dental appliances previously supplied by the Plan through GDS due to loss or theft is excluded, unless the participant received such appliance prior to the immediately preceding five-year period.
6. Any service or treatment begun while the participant was not covered by the Plan through GDS will not be covered.
7. Hospitalization for any dental procedure is excluded.

8. Drugs, whether prescribed or over-the-counter, are excluded.
9. Dental implants, and any prosthesis, crown, bridge, or denture associated with a dental implant are excluded.
10. Services rendered by prosthodontic specialists are excluded.
11. Procedures requiring fixed prosthodontic restorations that are necessary for complete oral rehabilitation or reconstruction are excluded.
12. Procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion are excluded.
13. General anesthesia is covered only when administered in an oral surgeon's office for extractions.
14. Treatment of malignancies, cysts, neoplasms or congenital malformations is excluded.
15. Services for injuries or conditions which are covered under Workers' Compensation or employer's liability laws are excluded; services which are provided by any municipality, county, or other political subdivision are excluded.
16. Any service that the appropriate regulatory board determines was provided as a result of a prohibited referral. *Participating Dentists* are prohibited from referring you, or requesting reimbursement for, dental care services from a provider outside the *Participating Dentist*'s office or group practice if:

    a. The *Participating Dentist*, or the *Participating Dentist* in combination with his or her immediate family, owns a beneficial interest in that provider's business;

    b. The *Participating Dentist*'s immediate family owns a beneficial interest of three (3) percent or more in that provider's business; or

    c. The *Participating Dentist*, his or her immediate family, or the *Participating Dentist* in combination with his or her immediate family has a compensation arrangement with that provider.

Grievance Procedure
Grievances or complaints may be directed orally or in writing to the GDS Administrative Office at 15400 Calhoun Drive, Suite 300, Rockville, MD 20855, telephone number (800) 242-0450. A Member Services representative will personally handle your complaint and attempt to resolve it in an equitable and fair manner. You will be told, either verbally or in writing, about the disposition of your complaint within twenty (20) days of the date it was received by GDS, unless you agreed to extend this period.

Appeals Process
If your dental claim is denied by GDS and you are not satisfied with the result of the GDS Grievance Procedure, described above, or you do not wish to file a grievance, you have the right to appeal the denied claim within 180 days of the denial. GDS's Manager of Member Services will handle your complaint if it concerns administrative issues, fee disputes, communication of covered services, or a question of eligibility. If the complaint concerns quality of care, your appeal will be decided by GDS's Director of Quality Assurance. In either case, the appeal must be made by a written request to the Member Services representative. The Manager of Member Services or the Director of Quality Assurance will attempt to reach a fair and equitable decision within 14 days following receipt of all the pertinent information. The decision shall be conveyed to you in writing. If you are dissatisfied with the result of the appeal, you may appeal the decision by writing to the Board of Trustees of the *Fund*.

These procedures in no way limit any rights you may have to appeal directly to the Board of Trustees as explained below.

Appeals
If you have a dental claim denied by Group Dental Service of Maryland (GDS-MD), you have the right to appeal within 180 days of the denial. If GDS-MD denies your appeal, the *Fund* offers you

an additional 45 days from the date of GDS-MD'S denial to appeal to the Board of Trustees. In this case, appealing to the Board of Trustees is entirely voluntary and will not affect your legal right to bring suit against GDS-MD under ERISA. However, please note the following if you choose to take advantage of this option: (1) Upon request and free of charge, the *Fund* will provide you with information relating to a voluntary level of appeal. This information will be sufficient to enable you to make an informed judgment about whether to submit your denied dental benefit claim to the Board of Trustees. It will also include a statement that your decision (as to whether to submit your dental benefit dispute to this voluntary level of appeal) will have no effect on your right to any other benefit under the Plan. Additionally, it will include information about applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker (such as financial or personal interests in the result of any past or present relationship to any party in the review process). (2) You may elect to file a voluntary appeal to the Board of Trustees only after your appeal has been denied by GDS-MD. (3) The *Fund* will not impose any fees or costs on you as part of this voluntary appeal. (4) The time it takes to decide your appeal under this voluntary appeal process will not be counted against you in determining whether any lawsuit you file afterward is brought in a timely manner. (5) Your appeal to the Board of Trustees must be submitted in writing within 45 days of the date you receive your appeal denial from GDS-MD. (6) Unless received within 30 days of the meeting, the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal. (7) If your appeal is received within 30 days of the Board of Trustees quarterly meeting, it will be reviewed at the second quarterly meeting following receipt of the appeal. (8) If special circumstances require an extension of time beyond the second quarterly meeting, you will be notified in writing of the circumstances and the date on which a decision is expected. In no

