UFCW LOCAL 655

WELFARE FUND

SUMMARY PLAN DESCRIPTION

2018 Edition

UFCW LOCAL 655
WELFARE FUND

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The Board of Trustees will make all final determinations on questions of fact, eligibility, benefits and any other provisions of the Plan. The Board of Trustees reserves the right to change or terminate the Plan. If this happens, you will be notified.

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To All Eligible Employees:

The Board of Trustees is pleased to present you with this new booklet describing the benefits of the United Food and Commercial Workers Union (UFCW) Local 655 Welfare Fund (the Plan). This document is both the Plan's Summary Plan Description and Plan Document. It is effective as of January 1, 2018, and it replaces and supersedes any prior booklets or explanatory material.

Your Schedule of Benefits, which is a part of this Summary Plan Description and Plan Document, describes the ways that medical benefits are provided to you through the Plan. Currently, there are four different plans of Schedule of Benefits: Plan A, Plan B, Plan C, and Plan D. If you know your current plan selection you may view your Schedule of Benefits online. If you need to know which plan you are enrolled in or need to request a hard copy of your Schedule of Benefits, please call the Fund office.

You have the choice of receiving medical benefits through PPO Network providers or out-of-network providers. PPO network benefits are provided through a network of physicians and hospitals that has contracted with the Plan to offer medical care at discounted rates through a Preferred Provider Organization (PPO).

You may also obtain care from an out-of-network physician or hospital. A non-network physician or hospital is one that does not belong to the PPO.

When you use the services of network providers, the Plan may pay a higher percentage, sometimes 100% of your covered expenses after you make a small copayment for certain services, or the Plan may pay a percentage of your covered expenses after your deductible, but not 100%. When you use out-of-network providers, the percentage paid by the Plan is generally lower than the percentage the Plan pays for PPO providers. Your service provider options and the percentages paid by the Plan are listed in your schedule of benefits that accompanies this booklet.

The Plan provides you with assistance if you need treatment for Mental Health Disorders or Substance Use Disorders (Chemical Dependency). You will be provided with free counseling by telephone when you call the member assistance program listed on your schedule of benefits. If your condition requires inpatient treatment, you should seek prior authorization (pre-certification) of your care. When you call the member assistance program, a counselor will assist you in choosing a course of treatment under the Plan. See your schedule of benefits for additional information.

Please read this booklet carefully so that you can fully understand your benefits. If you are married, show this booklet to your spouse and let your spouse know where you keep it filed. You can also view electronic copies of the Summary Plan Description and your Schedule of Benefits online at www.655hw.org. If you have any questions about the Plan, call the Welfare Fund office at 314-835-2700 in the St. Louis area or toll free in Missouri or in Illinois at 1-866-565-2700.

Sincerely,
Board of Trustees

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The use of the term "you" and "your" throughout this booklet generally refers to covered plan participants, which may include the employee and the employee's dependents. In certain circumstances, these terms may refer only to the employee.

The use of the term "Plan" throughout this booklet means the United Food and Commercial Workers Union Local 655 Welfare Fund (the "Fund" or "Welfare Fund") as set forth in this booklet, which serves as the Fund's Summary Plan Description and Plan document.

INTRODUCTION

The United Food and Commercial Workers Union Local 655 Welfare Fund, also known as the UFCW Local 655 Welfare Fund, (the "Plan") offers health care coverage to help you and your eligible dependents stay healthy and to provide financial protection against catastrophic medical expenses. The Plan was established by the Union and Trustees and is maintained in accordance with the provisions of the Trust Agreement (the "Trust"). The Plan is intended to provide welfare benefits for employees of contributing employers. If you qualify for benefits, the Plan provides:

- **Medical benefits**
- **Prescription drug benefits**
- **Dental benefits**
- **Vision care benefits**
- **Life insurance benefits**
- **Accidental death and dismemberment (AD&D) benefits**
- **Weekly disability income benefits**
- **Mental health and substance abuse benefits**

Your specific benefits are described and provider contact information is provided in the Schedule of Benefits that accompanies this booklet. It is part of the Summary Plan Description and Plan. Contact the Welfare Fund office if you need another Schedule of Benefits.

Rules about Plan interpretation. Only the Board of Trustees is authorized to interpret the Plan. The Board has full discretion regarding all questions about the Plan, including questions about your eligibility for benefits and the amount of benefits payable to you. Individual Trustees, employers or union representatives do not have the authority to interpret the Plan on behalf of the Board or to act as agents of the Board. The Board also has the discretion to determine the facts of any claim you make for Plan benefits. Benefits under the Plan will be paid only if the Trustees and other Plan fiduciaries decide in their discretion that an applicant is entitled to them.

If you have a question. If you have an important question about your benefits, please write to the Welfare Fund office. The Board has authorized the Welfare Fund office to respond in writing to your written questions. As a courtesy to you, the Welfare Fund office may also respond informally to your oral questions by telephone or in person at the Welfare Fund office. However, these oral answers are not binding upon the Board of Trustees. In addition, you cannot rely on oral answers in any dispute concerning your benefits.

Plan continuation and changes. The Trustees intend to continue the Plan indefinitely. However, the Trustees have been given the power to amend or terminate the Plan, as they deem necessary. Plan rules and benefits may change from time to time. If this occurs, the Welfare Fund office will send you a written notice explaining the change. Please be sure to read all Plan communications and keep them with this booklet.

To qualify for the benefits described in this booklet, you must:

- ☑ **Be covered under a collective bargaining agreement or participation agreement that requires your employer to make contributions on your behalf; and**
- ☑ **Meet the eligibility requirements to qualify for the benefits described in this booklet.**

ELIGIBILITY FOR BENEFITS

Initial Enrollment in the Plan

When you become eligible to participate in the United Food and Commercial Workers Union Local 655 Welfare Fund, you will receive an enrollment package from the Welfare Fund office that contains an Enrollment and Beneficiary Form, along with other necessary forms to enroll. You must complete these forms and return it to the Welfare Fund office. After the Welfare Fund office receives your completed information, the Plan will begin providing benefits on your behalf, unless you have declined coverage. You must use an enrollment form to:

- **Sign up as a new plan participant**
- **Decline coverage**
- **Add or drop coverage for your spouse**
- **Add or drop a dependent child**
- **Change your address**
- **Change your beneficiary**

When you complete an enrollment form, you will give the following information:

- **Your name and address**
- **Your social security number**
- **Your date of birth**
- **Your gender**
- **Your marital status**
- **Your employer's name**
- **Your hire date**
- **Your beneficiary for life insurance benefits**
- **Your beneficiary's relationship to you and his or her address and phone number**
- **Information about your eligible dependents, including:**
  - → **Names;**
  - → **Addresses**
  - → **Social security numbers;**
  - → **Birth dates; and**
  - → **Relationship.**
- **Information about other insurance coverage;**
- **Information about coverage your spouse has through employment on the Spousal Coverage Verification Form**

You must complete and submit your Enrollment and Beneficiary Form to participate in the Plan or to decline coverage in the Plan. Once you meet the Plan's eligibility requirements and enroll in the Plan, you become a plan participant and you continue to be a plan participant as long as you continue to meet those requirements. If you work for an employer that requires you to pay a portion of your premium, you should review the Premium Share, Spousal Surcharge and Open Enrollment Section on page 4.

The enrollment form requires you to record the social security numbers of all eligible dependents. When you sign the form, you are stating that the information on the form is true.

Insurance Card

You will receive your insurance card within two weeks of your initial eligibility date. The insurance card provides information about your group and identification numbers for medical, mental health disorder and substance use disorder, prescription, vision, and dental benefits. It lists contact and referral telephone numbers and claims filing instructions. The treatment that requires notification and referral is listed in your Schedule of Benefits.

Declining Plan Coverage

If you decide to decline your health coverage under the Plan, you must do so on the enrollment form at the time of Initial Open Enrollment or Annual Open Enrollment. The decision to decline health coverage is voluntary and is made by the individual participant and, if applicable, his or her spouse. To enroll in the Plan after declining coverage, you must provide the completed enrollment form to the Welfare Fund office during the Annual Open Enrollment period, and benefits will be effective January 1, subject to receipt of the enrollment form, and satisfaction of eligibility provisions. Besides the Annual Open Enrollment period, there are also Special Enrollment Rights (see below) providing additional enrollment opportunities in the Plan as outlined in the next section.

Special Enrollment Rights

If you decline coverage for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your eligible dependent's other coverage). **You must request enrollment within 31 days after your or your eligible dependent's other coverage ends (or after the other employer stops contributing toward the other coverage).**

In addition, if you have a life-changing event, you may request special enrollment. Such an event includes acquiring a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption. You may be able to enroll yourself and your eligible dependents due to such an event. **You must request Special Enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.**

To request Special Enrollment or obtain more information, contact the Welfare Fund office.

Finally, under federal law, an individual has the special right to enroll in any other group health plan for which he or she may be eligible (such as a plan sponsored by a spouse's employer) within 30 days after his or her regular

coverage under this Plan terminates due to a qualifying event. The individual will not have to wait until that other plan's next open enrollment period. If that individual elects COBRA continuation coverage under this Plan, he or she will have that same special right to enroll in another group health plan at the end of the COBRA coverage if he or she keeps the COBRA coverage for the maximum period it is available.

Premium Share, Spousal Surcharge and Open Enrollment

If your employer requires that you pay a portion of the cost of your coverage under the Plan, you may have a designated amount deducted from your pay when you enroll in the Plan. The amount is based on the collective bargaining agreement that governs the terms of your employment. If you do not enroll in the Plan, you will be enrolled in the highest level of health and welfare benefits for which you are eligible. These include medical, prescription drug, dental, vision care, life insurance, accidental death and dismemberment insurance, and weekly disability benefits.

If you elect benefit coverage under the Plan, payroll deductions will be taken from each paycheck during the months you qualify for coverage. Electing benefits does not guarantee your coverage. You are still required to work the minimum amount of hours to qualify for coverage. In addition, your dependents must meet the definition of an eligible dependent under the Plan terms and you must submit proper documentation of your eligible dependent's status to the Welfare Fund office.

When you work the required hours, the Fund office will send you the enrollment materials referred to in the Initial Enrollment in the Plan section on page 2. You will need to complete the information requested by the Fund and begin payroll deductions for your share of the coverage premium.

If you enroll your spouse and you work the required amount of hours for him/her to qualify for coverage, you may be subject to an additional weekly deduction from your pay. **Employees whose spouses do not have their own primary health insurance (an insurance that pays before this Plan) will contribute an additional pre-tax employee contribution.**

Annual Open Enrollment

Once you are enrolled in the Plan, then each year, if your employer requires that you pay a share of your premium, you will be required to enroll for coverage during the months of September and October for the specified coverage that will begin on the following January 1st. This is known as Annual Open Enrollment. The Annual Open Enrollment period is the time during which you may choose a different coverage option for which you are eligible during the next calendar year (beginning January 1st). Options are employee only, employee and spouse, employee and child(ren) or employee and family. You must complete the Open Enrollment Form in writing in order to make changes to your coverage.

If you do not complete the Annual Open Enrollment Form during the months of September and October, then you will remain at the same coverage level for which you were enrolled for the prior year, such as employee only, employee and spouse, employee and child(ren) or employee and family. If you have never enrolled, you will automatically be enrolled in the highest level of coverage for which you are eligible, as determined by your hours worked, unless you opt for a lower level of coverage or you opt for no coverage. After open enrollment you will only have the option to change your coverage level, or discontinue coverage, if you experience a life-changing event. Otherwise, you will need to wait to change your coverage option during the next annual open enrollment period (generally September and October before the next calendar year).

Who Is Eligible for Benefits under the Plan

You are eligible for Plan benefits if you work for an employer that has signed a collective bargaining agreement or participation agreement with the United Food and Commercial Workers Union that requires your employer to make contributions to the Local 655 Welfare Fund on your behalf. The collective bargaining agreement or participation agreement your employer signs with the United Food and Commercial Workers Union establishes the amount of contributions your employer makes to the Plan.

If you do not know whether you are covered by the Plan, you may send a written request to the Welfare Fund office to obtain:

1. A complete list of employers contributing to the Plan.
2. Information as to whether a particular employer contributes to the Plan and, if so, that employer's address.
3. A copy of the collective bargaining agreement or participation agreement language that governs your employer's contributions to the Plan.
4. Information about your level of coverage.

The number of hours you work determines your eligibility for coverage under the Plan. You earn eligibility for Plan benefits through the average weekly hours you work each month for which your employer reports your hours and contributes to the Welfare Fund on your behalf. You must also pay your required employee share of the premium for your benefit coverage, if applicable. This is called your "premium share."

