United Food and Commercial Workers

Local 152 Health and Welfare Fund

Summary Plan Description

January 1, 2020

UFCW Local 152 Health & Welfare Fund
27 Roland Avenue, Suite 100
Mt Laurel, NJ 08054
Telephone: (856) 793-2500 (TTY: 711)
Fax: (856) 793-3100

Dear Participant:

This book and the accompanying ***Summary of Benefits Insert*** make up the Fund's entire Plan document. These documents are referred to as your Summary Plan Description ("SPD" or "Plan") and also serve as the Plan document, as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This SPD describes the benefits available to you as of November 1, 2018 from the UFCW Local 152 Health & Welfare Fund ("Fund").

Keep in mind that you may not be eligible for every benefit described in this book; THE *SUMMARY OF BENEFITS INSERT* SPECIFIES THE BENEFITS THAT APPLY TO YOU AND YOUR ELIGIBLE FAMILY MEMBERS.

The Board of Trustees may change benefits and this SPD at any time. You will be notified of all changes as required by law. The Board of Trustees also has the full and exclusive power to determine benefits eligibility as well as interpret, apply, construe and amend the provisions of the SPD and make factual determinations regarding its construction, interpretation and application. Any decisions made by the Board of Trustees in good faith, are binding upon contributing employers, Participants, dependents, providers and all other persons who may be involved with the Fund. From time to time, the Plan may engage the services of a third-party administrator (referred to as a "TPA") to provide certain administrative and claims processing services to the Plan.

Benefits are provided for eligible family members in accordance with the provisions of the Plan and the Collective Bargaining Agreement (referred to as a "CBA") or Memorandum of Agreement (referred to as a "MOA") governing your participation in the Plan. The Plan Trustees are dedicated to providing you and your eligible family members with a comprehensive benefit program. Please use these benefits wisely.

- Question what appears to be unnecessary treatment.
- Check with Horizon Blue Cross Blue Shield if you are not sure whether a treatment or service is covered. **REMEMBER:** The Fund may be able to direct you to a Physician or facility that may provide treatment at a lower cost.
- **WHENEVER POSSIBLE <u>DO NOT</u> HAVE NON-EMERGENCY X-RAYS AND LAB TESTS PERFORMED IN THE "OUTPATIENT DEPARTMENT" OF A HOSPITAL. CHARGES ARE TYPICALLY MORE EXPENSIVE AND YOU MAY BE RESPONSIBLE FOR LARGER OUT-OF-POCKET BALANCES.**

If you have difficulty understanding any part of this book or have any questions about your benefits, contact the Fund Office at (856) 793-2500 or (800) 555-4959.

Sincerely,

Brian String, Chairman
For the Board of Trustees

INTRODUCTION

This book and the Summary of Benefits Insert describe the benefits provided by the UFCW Local 152 Health & Welfare Fund. Together, this book and the Summary of Benefits Insert make up your Summary Plan Description (SPD), which replaces any previous SPDs you may have received describing these benefits.

This book includes information about eligibility, enrollment, when coverage starts and administrative provisions and procedures. It also includes information required by the Employee Retirement Income Security Act of 1974, as amended (ERISA). The **About Your Benefits** section provides a description of Plan benefits. Keep in mind that you may not be eligible for all of the benefits described in this section. See your Summary of Benefits Insert.

A separate **Summary of Benefits Insert** describes the benefits that apply to you, who is eligible for those benefits, Plan allowances and any exclusions and limitations that may apply. It is your resource for determining what coverage is in place for you and your eligible dependents.

Please read both this book and the Summary of Benefits Insert. Then, share this information with your eligible family members and keep it in a safe place for future reference. You and your eligible dependents should rely on this SPD for a description of Plan benefits. If you need additional assistance or have a question, contact the Fund Office.

Have a Question?

If you have a question about Plan benefits, you should call the Fund Office at (856) 793-2500 or (800) 555-4959.

If these benefits are modified, you will receive a Summary of Material Modification ("SMM") that will explain the changes.

VERY IMPORTANT NOTES

- When the term "you" or "your" is used in this book, it means an Employee/Participant/member of UFCW Local 152, UFCW Local 27 and UFCW Local 1262, unless the context requires otherwise or the result would be unreasonable.
- When the term "family member" is used, it means you and/or an eligible dependent (as defined under the Eligibility provisions of the Plan).
- Not all Participants or their eligible family members are entitled to all of the benefits described. **YOU AND YOUR ELIGIBLE FAMILY MEMBERS ARE ONLY ENTITLED TO THOSE BENEFITS DESCRIBED IN THE ACCOMPANYING SUMMARY OF BENEFITS INSERT.**
- With the exception of Life Insurance, the Fund only provides coverage for non-occupational injuries and illnesses. Work-related injuries or illnesses must be filed with your employer's Workers' Compensation carrier.

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WHO IS ELIGIBLE

You and your eligible family members (except where otherwise noted in either this book or the Summary of Benefits Insert) will become and remain eligible to participate in this Plan as long as your employer is making the appropriate contributions on your behalf to this Fund pursuant to a CBA or MOA.

If you are a retiree, the Summary of Benefits Insert provides information about your eligibility for benefits as well as a description of those benefits.

WHEN COVERAGE BEGINS

Your employer will begin making the appropriate contributions to the Fund on your behalf on the date required in the CBA or MOA governing your participation in the Fund. You generally become eligible for benefits the first of the month following the end of your probationary period as detailed in your CBA or MOA. In no event will your coverage begin later than the date on which it is required to begin under applicable law.

Delay in Eligibility

For all non-health benefits (legal services, life insurance and disability benefits), if you are not actively at work in Covered Employment on the day your benefits would otherwise begin, the effective date for coverage of all non-health benefits will be deferred until the first date you are actively at work in Covered Employment.

For health benefits (medical, hospital, dental, vision and prescription drug), if you are not actively at work in Covered Employment on the date your benefits would otherwise begin (other than for reasons of illness or injury), the effective date for benefits will be deferred until the first date you are actively at work in Covered Employment. If you are not actively at work due to illness or injury, the effective date for benefits will not be deferred.

Family Members

"Family member" means you (the active Participant) and, depending on the Plan of benefits under which you are covered, the following dependents (the accompanying Summary of Benefits Insert identifies who is a covered family member under your program of benefits):

- Your lawful spouse with whom you have the same principal address, unless, if at least one spouse resides in a jurisdiction that recognizes legal separations, you are legally separated under the laws of that jurisdiction, or if both spouses reside in jurisdictions that do not recognize legal separations, you and your spouse have entered into a separation agreement or other similar agreement. If you and your spouse have been divorced by bed and board, your spouse's eligibility ends on the effective date of the divorce from bed and board. Individuals in a "common law" arrangement are not considered legal spouses under the Plan.
- Your natural child, legally adopted child, or a child placed in your home for adoption, step-child or foster child, until the end of the month in which each child reaches age 26.

- A child considered by the Board of Trustees to be an "alternative recipient" under the terms of a Qualified Medical Child Support Order (QMCSO). Federal law requires group health plans (including the Fund) to provide coverage to an eligible dependent pursuant to a Qualified Medical Child Support Order (QMCSO) (as described in the "Qualified Medical Child Support Order" section on page 39).
- A child older than age 26 if he/she was a covered dependent and became disabled before age 26, lives with you on a full-time basis and is dependent on you for support. Extended coverage for a disabled child will continue only while your coverage is in force and the child remains unmarried and physically or mentally incapable of self-support. To be eligible for extended coverage, the Fund Office must receive proof of the child's disability, satisfactory to the Board of Trustees, at least 60 days before the child's 26th birthday. You must provide such proof by December 31 of each year of the child's continued disability. Failure to do so will cause your child's benefit to terminate when the child reaches age 26.

Dependent Verification

For dependent coverage to be effective, you are required to provide:

For your spouse:

- Marriage certificate
- Proof of your spouse's residence, and
- Your spouse's Social Security number.

For each of your dependent children:

- Proof of your relationship to that person, including:
  - Birth certificate for a biological child (must include names of both parents), or
  - Adoption papers for an adopted child, or
  - Marriage certificate and birth certificate for a step-child, and
- Your child's mailing address and Social Security number.

In addition to providing this documentation when you enroll, you may periodically be required to provide certain documentation to prove your dependents still qualify for coverage under the Plan. If you do not provide the required documentation within the time period required by the Fund, the Fund reserves the right to terminate your dependents' coverage.

You can send the documents:

By fax to: (856) 793- 3100

By regular mail to: UFCW Local 152 Health & Welfare Fund Office
27 Roland Avenue, Suite 100
Mt Laurel, NJ 08054

Change in Family Status or Your Address

You must provide prompt, written notice to the Fund Office of any change in your family status, such as marriage, birth or adoption of a child, death of a family member, divorce or separation.

In addition, if you move, always advise the Fund Office of your new address. Failure to report such changes may result in a delay or denial of your claims or adversely affect other Plan benefits you would otherwise be entitled to receive.

Notifying your employer or the Union of such changes does not guarantee that the Fund will be advised of any changes. You must notify the Fund directly.

It is your responsibility to notify the Fund Office when a dependent no longer meets the Plan's eligibility requirements. If you fail to do so and the Plan pays benefits, you will be required to reimburse the Plan for any benefits paid erroneously.

WHEN COVERAGE ENDS

For You

You are covered under the Plan until the earlier of the following dates:

- The date you stop actively working for a contributing employer, unless you elect to continue your coverage under COBRA
- The date you cease to qualify for COBRA
- The date Plan coverage terminates
- The date your employer is no longer a contributing employer to the Fund
- The date on which you are not working in a job classification for which contributions are required to be made to the Fund, or
- If your employer is delinquent in its contributions to the Fund in accordance with the Fund's Collection Policy.

However, if you are absent from Covered Employment due to illness or injury, or if you are on an approved leave of absence under the New Jersey Family Leave Act (or under the Federal Family and Medical Leave Act outside of New Jersey), your coverage will end on the earlier of: (1) 90 days following your departure from active employment, or (2) the date you fail to return to work following the end of your approved leave. If you return to work after an approved leave of absence, coverage will start again on the first day of the month after you return.

For Your Dependents

Your dependents' coverage normally ends when your coverage ends. Coverage for dependents will also end on the earliest of:

- The date your dependent no longer qualifies as your dependent, unless they elect to continue coverage under COBRA
- The date your dependent ceases to qualify for COBRA
- The date you are no longer eligible to cover your dependent, i.e., you move from full-time to part-time employment, or
- The date dependent coverage is discontinued under the Plan for all Participants.

When coverage ends for either you or your covered dependents, you may be eligible to extend coverage at your own expense through COBRA as described on page 31.

HOW TO ENROLL

To be eligible for benefits from the Fund, you must first complete an enrollment form, which is available from the Fund Office. Be sure to fill in all of the required information and return it to the Fund Office promptly. Otherwise, the date your benefits start may be delayed.

When you enroll, you will receive identification cards to present to providers when you receive services.

HIPAA Special Enrollment Rights

Once you become eligible for coverage, your benefits will not start until you return a properly completed enrollment form. If your CBA allows you to waive coverage, you must complete a form permanently waiving your enrollment in Fund coverage. If you complete a waiver, you will never be allowed to enroll in Fund coverage, unless you have a special enrollment right and properly enroll within the timeframes described below.

If:	You must enroll within:
You, your spouse or your child loses eligibility for coverage under another plan that was covering you, your spouse or your child You acquire a new dependent through marriage, birth or adoption (but only for your new dependent)	30 days of the date on which coverage is lost or the date on which your new dependent is acquired

If:	You must enroll within:
You or a dependent: • Loses eligibility for coverage under the Children's Health Insurance Program (CHIP) or Medicaid • Becomes eligible for premium assistance under the State's Children's Health Insurance Program (CHIP) or Medicaid	60 days of the date on which you or a dependent lost coverage under CHIP/Medicaid or became eligible for premium assistance

In addition to providing the Fund with a properly completed enrollment card, you must also provide proof satisfactory to the Board of Trustees of the reason for the special enrollment. For example, if you lost other coverage, you must provide documentation showing the date on which your other coverage terminated. If you seek to enroll a new spouse, you must provide the Fund with a copy of your marriage certificate and proof of your spouse's residence.

CLAIMS AND APPEALS PROCEDURES

This section and the Summary of Benefits Insert describe the procedures for filing claims for Plan benefits, the procedure to follow if your claim is denied in whole or in part and you wish to appeal this decision to deny a claim. The procedures to file a claim and/or appeal a denied claim are similar for all of the Plan's benefits, however, there may be important differences. Therefore, it is important that you follow the specific claims and appeals procedures for a particular benefit very carefully.

If a particular benefit does not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply. If you have any questions about which set of claims and appeals procedures you should follow or any other questions about making a claim, contact the Plan Administrator.

For purposes of the Plan's default claims and appeals procedures, the Plan Administrator (or any third party the Plan Administrator has authorized to review and evaluate claims, such as a claims processor) is referred to as the "Claims Administrator" for an initial claim and the "Appeals Administrator" for claim appeals.

Remember, coverage is not provided for:

- Conditions related to motor vehicle accidents. However, if you can provide acceptable proof to the Board of Trustees that you are not required by law to have motor vehicle insurance, eligible claim expenses will be subrogated.
- Conditions related to occupational injuries or disease. The only exception is the life insurance benefit, which may be payable to your beneficiary regardless of the cause of death, consistent with the provisions of the insurance policy.

Claims for Benefits

To file a claim for benefits you or your authorized representative must follow the Plan's claim filing guidelines. Generally, claims must be in writing (except urgent care claims, which may be made orally) and submitted to the Claims Administrator. Any claim that does not relate to a specific Plan benefit (for example, a general eligibility claim) must be filed with the Plan Administrator. When you use an in-network provider, the provider will generally submit the claim for you on your behalf.

How to File Claims

Generally, all claims should be submitted as soon as possible, but not later than December 31 of the year following the year the service was provided.

- For ***Inpatient Hospital Benefits***
  - Present your UFCW Local 152 Health & Welfare Fund group health identification card to the Admissions Office of the hospital. A claim form is not required.
- For ***Outpatient X-rays and/or Diagnostic Services***
  - If you follow the procedure outlined in the Summary of Benefits Insert, a claim form is not required.
- For ***All Other Covered Medical Expenses***
  - Present your UFCW Local 152 Health & Welfare Fund group health identification card. A claim form is not required.
- For ***Dental Services***
  - If you receive services from an in-network provider, present your dental identification card. A claim form is not required.
  - If you use an out-of-network provider, submit an itemized bill directly to the dental network administrator identified in your Summary of Benefits Insert.
- For ***Vision Benefits***
  - A vision claim form is not required.
- For ***Hearing Aids***
  - Complete the medical claim form and submit it directly to the Fund Office for processing.
- For ***Weekly Disability Benefits***
  - Complete the disability claim form, which is available from, and should be returned to, the Fund Office. Keep in mind that if you provide inaccurate or incomplete information, it will delay the processing of your claim. You must file your claim within 30 days of the onset of the disability (within 30 days from your discharge from a hospital). Failure to timely file a claim will result in denial of your disability claim.
- For ***Legal Services***
  - You must use a participating attorney to be eligible for benefits. No claim form is required.

- For ***Life and AD&D Insurance***
  - You, or your beneficiary in case of your death, must complete the Employee section of the claim form and attach an original copy of the medical report plus the police report (if an accident) or the certified death certificate (in case of death). Claims must be filed with the Fund Office within 90 days of the date of death or dismemberment.

Important Claims Information

The delay in processing dental and disability claims is generally due to Participants' failure to use the proper claim form or submitting incomplete or inaccurate information. Please carefully follow the instructions.

Have your doctor provide an itemized bill listing the diagnosis, date of each treatment, service performed and the charge for each treatment if filing their bill electronically with your UFCW Local 152 Group Health Plan carrier or a dentist filing a bill with your dental plan provider.

The following are not considered claims for benefits:

- Inquiries about Plan provisions or eligibility rules that are unrelated to any specific benefits claims
- A request for prior approval of a benefit that does not require prior approval by the Fund.

Authorized Representatives

You may appoint an authorized representative to take action on your behalf, such as completing claim forms. To do so, you must notify the appropriate claims-processing entity and the Fund Office in writing of the representative's name, address and telephone number and authorize the release of information (which may include medical information) to your representative. You may be required to provide additional information to verify that your representative is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim without your having to complete an authorization form. You may only assign your rights under ERISA to a provider, such as your right to receive Plan documents, to the extent such rights relate directly to the particular claim or appeal involving that provider.

Reviewing Claims

In making decisions on claims and appeals, the appropriate claims-processing entity will apply the terms of the Plan and any applicable guidelines, rules and schedules. The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending on 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.

For Claims for Non-health Benefits

In the case of a claim for non-health benefits (e.g., Life, AD&D, Disability, etc.), you, your beneficiary or authorized representative must file an initial claim for Plan benefits in writing to the proper claims processor identified on page 10 and 14.