event will the decision be made later than the third quarterly meeting after receipt of your appeal, and (9) The Board of Trustees will send a written notice, approving or denying your appeal, within five days of its decision.

OPTICAL BENEFITS

Optical benefits under the Plan are provided by
Group Vision Service ("GVS")
6700 Alexander Bell Drive, Suite 200
Columbia, MD 21046
(240) 453-2000
Member Customer Service – 1-866-265-4626

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.

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*
**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	$40.00	Contact Lens Fitting & 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:

- Contact Lenses.
- 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.

CLAIMS FILING AND REVIEW PROCEDURE

General Information Regarding Benefit Claims
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 vision or dental benefit appeals for eligibility denials. Further, if you appeal a denial of dental benefits pursuant to the procedures provided by Group Dental Service, and that appeal is denied, please refer to the Special Rule Regarding Appeals of Dental Benefit Claims 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, alternate payee or beneficiary, and any provider who provided services to you or your spouse, 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
You should consult the book provided to you by the relevant dental or optical benefit insurer for a description of the types of claims for benefits and the procedures and time limits for their review.

Denial of a Claim
You should consult the book provided to you by the relevant dental or optical benefit insurer for a description of the procedures for denial of claims for those benefits.

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

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 in the book provided by the relevant dental or optical benefit insurer, 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, as defined in the book provided by the relevant dental or optical benefit insurer, 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, as defined in the book provided by the relevant dental or optical benefit insurer, 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.

Special Rule Regarding Appeals of Dental Benefit Claims

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

- Upon request and free of charge, the *Fund* will provide you with sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a dental benefit dispute to the voluntary level of appeal, including a statement that your decision as to whether to submit your dental benefit dispute to the voluntary level of appeal will have no effect on your right to any other benefits under the Plan, information about the applicable rule, your right to representation, the process for

selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision, such as financial or personal interests in the result or any past or present relationship to any party to the review process.

- You may elect to file a voluntary appeal to the Board of Trustees only after a denial of your appeal by GDS-MD.

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

Your voluntary appeal must be submitted in writing to the Board of Trustees within 45 days of the date you receive your appeal denial from GDS-MD. 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.

Weekly Disability Claims

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, 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 procedures and time limits, 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.

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.

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, the specific reason or reasons for the denial, the specific Plan provisions on which the decision is based, 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.

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 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 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 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.

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 if there is a loss of coverage under the plan as a result of a qualifying event, you 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 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.
- Benefit access which allows you to track your claims and view the following:
  - Weekly Disability Claims – displays claims submitted to the Plan on your behalf
  - Eligibility – your past and present eligibility
- Dashboard – a landing page containing quick navigation to other benefit information.
- Demographics –a demographic page displaying your address, phone number, and other information.

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 had a password for NETime, the online access service previously offered by the *Fund*, it will not apply to this site. You will need to create a new username and password for MemberXG.

If you have 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 Weekly Disability 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 participant.
- 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. 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.

PARTICIPATING EMPLOYERS AND UNIONS

Shoppers/Basics/Metro
16901 Melford Blvd.
Bowie, MD 20715

United Food and Commercial Workers
Local 27
21 West Road – Second Floor
Towson, MD 21204

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
Fund Office (Landover Local Line).......................	(301) 459-3020
Group Dental Service of MD...............................	(800) 242-0450
Group Vision Service...	(866) 265-4626
MetLife...	(800) 638-6420

ADDRESSES

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

Special P.O. Box for Claims
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

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