Initial Eligibility

Benefit eligibility is subject to payment of:

1. **Your premium share to your employer, as specified in your collective bargaining agreement; and**
2. **Your employer's payment to the Welfare Fund.**

Please use the guide below to help determine your eligibility and the plan for which you qualify.

Plan D
Hired on or after January 1, 2017

Unit 1: 35 hours average per week; after 12-month waiting period (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Unit 2: 25 hours average per week; after 12-month waiting period (employee-only coverage for medical, prescription drug, vision, life, and AD&D insurance).

Unit 1 Monthly Participant: Determined by your employer's agreement with the Union (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Plan C
Hired on or after December 1, 2010

(After 72 months of employment the employee shall move to Plan B Coverage)

Unit 1: 32 hours average per week; after 12-month waiting period (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Unit 2: 20 hours average per week; after 12-month waiting period (employee-only coverage for medical, prescription drug, vision, life, and AD&D insurance).

Unit 1 Monthly Participant: Determined by your employer's agreement with the Union (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Plan B
Hired on or after September 1, 2007

Unit 1: 32 hours average per week; after 12-month waiting period (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Unit 2: 20 hours average per week; after 12-month waiting period (employee-only coverage for medical, prescription drug, vision, life, and AD&D insurance).

Unit 1 Monthly Participant: Determined by your employer's agreement with the Union (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Plan A
Hired on or before November 1, 2003

Unit 1 Family coverage; if hours paid in the prior year averaged at least 32 per week and you continue to average 32 hours per week for the current year; you will maintain family coverage in Plan A. You are eligible for family coverage in the current year if you average 25 hours per week during a month, however, you may lose family eligibility for Plan A for the following year. (Medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance.)

Unit 1 Employee Only coverage; 25 hours average per week; (medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Unit 2 Employee only coverage: 16 hours average per week; (medical, prescription drug, vision, life, and AD&D insurance).

Unit 1 Monthly Participant: Determined by your employer's agreement with the Union (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Plan A
Hired after November 1, 2003 but prior to September 5, 2007

Unit 1: 32 hours average per week; after 12-month waiting period (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Unit 2: 20 hours average per week; after 12-month waiting period (employee-only coverage for medical, prescription drug, vision, life, and AD&D insurance).

Unit 1 Monthly Participant: Determined by your employer's agreement with the Union (family coverage for medical, prescription drug, vision, dental, weekly disability, life and AD&D insurance).

Initial Eligibility Defined

Your initial eligibility is based on whether you are hired as a Variable Hour Employee or known Full-Time Employee, the average number of weekly hours you work (please see definition of a week on page 116) , the date you started working for your employer, when your employer starts making contributions to the Plan on your behalf, and the payment of your premium share for benefit coverage.

Per the Affordable Care Act:

- **A full-time employee is a person who works in a position that is designated as a full-time position and works at least 30 hours per week, or at least 130 hours in a calendar month.**

Initial Eligiblity for Known Full-Time Employees

If you are hired as a **known Full-Time Employee**, you are initially eligible for coverage on the first day of the month following the date that is 60 days after your date of hire, provided you work the minimum of 30 hours per week.

Continuing Eligibility for known Full-Time Employees. You will remain eligible for coverage regardless of the number of hours you work until you complete your first ongoing 12-month measurement period after your date of hire.

After you complete your first ongoing 12-month measurement period, you remain eligible by paying any required premium share for coverage and:

- Averaging 30 hours of work each week during a 12-month ongoing measurement period; or
- Averaging 25 weekly hours of work each month if hired on or after 1/1/2017, 20 weekly hours if hired between 11/1/2003-12/31/2016, and 16 weekly hours if hired before 11/1/2003.

The following rules apply to continuing eligibility for known Full-Time Employees:

- **If You Work 30 Hours or More During an Ongoing Measurement Period.** Every year, the Fund will measure your hours during an ongoing 12-month measurement period beginning with the first full payroll period starting in each October. If you average 30 hours of work per week during the 12-month ongoing measurement period, then you will be eligible for coverage for the following calendar year (known as a stability period), regardless of your hours worked during the stability period. This ongoing measurement will occur each year of your employment.

- **If You Work Less Than 30 Hours During the Ongoing Measurement Period.** If you do not average 30 hours of work each week during an ongoing 12-month measurement period, then you may maintain eligibility for the following calendar year on a monthly basis by averaging 25 weekly hours of work each month if hired on or after 1/1/2017, 20 weekly hours if hired between 11/1/2003-12/31/2016, and 16 weekly hours if hired before 11/1/2003.

Initial Eligibility for Dependents of known Full-Time Employees. If you are a known Full-Time Employee, your dependents become initially eligible for coverage, as follows:

1. For your dependent child, at the same time you become eligible. The premium share for child coverage is the full cost of coverage except for those months for which you averaged 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003 in the second preceding month.
2. For your dependent spouse, on the earlier of:
    a. The first day of the 14th month of your employment with a contributing employer, if you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003, in the 12th month of employment, provided your employer makes the required contribution for the month; or
    b. The first day of the month following the date that is 60 days after you complete 1,200 hours of employment with a contributing employer.

If you are a known Full-Time Employee and you do not satisfy either a. or b. above, then your spouse will be eligible as of the first day of the second month following a month in which you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003.

3. **Continuing Eligibility for Dependents of known Full-Time Employees.** Subject to your payment of any required premium share, if you are a known Full-Time Employee, your dependents maintain eligibility based on the average weekly hours you work during the 12-month measurement period or, on a monthly basis as follows:

4. **Prior to Completion of Full Ongoing Measurement Period.** Until you complete your first ongoing measurement period, your children remain eligible for coverage regardless of your hours worked. The premium share for child coverage is the full cost of coverage, except for those months for which you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003. Your spouse will maintain eligibility for those months for which you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003.

5. **After Completion of Full Ongoing Measurement Period.** After you complete your first ongoing measurement period, your dependents will remain eligible under these rules:
    a. Your spouse is eligible on a month-to-month basis if you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003; and
    b. Your child is eligible:
        i. For a 12-month stability period if you average 30 hours of work per week in a measurement period (The premium share for child coverage is the full cost of coverage, except for those months during the stability period for which you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003); or
        ii. On a month-to-month basis if you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003.

Measurement period:

- **A measurement period is a 12-month period.**
- **Your initial measurement period is the 12-month period that starts on the first day of the month after your employment begins.**
- **All measurement periods after your first measurement period are called ongoing measurement periods and are 12-month periods that begin with the first payroll period starting in each October.**

Initial Eligibility for Variable Hour Employee

If you are hired as a **Variable Hour Employee** you will have a 12 month waiting period. You will be initially eligible on the first day of the 14th month of employment provided you average 25 weekly hours of work each month if hired on or after 1/1/2017, 20 weekly hours if hired between 11/1/2003-12/31/2016, and 16 weekly hours if hired before 11/1/2003. If you do not work the required amount of hours on the 12th month of employment, you will be eligible as of the first day of the second month following a month in which you average 25 weekly hours of work each month if hired on or after 1/1/2017, 20 weekly hours if hired between 11/1/2003-12/31/2016, and 16 weekly hours if hired before 11/1/2003.

Continuing Eligibility for Variable Hour Employees. Once enrolled, you will remain covered as a Variable Hour Employee if you work 25 weekly hours of work each month if hired on or after 1/1/2017, 20 weekly hours if hired between 11/1/2003-12/31/2016, and 16 weekly hours if hired before 11/1/2003 or during a 12-month measurement period. Your continued eligibility for coverage as a Variable Hour Employee requires that you be credited with an average of the required number of contribution hours each week during a calendar month or during a 12-month ongoing measurement period.

You may maintain eligibility if you pay any required premium share for coverage, your employer makes contributions on your behalf, and you:

- Average 30 weekly hours of work in a 12-month ongoing measurement period; or
- 25 weekly hours of work each month if hired on or after 1/1/2017, 20 weekly hours if hired between 11/1/2003-12/31/2016, and 16 weekly hours if hired before 11/1/2003.

The following rules apply to continuing eligibility for Variable Hour Employees:

- **If You Work 30 Hours or More During the Initial Measurement Period.** If you average 30 hours of work per week during the 12-month measurement period that begins after your date of hire, then, after a one-month administrative period, you will be eligible for coverage for the subsequent 12-month period (known as a stability period), regardless of your hours worked during the stability period.

- **If You Work 30 Hours or More During the Ongoing Measurement Period.** Every year, the Fund will measure your average weekly hours during an ongoing 12-month measurement period that begins with the first full payroll period starting in each October. If you average 30 hours of work per week during the 12-month ongoing measurement period, then you will be eligible for coverage for the following calendar year (known as a stability period), regardless of your hours worked during the stability period. This ongoing measurement will occur each year of your employment.

- **If You Work Less Than 30 Hours per Week During the Ongoing 12-Month Measurement Period.** If you do not average 30 hours of work per week during an ongoing 12-month measurement period, then you can maintain eligibility on a monthly basis by averaging 25 weekly hours of work each month if hired on or after 1/1/2017, 20 weekly hours if hired between 11/1/2003-12/31/2016, and 16 weekly hours if hired before 11/1/2003.

Average hours worked per week are determined on a monthly basis or on the basis of a 12-month measurement period. Weeks vary according to your employer's payroll periods. If your employer's weekly payroll period ends on a Saturday, then hours worked in each week count for the month in which the Saturday occurs.

Initial Eligibility for Dependents of Variable Hour Employees. If you are a Variable Hour Employee, your dependents become initially eligible for coverage on the earlier of:

1. For your eligible spouse and child, the first day of the 14th month of your employment with a contributing employer, if you you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003 in the 12th month of your employment, provided your employer makes the required contribution for the month; or
2. For your eligible child, the first day of the month after you average at least 30 but less than 32 weekly hours during your first 12 full months of employment with a contributing employer, followed by a one-month administrative period (The premium share for child coverage is the full cost of coverage except for those months for which you averaged 35 weekly hours if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003 in the second preceding month,); or
3. For your eligible spouse and child, the first day of the month after you average at least 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003 during your first 12 full months of employment with a contributing employer, followed by a one-month administrative period.

If you are a Variable Hour Employee and you do not satisfy any of the foregoing rules, then your dependent spouse and/or children will be eligible as of the first day of the second month following a month in which you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003.

Continuing Eligibility for Dependents of Variable Hour Employees. Subject to your payment of any required premium share, if you are a Variable Hour Employee, your dependents maintain eligibility based on the average weekly hours you work during the 12-month measurement period or on a monthly basis as follows:

1. **If You Work 30 Hours or More During the Measurement Period.** If you average 30 hours of work per week during a 12-month measurement period, then:
   a. **You and your children** will be eligible for coverage for the following calendar year (known as a stability period), regardless of your hours worked during the stability period. For those months during the stability period for which you average fewer than 35 weekly hours of work

each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003, the premium share for the children will be the full cost of coverage.

b. **Your spouse** will be eligible for coverage on a month-to-month basis if you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003.

If You Work Less than 30 Hours Per Week During a Measurement Period. If you do not average 30 hours of work per week during a 12-month measurement period, then you can maintain eligibility for your children and spouse on a monthly basis by averaging 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003.

Whether you are a known Full-Time Employee or a Variable Hour Employee, you should refer to your schedule of benefits for the minimum amount of hours you must work to be eligible for Employee only coverage and Family Coverage.

Monthly Employee

Your benefit coverage may be determined on a monthly basis rather than an hourly basis if the collective bargaining agreement or participation agreement your employer signed with the United Food and Commercial Workers Union requires monthly contributions. You may refer to your collective bargaining agreement or participation agreement or contact the Welfare Fund office to determine whether your employer is required to make monthly contributions to the Welfare Fund for Unit 1 benefits.

To be eligible for benefit coverage you are required to work a certain average number of hours per week for Unit 1 Monthly benefit coverage. The required average number of hours is determined by your employer's agreement with the UFCW. If you are a Unit 1 Monthly employee, you are not eligible for Unit 2 (part-time) benefits. Your eligibility for monthly benefits will begin on the first day of the third month for which your employer makes a monthly contribution to the Welfare Fund on your behalf.

Election of Dependent Coverage

Complete Dependent Information on Your Enrollment Form. Your eligible dependents must be listed on your enrollment form. Until your eligible dependents are listed on the enrollment form, and the Fund office receives the form, your dependents will not be covered. You must complete a new enrollment form to add new eligible dependents to your coverage. In order for your eligible dependent to be covered from the date you acquired your eligible dependent, you must enroll your new eligible dependent within 31 days of acquiring your eligible dependent.