You will receive a response within 90 days (45 days for a claim involving disability benefits) after receipt of the claim. For claims other than claims involving disability benefits, if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim. In the case of a claim involving disability benefits, the Claims Administrator will notify you within the initial 45-day period that the Claims Administrator needs up to an additional 30 days to review your claim. If the Claims Administrator determines that additional time is necessary to review your claim for disability benefits, the Claims Administrator may notify you of an additional 30-day extension.

For Claims Involving Health Benefits

There are several different types of health benefit claims that you may bring under the Plan, as described below. The procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend on the particular type of claim.

Pre-service Claims

A Pre-service Claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the approval of benefits before you receive the medical care. You will be notified of a decision on your Pre-service Claim (whether approved or denied) within 15 days of the receipt of a properly completed claim form, unless additional time is needed. The time for response may be extended for up to an additional 15 days if necessary, due to matters beyond the control of the appropriate claims processing entity. You will receive written notification of such extension before the end of the initial 15-day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which a decision is expected to be made.

If you improperly file a Pre-service Claim, you will be notified within 5 days after receipt of the claim of the proper procedures to re-file the claim. If the claim is not properly re-filed, it will not constitute a claim. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given 45 days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly re-file the claim, your claim will be decided based on the information available. During this 45-day period, the deadline for making a decision on your claim will be suspended from the date of the extension notice for either 45 days or until the date on which your response is received, whichever is earlier. The appropriate claims processing entity will then have 15 days to make a decision on your Pre-service Claim and notify you of its determination.

Urgent Care Claims

An Urgent Care Claim is a Pre-service Claim that requires shortened time periods for making a determination because the longer time periods for making Non-urgent Care determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If your Urgent Care Claim is filed improperly, you will be notified of the problem (either orally or in writing, unless you request it in writing) within 24 hours of the date you filed the claim. You will be notified of the decision on your Urgent Care Claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the Plan.

If more information is needed to decide your Urgent Care Claim, you will be notified of the specific information necessary to complete the claim within 24 hours after receipt of the claim by the appropriate claims processing entity. You will then have up to 48 hours to provide the requested information. You will be notified of the decision within 48 hours after the earlier of:

- The Fund's receipt of the specified information, or if earlier
- The end of the period you were given to provide the specified information.

Concurrent Care Claim

A Concurrent Care Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. An example of a Concurrent Care Claim is an inpatient hospital stay that was initially certified for 5 days and is reviewed at 3-day intervals to determine if additional days are appropriate. In this case, the decision to reduce, end or extend treatment is being made while treatment is taking place.

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

Post-service Claims

A Post-service Claim is any claim submitted for payment after health services and treatment have already been obtained. If your Post-service Claim is denied, in whole or in part, you will be notified of the claim denial within 30 days after the claim is received. The period for a decision may be extended for up to 15 additional days due to matters beyond the control of the appropriate claims processing entity, provided you receive advance written notice of such extension before the initial 30-day period expires. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which a decision is expected to be made.

If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given 45 days from receipt of the notice to provide the requested information. If you do not provide the information requested, your claim will be decided based on the information available. During this 45-day period, the deadline for making a decision on your claim will be suspended for either 45 days or until the date on which your response is received, whichever is earlier.

Claims Denial Notification

You will be provided with a written notice of any denial of a claim (whether denied in whole or in part), which will include the following information:

- The claim involved (including the date of service, the provider involved, if applicable, and the claim amount)
- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning
- The specific reason(s) for the denial
- A reference to the specific Plan provision(s) on which the denial was based
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request
- If the denial of your claim was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request
- A description of any additional material or information necessary to support the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures (including voluntary appeals, if any) and external review process and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review, and any applicable statute of limitations and forum selection
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims (keep in mind that for Urgent Care Claims, you may first be notified over the phone or in person, with written notification to follow).

As part of the Fund's internal claims and appeals review process, you have the right to review your claim file and to present evidence and testimony in support of your claim and appeal. You will be provided,

free of charge, with any new or additional evidence considered, relied upon, or generated by or at the direction of the Fund, the Board of Trustees, or the Fund's other applicable claims processing entities.

Claims and Appeals Procedures for Disability Claims

This subsection sets forth the claims procedures for disability benefits (not provided under an insurance contract, by a state, or when determined by the Social Security Disability Administration) that are provided by the Plan. Claims for disability benefits shall be filed in accordance with the procedures established for this purpose and on forms available from the Fund Office upon request.

A claim for disability benefits shall be decided within a reasonable period of time following the Plan's receipt of the claim, but not later than 45 days after receipt. The initial 45-day period to consider a disability claim may be initially extended for up to an additional 30 days and then for up to an additional 30 days after the initial extension if, in each case, the extension is necessary due to matters outside the control of the Fund. Written or electronic notice of an extension shall be provided to the claimant before the end of the applicable prior period. Said notice shall describe or explain (i) the circumstances requiring the extension, (ii) the date by which the Fund expects to decide the claim, (iii) the standards on which entitlement to the benefit is based, (iv) the unresolved issues that prevent a decision on the claim, and (v) any additional information needed to resolve said issues.

If the reason for extending a period to decide a claim for disability benefits is due to the claimant's failure to submit information necessary to decide the claim, the claimant shall be so notified and shall be provided with at least a 45-day period to provide the material or information. In such a case, the period to decide said claim shall be put on hold, and a decision on the claim shall be made no later than 30 days after the earlier of (i) the date the claimant responds to the request for additional information, or (ii) the date the period to submit the additional information ends.

The Board of Trustees does not make any decision regarding hiring, compensation, termination, promotion, or other similar matters with respect to any Fund Office personnel based upon the likelihood that the individual will support the denial of benefits.

In the event a claim for disability benefits is wholly or partially denied:

- Written or electronic notice of the denial shall be provided to the claimant in a culturally and linguistically appropriate manner by the date established above
- The denial notice shall set forth (i) the specific reasons for the denial, (ii) specific references to the pertinent provisions of the Plan, (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why it is necessary, (iv) an explanation of the procedures for review of the denied claim, including the applicable time limits, (v) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents relevant to the claim for benefits and (vi) a statement of the claimant's right to bring a civil action under ERISA following an adverse determination upon review.
- If applicable, the denial notice shall also include (i) any internal rule, guideline, protocol or other similar criterion relied on for the denial, or a statement that it was relied on and a copy will be provided free of charge upon the claimant's request, (ii) if the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the plan terms to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant's request, and (iii) a discussion of the decision that includes an explanation of the basis for disagreeing with or not

following (a) the views presented by the claimant to the Fund of health care professionals treating the claimant and vocational professionals who evaluated the claimant, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the determination, and (c) a disability determination regarding the claimant presented by the claimant to the Fund made by the Social Security Administration.

A claimant may appeal a denial of disability benefits to the Board of Trustees for review. Such appeal shall be made in writing no later than 180 days of the date of the denial and should be sent to the Fund Office. An appeal shall set forth all of the reasons the claim should not have been denied and shall identify and include all of the issues related to the claim for benefits. A claimant shall be entitled to review all relevant documents and to receive copies free of charge and to submit written documents, records and other information related to the claim and have the same taken into account whether or not previously submitted or considered.

If an appeal of a denial of disability benefits is timely filed, the Board of Trustees shall conduct a full and fair review of the claim and provide written or electronic notice of its decision on review to the claimant as follows:

- The review shall take into account all comments, documents, records and other information submitted by the claimant, whether or not submitted or considered in the denial of the benefit.
- The review shall not afford any deference to the initial benefit determination, and it shall not be made by the individual who made the initial benefit determination or by a subordinate of that individual.
- If the initial benefit determination was based on a medical judgment, the determination shall be made after consultation with a health care professional who has appropriate training and experience in the relevant field of medicine. Said health care professional shall not be an individual who was consulted with respect to the initial benefit determination or a subordinate of that individual.
- It shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied on in making the determination.
- Before the Board of Trustees can make an adverse determination on appeal, the Fund will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund or other person making the benefit determination in connection with the claim. This evidence must be provided as soon as possible and sufficiently in advance of the date on which notice of an adverse determination on review is required and the claimant must be given a reasonable opportunity to respond prior to that date.
- Before the Board of Trustees can make an adverse determination on appeal that is based on a new or additional rationale (that was not relied upon when the claim was initially denied), the Board of Trustees shall provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of an adverse determination on review is required and the claimant must be given a reasonable opportunity to respond.
- An appeal will be determined by the Board of Trustees at its next regular meeting after it is received, unless the appeal is received within 30 days of the next regular meeting. In such a case, the Board of

Trustees will determine the appeal no later than the date of the second meeting following receipt of the appeal. If special circumstances require a further extension, the Board of Trustees shall determine the appeal no later than the third meeting following receipt of the appeal. If such an extension is required, the claimant will be notified in writing of the extension and the special circumstances necessitating the extension. The claimant will also be told at that time the date on which the appeal will be determined.

Claimants will be notified by the Board of Trustees of its determination on appeal within 5 days of the meeting at which the Board of Trustees made its determination. If the decision on the review of an appeal of a denied claim for disability benefits is adverse:

- The notice of the decision shall set forth, in a culturally and linguistically appropriate manner, (i) the specific reasons for the decision, (ii) specific references to the pertinent provisions of the Plan, (iii) a statement that you are entitled to review all relevant documents and to receive copies free of charge, and (iv) a statement of your right to bring a civil action under ERISA and a description of any applicable contractual limitations period that applies to your right to bring a civil action, including the calendar date on which the contractual limitations period expires for the claim.
- If applicable, the notice of decision shall also include (i) any internal rule, guideline, protocol or other similar criterion relied on for the decision, or a statement that was relied on and a copy will be provided free of charge upon your request, and (ii) if the decision was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision, applying the Plan terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request.
- If applicable, the notice of decision shall include an explanation of the basis for disagreeing with or not following (i) the views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the Fund made by the Social Security Administration.

Appealing a Denied Claim

If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an Urgent Care Claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. The Appeals Administrators are as follows:

- **For Medical/Hospital Claims**

  Horizon BCBS
  P.O. Box 1609
  Newark, NJ 07101-1609
  1-800-355-2583

- **For Dental Claims**

  The dental network administrator identified in your Summary of Benefits Insert

- **For Prescription Drug Claims**

  UFCW Local 152 Health & Welfare Fund
  27 Roland Avenue, Suite 100
  Mt Laurel, NJ 08054
  Telephone: (856) 793-2500 (TTY: 711)

- **For Vision Benefits**

  UFCW Local 152 Health & Welfare Fund
  27 Roland Avenue, Suite 100
  Mt Laurel, NJ 08054
  Telephone: (856) 793-2500 (TTY: 711)

If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

If your first level appeal is denied, you may file a second-level appeal with the Board of Trustees within 180 days after the date on which your first appeal is denied. This second-level of appeal is voluntary – you are not required to file an appeal with the Board of Trustees in order to be eligible to file a lawsuit under ERISA or to seek external review by an Independent Review Organization, as described below.

Any lawsuit filed against the Fund or its Board of Trustees must be brought in the federal district courts in the State of New Jersey and must be filed within 2 years of the date on which your first-level appeal is denied.

In support of your appeal, you have the right to:

- Present evidence and written testimony relating to your claim, including written comments, documents, records, and other information relating to your claim for benefits
- Upon request, obtain reasonable access to, and free copies of, all documents, records and other information relevant to your claim for benefits, and
- Review your claim file.

In making a decision on review, the reviewer will review and consider all comments, documents, records, and other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered during the initial claim determination. In reviewing your claim, the reviewer will not automatically presume that the initial decision was correct, but will independently review your appeal. If any new or additional evidence is considered in connection with your appeal, that evidence will be provided to you, free of charge, as soon as possible, and you will be given an opportunity to respond. Further, if the decision is based on a new or additional rationale, you will receive an explanation of the rationale, and you will be given an opportunity to respond before a final determination is made on 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 and Appropriate), the reviewer will consult with a health care 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 experts who provided advice on the initial claim.

In the case of an appeal of an Urgent Care Claim, the reviewer will notify you of the decision on your appeal within 72 hours after receipt of your appeal. In the case of an appeal of a Pre-service Claim or a Concurrent Care Claim, the reviewer will notify you of the decision regarding your first-level appeal within 15 days after receipt of your appeal. If you file a second level appeal to the Board of Trustees, or a committee of the Board of Trustees, you will be notified of the decision within 15 days of the date on which your appeal is received by the Fund. You may also be asked to voluntarily extend the period of time for the reviewer to make a decision on either level of your appeal.

For Post-service Claims, first-level appeals will be heard within 30 days after receipt of your appeal. If you are not satisfied with the decision and decide to file a second-level appeal to the Board of Trustees, the Board of Trustees will hear your appeal at its next regularly scheduled appeals committee meeting that is held at least 30 days after your appeal is received by the Fund. If special circumstances require an extension of the time for review by the Board of Trustees, you will be notified in writing of the circumstances requiring the extension and the date on which a decision is expected. In no event will a decision be made later than the third meeting after receipt of your appeal. The Board of Trustees will send you a written notice of their decision (whether approved or denied) within 5 days of the date on which the decision is made.

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. Please remember that you are not required to appeal a decision regarding your claim. However, you must exhaust your administrative remedies by timely filing a first-level appeal before you have the right to seek external review or file suit in federal court. Administrative remedies do not include the voluntary appeal to the Board of Trustees. You have a right to file suit in federal or state court under ERISA Section 502(a) on your claim for benefits. Failure to exhaust these administrative remedies will result in the loss of your right to file suit.

No consideration will be given in connection with any decision regarding the hiring, compensation, promotion, termination or other similar matters with respect to an individual or entity involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any Participant, whether or not such individual or entity is likely to support the denial of benefits to such Participant.

Notification of Appeal Denial

If your appeal is denied, you will be notified of the following:

- The claim involved (including the date of service, the provider, if applicable, and the claim amount)
- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered a request for external review)
- The specific reason or reasons for denial, including the standards used and a discussion of the decision
- Reference to specific Plan provisions on which the denial is based

- If an internal rule, guideline, protocol or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge upon request
- If the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits, and
- A statement of your right to seek external review and to bring a civil action under ERISA Section 502(a) following a denial of your appeal and any applicable statute of limitations or forum selection.

External Review of Denied Claims

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

A request for external review must be filed within 4 months after you receive notice of the denial of your appeal (or if earlier, by the first day of the fifth month after receipt of the decision on your appeal). Requests for external review are filed with the Fund Office.

Preliminary Review. Within 5 business days of receiving your request for an external review, the Fund will complete a preliminary review of your request to determine whether it is eligible for external review (e.g., whether you have exhausted the Fund's claims and appeals procedures and provided all the necessary information).

Within one business day after the preliminary review is completed, you will be notified whether the claim is eligible for external review, except that to the extent required by law, the preliminary review may be referred to an IRO to determine whether the claim involves medical judgment. If your external review request is complete but your claim is not eligible for external review, you will receive a notice stating the reason(s) it is not eligible, and you will receive contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to make your request complete. You may submit additional required information within the original 4-month filing period or within the 48-hour period following your receipt of the decision regarding your eligibility for external review, whichever is later.

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

You are permitted to submit in writing to the assigned IRO, within 10 business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days. If you choose to submit such information, within one business day, the assigned IRO will forward the information to the Fund. Upon receipt of any such information, your claim that is subject to external review may be reconsidered. Reconsideration will not delay the external review. The external review may be terminated as a result of the

reconsideration only if the Board of Trustees decides, upon completion of its reconsideration, to reverse its denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

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

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

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

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

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

Expedited External Review of Denied Claims

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if the claimant has not yet been discharged from the facility. You may request an expedited external review at the same time an appeal is submitted.

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

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

GENERAL PLAN INFORMATION

Medicare

Medicare is a health insurance plan for individuals:

- Age 65 or older, whether they are retired or continue working, or
- Who are disabled and have received Social Security disability benefits for 24 months, have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), or have permanent kidney failure.

Medicare has the following parts:

- Original Medicare – made up of hospital insurance (Part A) and medical insurance (Part B)
- Medicare Advantage plans (Part C) which are available in many areas (which you can elect instead of Parts A and B, if available)
- Prescription drug coverage (Part D).

Your Coverage Options if You Continue Working After Age 65

If you continue as an Employee after age 65, you can choose to:

- Keep this Plan as your primary coverage with Medicare as your secondary coverage. In this case, all claims should be submitted to this Plan first; Medicare will then consider any remaining expenses.
- Elect Medicare as your only coverage. In this case, you must notify the Fund Office and sign any documents required by the Fund to waive coverage, if permitted by your CBA/MOA. Once you complete the necessary forms, coverage under this Plan stops for you and your covered dependents regardless of their age. If you elect this option, you will not be able to get back into this Plan in the future. Your claims should be submitted to Medicare.
- Choose this Plan as your only coverage. In this case, all claims should be submitted to this Plan.

Subrogation and Third-Party Reimbursement

The Fund does not cover any expenses that are related to an injury or illness for which a third party is responsible. The Fund also does not cover any expenses for which other non-group medical benefits (including automobile insurance), or medical expense type coverage, is available. However, since recovery from third parties is often time consuming, as a service to you, the Fund will pay claims for which a third party is responsible under the following terms and conditions.

You and/or your dependent are required to notify the Fund within 10 days of any accident or injury for which someone else may be liable. Further, the Fund must be notified within 10 days of the initiation of any lawsuit or settlement negotiations relating to the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the Fund's claims.

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

Also, if you or your dependent receives any benefit payments from the Fund for any injury or illness, the Fund is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery that has accrued, may accrue or which is asserted in connection with such injury or illness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such injury or illness in your or your dependent's name and also has a right to intervene in any such action brought by you or your dependent, including any action against an insurance carrier 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 illness, and regardless of whether you and/or your dependent actually receive the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recoveries in connection with the injury or illness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. This recovery includes amounts payable under your or your dependent's own uninsured motorist insurance, under insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the Fund's rights of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery.

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

Consistent with the Fund's rights set forth in this section, if you or your dependent submits claims for or receives any benefit payments from the Fund for an illness or injury that may give rise to any claim against any third party, you and/or your dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" ("Subrogation Agreement") affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Subrogation Agreement must also be executed by your or your dependent's attorney, if applicable.

Alternatively, if you or your dependent or a representative of you or your dependent (including your or your dependent's attorney) fail or refuse to execute the required Subrogation Agreement and the Fund nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute your or your dependent's agreement to the Fund's right to subrogation or reimbursement from any payment amount and/or recovery received by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your dependent's agreement to a constructive trust, lien and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your dependent recovers from a third party.

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

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

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

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

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

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

If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Board of 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.

Overpayment of Benefits

If the Fund pays benefits in error, such as when the Fund pays for benefits to which you or your dependent is not entitled, or if the Fund advances benefits that you or your dependent is required to reimburse because, for example, you have received a third-party recovery (see the Section titled "Subrogation and Third-party Reimbursement"), you are required to reimburse the Fund in full and the Fund shall be entitled to recover any such benefits.

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

Any refusal by you or your dependent to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

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

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Board of 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.

Coordination of Benefits

The coordination of benefits provision applies when you or your dependent is covered under more than one plan. It is designed so that reimbursement from the Fund and the other plan will not be more than 100% of the expense you or your dependent incurs.

Other plans include:

- Group blanket or franchise insurance coverage
- Hospital service prepayment plan, medical service prepayment plan or group practice plan
- Any coverage under a labor-management trusteed plan, union welfare plan, employer organization or employee benefit organization plan
- Any coverage under governmental programs to the extent permitted by law, and any coverage required or provided by any statute
- Automobile insurance, including but not limited to "no-fault" or personal injury protection insurance
- Any personal insurance
- Any plan considered an "excess" plan
- Any other group health plan or individual plan, including those purchased through the Health Insurance Marketplace
- Medical payments available through a homeowner's insurance policy.

If you or your dependent incurs a covered expense that is covered by this Plan and another plan, the primary plan will pay benefits first, then the secondary plan will pay its benefits, if any are to be paid – up to 100% of the covered charges.

Determining which plan is primary and which is secondary is based on the following rules for coordination with another group health plan or individual plan.

- If the other plan does not have a coordination of benefits provision, it pays benefits first.
- If the other plan providing benefits for a family member does not have a standard COB provision, the following rules will apply for determining which plan pays its benefits first (primary carrier). The plan determined to pay second (secondary carrier) shall not be obligated to provide benefits until the primary carrier has provided its benefits.
  - The plan covering the patient as a subscriber/Participant (Employee) is always the primary plan. However, in the event the patient is covered as a subscriber/Participant (Employee) under two different plans, one providing coverage as a full-time subscriber/Participant (Employee) and another providing coverage as a part-time subscriber/Participant (Employee), the plan providing the full-time coverage shall be primary.
- When both plans have a coordination of benefits provision:
  - The plan covering the person as an Employee is primary and will pay benefits first. The plan covering the person as an inactive Participant (such as a retired or laid-off individual or as a spouse) will pay benefits second.

    Caution: If your dependent elects not to receive treatment or did not follow the rules for receiving treatment under the other plan, this Plan will only provide secondary coverage on those charges that would have remained unpaid if the primary carrier had covered its usual charges.
  - If the dependent of a Participant is entitled to insurance coverage that would duplicate coverage available from this Plan at no cost to the dependent, or if the dependent receives financial remuneration of any kind for declining such coverage, benefits shall be payable from this Plan as if the dependent had elected to receive such coverage.

    Note #1: When both a husband and wife are covered by this Plan as eligible Participants, Plan deductibles and copayments will be waived. This will also apply to any Participant or eligible dependent who has primary coverage elsewhere. Benefits will be determined based upon Fund allowances and under the Coordination of Benefits provision of this Plan.
  - If a dependent child is covered by both parents' plans, the plan of the parent whose birthday occurs earlier in the calendar year is primary (regardless of the year of birth) – provided both plans have this birthday rule.

- If the parents are divorced or separated:
  - The plan of the parent with custody pays first; the plan of the parent without custody pays second, or
  - If the parent with custody has remarried, the plan of the parent with custody pays first; the plan of the stepparent pays second; and the plan of the parent without custody pays third, or
  - If parents have joint custody and neither parent is designated as responsible for health care expenses, the birthday rule applies
  - If there is a court decree that specifies which parent is responsible for a child's health care expenses, that parent's plan will pay first. This does not apply to any claim for benefits paid or provided before the other insurer has actual knowledge of the court decree
- If payment responsibility is still unresolved, the first plan to make payment is the one covering the individual the longest. The Plan covering the patient the second longest pays benefits second, and so on.

- If you or your dependent is covered by Medicare or Medicaid, special rules apply. Contact the Fund Office for additional information.
- If the other plan is a reimbursement type of program or through automobile insurance, homeowner's insurance or other similar policy, this Plan will automatically pay benefits second.

If this Plan is the primary payer, it will pay benefits as if there was no other coverage. If this Plan is the secondary payer, it will pay the difference between the covered expense and the amount paid by the other plan but in no case more than this Plan would have paid had it been the only coverage.

Moving Between Other Health Benefit Plans Sponsored by UFCW Local Union 152

If your employment ends with an employer that contributes to another health benefit fund sponsored by UFCW Local 152, and, within 90 days (unless your CBA or MOA specifies otherwise) you begin working for an employer that contributes to this Fund, your coverage with this Fund will become effective on the first day of the month following the date you are hired by a contributing employer to this Fund.

To maintain continuous coverage during the period in which you move between benefit funds, you should consider electing to continue your coverage under COBRA with the other fund.

Rescission of Health Coverage

The Plan reserves the right to terminate health coverage for you and your dependents prospectively without notice for cause (as determined by the Plan Administrator), or if you and/or your dependents are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your dependents commit fraud or intentional misrepresentation in connection with your health coverage under the Plan, which includes your failure to provide the Fund with any necessary information (e.g., the occurrence of a divorce or separation), the Fund may terminate your coverage retroactively.

Continuity of Coverage

Coverage ceases on the last day of the benefit month in which you or your covered dependent's eligibility terminates. However, if you or your covered dependent is receiving covered inpatient care at the time eligibility terminates, Hospital and Professional benefits, if available, will continue for that confinement.

Extension of Benefits

The CBA or MOA governing your participation in the Plan provides information about whether and for how long benefits may continue if you have a break in employment as a result of lay-off, sickness, disability or worker's compensation.

Suspension of Benefits

If your employer is late in making its required contributions on your behalf, your benefits may be suspended. Specifically, if your employer is delinquent in its contributions to the Fund on your behalf for at least 90 days, your coverage will be suspended until all amounts owed to the Fund are paid. This means that the Fund will not pay any claims submitted by you or on your behalf until all amounts owed to the Fund on your behalf are paid. You will be notified by the Fund if your benefits are being suspended.

Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that the Fund provide you with the right to elect continued health coverage for up to 24 months if you are absent from employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

Coverage Under USERRA. If you are absent from employment because of service in the uniformed services, you can elect to continue coverage for your eligible dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage available under USERRA begins on the date on which your absence begins and ends on the earlier of:

- The end of the 24-month period beginning on the date on which the absence begins, or
- The day after the date on which you are required to, but fail to, apply under USERRA for or return to a position of employment for which contributions must be made to the Fund.

This right to temporarily continue coverage from the Fund does not include the right to receive any life insurance or other similar non-health benefits provided under the Fund. In addition to the right to continued coverage under USERRA, you and your dependents also may have rights to elect continuation coverage under COBRA, if they experience a qualifying event, as described beginning on page 31.

Notice and Election of USERRA Coverage. If you wish to elect USERRA coverage, you must notify the Fund Office of your absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. In addition, your election to receive USERRA coverage must be received within 60 days of the last day of Covered Employment; otherwise, you lose your right to continue your coverage under USERRA.

Paying for USERRA Coverage. You may be required to pay all or a portion of the cost of coverage. If the period of military service is less than 31 days, coverage under the Plan will continue as if you were still working in Covered Employment. If the military service extends more than 31 days, you must pay 102% of the cost of the coverage unless the employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the cost for COBRA continuation coverage. You should contact the Fund for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if you had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If you timely elect and pay for USERRA coverage, coverage will be provided retroactive to the date of your departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If you fail to pay the full payment by each due date (or within the 30-day grace period), you will lose all USERRA coverage and such continuation coverage cannot be reinstated.

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

When you return to Covered Employment after receiving an honorable discharge within the time periods required by law, you will be eligible to continue your coverage from the Fund.

Family and Medical Leave (FMLA)

The Family and Medical Leave Act ("FMLA") of 1993 allows you to take unpaid leave for up to 12 weeks during any 12-month period due to:

- The birth or adoption of a child or the placement of a child with you for adoption
- To provide care for a lawful spouse, child or parent who is seriously ill
- Your serious illness, or
- A qualifying exigency that arises in connection with the active military service of your child, spouse or parent. A qualifying exigency includes (a) notification of military deployment within 7 days of the deployment date, (b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings, (c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings, (d) making financial and legal

arrangements, (e) attending counseling sessions, (f) up to 5 days of rest and recuperation, (g) attendance at post-deployment activities.

You may also be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in military service.

During FMLA leave, you can continue your coverage under this Plan provided your contributing employer properly notifies the Fund and makes the required payments.

General Notice of COBRA Continuation Coverage Rights

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to continue their health coverage for limited periods of time under certain circumstances on a self-pay basis. "Health coverage" includes medical, mental health, dental, prescription drug and vision coverage.

You do not need to prove that you are in good health to elect COBRA coverage, but you do need to meet the eligibility requirements and you must apply for the coverage. The Fund can terminate your COBRA coverage retroactively if you are determined to be ineligible for COBRA. The chart beginning on page 31 shows when you and your eligible dependents may qualify for COBRA and how long coverage may continue.

To qualify for COBRA continuation coverage, you must have a "Qualifying Event" that would otherwise end your coverage. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Only qualified beneficiaries may elect to continue their group health plan coverage. A qualified beneficiary is someone who loses coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, a Participant and the covered dependents of Participants may be qualified beneficiaries. (Certain newborns, newly-adopted children and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries.)

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for coverage.

FMLA Leave. If you do not return to Covered Employment after your FMLA leave of absence, you become eligible for COBRA coverage as a result of your termination of employment. For the purposes of determining your eligibility for COBRA, your employment is considered terminated at the end of your FMLA leave, or the date that you notify your employer that you will not be returning to Covered Employment.

If you marry, have a newborn child or have a child placed with you for adoption while you are covered under COBRA, you may enroll that spouse or dependent child for coverage for the balance of your COBRA continuation period, on the same terms available to active Employees. The same rules about dependent status and qualifying changes in family status that apply to active Employees will apply to you and/or your dependent(s).

Notification to the Fund. The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred, as shown in the following chart.

Who is a qualified beneficiary?	What is a qualifying event?	Who must notify the Fund Office of the event?
You if you are a Participant and lose Plan coverage because	■ Your hours of employment are reduced	The employer within 30 days of the event
	■ Your employment terminates	The employer within 30 days of the event
	■ You retire	The employer within 30 days of the event
A spouse of a Participant who loses Plan coverage because	■ The Participant dies	The employer within 30 days of the event
	■ The Participant's hours of employment are reduced	The employer within 30 days of the event
	■ The Participant's employment terminates	The employer within 30 days of the event
	■ The Participant becomes entitled to Medicare	The Participant within 60 days of the event
	■ The Participant and spouse are divorced or legally separated	The Participant within 60 days of the event

Who is a qualified beneficiary?	What is a qualifying event?	Who must notify the Fund Office of the event?
A dependent child* of a Participant who loses Plan coverage because	■ The parent-Participant dies	The employer within 30 days of the event
	■ The parent-Participant's hours of employment are reduced	The employer within 30 days of the event
	■ The parent-Participant's employment terminates	The employer within 30 days of the event
	■ The parent-Participant becomes entitled to Medicare	The Participant within 60 days of the event
	■ The parents are divorced or legally separated	The Participant within 60 days of the event
	■ The child no longer meets the eligibility requirements	The Participant within 60 days of the event
*Children who are born to or placed for adoption with a covered Participant during the period of the Participant's continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. Once the newborn or adopted child is enrolled in continuation coverage, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).		

The notification to the Fund Office must be in writing and must include the name and address of the Employee or qualified beneficiary, the Participant's Social Security number, the type and date of the qualifying event and proof of the qualifying event. For example, if the qualifying event is divorce or legal separation, you must submit a copy of the divorce decree or written proof of the legal separation.

Within 14 days after the Fund Office receives notice of a qualifying event, they will send a COBRA Notice and Election Form to each qualified beneficiary. The notice will identify the options available, their costs and the conditions that will cause continuation coverage to end.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

To elect continuation coverage, you or your dependent must complete and return the Election Form to the Fund Office within 60 days after you receive the COBRA Notice and Election Form. You must pay the first premium retroactive to the date coverage terminated, within 45 days after you return the Election Form.

If you or a dependent qualifies for COBRA continuation coverage and you waive your right to coverage during the election period, you or your dependent may later elect COBRA coverage as long as you do so within 60 days of the Qualifying Event.

Paying for Coverage

As provided by law, you and/or your dependents must pay the full premium cost of coverage plus 2% for administrative expenses for the full 18- or 36-month period. In cases of extended continuation coverage due to disability, the cost for months 19 to 29 is 150% of the full premium cost for the coverage.

The premium due date for subsequent premiums is the first day of the month. For example, premiums for the month of November must be paid on or before November 1st. Failure to pay the full premium by each due date (or within the 30-day grace period thereafter) will result in a loss of all coverage. A payment will be considered timely if it is postmarked no later than the due date.

The Fund will **not** notify you and/or your dependents that a premium payment is due or late. If you do not make payment by the due date, the Fund will notify you or your dependent that coverage for you and your dependents has terminated.

Duration of Coverage

The following chart shows the qualifying events and the periods of eligibility for COBRA continuation coverage.

Qualifying COBRA Events		
If you lose coverage because:	**These people would be eligible:**	**For COBRA coverage for up to:**
Your employment terminates for reasons other than gross misconduct	You and your eligible dependents	18 months
Your working hours are reduced	You and your eligible dependents	18 months
You are determined to be disabled by the Social Security Administration	You and your eligible dependents	29 months
You die	Your dependents	36 months

Qualifying COBRA Events		
If you lose coverage because:	**These people would be eligible:**	**For COBRA coverage for up to:**
You divorce or legally separate	Your dependents	36 months
Your dependent children no longer qualify as dependents	Your dependent children	36 months
You become entitled to Medicare benefits	Your dependents	36 months

Coverage through COBRA will end before the maximum period shown above on the date indicated below if any of the following events occur:

- The date Plan coverage terminates
- The date a required premium is due and unpaid after the applicable grace period expires
- The date you and/or your dependents become covered under another group health plan
- The date you or your eligible dependent first becomes eligible for Medicare
- If coverage has been extended for up to 29 months due to disability and there has been a final Social Security Administration determination that the individual is no longer disabled, coverage will end as of the month that begins more than 30 days after the date of the SSA final determination
- The date your employer no longer provides coverage under the Plan for its Employees.

Once COBRA coverage terminates, it cannot be reinstated unless otherwise permitted by law.

If the qualifying event is the end of your employment or reduction in your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for your qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Extension of 18-month COBRA Coverage Period for a Disability

If you or any enrolled dependent is determined by the Social Security Administration to be disabled for Social Security disability purposes before the 60th day of COBRA continuation coverage, you may continue coverage for up to an additional 11 months (for a total maximum of 29 months), from the original qualifying event date. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month extension.

You must inform the Fund Office of your disability in writing within 60 days of the date of the Social Security Administration's disability determination letter.