Because you must pay for dependent coverage, when you become eligible for such coverage, you will be allowed to choose one of the following options:

1. **No Dependent Coverage.** You may elect to take employee-only coverage; or
2. **Dependent Coverage Based on Monthly Hours Worked** You may elect dependent coverage only for those months for which you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003. Your dependents, including your legal spouse, will

only be eligible in months for which you average 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003, and you pay the standard premium share for dependent coverage. No dependent coverage will be provided for months for which you average fewer than 35 weekly hours of work each month if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003; or

3. **Dependent Coverage Based on Measurement Period.** You may elect dependent child coverage regardless of your monthly hours worked if you qualify for coverage in the prior 12 month measurement period by averaging 30 hours of work per week, or if you were hired as a known Full-Time employee. However, you will pay the full cost of coverage for your children in the months in which you average less than 35 weekly hours of work if hired on or after 1/1/2017, 32 weekly hours if hired between 11/1/2003-12/31/2016, and 25 weekly hours if hired before 11/1/2003.

   Coverage based on hours worked in a 12 month measurement period applies to dependent children only.

Special Rules for Coverage of Your Spouse. If your spouse is employed and offered employer health insurance that is subsidized in any way, they must enroll in their employer's plan to be covered under this plan.

A subsidized plan means the employer pays a portion of the cost of the health insurance.

Once your spouse is covered under the other plan, your spouse will continue to be covered under this Plan, provided you pay the applicable premium share for your spouse's coverage. Your spouse's other plan will be his or her primary plan, which means that the other plan pays benefits first. Your spouse may then submit for reimbursement from this Plan, his or her costs that are not covered under the other plan. By coordinating benefits in this way, your spouse may receive more benefits than if he or she were covered under only one plan.

This requirement applies only to your spouse. Eligibility requirements for dependent children are described in the previous subsections. If your spouse can elect coverage only during a specific enrollment period under the spouse's plan, this Plan will provide coverage up to the date of the open enrollment, provided you pay the applicable premium share for your spouse's coverage.

You must complete and return a Spousal Coverage Verification Form if you are married. The form is your certification of your spouse's employment situation that informs the Plan whether your spouse is eligible for coverage under a subsidized plan of his or her employer. The Fund will not pay claims incurred by your spouse until you complete and return this form to the Welfare Fund office. This form will also help the Welfare Fund office coordinate benefits for your spouse and confirm your spouse's eligibility for coverage under this Plan.

Your Eligible Dependent Defined

See the definition of eligible dependent in **Appendix G: Glossary.**

Qualified Medical Child Support Orders

The Plan provides coverage for your children that are required to be covered under the terms of a Qualified Medical Child Support Order (QMCSO) (or under a National Medical Support Notice). A QMCSO is generally a court order that directs a medical plan covering a parent to provide benefits to the parent's children. The Plan will provide benefits in accordance with such an order. A

child covered by a QMCSO is called an alternate recipient and is treated as an eligible dependent under the Plan if he or she meets the criteria specified in the law governing QMCSOs. If you think this law may apply to you, you may want to contact your legal counsel. You may contact the Welfare Fund office if you have questions about the Plan's QMCSO procedures, or if you need a copy of those procedures, which are available free of charge.

When the Plan pays benefits for an eligible dependent pursuant to a QMCSO to reimburse expenses paid by that eligible dependent's custodial parent or legal guardian, the Plan may pay either the eligible dependent or the eligible dependent's parent or legal guardian or, as applicable, the person designated by the QMCSO to receive such reimbursement.

When the Fund Administrator receives a QMCSO, the Fund Administrator will promptly give notice to you and each dependent or the dependent's parent or legal custodian that the Plan has received the order. The Fund Administrator will also give notice of the Plan's procedures for determining whether the order is a QMCSO. The Fund Administrator will make that determination in accordance with the Plan's procedures and notify you and each affected dependent of its determination. Your child will be enrolled in the same coverage option as you.

When Coverage Ends

Your eligibility ends on the earlier of:

1. The last day of the month in which your employer reports your termination of employment;
2. The last day of the second month following the month for which you last met your Plan's hours requirements for either Unit 1 or Unit 2 coverage;
3. The date the Plan ends;
4. The date of your death;
5. The date that the Plan does not receive your employer contribution for your coverage.

When Your Dependent's Coverage Ends

Your eligible dependent's eligibility ends on the earlier of:

1. The date your eligibility terminates;
2. The date the Plan ends;
3. The date your eligible dependent no longer meets the definition of eligible dependent as defined on page 117-118.
4. The date you choose not to cover your dependents or the date that you do not meet the requirements for coverage of your dependents; or
5. The date that the Plan does not receive your employer contribution for your dependent's coverage.

In the event of your death, coverage for your eligible dependents will be continued for three months immediately after the end of the month in which your death occurred. The extension of coverage to your surviving eligible dependents is provided by the Plan free of charge if they are covered in the month that your death occurs.

Your eligible dependent's eligibility for Plan benefits ends three months after the end of the month in which your death occurred unless your eligible dependent elects COBRA continuation coverage as described on page 19. The

COBRA continuation period begins after the three-month period.

Disabled Child

If your eligible dependent is covered as a disabled child, eligibility for benefits automatically and immediately stops on the earliest of the following dates:

1. The date your child's disability no longer exists;
2. The date your child fails to submit to any required medical examinations;
3. The date that the Plan does not receive your employer contribution for you or your dependent's coverage.
4. The date you fail to provide required proof of the uninterrupted existence of your eligible dependent child's disability; or
5. The date your child is no longer either your disabled eligible dependent child or your qualifying relative, as described on page 117-118.

Special CHIPRA Enrollment Rights

CHIPRA (the Children's Health Insurance Program Reauthorization Act of 2009) created two new special enrollment events if you are an eligible participant in the Plan but are not enrolled in the Plan. First, if you or your eligible dependents were covered under Medicaid or a state CHIP plan and lose that coverage, you or your eligible dependents are entitled to a special enrollment period in this Plan. Second if you or your eligible dependents become eligible for the state's premium assistance you are entitled to a special enrollment period. You have 60 days to notify the plan of the event, and 31 days to provide proof of eligibility and enroll. To request Special CHIPRA Enrollment or obtain more information, contact the Welfare Fund office at 314-835-2700.

CHIPRA special enrollment rights apply only to individuals who are eligible under the Plan.

For those who are covered under a unit that does not offer dependent coverage there is no special enrollment event for dependents.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative record keeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay the required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – for the future – once the

mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days advance written notice.

You May Continue Coverage During Family and Medical Leave

The Plan complies with the federal Family Medical Leave Act (FMLA) of 1993, as amended. The FMLA allows certain employees to take up to 12 weeks of unpaid leave during any 12-month period for:

- The birth, adoption, or placement with you for foster care, or adoption of a child;
- The care of a seriously ill spouse, parent or child;
- Your serious illness; or
- A qualifying urgent need for a leave because your spouse, son, daughter or parent has been notified of an impending call to order to active duty or is on active duty in the U.S. armed services in support of a military operation as defined under the FMLA.

In addition, certain employees are allowed to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member who must be the son, daughter, parent, or next of kin of the employee, must be undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty in the armed services, and must be an outpatient or on the temporary disability retired list of the armed services.

See your employer to learn if the FMLA applies to you. If your employer approves your leave, the Fund will extend your Plan coverage and that of your covered eligible dependents, if eligible, at no cost to you during your leave.

You will remain eligible until the end of the leave only if your employer:

- Properly grants the leave under the FMLA; and
- Notifies the Welfare Fund office in writing.

Your employer is required to continue your health coverage during your leave under the same terms and conditions as if you had continued to work.

Your Family and Medical Leave Act Hours Are Counted

If your employer is subject to the Family and Medical Leave Act (FMLA) and you are granted FMLA leave, the hours you miss from scheduled work because of FMLA leave will count as hours worked in determining your eligibility for Plan benefits. If you are eligible for FMLA coverage, you should make sure that your employer reports your hours spent on FMLA leave to the Welfare Fund office.

Duty of Your Employer

Your employer has the responsibility to grant or deny your FMLA leave. The employer must notify the Welfare Fund office of all leaves it grants and provide the Welfare Fund office with documentation concerning the reason for your leave.

FMLA eligibility. You are eligible for a leave under the Family and Medical Leave Act if you:

- ☑ **Have worked for a covered employer for at least 12 months; and**
- ☑ **Have worked in covered employment at least 1,250 hours over the previous 12 months; and**
- ☑ **Work at a location where at least 50 employees are employed by your employer within a 75-mile radius; and**
- ☑ **The leave is approved by your employer.**

Extension of Coverage for Disability

If your average number of contribution hours is reduced because you are absent from work due to a non-work-related sickness or injury and you are under the care of a physician for that sickness or injury, your coverage will be extended for up to three months beyond the date it would normally end. You may elect COBRA continuation coverage if you are still absent after this three-month extension. This three-month disability extension is not counted in calculating the amount of your COBRA continuation period. Your COBRA period will begin after the disability extension period.

The extension of your eligibility for three months due to absence from work because of non-work-related sickness or injury includes any absence from scheduled work that you take as leave under the FMLA. No additional extension beyond the stated maximum three months will be granted under the FMLA (except for the 26-week FMLA leave to care for a service-member).

If your absence is due to a work-related sickness or injury covered by Workers' Compensation, your eligibility can be extended for up to six months while you are disabled. You may elect COBRA continuation coverage if you are still absent after this six-month extension and the COBRA period will start at the end of the six-month extension. See page 18-21 for information about COBRA continuation coverage.

Your eligibility will be extended under the same benefits for which you were eligible during the month you would have otherwise lost eligibility. To qualify for the Disability Extension of Eligibility as set forth in this section, you must notify the Welfare Fund office of your claim for extended eligibility due to disability and present medical evidence to support your disability claim that:

- ▸ Is satisfactory to the Board of Trustees; and
- ▸ Shows you are unable to work due to sickness or injury.

The Welfare Fund office must be notified of your work-related or non-work related sickness or injury to extend benefits.

Extension of Certain Benefits for Total Disability

If an employee becomes totally disabled while covered under this Plan, and coverage is terminated while treatment is in progress, coverage for some benefits for the disabled employee will be continued beyond the date coverage would otherwise end. Limited coverage will be continued under the medical plan only under the coverage level you are enrolled in. Your medical provider and employer will be required to submit additional information to the Welfare Fund office to qualify you for this extension. The Plan will determine whether or

not you are totally disabled on the basis of the information submitted by your medical provider and employer.

Benefits under the medical plan will be extended until the first of the following:

- The end of a 12-month period after the date eligibility would normally end; or
- The first day that the employee is no longer totally disabled.

The extension applies:

- Only to the charges related to treatment of the disabling condition that existed on the eligibility termination date.
- Only if the employee has not received the maximum benefits under this Plan.
- If COBRA is elected, this provision applies after COBRA is exhausted or terminated.
- If the employee is covered under the extension of benefits provision and becomes eligible under another group plan as an employee, the extension of benefits will end on the date the employee becomes covered or would have become covered under the other plan.

Special Note. The extension of benefits covers only the disabling condition. If you want to be covered for other medical conditions, or beyond the extension time period, you must elect COBRA continuation coverage within 60 days of the date of your COBRA election notice. (see page 21). You will not be given the opportunity to elect COBRA continuation coverage when the extension of benefits ends unless it is within this 60-day period.

You May Continue Coverage During Military Service

Your health care coverage will continue if you serve in the Uniformed Services of the United States (active duty or inactive duty training) for up to 31 days. If you serve for more than 31 days, you may continue your coverage at your own expense for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Leave under USERRA will be administered in the same manner as COBRA coverage, except that coverage may extend to 24 months. See the next section for more information about COBRA continuation coverage. You may also continue coverage for your eligible dependents if they were covered under the Plan at the time you entered military service.

Generally, the rules for giving the Welfare Fund office notice of your active duty and the time limits for electing and paying for coverage while you are on active duty are the same as the notice, election and payment rules for COBRA coverage.

If you leave contributory employment to enter the Uniformed Services, you may use up your remaining earned eligibility while you are in the Uniformed Services or you may choose to save that already earned eligibility to cover you when you return to contributory employment. If when you return to contributory employment, you do not have any remaining already earned eligibility, you may pay for your benefits (at COBRA rates) until you have re-qualified for coverage under the Plan based on your status as a known Full-Time or Variable Hour Employee.

If you continue your coverage under USERRA at your own expense, it will stop at the earliest of the following:

- The date of your death;
- The date you or your eligible dependents do not make the required payments within 30 days of the due date;
- The date the Plan no longer provides any group health benefits;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA.
- The day you lose eligibility under USERRA (for instance, for a dishonorable discharge); or
- The last day of the 24th consecutive month of coverage or the last day of any extension of the coverage period allowed under the COBRA or USERRA rules.