The notice must be in writing and must include the name and address of the Employee or qualified beneficiary, the Participant's Social Security number, the type and date of the qualifying event and proof of the second qualifying event. In addition, you must notify the Fund Office in writing before the end of the 18-month continuation period. If you do not notify the Fund Office within the timeframes stated above, you will not qualify for this extension.

Address Changes

To protect your family's rights, you should keep the Fund Office informed of any changes in address for you and any of your eligible family members. You also should keep a copy of any notices you send to the Fund Office.

Financial Responsibility for Failure to Give Notice

If you fail to give proper notice within 60 days of the date of the qualifying event for which you are responsible to give notice (see above), or if your employer fails to give notice within 30 days of the qualifying event for which the employer is required to give notice (see above), and, as a result, the Fund pays a claim on behalf of you or your dependents whose coverage terminated due to a qualifying event and who does not elect continuation coverage under this provision retroactive to the date coverage should have ended, then you or your employer, as appropriate, shall be obligated to reimburse the Fund for any claims that should not have been paid. If you fail to reimburse the Fund after being requested to do so, the Fund reserves the right to deduct the unpaid amount from other benefits payable on behalf of you or your dependents in the future.

If your employer fails to give proper notice within 30 days of the qualifying event and, as a result, you are permitted to elect, but do not elect COBRA coverage within 90 days after the date of the qualifying event, both the Participant and employer will be jointly responsible to reimburse the Fund for all claims paid on behalf of you and/or your dependents.

In addition, you must notify the Fund Office immediately if you or any of your dependents become covered by any other plan of group health benefits whether through employment or otherwise. The Fund must be repaid for any claims paid in error as a result of failure to notify the Fund Office of any other health coverage.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Federal privacy regulations to protect personal medical information went into effect on April 14, 2003 and were amended effective September 23, 2013 by the Health Information Technology for Economic and Clinical Health Act (HITECH). These privacy rules set limits on how health plans, pharmacies, hospitals, clinics, nursing homes and other direct-care providers (called covered providers) use individually identifiable health information.

This overview of HIPAA is intended to help you understand your rights and protection of personal information related to your health. Please review it carefully.

Key provisions of these privacy standards include:

- **Access to Medical Records** – HIPAA gives you the ability to review and obtain copies of your medical records. If your medical records are maintained electronically, you may request access to your electronic medical records, if that format is readily producible. Otherwise, the covered provider must provide the requested information in an electronic format that you can read on your computer (e.g., Word, Excel, etc.) You may also request corrections if you have identified any errors. Covered providers generally should provide access to your records within 30 days of your request and may charge for the cost of copying and sending the records to you.
- **Notice of Privacy Practices** – Covered providers will provide you with a HIPAA notice advising you of your rights. You may be asked to sign, initial or otherwise acknowledge that you have received this notice. You may also ask to restrict the use or disclosure of your information beyond the practices included in the notice, but the covered providers would not have to agree to the changes.
- **Limits on Use of Personal Medical Information** – The privacy rule sets limits on how covered providers may use your identifiable health information. These limits do not restrict the ability of health care professionals to share any medical information needed for treatment. They do restrict its use for purposes not related to health care. Covered providers may use or share only the minimum amount of protected information needed for a particular purpose. In no case will a covered provider use or disclose your personal medical information which is genetic information for underwriting purposes. You must provide written authorization for the following medical information to be disclosed:
  - Psychotherapy notes if maintained by the plan.
  - Personal medical information for marketing purposes. For example, your written authorization will be required for the covered provider to share your medical information to promote health care products or services, alternative treatments, or provide appointment or treatment reminders. Your written authorization will not be required for prescription refill reminders, general health and wellness communications or communications about government or government-sponsored programs, such as eligibility for Medicare or Medicaid.

- Disclosures that constitute a sale of your personal medical information. A sale means that the covered entity receives direct or indirect remuneration in exchange for personal medical information. Your authorization is not required if remuneration for personal medical information is required to perform activities or provide service, such as research or for the services provided by the health information exchange.
- Personal health information released to a life insurer, a bank, a marketing firm or another outside business for purposes not related to your health care.

- **Stronger State Laws** – The federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; any state law providing additional protections would continue to apply. When a state law requires a certain disclosure – such as reporting an infectious disease outbreak to the public health authorities – the federal privacy regulations would not preempt the state law.
- **Confidential Communications** – Under the privacy rule, you can request that your doctors, health plans and other covered providers take reasonable steps to ensure that their communications with you are confidential. For example, you could ask your doctor to call you at work rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.
- **Complaints** – You may file a formal complaint regarding The Local 152 Health & Welfare Fund's privacy practices to:

  HIPAA Privacy Official
  UFCW Local 152 Health & Welfare Fund Office
  27 Roland Avenue, Suite 100
  Mt. Laurel, NJ 08054
  (856) 293-2500 or (800) 555-4959

  Complaints may also be made in writing to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation.

  If there is a breach of your unsecured personal medical information, you will be notified promptly.

For More Information – You can find additional HIPAA information on the Internet at **www.hhs.gov/ocr/hipaa** or by calling (866) 627-7748. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at (866) 444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at (800) 633-4227 (ask for Protecting Your Health Insurance Coverage). These publications and other useful information are also available on the Internet at: **www.dol.gov/ebsa** the DOL's interactive Web pages – Health elaws.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act prohibits discrimination in health coverage and employment based on genetic information. GINA, together with provisions of HIPAA, generally prohibits health insurers or health plan administrators from requesting or requiring genetic information of an individual or an individual's family members, or using this information for decisions regarding coverage, rates, or preexisting conditions. GINA also prohibits employers from using genetic information for hiring, firing, or promotion decisions, and for any decisions regarding terms of employment.

Qualified Medical Child Support Orders

Benefits under this Plan are not assignable to anyone other than a health care provider, except as required by law. Benefits are also not subject to the claims of a creditor and cannot be assigned by legal process except under a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order issued by a state court or agency that requires an Employee to provide medical coverage under a group health plan to a child who is a dependent of the Participant, but has not been enrolled in coverage. A QMCSO usually results from a divorce or legal separation. Whenever the Fund receives a QMCSO, it will be reviewed in accordance with the Fund's QMCSO Procedures and federal law. To obtain a copy of the Fund's QMCSO Procedures, please contact the Fund Office.

Fraud

The Board of Trustees reserves the right to cancel or rescind fund coverage for any Participant or dependent, who willfully and knowingly engages in any activity intended to defraud the Plan, to the maximum extent permitted by applicable law. Failure to follow the terms of the Plan, such as failing to notify the Fund of a change in dependent status, accepting benefits after your eligibility ends or failing to notify the Fund of other coverage in which you or your dependent is enrolled, will be considered fraud and the Fund will seek reimbursement from you.

PLAN ADMINISTRATION AND LEGAL INFORMATION

Edition Date	This Summary Plan Description describes the benefits in effect as of November 1, 2018
Plan Name	UFCW Local 152 Health & Welfare Fund
Plan Sponsor	Board of Trustees of the Fund
Employer Identification Number (Plan Sponsor)	21-0681336
Plan Number	501
Type of Plan	Welfare plan

Plan Year	January 1 through December 31
Contract Administrative Manager	Tri-State Administrators UFCW Local 152 Health & Welfare Fund 27 Roland Avenue, Suite 100 Mt. Laurel, NJ 08054 Phone: (856) 793-2500 or (800) 555-4959
Plan Trustees	The Plan Trustees are shown in your Summary of Benefits Insert.
Agent for Service of Legal Process	UFCW Local 152 Health & Welfare Fund Office 27 Roland Avenue, Suite 100 Mt. Laurel, NJ 08054 (856) 793-2500 or (800) 555-4959 Fax: (856) 793- 3100 In addition, service of legal process may also be made on any Fund Trustee.
Type of Plan Administration	The Plan offers self-insured medical, hospital, prescription drug, vision and disability benefits. The Fund also offers insured life insurance, dental and legal benefits.
Financing of the Plan	The Fund is financed by employers that have a CBA or MOA with UFCW Local 152, UFCW Local 27 and UFCW Local 1262 that requires contributions to be made to the Fund. All Plan assets are held in trust by the Board of Trustees for the benefit of Participants and beneficiaries of the Fund. The Board of Trustees has the ultimate responsibility for the management of Fund assets and may from time to time utilize the services of investment managers to invest Fund assets. Fund assets must be used only for the benefit of its Participants and beneficiaries. Upon termination of the Fund, the Board of Trustees shall apply the monies of the Fund to provide benefits or otherwise carry out the purposes of the Fund in an equitable manner until the entire remainder of its assets have been distributed. The total liability for the payment of all uninsured benefits as provided herein shall be limited to the assets of the Fund.
Collective Bargaining Agreements/Memorandums of Agreement	This Fund is maintained in accordance with collective bargaining agreements or memorandums of agreement. You may obtain a copy of the agreement that applies to you by making a written request to the Union Office.

Participating Employers	Upon written request to the Fund Office, you may ask whether a particular employer participates in the Plan. If so, you may also request the employer's address.
Plan Benefits Provided By	UFCW Local 152 Health & Welfare Fund

Plan Amendment or Termination

The Board of Trustees of the Fund is authorized at any time and on such basis as it, in its sole discretion, deems appropriate, to amend, modify, add to or eliminate any provision or benefit from the Fund. The Board of Trustees reserves the right to terminate the Plan at any time for any reason.

YOUR RIGHTS UNDER ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

Review Information About Your Plans and Benefits

- Examine, without charge, at the Plan Administrator's or Union office and at other specified locations, such as worksites, all documents governing the Plans, including CBAs or MOAs, and a copy of the latest annual report (Form 5500 Series) filed by the Plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents are available upon written request to the Plan Administrator.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plans, including copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plans' annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Continuation of Coverage section for 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 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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial and have a right to obtain without charge copies of documents relating to the decision. You also have the right to have the Board of Trustees review and reconsider your claim, as described in the "Appealing a Denied Claim" section on page 17.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 Plan Administrator. After exhausting your appeal rights, you may file suit in a state or federal court if you have a claim for benefits that is denied or ignored, in whole or in part. After exhausting your appeal rights, you may file suit in federal court if you disagree with the Plan's decision.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about these Plans, 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 area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA, including COBRA, HIPAA, and other laws affecting group health plans by visiting the U.S. Department of Labor's EBSA website at **www.dol.gov/ebsa** or call their toll-free number at (866) 444-3272. For more information about the health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov**.

HEALTH PLANS AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

For some Participants (as indicated in the Summary of Benefits Insert), the Plan is not considered grandfathered under the Patient Protection and Affordable Care Act (ACA). This means that there are certain ACA-related provisions that apply to the Plan. These include (but are not limited to):

- Mandated limits on out-of-pocket maximums for in-network benefits that prevent you from incurring excessive costs
- 100% coverage for many preventive care services.

If you have any questions about the Plan, you should contact the Fund Office at (856) 793-2500 or (800) 555-4959.

In some cases, as noted in your Summary of Benefits Insert, the Plan is grandfathered. In that case, the out-of-pocket maximums and any preventive care services are as described in the Summary of Benefits Insert.

Affordable Care Act Notice of Nondiscrimination

The Board of Trustees of the UFCW Local 152 Health & Welfare Fund are obligated under the ACA to send this Notice to you.

The above Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages.

If you need these services, contact the Fund Office.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex you can file a grievance with:

UFCW Local 152 Health & Welfare Fund
27 Roland Avenue, Suite 100
Mt. Laurel, New Jersey 08054
Telephone Number: (856) 793-2500 (TTY: 711)
Fax Number: (856) 793- 3100

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, call the Fund Office for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 522-4161.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 522-4161.

Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele

(800) 522-4161.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 522-4161.

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 522-4161.

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 522-4161 번으로 전화해 주십시오.

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم(800)-522-4161

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 522-4161.

Italiano (Italian)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 522-4161.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 522-4161.

Polski (Polish)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 522-4161.

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (800) 522-4161.

(Gujarati)

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (800) 522-4161.

اُردُو (Urdu)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (800) 522-4161.

אידיש (Yiddish)

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט-

(800) 522-4161.

(Bengali)

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন

(800)522-4161.

ABOUT YOUR BENEFITS INTRODUCTION

The Fund provides coverage for certain:

- Hospital and medical expenses
- Prescription drug expenses
- Dental expenses
- Vision and hearing expenses
- Legal expenses.

It also provides financial assistance to you in case of disability and to you or your beneficiary in case of your death or dismemberment.

GLOSSARY OF KEY TERMS

Accidental Bodily Injury – An injury that results from an external, violent and unforeseen event.

Acute Care Hospital – See definition of hospital.

Amicus Curiae – A friend of the court, not a party to a lawsuit, who volunteers assistance to the court on matters of law.

Applicable Law – The provisions of federal law that apply to the benefits described in this book and the Summary of Benefits Insert.

Attorney – Any person licensed to practice law in the jurisdiction in which he/she practices and employed by the legal service provider under contract to the Fund.

Beneficiary – The person or persons you name to receive any life insurance payments payable on your behalf following your death. You may name anyone as your beneficiary and can change your choice at any time and for any reason in the manner required by the Fund or its life insurance carrier. Your primary beneficiary is the individual who will receive your death benefit if you die. Your contingent beneficiary receives your death benefit if your primary beneficiary dies before receiving benefits. If you name more than one primary or contingent beneficiary, they will share the benefit equally, unless you designate otherwise.

Calendar Year – January 1 through December 31 of the same year.

Charge(s) – The allowable covered charges up to the maximum amounts described in this SPD.

Claim Date – The specific date of service which is used to determine eligibility for a particular benefit. Please refer to each specific benefit in this booklet to determine which date would apply.

Collective Bargaining Agreement and Memorandum of Agreement – The CBA or MOA in force and in effect from time to time between the UFCW Local 152, UFCW Local 27 and UFCW Local 1262 and an employer and which obligates the employer to make contributions to the Fund on behalf of its Employees covered by the CBA or MOA.

Contested Divorce – Any suit for divorce in which any marital issue (support, visitation, custody, equitable distribution of property, etc.) is contested.

Contributions – Payments received by the Fund from an employer on behalf of the Employee for work performed pursuant to the terms of a CBA or MOA or pursuant to the terms of a Participation Agreement between the Board of Trustees and the employer.

Covered Employment – An Employee's employment with a participating employer for which contributions are required to be made to the Fund.

Covered Expenses – Charges agreed to by In-network providers for a service or supply provided to an eligible family member as a result of treatment and care of a non-occupational accidental injury or sickness upon the recommendation of a Physician. Covered expenses are specifically listed as a covered service or supply in this book or the accompanying Summary of Benefits Insert and not specifically excluded as a covered service or supply. For services with an out-of-network provider, the Fund will cover charges incurred only in the event of an emergency and only up the maximum amount required by law.

Deductible – The amount that a Participant must pay out of pocket each calendar year for those benefits that have a deductible before the Plan will begin coverage. If 2 or more eligible family members are injured in a common accident, only one deductible must be satisfied for all expenses resulting from that accident. Deductible amounts are never reimbursed by the Plan.

Defendant – The person sued in an action; the party against whom relief or recovery is sought in a lawsuit.

Divorce – See contested divorce.

Doctor/Physician – A legally qualified Physician or surgeon who is a Doctor of Medicine (MD), or a Doctor of Osteopathy (DO), and who is licensed to practice medicine and surgery in all its branches. A dentist (DDS), podiatrist (DPM), chiropractor (DC), optometrist (OD), psychologist (PhD), nurse practitioner (NP) or advanced practice nurse (APN) will be considered a doctor under this Plan only for services performed within the scope of each such individual's specialty and license and within the provisions and limitations of the Plan. A Doctor/Physician does not include any services rendered by a family member or close relative.

Donor – An individual who donates an organ or organs to a Participant or eligible dependent.

Emergency – Sudden and unexpected medical condition with acute and/or severe symptoms.

Employee – An active full-time Employee of an employer, whose employment terms and conditions are subject to a CBA or MOA for which contributions to the Fund are required.

Experimental or Investigational – Any treatment, procedure, facility, equipment, drug, device or supply which fails to meet any one of the following tests:

- It is approved by the appropriate federal agency and has been in use for the purpose defined in that approval or proven to the Plan's satisfaction to be the standard of care. (Drugs, biological products, devices and any other product or procedure must have final approval to market from the FDA or any other federal government body with authority to regulate it.) Keep in mind that this approval does not automatically mean the Plan will consider it Medically Necessary and Appropriate.

  Note: The Plan will evaluate a prescription drug for uses other than those approved by the FDA if the drug is recognized to be Medically Necessary and Appropriate for the condition for which it has

been prescribed by the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information.

- There must be sufficient proof (i.e., well-designed and well-documented investigations), published in peer-reviewed scientific literature, that confirms its effectiveness.
- It must result in measurable improvement in health outcomes and the therapeutic benefits must outweigh the risks, as shown in scientific studies.
- It must be safe and effective as any established modality.
- It must demonstrate effectiveness when applied outside of the investigative research setting.