USERRA continuation coverage runs concurrently with your COBRA continuation coverage. You will not be offered COBRA continuation coverage after your USERRA coverage ends. For more information about paying for your own coverage under USERRA, contact the Welfare Fund office at 314-835-2700 in the St. Louis area or call toll free at 1-866-565-2700 in Missouri outside St. Louis or in Illinois.

Generally Uniformed Services means service in the United States Army, Navy, Marine Corps, Coast Guard, National Guard or Commissioned Corps of the Public Health Service, as well as reserve components of each of these Services.

You May Continue Coverage Through COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended), or COBRA, you or your covered eligible dependents may continue health care coverage past the date coverage would normally end. If you qualify for COBRA coverage, you will be given the option to self-pay at group rates for the same medical, dental and/or vision benefits you qualified for as an active employee.

Life, accidental death and dismemberment, weekly disability coverage and other disability extension benefits are not available through COBRA.

You Must Have a Qualifying Event

You do not have to show that you are insurable for COBRA continuation coverage. It is offered to you if you lose coverage and, to your eligible dependents, if they lose coverage, if loss of coverage is the result of certain circumstances known as qualifying events. To be eligible for continuation coverage, you and your eligible dependents must be covered by the Plan at the time of the qualifying event. These qualifying events and the length of coverage are shown in the Length of Coverage chart on page 20.

Each covered individual who loses eligibility for health care benefits due to one of the qualifying events described below is a "qualified beneficiary." Each qualified beneficiary has an independent right to elect COBRA coverage. However, one qualified beneficiary can elect COBRA coverage on behalf of all of the qualified beneficiaries who lost coverage due to the same qualifying event. Under the law, a qualified beneficiary is any employee or the spouse or eligible dependent child of an employee who is covered by the Plan on the day

before a qualifying event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes an eligible dependent child by birth, adoption or placement for adoption with the covered employee (qualified beneficiary) during a period of COBRA Continuation Coverage is also a qualified beneficiary.

If you have a newborn child, adopt a child, have a child placed with you for adoption (for whom you have financial responsibility), add a spouse through marriage or otherwise, add an eligible dependent while your COBRA continuation coverage is in effect, you may add that eligible dependent to your coverage. You must give the Welfare Fund office written notice of the birth, adoption, placement of a child with you for adoption or addition of a spouse in order to have the eligible dependent added to your coverage. Newborn or newly adopted children who are added while your COBRA coverage is in effect will have the same COBRA rights as if they were qualified beneficiaries covered by the Plan before the event that triggered COBRA continuation coverage. Any other eligible dependents who are added to your coverage will not be treated as qualified beneficiaries. As with qualified beneficiaries, you must make continuous COBRA payments on time to keep uninterrupted coverage for eligible dependents you add.

If you become entitled to (eligible for and enrolled in) Medicare within 18 months before the qualifying events of your termination of employment or reduction in hours, your covered eligible dependents will be eligible to continue coverage under COBRA for up to 36 months from the date of your entitlement to Medicare. However, you will be entitled to elect COBRA coverage for only 18 months from the date of your termination or reduction in hours.

Qualifying Event

You, as the employee, will experience a qualifying event if you lose coverage for one of the following reasons:

- Termination of your employment; or
- You have a reduction in the required number of hours for eligibility.

Your eligible dependents will experience a qualifying event if they lose coverage for one of the following reasons:

- Termination of your employment;
- You have a reduction in the required number of hours for eligibility;
- You and your spouse divorce or legally separate;
- You pass away;
- You become entitled to (eligible for and enrolled in) Medicare; or
- Your dependent child no longer meets the definition of eligible dependent under the Plan.

Second Qualifying Event

If your eligible dependents experience another qualifying event while purchasing coverage during their 18-month COBRA coverage period and that qualifying event would have resulted in a loss of coverage if it occurred while you were actively working, your eligible dependents may extend the length of coverage for up to 36 months.

The extension:

- Cannot exceed 36 months from the date of the first qualifying event; and
- Applies only to individuals who were qualified beneficiaries under the Plan as of the date of the first qualifying event and who were covered under the Plan at the time of the second qualifying event.

LENGTH OF COBRA COVERAGE

If this qualifying event occurs while you and your dependents are covered by the plan	COBRA coverage is available for	The maximum length of coverage from the qualifying event is
End of your employment (for reasons other than gross misconduct)	You and eligible dependents covered by the Plan	→ 18 months → 29 months if you or your eligible dependent is disabled*
Reduction in your hours so that you no longer meet elibility requirements	You and eligible dependents covered by the Plan	→ 18 months → 29 months if you or your eligible dependent is disabled*
Your death**	Eligible dependents covered by the Plan	→ 36 months
Your entitlement to Medicare within 18 months prior to your termination or reduction in hours	Eligible dependents covered by the Plan	→ 36 months from the date of entitlement to Medicare
Your entitlement to Medicare during the first 18 months of COBRA	Eligible dependents covered by the Plan	→ 36 months only if it would have resulted in a loss of coverage if it occured while you were an active employee
Divorce or legal separation	Eligible dependents covered by the Plan	→ 36 months
Child(ren) no longer qualify as eligibile dependent(s)	Eligible dependent children covered by the Plan	→ 36 months

* For continuation of an additional 11 months of coverage, you must notify the Welfare Fund office within 60 days from the date of the Social Security disability determination and no later than the end of the 18-month initial COBRA period. You must also pay for COBRA coverage for the first 18 months to be eligible for the 11-month extension. If either you or your dependent is no longer considered disabled by Social Security, you must notify the Welfare Fund office within 30 days of the determination.

** See also the section entitled Continuation of Dependents' Medical Benefits After Your Death on page 23.

Additional COBRA Coverage for Disability: As noted in the Length of Coverage chart, in cases of disability, coverage for you and your eligible dependents may continue for a total of 29 months (an additional 11 months) after your employment ends or you have a reduction in your hours. This additional coverage is available to all family members of the disabled qualified beneficiary. To qualify, you or one of your eligible dependents must be totally disabled (as determined by the Social Security Administration) either:

- At the time of your termination or reduction in hours; or
- During the first 60 days of your 18-month COBRA continuation coverage period.

You must notify the Welfare Fund office of the determination of your Disability by the Social Security Administration within 60 days of the decision and no

later than the end of the 18-month initial COBRA period. All family members of the disabled qualified beneficiary may elect the additional coverage. If you or your eligible dependents do not notify the Welfare Fund office within 60 days of the Social Security disability determination, the right to elect the extension of coverage is lost.

You Must Notify the Welfare Fund Office

You, your eligible dependent or representative must inform the Welfare Fund office in writing within 60 days of the date you legally separate, divorce or your child loses eligible dependent status under the Plan. If you do not notify the Welfare Fund office in writing within 60 days of such an event, you lose your right to elect COBRA continuation coverage. You or your eligible dependents must notify the Welfare Fund office of a second qualifying event. In addition, you must notify the Welfare Fund office of a disability, as noted in the previous section.

Your employer will notify the Welfare Fund office of your termination of employment, reduction in hours, or death. However, because employers contributing to the Fund may not be aware of these events, the Welfare Fund office will rely on its records for determining when eligibility is lost under these circumstances. To ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Welfare Fund office of any qualifying events as soon as they occur.

You Must Elect COBRA Continuation Coverage

When the Welfare Fund office is notified that one of these events has occurred, you and your eligible dependents will be notified of your right to elect COBRA coverage when the Fund sends you a COBRA notice. The COBRA notice will give you information about how to elect COBRA continuation coverage. Once you receive a COBRA notice, you have 60 days to respond (from the date of the COBRA notice) if you wish to elect COBRA continuation coverage. Even if you do not elect coverage, your eligible dependents have the opportunity to elect coverage independently from you if they were covered under the Plan. If a COBRA election is not made and returned within the 60-day period, the right to COBRA coverage is lost.

Notify the Welfare Fund office promptly of these events. You have only 60 days from the date of these events to notify the Welfare Fund office of:

- ☑ **Legal separation;**
- ☑ **Divorce;**
- ☑ **Your child's loss of dependent status;**
- ☑ **Social Security disability determination.**

Contact for COBRA Questions

If you or your eligible dependent has any questions regarding this Plan's COBRA continuation coverage, call or write:

COBRA Coordinator
UFCW 655 Welfare Fund
13537 Barrett Parkway Drive, Suite 100
Manchester, Missouri 63021-5866
(314) 835-2700 or 1-866-565-2700

You Must Pay for COBRA Continuation Coverage

The Welfare Fund office will notify you and/or your eligible dependents of the cost of COBRA continuation coverage when it gives notice of your right to COBRA coverage. The Trustees determine the cost for COBRA coverage each year. The cost will not exceed 102% of the Plan's cost to provide this coverage. The cost to the disabled person for the extended 11 months of coverage due to disability (from the 19th month through the 29th month of disability) is an amount determined by the Trustees, not to exceed 150% of the Plan's cost to provide coverage.

The first payment for continuation coverage must include payments for any months back to the day you and/or your eligible dependents lost coverage under the Plan. This payment is due no later than 45 days after the date you or your eligible dependent signed the election form and timely returned it to the Welfare Fund office.

Subsequent payments are due on the first business day of each month for which coverage is provided, with a grace period of 30 days. If payment is not received by the due date, your benefits will stop immediately. The Welfare Fund office will not give any notice prior to terminating COBRA coverage for non-payment. Once your COBRA continuation coverage stops, it cannot be reinstated.

Coverage During COBRA Election Period and Payment Periods

After regular coverage ends and before you and/or your eligible dependent submits both the election form and the payment for COBRA continuation coverage, the Plan cannot pay any claims. If a provider inquires about whether you and/or your eligible dependent has coverage, the Welfare Fund office will inform the provider that you and/or your eligible dependent is in the COBRA election and payment period. If you and/or your eligible dependent ultimately elects and pays for COBRA within the time limits, the Welfare Fund office will then adjudicate claims incurred during the election and payment period.

Similarly, if you and/or your eligible dependent does not make a monthly payment by the due date, benefits will be interrupted until the monthly payment is received. If payment is ultimately made prior to the end of the 30-day grace period, claims incurred during the grace period will be adjudicated.

Special note. The Plan intends to strictly enforce the deadline dates for electing coverage and making self-payments under COBRA. These dates will be determined by postage cancellation.

Therefore, it is very important that you carefully read the notices sent to you from the Welfare Fund office so that you can become informed about your choices and how to respond in making an election.

Other coverage options besides COBRA Continuation Coverage

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

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under

COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it may be difficult or impossible to switch to another coverage option.

Continuation of Dependents' Medical Benefits after Your Death

In the event of your death, if your eligible dependents are covered under the Plan, Their eligibility will be continued for the three-month period immediately after the end of the month in which your death occurred. This extension of eligibility to your surviving eligible dependents is provided by the Welfare Fund free of charge. At the end of the three-month period, your eligible dependents will be eligible for COBRA coverage.

Your eligible dependents should call or write the Welfare Fund office for information on continuation of their coverage and refer to the information on page 13-14.

You Can Lose Your COBRA Coverage

The period of COBRA continuation coverage for you or your eligible dependents may be cut short for any of the following reasons:

- You and/or your eligible dependents do not make the required COBRA payments within 30 days of the due date;
- The Plan stops providing any group health benefits;
- The COBRA period of coverage to which you are entitled has expired;
- After the qualifying event you or your eligible dependents become covered under another group health care plan; or
- You or a qualified beneficiary becomes entitled to Medicare.

When COBRA coverage ends, certification of length of coverage under this Plan will be given as noted above.

In order for the Plan to make sure that you and all of your covered eligible dependents get all of the notices about COBRA, please keep the Welfare Fund office informed of your current address and the addresses of any covered eligible dependents who do not live in your home.

Coverage for Retirees

The Plan offers eligible employees an opportunity to enroll in the Early Retirement Incentive Program (ERIP). ERIP provides coverage for you and your covered eligible dependents until your 65th birthday on a self-pay basis, if you retire before your 65th birthday and meet certain criteria determined by the Board of Trustees. Generally, you will be eligible for ERIP coverage if you meet the following guidelines:

- You must have Unit 1 coverage in the month immediately preceding the month in which the ERIP coverage begins. The coverage available under ERIP is the same coverage you had in the month immediately preceding the month in which the ERIP coverage begins. Please note: If you are required to pay any portion of your health insurance, as per

your Collective Bargaining Agreement, you must enroll in health care benefits during the open enrollment period. You should select the same coverage during open enrollment that you are interested in purchasing through the ERIP Program. For example, if you only elect employee coverage on the Open Enrollment Election form, then you can only elect single (employee) coverage for ERIP.

You must advise the Health and Welfare office of your intent to begin coverage under the ERIP program by submitting a completed enrollment form, no later than your last day of work.

- You are not eligible for Medicare.
- You must work one day in the calendar year in which the ERIP coverage begins.
- You must meet the criteria listed under a., b., or c. below:

a. If you are 62-64 years of age and have twenty (20) years of continuous participation in this Health and Welfare Fund

OR

b. If you are 62-64 years of age and have twenty (20) years of continuous employment with the contributing employer (or a predecessor employer) if the employer has contributed to the Health and Welfare Fund for at least ten (10) years.

OR

c. If you are 62-64 years of age, have twenty (20) years of service under one or more of the following Pension Plans, and are eligible, as well as approved for an early or normal retirement benefit from one or more of the following Pension Plans:

UFCW Local 655 Food Employers Joint Pension Plan

UFCW Midwest Pension Plan

UFCW Local 534 Grocery Pension Plan

UFCW Local 534 Meat Pension Plan

You fully meet any other optional eligibility guidelines that may be established by the Trustees of the Welfare Fund.

If you are eligible under the ERIP, you must pay one-half (½) of your monthly retiree health care coverage until you reach age sixty-five (65).

You should contact the Welfare Fund office for information about eligibility if you have questions about ERIP coverage. The Trustees reserve the right to modify or discontinue the provisions of the Early Retirement Incentive Program at their discretion.

As with all of the benefits provided under this Plan, the benefits provided to retirees and their eligible dependents are not guaranteed to continue. The Trustees reserve the right and discretion to alter, amend, reduce or terminate those benefits, as they deem appropriate.

Spouse and Dependent Continued Coverage Through Early Retirement Incentive Program (ERIP)

If you enrolled for family coverage under the Early Retirement Incentive Program (ERIP) and your eligibility ends when you reach age 65, your spouse and children will be offered the opportunity to pay for continuation coverage. The self-pay rates for coverage are equal to the self-pay rates under COBRA.

To continue coverage, your spouse and eligible dependents must:

- Pay for the coverage; and
- Waive their rights to COBRA continuation coverage.

Your spouse may continue coverage until:

- Your spouse reaches Medicare eligibility age;
- Your spouse dies;
- You and your spouse divorce;
- Your spouse does not pay for coverage; or
- The Plan ends.

Your eligible dependent may continue coverage:

- As long as the dependent remains an eligible dependent;
- Until payments for coverage end; or
- Until the Plan ends.

Reinstatement of Eligibility

Your eligibility will be reinstated for benefits under the Plan:

- If you meet the contribution requirements described in the continued eligibility section;
- Beginning on the first day of the second month following the month in which you were credited with the required employer contributions.

Reinstatement of Eligibility after Leaves of Absence

If your coverage ends while you are on an approved leave of absence or while you are on family medical leave under the Family and Medical Leave Act (FMLA) that exceeds 12 weeks (or 26 weeks, if applicable) or that is not approved by your employer, your coverage will be reinstated on the first day of the second month following the month in which employer contributions are received on your behalf, subject to all eligibility guidelines and hours requirements listed in the Eligibility Section on pages 5-6. This provision is not effective if you were terminated and rehired. See the section explaining FMLA leave on pages 15-16.

If your coverage ends while you are on an approved leave of absence for military service in the Uniformed Services or while you are on an approved family medical leave under the Family and Medical Leave Act (FMLA), your coverage will be reinstated, without evidence of good health, as required by federal law (see pages 17-23).

Reciprocity Agreements

The Board of Trustees is authorized to enter into "reciprocity agreements" with other welfare funds covering members of the United Food and Commercial Workers Union. Generally, a reciprocity agreement provides a shorter period for you to become eligible under the UFCW Local 655 Plan if you were formerly covered under another welfare plan that has signed a reciprocity agreement. However, a reciprocity agreement may provide for other aspects of coverage under the Plan. You should notify the Welfare Fund office if you think this may be applicable to you.

MANAGING THE COST OF MEDICAL CARE

Your Plan includes programs designed to manage your costs for health care. Some Plan benefits have certain restrictions or limitations. See your Schedule of Benefits, the list of Covered Medical Expenses on page 32, and the list of Exclusions and Limitation on Medical Benefits (pages 44-48) for more information. In order to maximize your Plan benefits, please read the following provisions carefully.

Your Choice

With this Plan of medical care, your choice determines the level of benefits you will receive. The Plan is designed to provide you with maximum freedom to choose how your health care is handled. You decide, at the time you need medical service, if you will receive care from:

- A physician or hospital in a Preferred Provider Organization (PPO network); or
- An out-of-network physician or hospital.

PPOs are independent provider network organizations. Neither the PPO, nor any out-of-network provider is an agent of the Plan, and the Plan is not responsible for their errors.

The PPO network includes a large number of physicians and hospitals throughout your geographic area. "Out-of-network" refers to all other licensed physicians and hospitals that do not belong to the network. If you need assistance in finding a network provider, you may contact the Welfare Fund office, or contact the network identified on your medical benefits ID card.

You save money when you use the PPO in-network option:

- The percentage you pay is applied to a discounted fee.
- The percentage you pay is smaller, or you only pay your copayment.

The provider has agreed to accept the discounted fee as payment in full. In other words, you are not subject to balance billing, except for applicable co-payments, co-insurance, and deductibles. Certain networks (or groups) of physicians and hospitals have agreed to provide services at negotiated fees.

Network physicians under certain plan options may charge you and your eligible dependents only a small co-payment for office visits, or you may be charged a smaller percentage for their services. Network hospital charges under certain plan options may be covered up to as high as 100% and may not require satisfaction of a deductible.

Out-of-network costs are generally higher:

- Out-of-network physicians and hospitals do not have contracts to provide services at specified fees.
- Care or treatment you receive from an out-of-network provider is not at a negotiated rate. You will be responsible for paying any charges that are over the amount the Plan considers to be the allowable charge.
- Payments you make for charges that exceed the amount determined by the Plan to be the allowable charge do not count toward your deductible or annual out-of-pocket maximum.
- Out-of-network ancillary providers such as anesthesiologists, radiologists, and pathologists may provide services for network physicians and hospitals.

- If you receive treatment from an out-of-network physician or in an out-of-network hospital you will generally be required to satisfy an annual deductible that is higher than the deductible when you use network providers. The deductible amount for out- of-network providers includes any deductible amount you satisfied when treated by a network provider.
- After you satisfy your deductible, the Plan will pay a percentage of your medical expenses, but the percentage is lower when you use out-of-network providers. This means that the amount you pay for treatment by an out- of-network physician or in an out-of-network hospital is higher than when you are treated by network providers.
- Always request services of a network provider to lower your out-of-pocket costs.

For illnesses treated in a hospital emergency room, you may have to pay an additional co-payment unless you are admitted to the hospital that day for the illness that was treated. Your hospital emergency room co-payment is listed on your Schedule of Benefits.

Once you reach your out-of-pocket maximum, the Plan will pay 100% of your eligible expenses. You should refer to your Schedule of Benefits that accompanies this booklet for the deductible amount and the percentage the Plan pays for in-network and out-of-network providers.

Co-payments you make do not count against the in-network or the out-of-network deductibles or medical out-of-pocket maximums. However, co-payments are considrered in the co-payment out-of-pocket maximum.

For information about how to file claims for reimbursement of your covered out-of-network expenses, see Filing Claims (pages 63-64).

Contact the Welfare Fund office if you have any questions about network providers.

Schedule of Benefits

The Schedule of Benefits summarizes the benefits available to you and your covered eligible dependents.

If you need to see a physician:

- Check your network directory to see if your physician or other provider is part of the network available to you. Your physician's participation in the network may change between your visits, so you should check to see if your physician is still in the network when you make your appointment. You may check with the Welfare Fund office or check the online provider directory. See your medical ID card for more information.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your physician important questions during your appointment.
- Make a list of any medications you are taking. Be sure to note how often you take the medications.
- Show your ID card when you go to your appointment.
- If you use an out-of-network provider, notify the Welfare Fund office of your claim within 90 days and file a complete proof of claim within one year from the time you receive medical care. If you do not file a claim within this time frame, the Plan will not pay your claim.
- If you use the services of a provider in your network, your physician will file your claim for you and there is no need for you to send anything to the Welfare Fund office.

Prior Authorization

It is VERY IMPORTANT that you obtain prior authorization before services are rendered. This process is also referred to as pre-certification. If you do not do so, you may discover after services are rendered that a hospitalization or other service or supply is not covered by the Plan and you may be responsible for the full cost of the service. You, your physician or hospital should contact the Welfare Fund office prior to any non-emergency inpatient or outpatient hospitalization or surgery or major procedure (such as chemotherapy for cancer treatment).

If you receive services or supplies that are subject to prior authorization and your health care provider is a network provider, the network provider is responsible for obtaining the required prior authorization. If your health care provider is an out-of-network provider, you or your out-of-network provider should contact the provider network to obtain the required prior authorization (as more fully discussed below). In any event, you are responsible for obtaining prior authorization if your out-of-network provider fails to do so, and you may be responsible for the full cost of the service or supply if prior authorization is not obtained.

1. Prior Authorization

Prior authorization is a process for confirming that proposed services and supplies are considered by the Plan to be medically necessary and appropriate. This includes evaluation of the medical necessity and appropriateness of the proposed service or supply as well as where the service or supply is provided (e.g., whether hospitalization is medically necessary and appropriate and the duration).

To obtain prior authorization of hospitalization, surgery and other services, you, your physician or hospital should contact the provider network by calling the telephone number shown on your medical ID card. When prior authorization of hospital care is requested, the provider network will conduct ongoing review of the hospital stay called concurrent review in order to ensure the medical necessity of all care provided.

The following is a list of health services that are subject to prior authorization:

- All inpatient hospital admissions, including maternity admissions in excess of 48 hours (or 96 hours cesarean section) after childbirth
- All observation admissions
- Acute inpatient admissions
- Outpatient surgeries done by an out-of-network provider
- All ambulatory procedures
- All skilled nursing facility and rehabilitation admissions
- All inpatient Mental Health and Substance Use Disorder admissions
- Transplants
- Intensity Modulated Radiation Therapy (IMRT)
- Prosthetics for which the cost exceeds $10,000
- Durable medical equipment for which the cost exceeds $1,000
- Medications given intravenously, intramuscularly or subcutaneously
- Facility sleep studies
- Genetic testing
- Bariatric surgery

2. Response to Prior Authorization Requests

You and your Physician will be notified in writing of the decision made by the provider network or the Welfare Fund office, as applicable, in response to your request for prior authorization. Caution should be taken not to incur expenses until you receive such written notification.

3. Review of Prior Authorization Decisions

If you or your Physician disagrees with a prior authorization decision, you or your Physician may contact the provider network or the Welfare Fund office, as applicable, to review the situation. If you disagree with the decision, you may submit a written appeal to the Trustees. Or you may obtain the services and, when the claim is submitted after the services have been performed, the claim will be reviewed by the Plan without deference to the negative predetermination decision. If retrospective review results in a determination that the services are not Medically Necessary or appropriate, you may be responsible for incurred expenses.

Annual (Calendar Year) Deductible

Your deductible is the amount of covered expenses you must pay before the Medical Plan will pay.

The following expenses do not count toward your Annual Medical Deductible:

- Dental expenses;
- Vision expenses;
- Prescription drug expenses (Prescription drug expenses have a separate annual deductible, please refer to the Schedule of Benefits.); and
- Charges that are not covered expenses;
- Primary Care, Specialist, ER, and Urgent Care co-payments.

Co-insurance

Co-insurance is the percentage of covered medical expenses that you pay. The percentage the Plan pays after you have satisfied your deductible is shown in your Schedule of Benefits that accompanies this booklet. After the Plan pays its' percentage of your covered medical expenses, you pay the difference up to your out-of-pocket maximum.

Co-payment

Your co-payment is a specific dollar amount that you pay to the network provider for a certain service. Co-payments are listed in your Schedule of Benefits. The term "copay" that is used on the Schedule of Benefits has the same meaning as co-payment.

Out-of-Pocket Maximum

Your out-of-pocket maximum is the maximum you will have to pay in co-insurance for covered expenses for the calendar year – January 1 through December 31 – after the Plan pays its benefits. However, the following expenses do not count towards your out-of-pocket maximum:

- Charges you must pay for treatment received from an out-of-network physician or hospital that is over the allowable charge recognized by this Plan, and
- Charges that are not covered expenses.

Calendar Year Maximum

Certain Plan benefits are subject to an overall calendar year maximum, which is the maximum amount the Plan will pay (or the maximum number of visits or services allowed) for those particular medical care benefits during a calendar year. The Plan no longer imposes an overall calendar year maximum on all medical care benefits combined.

Any individual benefit calendar year maximums are listed in your schedule of benefits.