Fund – The UFCW Local 152 Health & Welfare Fund, the Trust Fund created pursuant to the Agreement and Declaration of Trust.

Fund Office – The office maintained by the Board of Trustees of the UFCW Local 152 Health & Welfare Fund. It is located at 27 Roland Avenue, Suite 100, Mt. Laurel, NJ 08054. The phone number is (856) 793-2500 or (800) 555-4959.

Generic Drug – A prescription drug that contains the same active ingredients as the equivalent brand-name drug but typically costs less.

Home Health Agency – A provider that mainly provides care for an ill or injured person in the person's home under a home health care program designed to eliminate hospital stays. The Plan will recognize an agency if it is:

- Licensed by the state in which it operates, or
- Certified to take part in Medicare as a Home Health Agency.

Home Health Care – Nursing and other home health care services rendered to a covered person in his/her home provided:

- The care is given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short-term basis
- Continuing hospitalization would be needed in the absence of home health care
- The care is furnished under a Physician's order and under a plan of care that is:
  - Established by that Physician and the home health care provider, and
  - Periodically reviewed and approved by the Physician.

Home Health Care Plan – A program certified by the attending Physician to be necessary in lieu of confinement in a Hospital. The plan must:

- Provide continued care and treatment
- Be established and approved in writing by the attending Physician.

Home Health Care Services – Any of the following services to the extent they would be covered if the person was a Hospital inpatient:

- Nursing care

- Physical, occupational or speech therapy
- Medical social work
- Nutritional services
- Medical appliances and equipment
- Drugs and medicines
- Lab services
- Special meals
- Diagnostic and therapeutic services (including surgical services) performed in a Hospital's outpatient department, doctor's office or other licensed health care facility.

Hospice – A provider that mainly provides palliative and supportive care for terminally ill or injured people under a hospice care program. A hospice must comply with all state and local laws governing hospices and it either is:

- Approved as a hospice by Medicare, or
- Accredited as a hospice by the Joint Commission or the National Hospice Organization.

Hospice Care Program – A health care program coordinated through an interdisciplinary team directed by a Physician for the terminally ill.

Hospital – An institution, which:

- Under the supervision of Physicians, is primarily engaged in providing inpatient diagnostic and therapeutic services for medical diagnosis, treatment and care or inpatient rehabilitation of injured, disabled or sick persons
- Maintains clinical records for all patients
- Has by-laws in effect with respect to its staff of Physicians
- Provides 24-hour nursing services by or under the supervision of a registered professional nurse
- Has a hospitalization review plan in effect
- Is licensed by the State and municipality in which it operates
- Is accredited by the Joint Commission or approved as a Hospital by Medicare.

Unless specifically provided, the term "Hospital" does not include any institution, or part of one, which is used primarily as a convalescent home, a rest or nursing facility, an infirmary, a hospice, substance abuse center or facility (or part of one) that mainly provides domiciliary or custodial care, educational care, non-medical or ineligible services or supplies, rehabilitative care, or a facility for care of the aged.

The Plan will pay benefits for covered expenses and supplies incurred at hospitals operated by the US government only if:

- The services or supplies are for treatment on an Emergency basis, or
- The services or supplies are provided in a Hospital located outside of the US or Puerto Rico.

Illness – A bodily sickness, disorder, disease or pregnancy. Coverage for pregnancy is for Employees and covered spouses only. Pregnancy coverage is not provided for dependent children.

Inpatient – An individual who, while confined in a covered facility, is assigned to a bed in any department of the institution other than its outpatient department and for whom a charge (as defined) for room and board is made.

Instituted – The commencement of any legal proceedings, and specifically as to civil and criminal matters:

- Civil Matters -- The time legal process is served
- Criminal Matters -- The time of the first to occur:
  - Actual arrest, or
  - Issuance of a warrant for arrest.

Legend Drugs – Drugs, biologicals and compounded prescriptions which, by Federal law, can be dispensed only pursuant to a prescription, and are required to bear the legend, "Caution: Federal law prohibits dispensing without a prescription."

Medically Necessary and Appropriate – Generally recognized in the medical profession as effective and essential for treatment of the injury or illness for which care is ordered and provided at the appropriate level of care in the most appropriate setting based on the diagnosis. To be considered medically necessary the care must be based on generally recognized and accepted standards of medical practice in the United States and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care. A service, treatment, supply or confinement is not considered medically necessary if it is experimental or is primarily for scholastic, educational, vocational or developmental training or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his or her family or caretaker.

Any expense that is not medically necessary will not be considered an eligible expense under the Plan and will not be eligible for reimbursement. The Board of Trustees reserves the right to review medical care and to determine whether or not the service, treatment, supply or confinement is medically necessary. The Board of Trustees may rely on an independent reviewer to help make that determination. The fact that a Physician or any other health care provider orders or recommends a service, treatment, supply or confinement does not, in and of itself, make it medically necessary.

Member – A Participant.

Mental or Nervous Disorder – A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Observation Status – An outpatient service that does not require authorization or a physical "stay" in an observation unit and does not apply to ER observation of less than 6 hours. Observation services that result in an admission are subject to utilization management review for medical necessity.

Out-of-pocket Expense – Amounts you are required to pay personally for a covered expense, which are not reimbursed by the Plan.

Participant – An eligible Employee who meets the eligibility requirements to receive benefits from the Fund.

Pharmacist – A person licensed by the state to practice as a pharmacist and who regularly practices such profession in a pharmacy.

Pharmacy – An establishment that is registered as a pharmacy with the appropriate state licensing agency and in which prescription drugs are regularly compounded and dispensed by a pharmacist. Benefits are payable only in connection with participating in-network pharmacies, except as described herein.

Plan – The plan of benefits offered by the UFCW Local 152 Health & Welfare Fund as described in this booklet.

Practitioner (or Provider) – A person who:

- Is properly licensed or certified to provide medical or other care under the laws of the state in which he/she practices
- Provides medical or other services within the scope of his/her license and are covered services under the Plan.

Practitioners include, but are not limited to, Physicians, chiropractors, dentists, optometrists, pharmacists, chiropodists, psychologists, physical therapists, audiologists, speech language pathologists, certified nurse midwives, registered professional nurses, nurse practitioners and clinical nurse specialists.

Prescription – A written (or where permitted by law an oral) order of a Physician for Legend Drugs, provided the order is within the scope of such prescriber's license.

Prescription Order – The request for drugs issued by a prescriber duly licensed to make such a request in the ordinary course of his/her professional practice.

Rehabilitation Hospital – A facility that mainly provides therapeutic and restorative services to sick or injured people. The Plan will recognize it if it is either:

- Accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities, or
- Approved for its stated purpose by Medicare.

Residential Facility – A facility licensed, certified or approved for treatment of alcoholism or chemical dependence by the state in which it is located, and which is accredited by the JHAC. (A halfway house is not considered a residential facility).

Respondent – The party called upon to answer an appeal, petition, or bill in a proceeding in equity.

Spouse - Your lawful spouse with whom you have the same principal address, unless, if at least one spouse resides in a jurisdiction that recognizes legal separations, you are legally separated under the laws of that jurisdiction, or if both spouses reside in jurisdictions that do not recognize legal separations, you and your spouse have entered into a separation agreement or other similar agreement. If you and your spouse have been divorced by bed and board, your spouse's eligibility ends on the effective date of the divorce from bed and board. Individuals in a "common law" arrangement are not considered legal spouses under the Plan.

Surgical Center – An ambulatory care facility licensed by the state to provide same-day surgical services. In addition:

- Patients must be admitted and discharged within a 24-hour period, and
- Coverage will be limited to the same covered services that are considered covered outpatient hospital services under this Plan.

Trust Agreement – The amended agreement and declaration of trust establishing the UFCW Local 152 Health & Welfare Fund, and its rules of operation.

Totally Disabled, Total Disability – Any disability resulting from bodily injuries or disease occurring after the date that an Employee becomes a Participant, and that prevents the Participant from engaging in his occupation or employment for wage or profit.

Union – United Food and Commercial Workers (UFCW) Locals 152. 27 and 1262.

Urgent Care – Medical care or treatment of a Participant or eligible dependent for which the time periods for making non-urgent care determinations: (a) could seriously jeopardize the Participant's or dependent's life, health or ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Participant's or dependent's medical condition, would subject the Participant or dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Work Period – The month in which contributions are made on behalf of an Employee.

HEALTH CARE BENEFITS

Exclusive Provider Organization (EPO)

Each time you need health care, you have the freedom to choose the provider or facility you prefer. Keep in mind, however, that generally, no benefits are provided if you use a provider that does not participate in the EPO network.

EPO providers include Hospitals, Physicians and other providers who offer medical and hospital services at special negotiated rates, which saves you and the Fund money. Providers who participate in these networks are referred to in this SPD as preferred providers or in-network providers.

With some limited exceptions that are described in this booklet, because benefits are payable only if you use in-network providers, if an in-network doctor refers you to another doctor, it is your responsibility to check to see if that doctor is also an in-network provider. If they are not, you will be responsible for paying all charges you incur. An in-network provider has no obligation to refer you to another in-network provider.

Any payments you make to out-of-network providers WILL NOT be considered for reimbursement under the Plan, except to the extent required by law.

You can contact Horizon Blue Cross Blue Shield to obtain an EPO Directory or if you have a question as to whether a particular provider is an in-network provider.

Opportunity to Select a Primary Care Physician

The Plan does not require you to select a Primary Care Physician (PCP) or obtain a referral from a PCP to see a specialist. However, a PCP may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your dependents. If you choose to select a PCP, you and your dependents may each select a different PCP.

Pre-certification

Certain services, such as a non-emergency inpatient hospital stay and certain outpatient surgery require pre-certification. Pre-certification is a process that helps you and your Physician determine whether the services being recommended are covered expenses under the Plan. You or your Physician is responsible for obtaining pre-certification by calling the pre-certification number on your ID card for the following covered services. If a covered expense that requires pre-certification is not timely pre-certified, a penalty will apply as described in the chart below.

Covered services that require pre-certification:	Pre-certification is required:	Penalty for not timely obtaining pre-certification:
Emergency admissions to a hospital, rehabilitation facility, hospice care (basic medical benefit)	Within 72 hours after admission	Claims will be denied
Non-emergency admission to a hospital, rehabilitation facility, hospice care (basic medical benefit)	Prior to the admission	Claims will be denied
The outpatient surgical procedures listed on page 59 (basic medical benefit)	Prior to the procedure	Claims will be denied
Durable medical equipment rental (major medical benefit)	Before obtaining equipment	Claims will be denied
Professional services of an R.N. or an L.P.N. (major medical benefit)	Before obtaining services	Claims will be denied

WHAT THE PLAN COVERS

This section describes the expenses that are eligible for coverage under the Plan, subject to any applicable exclusions or limitations.

BASIC MEDICAL BENEFITS

Wellness Benefits

If you are eligible for wellness benefits, it will be indicated in your Summary of Benefits Insert.

Preventive Care

If you are eligible, the Plan covers a number of preventive care services if provided by an in-network Physician without any cost-sharing (copay, deductible, co-insurance) for you or your dependents. These services include annual physical exams and certain screenings, tests, vaccines, to the extent such services are included on the government's lists below, provided the services have been included on the list for at least one year prior to the Fund's Plan year. For example, if a preventive service was added to one of the lists in September 2017, it would be covered with no cost-sharing beginning January 1, 2019. The applicable lists are:

- Recommendations of the U.S. Preventive Services Task Force with a rating of A or B
- Recommended Immunizations of the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention, and
- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

You can access these lists at **www.healthcare.gov**.

To the extent a recommended preventive service is provided as part of a regular office visit with your provider, the applicable Out-of-pocket Expenses for office visits under the Plan will still apply to the extent permitted by law. However, you will not be responsible for any additional amounts with respect to any of the preventive services referenced in the lists above if you use an in-network provider.

Please note that the lists of preventive services include certain age, frequency, and other limitations that may affect your ability to receive coverage for the service without cost sharing. If you do not satisfy these limitations, you may incur Out-of-pocket Expenses.

If you have questions about whether a particular service is covered by an in-network provider with no cost-sharing, please contact the Fund Office at (856) 793-2500.

Well Child Care

If you are eligible, the Plan covers:

- An initial hospital check-up, following birth
- Office visits based on the guidelines supported by the Health Resources and Services Administration from birth to age 19 (at age 20, coverage is provided under Well Adult Care).

Covered office visit services include:

- Physical examination, developmental assessment, anticipatory guidance and lab tests ordered during a visit and performed in the office or at a laboratory
- The following immunizations
  - DPT (diphtheria, pertussis, tetanus)
  - Polio
  - MMR (Measles, Mumps, Rubella)
  - Hepatitis A and B
  - Herophilus
  - Pneumonia
  - Influenza

Well Adult Care

If you are eligible, the Plan covers well adult care for any member age 20 or older based on the guidelines supported by the Health Resources and Services Administration. Covered services include:

- Annual wellness visits and the following immunizations
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster (shingles) (beginning at age 50)
  - Human Papillomavirus
  - Measles, Mumps, Rubella (MMR)
  - Meningococcal conjugate (MCV4)
  - Revaccination with Pneumococcal Polysaccharide 23 (PPSV23) for adults age 65 and older
  - Tetanus and Diphtheria, Pertussis (Td/Tdap) booster
  - Varicella (chicken pox)
  - Annual influenza
- One routine mammography every year beginning at age 40
- Routine PAP test beginning at age 21
- Prostate cancer screening beginning at age 50; earlier if the covered person is at greater risk.

Limitations

The following services are not covered under this benefit:

- Services of a specialist to whom eligible family members may be referred as a result of receiving the above services
- Premarital exams, work-related injuries, legal cases and school physical exams or tests related to these exams
- Routine laboratory work or studies performed as part of follow-up medical care
- Any lab work or tests performed during a health evaluation which are not included in the health evaluation.

Physician Office Visits for Routine Physical Exams

If you are not eligible for Wellness Benefits, you may be eligible for benefits for Physician office visits for routine physical exams. Your Summary of Benefits Insert will indicate which of these benefits you are eligible to receive.

You and your eligible dependents age 16 or older may have a physical examination performed by an in-network Physician once every 12 months. There is no cost to you, other than any applicable copays, for the following services:

- Physical examination
- General metabolic panel
- Cholesterol panel
- PSA (age 45 and over)
- Urinalysis
- PAP smear
- EKG.

If you have a physical examination performed by an out-of-network Physician, it will not be covered and you will be responsible for paying 100% of the billed charges.

Limitations

The following services are not covered under this benefit:

- Services of a specialist to whom you or a family member is referred as a result of receiving the above services (coverage may be provided by major medical benefits)
- Premarital exams, work-related injuries, legal cases and school physical exams or tests related to these exams
- Routine laboratory work or studies performed as part of follow-up medical care (coverage may be provided by major medical benefits)
- Any lab work or tests performed during a health evaluation that are not included in the health evaluation.

X-ray and Laboratory (Diagnostic) Benefit

You can obtain diagnostic X-ray and laboratory services from an in-network provider.

Any maximum allowance under this benefit for all outpatient X-ray and laboratory expenses incurred in connection with the diagnosis of all illnesses and/or injuries during any one calendar year is shown in your Summary of Benefits Insert.

Limitations

No payments will be made under this benefit for:

- Laboratory tests or X-rays performed in connection with routine physical examinations or check-ups, (except the routine mammography screening, PAP smear and PSA test), but these tests may be covered under the preventive care benefit.
- Tests to determine if a dependent child is pregnant or any tests related to such pregnancy
- Any work-related condition
- Any condition related to an automobile accident.

Surgical Benefit

An in-network surgeon's charges for covered services will be covered, subject to the cost-sharing specified in your Summary of Benefits Insert. Charges by non-participating surgeons will be denied, except in the case of an Emergency, in which case the Fund will cover covered expenses up the amount that the Fund would have paid to an in-network provider for the same service, but in no event shall the amount paid by the Fund be less than the amount the Fund is required to pay under applicable federal law.

Assistant surgeon's charges are a covered expense subject to the same rules that apply to primary surgeons, but only if the use of an assistant surgeon is determined by the Fund to be Medically Necessary and Appropriate, and a qualified intern, resident or other in-house Physician is not available.

The ***Women's' Health and Cancer Rights Act*** requires plans that cover mastectomies (as this Plan does) to also cover:

- A hospital stay of at least 72 hours following a modified radical mastectomy and 48 hours following a simple mastectomy
- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Limitations

Benefits will not be provided under the Plan for surgery:

- Involving the transplant of a major body organ, unless specifically mentioned as covered in your Summary of Benefits Insert

- That is generally regarded as experimental in nature, as determined by the Fund
- Involved in the repair of complications resulting from plastic or cosmetic surgery
- That involves any type of cosmetic reconstruction, except for breast reconstruction following a mastectomy or to repair damage caused by an accidental injury
- Performed by an assistant surgeon unless it is determined that the use of an assistant surgeon is Medically Necessary and Appropriate, and a qualified intern, resident or other in-house Physician is not available. Such expense will be covered at 20% of the primary surgeon's allowance under major medical.