Medically Necessary Treatment

Medically necessary treatments are those treatments, supplies, confinements or services ordered by your physician to treat an illness or injury of a covered person and considered by the Board of Trustees to be:

- Necessary and appropriate to treat the condition; and
- Non-experimental or non-investigative; and
- Not in conflict with accepted medical standards; and
- Not solely for the convenience of a covered person, a physician or treatment facility.

The Trustees may consult with the network providers or receive advice from other professionals (not necessarily physicians) to determine if a treatment, supply, confinement or service is medically necessary. The decision of the Board of Trustees is final and binding. You must pay the cost of treatments that are not medically necessary. Your physician ordering or recommending a treatment, supply, confinement or service does not guarantee that it would be considered medically necessary treatment.

Your treatment must be medically necessary. The Plan does not cover medical expenses that are for cosmetic purposes only. The Plan Administrator or the Plan Administrator's designee has the discretion to determine whether treatment is medically necessary.

Allowable Charge

With respect to a network provider, the allowable charge is the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility, or organization and the Plan.

With respect to an out-of-network provider, the allowable charge means the amount as determined by the Board of Trustees for a particular service or supply. The Plan will only pay allowable charges for out-of-network services or supplies that are determined by the Board of Trustees, and not by any provider, facility, or other person or organization.

Mental Health and Substance Use Disorder Benefits and Referral Services

The Member Assistance Program is a managed Mental Health Disorder and Substance Use Disorder (Chemical Dependency) program built around an independent network of certified specialists. The program provides services and referrals for treatment of Mental Health and Substance Use Disorder (Chemical Dependency) problems. The Member Assistance Program is not an agent of the Plan and the Plan is not responsible for their actions or errors.

To access benefits under the Member Assistance Program (MAP), including free MAP services, contact a Member Assistance Program assessor (care manager) at the number listed in your Schedule of Benefits. Services are available 24 hours per day, 7 days per week, 365 days per year.

Program assessors/care managers are licensed mental health professionals – licensed masters-prepared clinical social workers and professional counselors – who are experienced in total mental health assessment. You may reach them by calling the number listed on your medical identification card.

When you or your eligible dependents need treatment, the care manager can arrange free Member Assistance Program (MAP) services or refer you to a Mental Health Disorder/Substance Use Disorder network provider, depending on assessed needs.

Covered Expenses under the Program

The Plan pays eligible expenses as provided in your Schedule of Benefits, up to your annual maximum medical benefit. The Plan provides eight (8) free counseling sessions through the MAP, and pays a percentage of other charges for covered services as described in the Schedule of Benefits. While you may use mental health and chemical dependency services without contacting the Member Assistance Program, it is important to note that the Plan will pay only medically necessary care. Any care received that is later determined not to be medically necessary will not be covered. To ensure best benefit coverage, call the Member Assistance Program to obtain a referral and establish medical necessity.

Emergency Services

When medically necessary, inpatient emergency services for Mental Health Disorder or Substance Use Disorder (Chemical Dependency) treatment are covered, whether the care is received inside or outside the program network in the same manner as other emergency room care, as provided in your Schedule of Benefits.

If you seek in-patient emergency care, you, your personal representative, or your provider/facility should call the Member Assistance Program within 48 hours of receiving emergency services. The Member Assistance Program care managers establish medical necessity of the care and assist in planning any needed ongoing mental health or substance abuse services.

Emergency services are medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in placing the patient's life or health in serious jeopardy. See page 118 for additional information regarding emergency services.

COVERED MEDICAL EXPENSES

The Plan will cover the following expenses for you and your dependents if they are eligible dependents under the Plan. In order to be covered, the expenses described below must be medically necessary (see page 30), except that those routine preventive services and health promotion services specifically described below are also covered. In all cases the amount of the charges must be the allowable charge (see page 30) or must be at the rate negotiated with the network provider. Expenses are subject to the limitations and exclusions contained in this Plan Document/Summary Plan Description, including the Schedule of Benefits. The Plan will not deny payment of covered services to health care providers based on the type of license the provider holds, as long as the health care provider is acting within the scope of the provider's license.

Hospital Expenses

Hospital expenses include:

- Room and board charges for a semi-private hospital room. If the hospital you enter only has private rooms, the Plan will pay the allowable charge for the hospital's least expensive private room.
- Surgical and related services provided by a physician.

Termination of Coverage While In-Patient

If you or your dependent is eligible for Plan coverage on the date you or your dependent is admitted as a patient for an inpatient hospitalization, the patient's coverage under the Plan will not be terminated until the later of the time provided in the section entitled When Coverage Ends or the date of discharge from the inpatient hospitalization. Coverage will terminate for other covered members of the family as provided in the section entitled When Coverage Ends, but they may elect COBRA Continuation Coverage, if eligible.

A hospital is an institution that:

- ☑ **Regularly keeps patients overnight;**
- ☑ **Has on-site full surgical and therapeutic facilities;**
- ☑ **Has diagnostic laboratory and x-ray facilities;**
- ☑ **Provides 24-hour nursing services by registered graduate nurses under the supervision of staff physicians;**
- ☑ **Operates lawfully in the jurisdiction of the state where it is located;**
- ☑ **Is licensed as an acute care hospital; and**
- ☑ **Is not licensed or used primarily as a clinic, skilled nursing facility, convalescent home, rest home, nursing home, residential home or home for the aged.**

Surgery

The Plan covers expenses of surgery, including surgery in a hospital or an in-network ambulatory surgical facility, or physicians office.

An ambulatory surgical facility is a freestanding institution where surgery can be performed without an overnight hospital stay. The facility does not have to be part of a hospital, but it must be licensed, permanently equipped and operated primarily to provide surgical services. A physician's office may be considered an ambulatory surgical facility for certain minor operations.

Out-of-network ambulatory surgical facilities are NOT covered.

Physician's Services

The Plan covers your physician's services during office visits or an in-patient confinement. A physician is a person who is licensed to practice medicine and surgery as a doctor of medicine or osteopathy while acting within the scope of his/her practice. A physician or doctor also includes a person legally licensed to practice as a psychiatrist, dentist, podiatrist, chiropractor, optometrist or psychologist, so long as practicing within the scope of his or her license, but does not include you or any member of your immediate family (parents, spouse, siblings by birth or marriage, or children). Treatment by a chiropractor is limited, as noted in your Schedule of Benefits.

Vaccination for Food Handlers

Hepatitis A vaccinations and follow-up booster vaccinations within 6 to 12 months will be provided free of charge to employees who are food handlers and are required by law to receive Hepatitis A vaccinations. This benefit is available, even if you are not otherwise eligible for coverage under the Plan, but the benefit is not available to covered eligible dependents of employees.

A food handler is an employee who prepares, handles or touches any food (except uncut produce), utensils, serving items, kitchen or serving area surfaces or materials in a place where food is routinely provided. These places include retail food establishments, restaurants, catering services, soda fountains, food vending carts and all other eating and drinking establishments, kitchens, commissaries or places where food or drink is prepared for sale elsewhere. Retail food establishments do not include the location of food vending machines.

Diabetic Supplies

Diabetic supplies are covered by the Plan, if purchased through a prescription drug card or durable medical equipment provider.

Chiropractic Services

Chiropractic services in the chiropractor's office or elsewhere are covered by the Plan, as limited in your Schedule of Benefits.

Diagnostic X-rays and Laboratory Tests

Diagnostic X-ray and laboratory tests including routine pap smears and mammograms are covered by the Plan. Chiropractic x-rays are covered by the Plan, as limited in your Schedule of Benefits.

Prescription Drugs

Drugs and medicines prescribed by a physician while you are confined in a hospital or skilled nursing facility are covered by the Plan. Other prescription drugs are covered under the Prescription Drug Card Program described on pages 49-51 and your Schedule of Benefits.

Surgical Supplies, Aids and Prostheses

Surgical dressings, casts, splints, braces, crutches, artificial limbs or eyes are covered by the Plan. An artificial limb is a corrective appliance or device that is designed to replace all or part of a missing leg or arm.

Durable Medical Equipment

Subject to the limitations in the Schedule of Benefits, durable medical equipment is covered if it is listed in Appendix A. The cost may not exceed the rental cost or purchase price of the amount listed in your Schedule of Benefits. Hearing aids are subject to additional limitations as explained in your Schedule of Benefits and on page 43. The Board of Trustees has the discretion to pay for durable medical equipment in excess of the limitations in the Schedule of Benefits. Contact the Welfare Fund office for more information.

Occupational, Physical, and Speech Therapy

Occupational, physical, and speech therapy are subject to a 40-visit maximum for visits combined, as provided in the Schedule of Benefits.

The Plan covers occupational and physical therapy, subject to the limitations in the Schedule of Benefits, if:

- Your physician orders the therapy;
- Therapy is provided by a registered physical therapist or a registered or state- licensed occupational therapist; and
- Therapy is prescribed for short-term (40 visits or less), non-maintenance restoration of a physical disability that is reasonably expected to improve.

The Plan covers charges for the services of a speech pathologist or audiologist certified by the American Speech-Language-Hearing Association (ASHA) and the state's Board of Registration. Such services include speech or language evaluations, hearing evaluations and necessary services to gain or regain speech, language or hearing. Speech therapy benefits are subject to the 40-visit limit per calendar year on speech, occupational, and physical therapy combined, as listed in your Schedule of Benefits when speech therapy is provided:

- To correct a speech impediment such as stuttering or the inability to pronounce certain letters; or
- For a speech problem that is the direct result of a documented illness or injury.

Maintenance care or treatment for developmental delay is not covered. However, the Plan covers occupational, physical, and speech therapy for children treated for developmental delay, including autism, subject to any applicable deductibles, co-pays or co-insurance.

Pregnancy and Maternity Care

Maternity care is provided for you and your eligible spouse, if your spouse is covered under the Plan.

Under the Plan and as required by Federal law, hospital stays for mothers and newborns in connection with childbirth are not less than:

- 48 hours for vaginal deliveries; or
- 96 hours for cesarean section deliveries.

The mother's physician or the newborn's physician may, after consulting with the mother, discharge the mother or her newborn earlier than 48 hours or 96 hours after childbirth, whichever is applicable. Neither you nor your physician is required to obtain pre-authorization for a hospital stay in connection with childbirth that is not greater than 48 hours (or 96 hours for cesarean section) after childbirth.

Mastectomy Medical and Surgical Benefits

If you or a covered eligible dependent receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, Federal law requires coverage in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas in a manner determined in consultation with the attending provider and the patient.

Anesthesia, Blood and Oxygen

Anesthesia, blood, blood plasma and oxygen and rental of equipment for its administration are covered by the Plan.

Ambulance

Subject to the limitations in the Schedule of Benefits, ambulance service for necessary transportation to the nearest hospital equipped to furnish the required treatment for an emergency injury or illness is covered by the Plan. See definition of Emergency Services page 118.

Injury to Teeth or Jaw

The services of a dental surgeon or dentist are covered by the medical Plan to repair damage to the jaw or natural teeth that is the direct result of an injury.

Mental Health Disorder and Substance Use Disorder Treatment

Treatment for Mental Health Disorders and Substance Use Disorders (including alcoholism) is covered as explained in the section on Mental Health Care on pages 30-31 and in your Schedule of Benefits.

Organ Transplants

Covered medical expenses for human organ or tissue transplants for the recipient of covered organ transplants (transplants of the pancreas, cornea, kidney, liver, skin, bone marrow, lung, or heart) are covered in accordance with the terms of your Schedule of Benefits. Transplant benefits are paid up to any maximum benefit per episode of transplant treatment as shown in your Schedule of Benefits.

All Organ transplants are approved through the medical PPO provider. Contact the Welfare Fund office for instructions on obtaining a pre-approval.

Covered organ transplant charges are those incurred during the transplant period and include:

- Organ tissue procurement, including removing, preserving and transporting the donated part.

- Transportation of the recipient and a companion to and from the site of the transplant. If the recipient is a minor, transportation of two persons who travel with the minor is included. Reasonable and necessary lodging and meal costs not to exceed $200 per day incurred by all such companions are included.
- Medical expenses recognized as covered medical expenses under any other provision of the Plan.
- Prescription drugs provided under the Prescription Drug Card Program.

The transplant benefit period begins five days before the date of the organ or tissue transplant. It ends 18 months after the organ or tissue transplant is completed.

Home Health Care

Home health care is provided, up to the maximum number of visits listed in your Schedule of Benefits. A home health care visit is defined as the shorter of either four hours of home health aide services or an actual visit by a member of a home health care agency team. Home health care includes the following when administered in the patient's home:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse (RN), other than a nurse who is a member of your immediate family (parents, spouse, siblings by birth or marriage or children);
- Part-time or intermittent home health aide services that are medically necessary as part of a home health care plan, under the supervision of a registered nurse (RN) or medical social worker and that consist solely of caring for the patient;
- Physical, respiratory, occupational, infusion, or speech therapy;
- One visit for nutrition counseling provided by or under the supervision of a registered dietitian; and
- Medical supplies, drugs and medications prescribed by a physician and laboratory services performed by or on behalf of a hospital when provided in lieu of a hospitalization.