Maternity coverage is generally provided only for the Participant and spouse, except that the Fund will cover prenatal care for dependent children to the extent required by the preventative care rules under the Affordable Care Act. ***The Newborns and Mothers Health Protection Act of 1996*** requires that the Plan pay benefits for a Hospital stay in connection with childbirth for the mother and newborn child, for up to 48 hours following a normal vaginal delivery and for 96 hours following a Cesarean section. However, the Plan may cover a shorter stay if the attending provider, in consultation with the mother, decides on an earlier discharge from the Hospital.

Some examples of excluded surgery include: insertion of a penile prosthesis, radial keratotomy, Lasik eye surgery or other vision corrective surgery, reversal of voluntary sterilization, surgery related to obesity, including but not limited to gastric bypass, intestinal bypass, lipectomy, suction or any other surgery performed simply to remove fat tissue, reduction mammoplasty (breast reduction, unless Medically Necessary and Appropriate), augmentation mammoplasty (breast enlargement).

Hospital/Hospice Facility Benefits

(Pre-authorization Required)
Your Summary of Benefits Insert shows whether you and your eligible family members are entitled to Hospital/hospice facility benefits and, if eligible, the amounts the Plan will cover.

Inpatient Hospital Benefits

Inpatient Hospital benefits are for treatment of a non-work-related illness or injury, up to the Plan's limits, as described in the Summary of Benefits Insert. To be eligible for coverage, the charges must be consistent with the diagnosis and treatment.

If you are admitted to a Hospital as a result of an emergency, you are required to obtain pre-certification within 72 hours of the admission. Failure to do so will result in the denial of your claim. All other Hospital admissions must be pre-certified in advance of your admission. Please call the pre-certification number on your hospital identification card. Except in the case of an emergency, if you do not use an in-network facility, your benefits will be denied.

Covered Hospital expenses include:

- Semi-private room and board (if you use a private room, you must pay the difference in cost between the semi-private and private room rate)
- Miscellaneous charges for each day the Hospital charges for room and board, including:
  - Other Medically Necessary and Appropriate Hospital services and supplies

- Diagnostic laboratory and X-ray studies

- Nursery room and board charges for healthy newborn infants.

Note: Anesthesia and its administration are covered under the anesthesia benefit.

Successive periods of hospital confinement will be considered one continuous period of confinement:

- Unless the subsequent confinement is entirely unrelated to the prior confinement, or
- **In the case of a Participant**, the subsequent confinement commences after returning to active employment for at least 30 days, or the subsequent confinement commences more than 90 days after the end of the previous confinement, or
- **In the case of other family members**, the subsequent confinement commences more than 90 days after the end of the previous confinement.

Outpatient Hospital Benefits

Covered outpatient Hospital services include:

- Surgical operations performed in a Hospital outpatient department or in an outpatient surgical center (certain procedures require pre-certification, as described below)
- Emergency care and treatment of accidental bodily injury provided in a Hospital emergency room or in an emergency treatment center
- Diagnostic laboratory and X-ray studies
- Outpatient non-surgical treatment of an illness rendered in the emergency department of a Hospital
- Pre-admission testing for scheduled surgery
- Radiation therapy, chemotherapy, dialysis services when received in a Hospital.

Note: **If you use the emergency room for a non-emergency condition, your benefits will be reduced by 50%.** Examples of medical emergencies include convulsions, severe burns, obvious bone fracture, heart attack, stroke, wounds requiring sutures. If you have a true, life threatening emergency, do not hesitate to call 911 or go to the emergency room. Otherwise, it's best to get care at an urgent care facility or your doctor's office.

The following outpatient procedures require pre-certification. **If you or a covered family member does not obtain prior authorization, the Plan will not pay any benefits for the service performed.**

- Arthroscopy of knee
- Lithotripsy
- Computerize Tomography (CT Scans) of the
  - Abdomen
  - Brain/Head
  - Spine
- PET Scans
- Epidural injections (other than surgical)
- Reduction mammoplasty (breast reduction)
- Cardiac Catherization
- Septoplasty
- Magnetic Resonance Imaging (MRI) of the
  - Abdomen
  - Brain/Head
  - Chest
  - Joints (upper and lower extremities)
  - Spine
- Nuclear testing

Rehabilitation Hospital Inpatient Services

Subject to pre-certification requirements, inpatient admission to a rehabilitation hospital is covered if the patient is admitted within 14 days after an acute care hospital stay. The patient must be eligible on the date of admission and his/her condition must warrant confinement in a rehabilitation facility as determined by the Fund. Benefit amounts and coverage limitations are described in the Summary of Benefits Insert.

Hospice Care

Hospice care is typically delivered at home or in a homelike setting to persons in the final phase of a terminal illness (meaning the person has a life expectancy of 6 months or less). Hospice care does not postpone death, but affirms life, emphasizing quality, not length. Hospice empowers patients to live with dignity, alert and pain-free, while involving families and loved ones in giving care.

To qualify for coverage, the hospice care service must be:

- Pre-approved by the Fund
- Provided while the terminally ill person is eligible under the Plan
- Ordered by the supervising doctor or attending Physician
- Charged by the pre-approved hospice care program
- Provided within 6 months of the terminally ill patient's entry or reentry (after a remission period) in the hospice care program
- Furnished or arranged for by a hospice that is pre-approved by the Fund.

Hospice care includes the charges for the following services:

- Confinement in an inpatient hospice facility

- Home health care furnished to the patient in the patient's home. Covered charges for home health care are:
  - Professional services of a registered nurse, a licensed practical nurse, or a licensed vocational nurse for skilled intermittent visits
  - Services of a home health aide as outlined in the plan of care
  - Physical, occupational, speech, respiratory or rehabilitation therapy as related to the terminal diagnosis
  - Rental or purchase (but not repair or replacement) of durable medical equipment
  - Laboratory services, medical supplies, drugs and medicines prescribed by a Physician
  - Nutrition counseling
  - Medical social services furnished to the terminally ill patient or the family unit
  - Bereavement counseling for up to 12 months following the patient's date of death
  - Palliative care (medicative/treatment directed toward relief)
  - Respite care.

Hospital and Hospice Care Limitations

No coverage will be provided under this benefit for:

- Personal convenience items, such as, but not limited to, telephone, radio, television, cosmetics, guest trays, magazines, or beds or cots for other family members
- Professional services performed by anyone not an Employee of an approved home health care agency.

Note: Each day of confinement in a rehabilitation hospital or hospice facility will reduce your available acute care hospital days by one-half day.

Anesthesia Benefit

If you are entitled to this benefit, it will be noted in your Summary of Benefits Insert, along with the Plan allowance and maximum benefits.

Covered charges include the administration of general anesthesia (charges for local anesthesia are considered for payment under the major medical benefit) by:

- A Physician anesthesiologist who is not the operating Physician or his/her assistant
- A certified registered nurse anesthetist (CRNA) employed by a professional provider.

Limitations

- Any anesthesia expense in excess of the basic anesthesia allowance will not be considered for payment under the major medical benefit.
- In no event will the Fund accept a charge from both a Physician anesthetist and a CRNA. In such situations, the Fund will accept the fee of the individual actually administering the anesthesia.

Note: Epidural injections without an associated surgery may be covered under the major medical benefit.

Diabetes Education

The Summary of Benefits Insert shows whether you are entitled to this benefit as well as the benefit allowance.

It has been medically determined that treatment of diabetes can be greatly enhanced through proper diet and exercise. The Fund provides this benefit to encourage those afflicted with this condition to participate in an educational program that will enable them to change their lifestyle and benefit accordingly.

The Fund will allow up to the amount indicated in your Summary of Benefits Insert towards an approved program of diabetic educational classes.

Note: If you need help locating an approved diabetes educator, please go online at **www.horizonblue.com** or call Member Services at (800) 355-2583.

Limitations

- The diabetes education program must be prescribed by your Physician
- You must provide proof satisfactory to the Board of Trustees that you completed the program.

Hearing Aid Benefit

Your Summary of Benefits Insert will indicate whether you are eligible for the hearing aid benefit as well as the benefit allowance amount. The hearing aid benefit is paid only once every 5 years and is for hearing appliances only.

Limitations

- An ear, nose and throat (ENT) Physician must prescribe that the patient be seen by a licensed audiologist
- The hearing device must be recommended and inserted by a licensed audiologist
- Any charges incurred for hearing tests may be processed under the X-ray and laboratory benefit
- Any covered expenses that the hearing benefit does not pay ARE NOT considered for payment under the major medical benefit.

Organ Transplant Program

(Pre-approval Required)

Your Summary of Benefits Insert shows whether you are entitled to this benefit and also indicates the benefit allowance. **This benefit requires pre-approval by the Fund before receiving treatment.** To obtain pre-approval, call the number shown on your ID card.

Horizon Blue Cross Blue Shield has an arrangement with one of the largest hospital networks in the country. If you or an eligible family member needs an organ transplant (but only for an organ listed in the Summary of Benefits Insert) covered expenses under this benefit include transportation to a facility that specializes in performing the organ transplant as shown in the Summary of Benefits Insert.

Program Eligibility

In addition to the Fund's normal eligibility requirements, the patient must have been eligible under this Plan for at least 36 of the 48 months just prior to the month in which the surgery is performed.

The Plan provides coverage for the following organ transplants (including the donor's expenses regardless of the number of organs transplanted):

- Bone marrow
- Cornea
- Heart
- Heart/lung
- Kidney
- Liver
- Lung
- Pancreas.

Limitations

The benefit amounts paid for organ transplants are shown in your Summary of Benefits Insert and include all expenses associated with the transplant, subject to any existing limitations within the patient's plan (as described in your Summary of Benefits Insert). The benefit amounts include the donor's expenses. Donor's expenses are covered only if the recipient is a Participant or an eligible dependent in the Plan.

No benefits are paid for pre-transplant testing of potential donors.

Supplemental Accident Benefit

Your Summary of Benefits Insert will indicate whether you are entitled to this benefit and, if so, the benefit allowance. This benefit is available only if services are provided by an in-network provider.

If you or an eligible family member is injured in an accident and you exhaust your basic benefits for treatment of that injury, any remaining charges will be processed under this benefit. If any unpaid charges remain after you have exhausted the supplemental accident benefit, those claims may be submitted to major medical.

To be eligible for this benefit, the injured family member must receive treatment within 48 hours after the accident causing the injury.

Note: Some Participants are not eligible for this benefit. In that case, benefits for treatment of an accidental injury are covered under the Fund's major medical program. See your Summary of Benefits Insert for additional information.

Limitations

No benefits are payable under this benefit for items normally covered under the dental, prescription drug or vision care benefits or for prosthetic appliances.

MAJOR MEDICAL BENEFITS

Unless your Summary of Benefits Insert notes otherwise, this part of the Plan pays benefits for medical expenses prescribed by a Physician for an eligible family member, if those expenses exceed:

- Any payments made under basic medical benefits described in this book and the Summary of Benefits Insert, and
- The deductible and copayment described in the Summary of Benefits Insert.

The Deductible

The deductible is the amount you must pay for certain covered services before the Plan pays benefits for those expenses. You can find which expenses are subject to the deductible – and the amount of any deductible – in the Summary of Benefits Insert.

Covered Major Medical Expenses

The expenses listed below are covered under major medical, provided they are incurred while a family member is eligible for the major medical benefit, the services and supplies are determined by the Fund to be Medically Necessary and Appropriate and are recommended or approved by a Physician.

If any expenses are excluded or limited under basic medical benefits described in this book or the Summary of Benefits Insert or listed in the "General Exclusions" section of this book, those expenses will also be excluded or limited under the major medical benefit.

Covered major medical expenses include:

- Ambulance services, for emergency travel to the nearest Hospital.
- Anesthetics (local only) or epidural for pain management and their administration.
- Artificial limbs, eyes, breast prosthesis (except as provided under "Breast Reconstruction" see "Surgical Benefit"); *only the **initial*** purchase of any such item is covered.
- Blood and blood derivatives, which are not donated or replaced, but not storage of your own blood.
- Cardiac rehabilitation, if listed in your Summary of Benefits Insert.
- Drugs (including injectable drugs), medicines and supplies obtainable only with a prescription from a Physician, unless provided under the prescription drug benefit.
- Durable medical equipment (or rental up to the purchase price), provided you receive pre-certification prior to obtaining the equipment by calling the number on the back of your identification card.

  Note: EPO providers have made arrangements with companies that provide durable medical equipment at a reduced cost.
- Hospital room (semi-private), board and miscellaneous services and supplies are covered on the same basis as under your basic benefit, if applicable (benefits vary by plan).
- Orthotics and shoe inserts, up to a maximum of $250 per pair if prescribed by a podiatrist (limited to one pair per calendar year).
- Oxygen.

- Physician fees, which include a clinical psychologist, psychiatrist or certified licensed counselor for the treatment of mental/nervous conditions, chemical or substance abuse.
- Professional services of an R.N. or an L.P.N. (who is neither a member of the patient's household nor a close relative). You must obtain pre-approval from Horizon Blue Cross in advance of treatment by calling the number on the back of your identification card. Your Summary of Benefits Insert may include other limitations.
- Physiotherapist treatment, (who is neither a member of the patient's household nor a close relative) subject to the allowance stated in the Summary of Benefits Insert.

  Note: Recreational therapy, Hippotherapy and aqua therapy are not covered.
- Speech therapy by a qualified speech therapist, if required to correct a congenital anomaly. The patient must have had any necessary corrective surgery before the therapy will be covered.

  For eligible dependent children up to the age of 12 to qualify for speech therapy benefits, the following criteria must be met:

  - The child must have been evaluated by an ear, nose and throat specialist who recommended speech therapy for the child, and
  - The child must have been eligible for coverage under the Fund at the time of birth and when the therapy is performed.
  - There is a maximum of 30 follow-up treatments.
- Surgical dressings, braces, casts, splints and other devices used in the reduction of fractures and dislocations.
- Well Child Care (up to the age stated in your Summary of Benefits Insert, which will also indicate if you have this coverage) including routine office visits, immunizations and vaccines.
- X-ray and laboratory examinations, radiation and chemotherapy and treatment.

Limitations

- Air ambulance charges are limited to 7 times the charge for surface transportation.
- Behavioral health care benefits, including alcoholism, chemical abuse and mental and nervous conditions are covered as any other Illness, as described in the Summary of Benefits Insert.
- Chiropractic services are limited to the amount stated in the Summary of Benefits Insert. The maximum benefit is available only once each calendar year. In addition, at least 90 days must have elapsed since the date the previous year's maximum was reached before services are covered in a new calendar year.

  Note: Osteopathic manipulations are treated the same as chiropractic treatment.
- Cardiac rehabilitation, physical therapy and speech therapy must be listed in your Summary of Benefits Insert to be covered, and are limited as stated in that insert.

PRESCRIPTION DRUGS

Mail Order Prescriptions could save you money. Call the Fund Office for details.

Prescription drug coverage provides benefits for prescription drugs and refills prescribed by a doctor and dispensed by a Pharmacist who is a member of a "Centralized Pharmacy Network" (as described below). You must make a copayment for each prescription or refill you obtain, as described in your Summary of Benefits Insert. If you obtain a prescription or refill from a pharmacy that is not part of the Centralized Pharmacy Network, it will not be covered.

To obtain the best prices and help control costs, the Fund has established a Centralized Pharmacy Network, which includes pharmacies located in Acme Markets and Shop Rite, as well as a number of local neighborhood pharmacies. Except as provided below, you must obtain prescription drugs from a member of the Centralized Pharmacy Network.

Mandatory Generic Drug Program

Under the Mandatory Generic Drug Program, you and your eligible dependents will pay more if a generic drug is available and you choose to fill a prescription with a brand name drug.

Generic drugs are safe and effective and must meet strict manufacturing and other rigid standards set by the FDA. Generic drugs work the same way as their brand name counterparts. They contain the same active ingredients and are available in the same dosage strengths and forms. And, the generic manufacturing, packaging and testing sites must pass the same quality standards as those of brand name drugs.

If you purchase a covered brand name drug when a generic equivalent is available, you will pay the difference in cost between the brand name and generic in addition to the brand name copayment. The additional cost will apply, even if your doctor has indicated “Dispense as Written” on your prescription.

If you are prescribed a covered brand name drug that does not have a generic equivalent, you pay the required brand name drug copayment amount.

Mail at Retail Drug Program

Under the "Mail at Retail" Drug Program you can obtain mail order prescription drugs directly from certain retail stores in the Centralized Pharmacy Network. The "Mail at Retail" network includes Acme Markets and Shop Rite. This gives you 2 options for filling maintenance prescription drugs – through the mail or at one of the "Mail at Retail" network pharmacies.

The "Mail at Retail" program works the same way as the traditional Mail Order Program.

- Ask your doctor to write your prescription for a 90-day supply.
- Then fill the prescription at a “Mail at Retail” participating pharmacy or mail it to the participating mail order carrier. You can obtain a mail order form through the Fund Office.
- When you pick up the prescription at a “Mail at Retail” pharmacy (or when your order is processed through the Mail Order Program), you will pay 2 copays for the 3-month supply, saving one copay for every 90-day supply you fill.

OTC Assist Program

The Plan covers the over-the counter (OTC) medications Claritin, Prilosec and Zyrtec that are dispensed at a pharmacy. ***The OTC Assist Program requires that your Physician write a prescription for these OTC medications.*** When you obtain the OTC medications from the pharmacy, you will be required to make a copayment. The alternative third tier medications listed below are also available, but at a higher copayment, provided your doctor writes a prescription for them.

Covered OTC Medications		**Retail copayment:**	**Mail order copayment:**
Non-sedating antihistamines:	**Proton pump inhibitors:**		
Claritin Zyrtec	Prilosec Omeprazole (generic)	$5	$10
Third tier alternatives:			
Clarinex Allegra	Aciphex Prevacid Prilosec Nexium Protonix	$35	$70

Step Therapy Program

The Step Therapy Program applies to patients newly diagnosed with a condition and given a newly prescribed maintenance medication within certain drug classes. You can obtain additional information about the Step Therapy Program and the classes of drugs covered from the Fund Office.

Medications covered by the Step Therapy Program are grouped into the following two categories:

- ***Front-line Medications:*** These are drugs recommended that you take first – usually generic medications, which have been proven safe and effective. Front line medications allow you to begin or continue treatment with safe, effective prescription drugs that are also affordable. You pay the lowest copayment for these drugs.
- ***Back Up Medications:*** These are brand name medications, like those you see advertised on TV. They are recommended only if a front-line medication does not work for you. You always pay more for brand name medications.

If you fail to follow the Step Therapy Program for medications that require it, the drug will not be covered by the Plan.

Most doctors are familiar with Step Therapy. Please bring the Step Therapy Program to your attending Physician's attention when he/she prescribes a new medication for you or a covered family member.

Limitations

No benefits are paid for:

- Brand name medications if there is a generic equivalent (see Mandatory Generic Drug Program)
- Prescriptions filled outside the Centralized Pharmacy Network
- Over-the-counter drugs or medicines, except as provided by the OTC Assist Program
- Injectable drugs (except for insulin). Please refer to the major medical provisions
- Drugs used for cosmetic purposes, hair growth or hair removal treatments, weight control, acne products including Retin-A for individuals over the age of 23, or drugs used to treat and/or prevent gum disease
- Fertility or potency drugs, unless noted otherwise in your Summary of Benefits Insert
- Experimental drugs as determined by the Fund
- Any appliances, devices or syringes or hypodermic needles (except for the administration of insulin)
- Medications prescribed for work-related conditions
- Medication while a person is an inpatient in a Hospital, a nursing home or other institution
- Medication for any condition related to an automobile accident
- Any drug being prescribed for use that is not for the drug's FDA-approved use (no off-label use)
- Any drug that is not specifically included on the Fund 's list of approved drugs. The list is available upon request from the Fund Office.

Your prescription benefit – and your prescription drug card – are valid only as long as you remain eligible. If you use your prescription card when you are not eligible, you will be liable for all charges. The Participant named on the prescription card is responsible if it is used inappropriately.

Filing Prescription Drug Claims

Take your prescription to a pharmacy in the Centralized Pharmacy Network and present your prescription card. If you have an eligible prescription filled and don't have your prescription card (regardless of the reason) you can get reimbursed by submitting a receipt, describing the medication in full to the prescription drug provider named in your Summary of Benefits Insert. Reimbursement will be the same as you would have received had you showed your prescription card when the prescription was filled. No benefits are paid for prescriptions filled outside the Centralized Pharmacy Network, except as described above.

Note: Any expenses remaining unpaid after prescription drug benefits are paid ARE NOT eligible for reimbursement under the major medical benefit.

Medicare Part D Notice

Important Notice from the UFCW Local 152 Health & Welfare Fund about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the UFCW Local 152 Health & Welfare Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are 3 important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The UFCW Local 152 Health & Welfare Fund has determined that its prescription drug program is, on average for all plan Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a 2-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current UFCW Local 152 Health & Welfare Fund coverage will be terminated and you will not be able to get this coverage back. If you join a Medicare drug plan, you must drop the Fund's drug coverage for yourself and all covered dependents. If you join a Medicare drug plan, you will not be able to reinstate your coverage or that of your dependents through the Fund.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

If you drop or lose your current coverage with the UFCW Local 152 Health & Welfare Fund and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the

Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For More Information About This Notice or Your Current Prescription Drug Coverage, and About What Happens to Your Current Coverage if You Enroll in a Medicare Drug Plan – Contact Our Office at (856) 793-2500.

NOTE: You'll receive this notice annually and if this coverage through the UFCW Local 152 Health & Welfare Fund changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call (800) MEDICARE [(800) 633-4227]. TTY users should call (877) 486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration online at **www.socialsecurity.gov**, or call them at (800) 772-1213 (TTY (800) 325-0778).

GENERAL EXCLUSIONS

No benefits are payable for expenses that would otherwise be covered by motor vehicle insurance (even if you are not covered by motor vehicle insurance or expenses exceed the limits of your motor vehicle insurance), unless you can provide proof, acceptable to the Board of Trustees, that you are not required by law to have motor vehicle insurance. In that case, eligible claim expenses will be subrogated. Check your Summary of Benefits Insert, as some plans have a more liberal motor vehicle insurance provision.

In addition to the limitations and exclusions described elsewhere in this book and Summary of Benefits Insert, the following expenses are not covered by the Plan:

- Charges incurred prior to the date a family member becomes eligible under the Plan, after eligibility terminates unless coverage is continued under COBRA or after your employer ceases its participation the Fund
- Charges that exceed the amounts described in this SPD as payable by the Fund, as determined by the Fund's third-party claims processor

- Charges that are incurred without the recommendation or approval of a provider of service recognized by the Board of Trustees or their delegate who is acting within the scope of his license
- Charges that are not Medically Necessary and Appropriate as determined by the Board of Trustees, or which are not approved by the attending Physician
- Charges for Injuries sustained while engaged in unlawful conduct
- Charges for treatment or services not specifically stated as covered in this book or the Summary of Benefits Insert
- Charges to the extent they are recoverable from any other person or organization, unless by the Coordination of Benefit rules contained herein this Fund is determined to be primary payor
- Acupuncture
- Artificial insemination
- Aqua therapy
- B-12 injections, unless for the treatment of pernicious anemia
- Bio-feedback therapy or hypnotherapy
- Convenience items, such as air conditioners, humidifiers, home elevators
- Cosmetic surgery, unless for the correction of damage caused by accidental injury or for correction of a birth defect. In such cases, the patient must have been eligible under this Plan without interruption from the date of the accident (or birth if for repair of a congenital defect) to the date of the operation in order to be eligible to receive Plan benefits for cosmetic surgery In addition, no payment will be made for any expenses related to repair of complications resulting from plastic or cosmetic surgery that was not originally covered by the Plan.
- Custodial, domiciliary care, rest cure or convalescent home
- Drugs or vitamins which can be purchased over-the-counter, unless specifically listed as covered under the Plan or which are available through the OTC Assist Program
- Educational assessments, testing or vocational training
- Eye exercises/orthoptic therapy
- Excess charges – charges in excess of the basic allowance under dental, vision and prescription drug benefits will not be considered for payment under the major medical benefit
- Experimental, investigational or ineffective procedures or treatments
- Foot care, including the cutting, debridement, trimming, reduction, removal, or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet

- Group therapy
- Handling fees to transport laboratory specimens or duplicate testing
- Hearing aids (or examination for or the fitting of hearing aids), unless otherwise noted in your Summary of Benefits Insert
- Home health aide services
- Immunizations and vaccines, except as may be covered under the Affordable Care Act (ACA) mandate
- Infertility treatment, including but not limited to in-vitro fertilization, and artificial insemination; however, reasonable expenses to determine the cause of infertility are covered
- Learning disabilities
- Expenses related to motor vehicle accidents, except that the Plan will consider for payment up to $100,000 under major medical or your Plan of benefits maximum, whichever is less, for any such eligible expenses which exceed $250.000. See your Summary of Benefits Insert to determine if you have this coverage.
- Occupational injuries, illnesses, diseases, except for purposes of the life insurance benefit
- Physical therapy determined to be no longer Medically Necessary or Appropriate
- Preventive services (but only if your Plan is grandfathered under the Affordable Care Act)
- Psychological testing
- Recreational therapy
- Routine check-up that is not necessary for treatment of an injury or illness, or which is given to determine whether a person has a specific injury or illness where no symptoms are present (unless your program under the Plan is grandfathered under the Affordable Care Act)
- Services provided by family members or close relatives
- Sexual dysfunction, except that the drug Viagra may be covered under your prescription drug benefits
- Special education, including counseling, therapy, or care for learning deficiencies or behavioral problems, unless required to be covered by federal law
- Strapping of the foot and/or ankle is limited to once every 2 weeks
- Surgery – Benefits will not be provided under the Plan for certain types of surgery. Some examples of types of surgery that are not covered are: insertion of a penile prosthesis, radial keratotomy, Lasik eye surgery or other vision surgery, reversal of voluntary sterilization, lipectomy, suctions, or any other surgery performed simply to remove fat tissue, reduction mammoplasty (breast reduction, unless Medically Necessary and Appropriate), augmentation mammoplasty (breast enlargement)
- Tattoo removal and complications related to tattoo removal

- Temporomandibular Joint Syndrome (TMJ) dysfunction, craniomandibular disorders, or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint (no payment is made regardless of cause)
- Tobacco addiction programs or treatments, unless required to be covered by federal law
- Transsexual surgery, hormone treatments or counseling, unless required to be covered by federal law
- Vocational rehabilitation
- War/service-related injuries/disease, or charges resulting from war or service-related injuries/disease, or charges for treatment, services or supplies provided by the United States government, or any government, unless the patient is legally obligated to pay for such treatment, services or supplies
- Weight reduction and or any services, supplies, treatment or surgical procedures rendered in connection with an overweight condition or condition of obesity.

Benefits will only be paid in accordance with provisions of the Fund's various Plans. For example, vision care is provided under the vision benefit and excess charges not covered under that benefit will not be paid under any other provision of the Plan unless specifically included in such other Plan provision. Unless a particular benefit states that excess charges will be considered for payment under the major medical benefit or another provision of the Plan no such payment will be allowed.

VISION BENEFIT

The services and supplies provided under this benefit are provided through a panel of in-network providers as well as out-of-network providers. If you use network providers, your out-of-pocket expenses will likely be lower. The Plan's allowance for using an out-of-network provider is indicated in the Summary of Benefits Insert.

How to Obtain Vision Care

Vision benefits are administered through a vision vendor identified in your Summary of Benefits Insert. While you have the freedom to visit a vision provider of your choice, you will pay less out of your pocket when you use an in-network provider. To find an in-network provider, visit your plan's vision care vendor website for a list of participating providers in your area and make an appointment for an exam. When scheduling an appointment, you should notify the in-network provider that your vision coverage is administered by your plan's vision care vendor. In-network providers will access benefits through the vision vendor's secure web portal and activate an electronic claim.

If you use an out-of-network provider, make an appointment with the provider of your choice, pay the provider his/her full fee and obtain an itemized receipt that includes the patient's name, date service began, services and material received, and type of lenses received (single vision, bifocal, etc.). Download or print an Out-of-Network Reimbursement Form from the vision care vendor's website, complete the form and mail or fax the form and receipts to the vision care vendor. In the alternative, you may upload the completed form and receipts via the vision care vendor's website. Reimbursement will be made according to the "Non-Participating Reimbursement Schedule" (see your Summary of Benefits Insert under "Out-of-network Provider" for details). If you use an out-of-network provider for your examination and use an in-network provider to fill your prescription, you should use the process

described in this paragraph to seek reimbursement for your examination, and the process described in the paragraph above for filling your prescription.

Covered In-network Services

Each eligible family member is covered for the expenses in connection with following services and supplies subject to the limitations listed in this section of the SPD. Any additional limitations, including how often care is covered, are shown in your Summary of Benefits Insert.

If you choose to go to an out-of-network provider, you will be reimbursed as described in your Summary of Benefits Insert. Keep in mind that you will pay less out of your own pocket if you go to an in-network provider.

Covered expenses include:

- Vision examination, including, a complete analysis of the eyes and related structures to determine the presence of vision problems.
- Eyeglass frames when required. In-network providers offer a wide selection of frames within the Plan's allowance. If you select frames which cost more than the amount allowed by your plan, you will be required to pay the difference.
- Eyeglass lenses, when indicated as a result of the vision examination. Covered expenses include clear single vision or standard type bifocals. All other lenses are considered extra and are available at wholesale volume discount prices less the Plan's allowance for lenses as provided in your Summary of Benefits Insert. You are responsible for paying any balance over the Plan's allowance to the provider.
- Contact lenses, if selected in place of eyeglasses, will be covered in the amount and frequency stated in your Summary of Benefits Insert. Contact lens benefits are in place of eyeglass frames and lenses. You will be responsible for paying any balance over the Plan's allowance to the provider. Contact lenses may otherwise be covered is they are deemed to be medically necessary and an in-network provider received prior approval in connection with services related to an eye disorder or injury: following cataract surgery, to correct extreme visual acuity problems not correctable with spectacle lenses, to correct for significant anisometropia or keratoconus.
- Dispensing services – When a vision exam indicates that lenses and/or frames are required, the following professional services required to supply them are considered covered services and will be provided at no cost by an in-network provider
  - prescribing and ordering of lenses
  - assisting in the selection of a frame
  - proper fitting and adjustment of eyeglasses
  - verifying the accuracy of the finished eyeglasses, progress or follow-up work as required and subsequent adjustment of frames, and consultation and instruction regarding vision problems.

Limitations and Extra Costs

If you or a family member obtains vision services or materials that are not covered under the Plan's allowances as set forth in your Summary of Benefits Insert, such as special or designer frames that cost more than the Plan's allowance, tinted, photochromic, polycarbonate hi-index, progressive or coated

lenses, contact lenses in excess of the Plan's allowance or rimless frames, you must pay the difference in cost between the Plan's allowance and the cost. Payment must be made directly to the in-network provider before the materials are delivered. For an out-of-network provider, submit itemized receipts to the vision care vendor.

The vision care benefit does not cover professional services or materials such as orthoptics or vision training, plano lenses (non-prescription), two pair of glasses in lieu of bifocals, medical or surgical treatment of the eyes, any eye exam or corrective eyewear required by an employer as a condition of employment, coated or other special types of lenses, subnormal vision aids, aniseikonic lenses, glasses and contacts during the same eligibility period or sunglasses.

DENTAL CARE BENEFITS

Dental benefits are administered through a contract with a dental vendor identified in your Summary of Benefits Insert. While you have the freedom to visit any licensed dentist, you will pay less out of your own pocket when you choose a dentist from the dental vendor's network.

We highly recommend that you verify the dentist's participation status within your dental vendor's network with your dental office before each appointment. You can locate and verify your dentist's status by going to your dental vendor's website or by contacting your dental vendor directly.

Covered Expenses

Covered expenses – which may be subject to certain exclusions and limitations (see your Summary of Benefits Insert) include the following:

- Preventive and diagnostic care
- Space maintainers
- Amalgam restorations
- Denture adjustments and repairs
- Extractions
- Endodontics
- Periodontics
- Oral surgery
- Prosthodontics
- Crowns and onlays
- Orthodontics.

Maximum Benefits

The Plan's maximum allowance for dental services in a benefit year (January 1 through December 31) is listed in your Summary of Benefits Insert. The annual maximum includes orthodontic care, which has a separate individual lifetime maximum of $1,000. These are the maximum dollar amounts the dental plan will pay toward the cost of covered dental care. There are no deductibles.

Pre-treatment Estimate

If you or your dentist are unsure of your benefits for a specific course of treatment, or if your treatment costs are expected to exceed $300, you should request a pre-treatment estimate. A pre-treatment estimate will let you know, in advance, how much the Plan will pay, as well as your estimated share of the cost of the treatment. The pre-treatment estimate is non-binding as benefits, eligibility and claim payments can change before the course of treatment is completed.

Emergency Treatment

If you have a dental emergency, go directly to any dentist for treatment. Keep in mind, however, that if you use an in-network provider your out-of-pocket costs will be less. If you use an out-of-network dentist, you will need to submit an itemized bill directly to your dental vendor.

Limitations

The Plan limits payments for:

- Root canal to one root canal and root canal retreatment per tooth every 5 years
- Prophylaxis (cleaning) and examinations to once every 6 months.