Home health agency is an agency primarily engaged in providing home nursing care and other therapeutic services that qualify for payment under Medicare, state licensed visiting nurse association or a similar agency qualified under applicable state law.

Skilled Nursing Facility

Subject to the limitations in the Schedule of Benefits, skilled nursing facility stays, up to an amount equal to the most common daily charge made for a semi-private room for which you or your eligible dependent was confined immediately before entering the skilled nursing facility (SNF), are covered provided that:

- The confinement begins within 14 days after a hospital confinement of at least three days;
- Maximum SNF confinement of 60 days per episode;
- The confinement is necessary for the care and treatment of the illness or injury that was the cause of the immediately preceding hospital confinement; and
- You or your eligible dependent is under the regular care of a physician or surgeon during the confinement.

A skilled nursing facility is an institution that operates to provide convalescent and skilled nursing care to inpatients on a 24-hour a day basis and is licensed and Medicare-certified. It employs a medical staff that, in part, consists of full-time registered professional nurses who furnish 24-hour care.

It is not, other than incidentally, a place for rest or domiciliary care, or for the aged, home for chemically dependent persons (where treatment is not provided) or a hotel or a motel.

Hospice Care

Benefits for covered medical expenses for care furnished by a Hospice to a terminally ill patient are provided by the Plan. A Hospice is an agency that provides a coordinated program of home and inpatient care for terminally ill patients. A Hospice must meet the standards of the National Hospice Organization and any applicable licensing requirements.

A terminally ill patient is a person with a life expectancy of six months or less, as certified in writing by the attending physician. If the patient survives beyond six months, coverage may be allowed to continue, subject to re-certification by the attending physician.

Emergency or Urgent Care Center Services

Emergency care is treatment received within 48 hours after an injury or the onset of a sudden and serious illness or medical condition which, if not immediately diagnosed and treated, could permanently jeopardize the patient's health, seriously impair a body part, or result in other serious medical consequences or death.

The Plan covers emergency treatment of medical conditions that are not the result of an injury or an illness with life-threatening symptoms when the services are provided by a licensed, freestanding emergency facility, such as an urgent care center.

Emergency Room Care

Emergency room care is covered by the Plan, subject to the limitations in the Schedule of Benefits. The required co-payment listed in your Schedule of Benefits is waived if the patient is admitted that day to the hospital as a result of the injury or illness that required the emergency care. All emergency room care obtained by participants will be processed as in network benefits, regardless of the network status of the facility or attending physician.

Voluntary Sterilization for Men and Women

Charges for voluntary sterilization procedures for men and women are covered by the Plan. Please refer to your schedule of benefits for in-network and out-of-network benefits.

Procedures to reverse sterilization are NOT covered for men or women.

Eye Surgery

Corrective eye surgery is covered when vision in the operated eye is worse than 20/70 before surgery and can be improved to 20/70 or better only by such surgery and not by contact lenses or eyeglasses. Corrective eye surgery is surgery to improve near- sightedness, farsightedness and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis surgery.

The Plan covers the initial refraction and first pair of eyeglasses or contact lenses purchased by the participant after eye surgery. The eye surgery must be covered by the Plan and be the cause for the change in the lens prescription. The expense for the initial refraction and first pair of eyeglasses or contact lenses is limited to the maximums provided under Vision benefits as outlined in your Schedule of Benefits. However, they will be provided in addition to regularly scheduled Vision Care Benefits.

Preventive Services

This Plan provides coverage for certain preventive services as required by the Patient Protection and Affordable Care Act of 2010 ("ACA"). Preventive services are paid for based on the Plan's payment schedules for the individual services. Coverage is provided on a PPO network basis with no cost-sharing (for example, no deductibles, coinsurance, or co-payments), and on an out-of-network basis with cost sharing as reflected in the Schedule of Benefits. The preventive services covered by the Plan include the following:

1. Items or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for newborns, infants and children as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including the American Academy of Pediatrics Bright Futures guidelines; and
4. Preventive care and screenings for women, listed in the comprehensive guidelines supported by the U.S. Health Resources and Services Administration (HRSA), including recommendations of the U.S. Preventive Services Task Force (USPSTF). The services covered by the Plan are outlined in the following subsection, Women's Preventive Services.

Women's Preventive Services

(a) Well-woman visits, including preconception and prenatal care;

(b) Screening for gestational diabetes;

(c) Human papillomavirus testing;

(d) Counseling for sexually transmitted infections;

(e) Counseling and screening for human immune-deficiency virus;

(f) Breastfeeding support, supplies and counseling;

(g) Screening and counseling for interpersonal and domestic violence; and

(h) The following contraceptive methods and related clinical services, including patient education and counseling, in each of the following eighteen categories of contraceptive methods are covered by the Plan, as long as the generic or least expensive option within a category is selected.

(1) Sterilization surgery for women;
(2) Surgical sterilization implant for women;
(3) Implantable rod;
(4) IUD copper;
(5) IUD with progestin;
(6) Shot/injection;
(7) Oral contraceptives (combined pill);
(8) Oral contraceptives (progestin only);
(9) Oral contraceptives extended/continuous use;
(10) Patch;
(11) Vaginal contraceptive ring;
(12) Diaphragm;
(13) Sponge;
(14) Cervical cap;
(15) Female condom;
(16) Spermicide;
(17) Emergency contraception (Plan B/Plan B One Step/Next Choice); and
(18) Emergency contraception (Ella).

In addition, a specific FDA-approved item will be provided without cost-sharing if your health care provider certifies that it is medically necessary for you. Medical necessity may be based on the severity of actual side effects, differences in permanence and reversibility of contraceptives, and the provider's determination of your ability to adhere to the appropriate use of the item or service. In the event that there is a dispute about whether the requested method of contraception is medically necessary, you may file a claim for benefits (medical or prescription drug, as appropriate) following the process set forth in the Processing Claims for Benefits Section of the SPD. Any claim relating to emergency contraception will be decided and communicated to you within 72 hours.

The Plan covers oral contraceptives for plan participants through the Plan's prescription drug program, subject to the applicable coinsurance or copayment provided in the Schedule of Benefits.

PPO network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or eligible dependent for PPO network services. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copay or deductible when you use PPO network providers.

If preventive services are received from a non-network provider, they will be eligible for coverage under this preventive services benefit, but will be subject to the cost-sharing noted in the Schedule of Benefits. However, the Plan will not cover genetic testing and counseling for BRCA 1 and BRCA 2 mutations from non-network providers.

Federal guidelines are unclear in some cases about which preventive care must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this preventive services benefit.

In certain circumstances, as determined by the Fund, the preventive services benefit is only payable with an appropriate diagnosis.

Routine Physical and Gynecological Exam Coverage

PPO network routine physicals and gynecological exams are not subject to the office visit copayment. There is a limit of one routine physical and one gynecological exam per calendar year. To avoid any possible office visit charges for preventive services during the calendar year, you should have all preventive services performed during your PPO network routine physical or gynecological exam.

Out-of-network routine physicals and gynecological exams are covered in the manner described in the Schedule of Benefits.

Well Child Care Exam Coverage

Well child care physical exams recommended in the American Academy of Pediatrics Bright Futures guidelines are treated as preventive services and paid at 100% if they are received from a PPO network provider.

Out-of-network well child care physical exams are covered in the manner described in the Schedule of Benefits.

Preventive Services Office Visit Coverage

For office visits other than office visits in connection with a routine physical or gynecological exam, the following applies:

PPO network office visits for preventive services may be subject to cost-sharing, depending on the circumstances of the office visit, as discussed below.

1. If a preventive services item or service is billed separately from the office visit, then the Plan will impose cost-sharing with respect to the office visit.
2. If the preventive services item or service is not billed separately from the office visit, and the primary purpose of the office visit:
    a. Is the delivery of such preventive services item or service, then the Plan will pay 100% for the PPO network office visit.
    b. Is not the delivery of such preventive services item or service, then the Plan will impose cost-sharing with respect to the PPO network office visit.

For example: If you have a cholesterol screening test during a PPO network office visit, and the physician bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit but not for the lab work. If you see your physician to discuss recurring abdominal pain and you have a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit. Keep in mind that if you receive your preventive services during your PPO network routine physical or gynecological exam, you will not be charged an office visit copay. See Routine Physical and Gynecological Exam Coverage above.

Routine physicals and tests are covered as provided in your schedule of benefits.

Out-of-network office visits are covered in the manner described in the Schedule of Benefits.

To avoid any possible office visit charges for preventive services you receive

during the calendar year, you should have all preventive services performed during your routine physical or gynecological exam. See Routine Physical and Gynecological Exam Coverage above.

Preventive Services Coverage Limitations and Exclusions

1. Preventive services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable Plan benefit, not the preventive services benefit. A service is covered for diagnostic reasons if you or your dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
2. Services covered under the preventive services benefit are not also payable under other portions of the Plan.
3. The Plan will use reasonable medical management techniques to control costs of the preventive services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific preventive services, which must be satisfied in order to obtain payment under the preventive services benefit.
4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered. However, travel immunizations are covered under the medical benefits after you pay the required deductible and copayment.
5. Examinations, screenings, tests, items, or services are not covered when they are experimental or investigative, as determined by the Plan.
6. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
   - When required for education, sports, camp, travel, insurance, marriage, adoption or other non-medical purposes;
   - When related to judicial or administrative proceedings;
   - When related to medical research or trials; or
   - When required to maintain employment or a license of any kind.
7. Over-the-counter drugs, medicines, vitamins, and/or supplements are covered only when required under the preventive services benefit, and only when prescribed by a physician. Other prescription medications are covered under the Plan's prescription drug benefit, as required under the ACA.

Hair Prosthesis

Charges for hair prosthesis needed when hair loss is due to a medical diagnosis or treatment covered by the Plan, limited to the separate lifetime maximum benefit listed in your Schedule of Benefits.

Smoking Cessation Guidelines

Prescription and OTC (with prescription) smoking cessation products (e.g. nicotine products, bupropion [generic only], Chantix) are covered by the Plan for adults. To ensure appropriate utilization, a quantity limit of 2 cycles per year applies to each active ingredient.

Second Surgical Opinions

Second surgical opinions are covered by the Plan, including any necessary X-rays or laboratory examinations received before admission into the hospital for surgery. The Plan will pay for a third opinion if the second surgical opinion does not agree with the original physician's opinion. The physician providing a second or third surgical opinion must be certified by the American Board of Surgery or other specialty board and must not be affiliated with the surgeon proposing and/or performing the surgery. Such visits are covered as an office visit.

Pre-Admission Tests

Pre-admission tests administered within two weeks before non-emergency surgery are covered by the Plan. The tests must be performed on an outpatient basis at the same hospital where the surgery is scheduled.

Attention Deficit Disorder and Hyperkinetic Syndrome

The Plan covers care provided by a physician for treatment of the physical components of Attention Deficit Disorder and Hyperkinetic Syndrome, payable as a medical benefit. Psychotherapy used to treat these conditions is subject to the restrictions under the Mental Health Disorder and Substance Use Disorder (Chemical Dependency) treatment program described on pages 30-31.

Weight Loss Treatment

Office visits and consultations by a physician and drugs requiring a prescription from a physician for weight loss and/or obesity are covered if pre-approved by the Welfare Fund office, subject to general limitations and exclusions listed on page 46 and subject to the lifetime maximum weight loss benefit amount listed in your Schedule of Benefits. In addition to office visits and consultations, prescription drugs are also subject to the lifetime maximum weight loss benefit amount listed in your Schedule of Benefits.

Supervised weight-loss programs recommended by a dietary consultant are covered up to the lifetime maximum weight loss benefit amount. Non-medical charges for services and supplies such as diet food supplements are not covered, even when directed or prescribed by a physician, unless they are part of a supervised weight-loss program pre-approved by the Welfare Fund office.

Cardiac Rehabilitation Phase I and II

Cardiac Rehabilitation Phase I and II is covered by the Plan. Contact the Welfare Fund office for more information and see the exclusions and limitations beginning on page 44.

Infertility Treatment

Infertility treatment, including surgical procedures, hormone therapy and prescription drugs, is covered by the Plan at 50% of eligible expenses up to the lifetime maximum benefit amount shown in your Schedule of Benefits per employee and covered spouse combined. Expenses for the spouse are covered only if the spouse is eligible for coverage under the Plan. Procedures for reversal of sterilization are not covered. Contact the Welfare Fund office for more information.