Your Summary of Benefits Insert will indicate whether your Plan includes orthodontic treatment. In general, orthodontic treatment is provided only for eligible dependents through age 18. Treatment must start while the individual is covered by the Plan.

No payments will be made under this benefit for any of the following:

- Cosmetic procedures or tooth whitening
- Crown or metal inlay, unless the tooth is broken down by decay or traumatic injury so that the tooth structure cannot be restored with an amalgam, silicate, acrylic or composite restoration
- Oral hygiene instructions
- Facings on pontics or crowns posterior to the second bicuspid
- Fluoride applications for any person age 15 or over
- Caries susceptibility testing
- Full mouth X-rays taken more than once every 36 months
- Fragmented services (the separate charging of services traditionally considered to be part of a complete service)
- Hospital expenses associated with any dental procedure unless due to dental treatment provided as a result of an accident that occurred while covered for the hospital expense benefit
- Recementation of inlays or crowns (only permanent cement is covered)
- Repairs, as follows:
  - More than 3 repairs on any denture in any period of 12 consecutive months
  - More than one repair on any fixed bridge in any period of 24 consecutive months
- Replacements

- For lost or stolen dentures or other prosthetic appliances
- For restorations, unless 24 months have elapsed for composite and silicate fillings, or 36 months have elapsed for amalgam fillings, or 60 months have elapsed for gold fillings, gold inlays or crowns, or 60 months have elapsed for dentures, provided any such denture cannot be made serviceable

- Sealants application to any person over age 14, or to teeth other than the posterior teeth, or more than one treatment in any 36-consecutive month period
- Space maintainers for any person age 12 or over
- Temporomandibular Joint Syndrome (TMJ) dysfunction, craniomandibular disorders, or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint (no payment is made regardless of cause)
- Temporary, partial or full dentures
- Flexible partial dentures.

Any covered expenses remaining unpaid after this benefit's payments, unless due to an accident, ARE NOT considered for payment under the major medical benefit.

WEEKLY DISABILITY BENEFIT (EMPLOYEE ONLY)

Eligibility

You will receive a weekly disability benefit if you are unable to work because of a non-occupational accidental injury or illness that begins while you are covered by this Plan (as described in the Summary of Benefits Insert). The weekly disability benefit is supplemental to any State or private disability plan. The injury or illness must wholly prevent you from engaging in the primary functions of your occupation or any other employment for wage or profit.

Benefit

Disability benefit payment amounts are described in the Summary of Benefits Insert. Premium hours are not included in your benefit calculation.

When Benefits Begin

You must be seen by a Physician for the disability and the Physician must verify the disability in writing on the claim form you submit to the Fund. Telephone consultations with a Physician will not be accepted. Once you have met this requirement, benefits will begin as described below. However, if your CBA or MOA provides for a different benefit commencement date, the provisions of the CBA or MOA will be followed.

- **For accidental injury or hospital confinement**, benefits will begin on the first day of disability, provided such disability commences within 48 hours from the date the accident occurred.
- **For sickness**, benefits will begin as of the fourth day of disability.

Your waiting period for benefits, if any, will be counted from the date you are treated by the Physician.

The Fund has the right and opportunity to have you examined by its own Physician when and so often as it may be reasonably required during the duration of the claim.

Benefit Amount and Duration

The amount of the weekly disability benefit is described in the Summary of Benefits Insert.

Once they begin, disability benefits will continue for up to 26 continuous weeks for any one continuous period of disability.

Successive Periods of Disability

Successive periods of disability will be considered as one continuous disability, unless:

- The subsequent disability is due to a completely and entirely unrelated cause
- The second disability period occurs after you have returned to work for at least 14 full regularly scheduled days during which you worked your regularly scheduled work day.

However, if you have received 26 consecutive weeks of disability benefits, you may not collect disability again until you have returned to work for at least 17 weeks. Regardless of the number of different disabilities, the Fund will not pay more than 35 weeks of disability benefits in any 52-week period.

Taxation of Benefits

Disability benefits are taxable as gross income on your federal income tax return and are also subject to FICA and Medicare tax. In accordance with federal law, the Fund office will withhold your share of the FICA and Medicare tax from each weekly disability benefit payment made to you and will send it to the government. You may also request that additional federal withholding tax be deducted from your payment. If you have a question about taxes, speak with your personal tax advisor or legal counsel.

Exclusions and Limitations

No disability payments will be made:

- For any disability for which you are not under the direct care of a Physician.
- During a period for which you are receiving disability payments, whether for the same or unrelated disability, from any other source, which provides benefits that are at least equal to the benefit payable by the Fund. If such benefits are less than would be paid by the Fund, the Fund's benefit will be supplemental to the other source up to the maximum stated in the Summary of Benefits Insert.
- For any disability that commenced prior to the date you became covered for this benefit.
- When a claimant refuses to be examined by a Physician of the Fund's choosing.
- Any disability related to a motor vehicle accident.
- Any work-related disability.
- For any disability related to an organ transplant unless the transplant is covered by the Plan under the Organ Transplant Program.
- For any disability related to a condition and/or injury not covered by the Plan.

The Fund subscribes to a service that determines the duration for each disability based on its cause. If your disability exceeds the expected duration, as determined by this service, the Fund reserves the right to have you examined by a doctor of its choice.

Disability benefits are paid in lieu of wages from any source such as vacation pay or other compensated absences.

How to File a Disability Claim

To file a claim for benefits, use the disability claim form, available from the Fund Office. Inaccurate or incomplete information WILL DELAY THE PROCESSING OF YOUR CLAIM.

Submit your claim within 30 days of the onset of your disability. If you are confined to a Hospital, you must submit the claim within 30 days of your discharge. If you do not file your claim on time, your disability claim will be denied.

LEGAL SERVICES PLAN

Your Summary of Benefits Insert will indicate if you are eligible for this benefit and will also show the legal vendor providing services. The Fund's legal services benefit is fully insured. An explanation of the benefits provided and the terms of coverage are described in the documents provided to you by the insurer ("Legal Benefit Documents"). This section of the SPD is a summary of those documents. **If there are any conflicts or inconsistencies between this SPD and Legal Benefit Documents, the terms of the Legal Benefit Documents will always control.**

Notice of No Fund Liability

Use of the services of any provider rendering legal advice, whether designated by the Fund or otherwise, is the voluntary act of the covered family member. This benefit 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 based on all the appropriate factors, only one of which is coverage by the Fund. Providers are independent contractors, not employees of the Fund. The Fund makes no representation regarding the quality of service by 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 services rendered.

Attorney-Client Relationship

Any attorney providing legal services under this Plan will have an attorney-client relationship with the covered member receiving the legal services. The attorneys have the same exclusive professional duties and obligations to covered persons as would be required with any other client who would normally retain an attorney on a private fee basis. Any attorney providing legal services under the Plan shall maintain the confidentiality of the attorney-client relationship in accordance with applicable professional standards.

Exercise of Discretion

Attorneys providing legal services under this Plan shall be free to exercise the right to refuse to provide legal services or representation for any matters which they believe to be clearly without merit or frivolous.

Complaints

If you have a complaint regarding the services rendered by an attorney providing legal services under this Plan, contact the Fund Office at (856) 793-1598. If you do not receive satisfaction you may then submit an appeal as described under the "Your Rights Under ERISA" section of this book.

Benefit

Coverage is for those eligible family members indicated in your Summary of Benefits Insert. Your Summary of Benefits Insert also includes the name and contact information for the legal firm providing benefits.

Covered Legal Services

The following is a general summary of the services provided:

- Adoption Proceedings – representation in all phases of agency and non-agency adoption proceedings consistent with applicable state statutes.
- Bankruptcy, Personal and Wage Earner – representation in bankruptcy proceedings in the event of a personal financial crisis.
- Civil Actions – defense in any civil lawsuit brought against you in any court, except as to courts of limited jurisdiction as stated in exclusions and limitations.
- Consumer Affairs – advice and assistance in matters of consumer affairs, for example:
  - Buying and selling of goods
  - Breach of warranties
  - Problems with service persons
  - Credit matters
  - Difficulties with banks and finance companies
  - Consumer fraud.
- Consultation with an Attorney – an opportunity to consult with an attorney concerning any legal question. Consultation is also available as a "Legal Checkup" or to prevent or minimize potential problems before they develop into a lawsuit.
- Criminal or Juvenile Court Matters – representation for certain misdemeanor charges, except high misdemeanors and offenses of the first, second and third degree. Service is limited to one (1) criminal and one (1) juvenile matter per family in a calendar year.
- Document Preparation and Review – examination and preparation of:
  - Contracts for purchase
  - Contracts for sale
  - Transfers
  - Assignments
  - Powers of attorney
  - Notary service
  - Leases
  - Releases
  - Settlements
  - Review of home improvement documents
  - Review of retail installment contracts
  - Review of warranties of good and services

- **Domestic or Marital Matters** – up to 50 hours per matter for representation in domestic or marital matters including:
  - Uncontested divorce
  - Contested divorce
  - Property settlement
  - Support and visitation cases
  - Equitable distribution problems
  - Abandonment cases
  - Custody of children
  - Annulments
  - Paternity cases

  This service includes filing of a complaint for divorce, separate maintenance or annulment, and defense of any marital action instituted against you.

  Since there is a potential conflict of interest in representing the covered member and his/her spouse, ethics require that this service and any consultations relating to domestic or marital matters be limited to covered members only. If the marital dispute is between 2 covered members, arrangements will be made with other counsel for the representation of each of the 2 members. There are certain expenses which will be charged in connection with representation in domestic or marital matters. These charges include out-of-pocket expenses such as filing fees, court costs, photocopying expense fees, etc.

- Estate Planning, Wills and Probate – preparation and execution of a Last Will and Testament. **This service does not include administration of estates or preparation of tax returns unless these items are specifically mentioned in your Summary of Benefits Insert.**
- Personal Injury – consultation in connection with a personal injury matter and advice and assistance in the processing and collection of any personal injury protection benefit that you are entitled to as a result of a motor vehicle accident.
- Real Estate – the review, preparation, and examination of documents concerning the purchase, sale or transfer of the covered Member's principal residence.

  Note: You are urged to consult with your Attorney before signing documents relating to the purchase or sale of your property.

- Settlement Negotiations – assistance of Attorney in the negotiation of any covered personal legal problem.
- Tenant Coverage – defense in eviction proceedings brought against you by a landlord.
- Traffic Offenses – representation in Municipal Court for any charge of driving while under the influence of alcohol or drugs. This is the only traffic offense covered. This service is limited to one (1) use per calendar year per family.

Exclusions and Limitations

The following services are not covered under this benefit:

- Any action involving an Employer who contributes to this Fund, UFCW Locals 152, 27 and 1262 Unions or its officers, the Attorney providing services under the Plan, the Fund and the Board of Trustees, any Employee of the Fund, or any matter arising out of a CBA, MOA and/or participation agreement and the benefits provided thereunder.
- Any matter that would not be considered to be personal legal services under Internal Revenue Service regulation section 1-120-2 including, but not limited to, matters involving individual, commercial, corporate, partnership interests or obligations, business pursuits, profit making ventures, patents, or copyrights.
- Out-of-pocket expenses such as filing fees, court costs, assessments, penalties, deposition costs, printing costs, long distance telephone use, title searches, insurance policies, bonds, transfer taxes, settlement fees, survey costs and other expenses not considered legal services.
- Any matter where an Attorney is normally paid by a contingency fee, such as a personal injury or worker's compensation case, or where the fee is provided by statute or by order of the court from a Fund sub judice.
- Any action, matter or proceeding Instituted or started prior to your eligibility for coverage for this benefit.
- Guardianship and competency proceedings, landlord and tenant matters (except as noted previously), appeal matters, in any civil proceedings under the jurisdiction of the Municipal Court, Small Claims Division, County District Court, District Justice Court, Justice of the Peace Court, District Magistrates Court and Maryland District Court – Civil Section.
- Any proceedings where services are available or provided through another plan or other means (for example, insurance defense). This does not apply to the criminal area where a voluntary public defender, etc. is available.
- Class actions, interventions, Amicus Curiae filings, or other matters not involving the personal, immediate and direct interest of the covered person.
- Duplication of services previously claimed and relating to the same cause of action if the matters occur or arise within 12 months of each other.
- Anything not specifically covered in the Legal Benefit Documents.

The coverage under this benefit is limited to and applicable to matters which occur only in the States of Pennsylvania, New Jersey, Delaware and Maryland.

BASIC LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFIT (EMPLOYEE ONLY)

Your Summary of Benefits Insert shows whether you are eligible for this benefit, as well as the amount of your coverage. The Fund's life insurance and AD&D benefit is fully insured through USAble Life. An explanation of the benefits provided and the terms of coverage are described in the documents provided to you by the insurer ("Insurance Documents"). This section of the SPD is a summary of those documents. **If there are any conflicts or inconsistencies between this SPD and Insurance Documents, the terms of the Insurance Documents will always control.**

Basic Life Insurance Benefit

Payment will be made to your named beneficiary in the event of your death from any cause.

Continuance of Basic Life Insurance in Case of Total Disability

If you become totally disabled while you are eligible for the basic life insurance benefit, you will continue to be covered under the basic life insurance benefit, provided the following requirements are met:

- Your total disability commenced prior to age 60, and
- You provide the Fund with written proof, satisfactory to the Board of Trustees or the appropriate Fund representative, that you are totally disabled. This written proof must be provided to the Fund within 6 months of the date on which you first receive oral or written notice from the Social Security Administration, a Physician, a health provider or any other source that you are totally disabled, and
- As soon as you receive your Social Security award, you forward a copy to the Fund office, and
- You are totally and continuously disabled for at least 9 months, and
- During the last 3 months of each subsequent year that you remain totally disabled, you provide the Fund with written, notarized proof of your continuing disability. This written proof must be in a form satisfactory to the Board of Trustees or their appropriate representative. **It is your responsibility to submit this yearly proof; no reminder will be sent to you by the Fund**.

This continuation of your basic life insurance will continue until:

- You are no longer totally disabled, or
- The date you fail to furnish any required proof of continued total disability, or
- The date you fail to submit to a requested medical examination by a Physician designated by the Board of Trustees, or
- The employer for whom you last worked no longer participates in the Fund, or
- You attain age 65, or
- You return to active employment.

Accidental Death and Dismemberment Benefit

The amount payable under this benefit for loss of life or serious bodily injury is in addition to your basic life insurance benefit described above. However, unlike the basic life insurance benefit, this benefit cannot be continued upon disability.

In general, if you suffer loss of life, limb or sight, and if such loss occurs within 90 days following the date of the accident, payment will be made to you (or to your beneficiary in the event of your death) in the amount stated in the Summary of Benefits Insert.

Losses Covered and Benefit Amount

The principal sum will be paid in the event of loss of:	One-half the principal sum will be paid in the event of loss of:
Life	One Hand
Both Hands or Feet	One Foot
Sight of Both Eyes	Sight of One Eye
One Hand and One Foot	
One Hand and Sight of One Eye	
One Foot and Sight of One Eye	

Loss of sight means, the total and irrecoverable loss of sight.

Loss of hand or foot means severance at or above the wrist or ankle.

Exclusions

No payment will be made under the AD&D insurance benefit for any loss resulting from or caused directly, in whole or in part, by:

- Disease or bodily or mental infirmity or medical or surgical treatment
- Any infections, except pyogenic infections occurring with and as a result of an accidental wound
- Participation in, or in consequence of having participated in an illegal act, which is in violation of any state or federal criminal statue
- Flying, unless on a commercial airline
- Insurrection, war or any act of war, whether declared or undeclared
- Suicide (whether while sane or insane)
- Self-administered drug overdose, whether intentional or unintentional.

Beneficiaries

As the Participant, you have the sole right to designate the beneficiary to receive your basic life insurance benefit (death benefit) and AD&D death benefit in the event of your death. You may change your beneficiary designation at any time, but you must do so in writing; and such change will take effect on the date your designation is received by the Fund Office.

- If you have more than one living beneficiary when you die, and you have not specified their respective interests, they will share the benefit equally.
- If any beneficiary dies before you, his/her rights and interests will automatically terminate.

- If your designated beneficiary does not file a claim for your basic life insurance and AD&D insurance death benefit within one year from your date of death and the whereabouts of this designated beneficiary are unknown, the disposition of any benefits will be determined by the provisions of the claim policy of the life insurance carrier indicated in your Summary of Benefits Insert.
- If you have not named a beneficiary or the beneficiary you named is no longer living or fails to file a claim for your basic life insurance and AD&D insurance death benefit, then the life insurance carrier indicated in your Summary of Benefits Insert will pay up to $250 to any person who may have incurred expenses in connection with your funeral expenses.

How to File a Claim for Benefits

You (or your beneficiary in the event of your death) must complete the Employee section of the claim form and attach an original copy of:

- The medical report and,
- The police report, if an accident, or
- The death certificate, in the event of death.

All claims must be filed with the Fund Office within 90 days of the date of death or dismemberment.