Dietary Consultations

One dietary consultation for other than weight loss treatment is covered by the Plan if it is (one per lifetime):

- Provided by a physician, registered nurse, licensed pharmacist, dietician or other health professional; and
- Designed to control a life-threatening disease such as diabetes or heart disease.

Hearing Exam/Hearing Aids

A hearing exam for hearing aids is provided by the Plan if it is obtained through a network provider. Hearing aids, up to the maximum benefit listed in your Schedule of Benefits per ear per each five-year period are covered by the Plan. Hearing aids must be ordered by a network provider.

Diabetes Self-Management Program

One diabetes self-management program (one per lifetime) is covered by the Plan, subject to the following limitations:

- The purpose of the program must be to improve the patient's knowledge of the disease, and teach techniques for diabetes self-management and compliance with proper health care treatments that are required for the diabetic patient's well-being.
- The benefit is limited to a maximum of four sessions for a total duration of no more than four hours. For example, a diabetes self-management program could consist of one four-hour session, two two-hour sessions, or four one-hour sessions.
- If you receive a dietary consultation for diabetes under the Dietary Consultations benefit that consultation will reduce the duration of your sessions under this benefit.
- You must complete all required sessions and present a certificate of completion in order to have your program covered by the Plan.
- The sessions must be provided by a PPO network provider at PPO network facilities.
- You must receive appropriate medical authorization, which consists of a written referral from your physician (PPO network or out-of-network) to participate in the program.

Flu Shots

A seasonal flu shot/vaccination is covered by the Plan for you and your eligible dependents as provided in your Schedule of Benefits.

Clinical Trials

The Plan covers charges for your participation in a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:

- Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if you were not participating in the Approved Clinical Trial; and
- Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

You are eligible for payment of charges related to participation in an Approved Clinical Trial if you:

- Satisfy the protocol prescribed by the Approved Clinical Trial provider; and

- Either:
  - → Your network participating provider determines that your participation in the Approved Clinical Trial would be medically appropriate; or
  - → You provide the Plan with medical and scientific information establishing that your participation in the approved clinical trial would be medically appropriate.

For the purposes of this provision, an approved clinical trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The approved clinical trial's study or investigation must be:

- Approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE), if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
- A study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- A drug trial that is exempt from investigational new drug application requirements.

The following expenses are not covered by the clinical trials benefits:

- Expenses incurred due to participation in an approved clinical trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- Expenses incurred at a non-network provider if a network participating provider will accept you in an Approved Clinical Trial.

Exclusions and Limitation on Medical Benefits

The charges listed below are not payable under the Plan. The amount of any charges meeting the descriptions of this section will be deducted from your medical expenses before the benefits of the Plan are determined. Benefits will not be paid for, and the term covered medical expenses or benefits will not include charges for:

- Any charges that exceed the allowable charge or charges for services or supplies that are not medically necessary.
- Charges for maintenance care. Maintenance care is care provided after your condition has plateaued, has ceased to improve or is only minimally improving. For example, spinal manipulations/adjustments and physical therapy are considered maintenance care if your condition is not improving significantly.
- Charges for treatment of eligible dependent children for mental or physical developmental delay, other than occupational, physcial, and

speech therapy. Treatment of developmental delay includes diagnosis and treatment of learning disorders.

- Services or supplies done while you or your eligible dependent is not covered under this Plan, except as provided under the Continuation of Coverage provisions.
- Charges incurred before you or your eligible dependent is covered under the Plan, including charges related to the birth of eligible dependent adopted children, or children placed with you for adoption.
- Charges incurred after coverage ends unless explicitly stated in the Plan.
- Charges for chiropractic treatments that exceed the Plan limitations in your Schedule of Benefits.
- Charges for chiropractic X-ray and lab charges in excess of the amount listed in your Schedule of Benefits.
- Charges for massage therapy.
- Charges for treatment or service due to a sickness that is covered by a Workers' Compensation Act or other similar legislation, or due to an injury arising out of or in the course of employment for wages or profit.
- Charges for any treatment or service that is paid for or furnished by any federal, state or local government or agency thereof.
- Services and supplies necessary for the treatment of any condition caused by any act of war, declared or undeclared, except to the extent exclusion of such is prohibited under Federal law.
- Services and supplies for treatment of an injury or illness that arose or was exacerbated while the patient was engaged in military, naval or air service of any country, except to the extent exclusion of such is prohibited under Federal law.
- Any treatment for cosmetic reasons, unless directly related to recovery from an injury. Treatment for cosmetic reasons includes surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation/breast reduction, elimination of redundant skin of the abdomen, treatment of varicose veins or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. Breast reconstruction in connection with a mastectomy is a covered expense, as explained on page 35.
- Any charges related to equipment, treatment, procedures, supplies, devices, drugs or medications that, with respect to the condition being treated, are Experimental or Investigative as defined on pages 118-119 of the booklet.
- Any charges incurred for custodial care or care while confined in a custodial care institution that is primarily a place of rest, a place for the aged or a nursing home. Custodial care is care that does not require the services of a registered nurse or a licensed practical nurse. When a caregiver or family member can be safely and effectively taught to provide certain care, that care is considered custodial. For example, your program does not provide benefits if you only need help taking your medications, or help with eating, bathing, dressing, toileting or walking.
- Charges for services for which you or your eligible dependent would not be obligated to pay in the absence of this coverage.
- Medical care received outside the geographic area of this Plan unless:
- Comparable services are not available within the geographical area of the Plan; or
- Such care is a medical emergency requiring immediate attention (see page 118 for a definition of emergency services) or

- The care is the receipt of durable medical equipment that is otherwise covered under the Plan and is shipped from a provider that is outside the geographical area of the Plan, but that is obtained in connection with your care and treatment by a PPO network provider.
- The geographic area of the Plan is the greater metropolitan area of St. Louis and any area within 100 miles from your employer's facility at which you are employed.
- Any charges or services not prescribed by a physician.
- Charges to complete forms required by the Welfare Fund office.
- Charges that exceed the maximums shown in your Schedule of Benefits or elsewhere in this booklet.
- The difference between the charge for a private room and the hospital's most common semi-private room charge if you elect a private room in a hospital that has both semi-private and private rooms.
- Any treatment or services by a dentist or dental surgeon, unless that treatment or service is necessary to treat an injury to the jaw or natural teeth that is the result of an injury.
- Non-invasive treatments for temporomandibular joint syndrome (TMJ) unless as covered under the Dental Benefit. (The Plan covers surgical treatment for TMJ under the medical benefits.)
- Charges incurred for an employment exam, including lab tests and immunizations.
- Charges that are incurred for services or treatments rendered in connection with weight loss and/or obesity, except for weight loss treatment and dietary consultations described on pages 42-43, or for a diabetes self-management program that meets the requirements for coverage under the Plan. Non-medical charges for educational programs, services and supplies such as diet food supplements are not covered, even when directed or prescribed by a physician, unless they are described under Weight Loss Treatment or Dietary Consultations on pages 42-43, or they meet the Plan's requirement for coverage as a diabetes self-management program.
- Home health care services:
  - → Not provided or coordinated by a home health care agency;
  - → Provided during any period in which the patient is not under the continuing care of a physician;
  - → For which benefits are payable under any other provisions of this Plan; or
  - → Services of Nurses aides.
- Hospital charges incurred on Friday or Saturday when the admission is for elective, non-emergency surgery, unless the actual surgery is performed on the day immediately following the date of admission.
- Weekly charges for home health care services that exceed the allowable weekly charge for inpatient care in a Skilled Nursing Facility.
- Pregnancy or infertility treatment for an eligible dependent child, except that the Plan will cover any pregnancy-related preventive care expenses as required under the Patient Protection and Affordable Care Act of 2010.
- Charges for elective abortions and care related to elective abortions. However, complications of elective abortions are covered by the Plan.
- Treatment of spider veins.
- Pulmonary Rehabilitation Programs. (Pulmonary Rehabilitation refers to a formal program of controlled exercise training and respiratory education under the supervision of qualified medical personnel capable of treating respiratory emergencies, as provided in a hospital outpatient department or other outpatient setting.)

- Cardiac Rehabilitation Phase III.
- Orthotripsy treatment for plantar fasciitis.
- Surgery to correct astigmatism, except as specifically provided on page 38.
- Charges of a physician or other provider who or which is not acting within the scope of his, her or its license.
- Charges for services or care provided by members of your immediate family (parents, spouse, siblings by birth or marriage or children).
- Vision care, except as provided under vision plan.
- Drugs, except as provided in the hospital or under the Prescription Drug Card Program.
- Reversal of sterilization.
- Personal comfort items.
- Injury or illness caused by the act or omission of third party, unless the participant signs the required subrogation agreement.
- Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
- Wigs or hair prosthesis, except as provided in your Schedule of Benefits.
- Personal blood storage.
- Hypnosis.
- Acupuncture.
- Any charges in excess of the maximums listed in the Schedule of Benefits.
- Any charges that are not for a medically necessary treatment.
- Non-emergency care when traveling outside the United States
- Private duty nursing services.
- Unless mandated by the Affordable Care Act (ACA), expenses for:
  - → Pre-implantation genetic diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if its normal.
  - → Genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, including: (1) pre-parental genetic testing (also called carrier testing) intended to determine if an individual is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected children; and (2) prenatal genetic testing intended to determine if a developing fetus is a risk for inheriting identifiable genetic diseases or traits except tests using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alpha-fetoprotein (AFP) analysis in pregnant women.
  - → All medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for the purpose of: (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.

- → Genetic testing for non-covered individuals: No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under the Plan. Genetic testing may be covered for a non-covered family member only if such testing would directly impact the treatment of a plan participant.
- → Home genetic testing kits and services.
- → Genetic testing by out-of-network providers.
- → Genetic testing and counseling for BRCA 1 and BRCA 2 mutations from non-network providers.

PRESCRIPTION DRUG CARD PROGRAM

The prescription drug card program covers prescription drugs that you obtain on an outpatient basis. The benefits described in this section are subject to all of the exclusions and limitations in the Plan. However, your prescription drug copayments and deductible do not count toward your medical deductible or out-of-pocket maximum.

Prescription drugs that your physician prescribes while you are confined in a hospital or skilled nursing facility are covered under the medical benefits portion of the Plan as described on page 32.

To receive prescription drug benefits under the Plan, you must visit a participating pharmacy and present your ID card or use the provider's mail order program. If you fill your prescription at a non-participating pharmacy, it will not be covered by the Plan.

Before prescription drug benefits are payable, you must meet the prescription drug deductible that is listed in your Schedule of Benefits. You will also be responsible to make a copayment for your prescription drug benefits. Copayments are listed in your Schedule of Benefits and differ, depending on whether you are receiving a generic, preferred brand-name, or non-preferred brand-name drugs.

An out-of-pocket limit protects you by limiting the amount you must pay out-of-pocket each year for prescription drug costs. See your Schedule of Benefits for your calendar year prescription drug out-of-pocket limit.

Filling Prescriptions through the Retail Pharmacy Program

When you need a prescription filled at a retail pharmacy, you should locate a participating pharmacy by calling the number or visiting the website listed on the back of your ID card. At the time that you fill your prescription, present your ID card and pay the applicable copayment. You do not have to complete any claim forms.

Filling Prescriptions in an Emergency through a Non-Participating Pharmacy

If an emergency arises in which all participating pharmacies are closed and you fill your prescription at a non-participating pharmacy, you may receive reimbursement from the Plan if you submit convincing medical evidence to the Welfare Fund office that you needed the prescription immediately on an emergency basis. If the Welfare Fund office finds, in its discretion, that your circumstances met the medical necessity requirement, the Plan may reimburse you for 75% of the cost of a covered prescription that you obtained at the non-participating pharmacy for which you are eligible.

Filling Prescriptions through the Mail Order Program

You should use the mail order program when you are filling prescriptions for medications that you take on an ongoing basis (known as maintenance medications). Maintenance medications are medicines you take on a long-term basis for ongoing conditions. The mail order program offers you the convenience of having prescriptions delivered to your home and it saves you money.

To use the program, follow these steps:

- Ask your physician to prescribe a 90-day supply of your medications with refills for one year.

- Mail the original prescription along with a completed order form, patient profile and your copayment to the mail order program in the envelope provided. If you need additional envelopes, you should contact the Welfare Fund office, call the number on your ID card or visit the prescription drug provider's website listed on your ID card.
- Allow about 14 days from the time you mail in your order to receive your prescription.
- After your first prescription is filled, you can obtain refills online at the website, through the mail or by calling the prescription drug provider. The contact information is on your ID card. When you reorder your prescription, have your prescription number, zip code and credit card information ready.

Covered Prescription Drugs

The following prescription drugs are covered by the Plan's prescription drug card program:

- Federal Legend prescription drugs;
- Drugs requiring a prescription under the applicable state law;
- Injectable insulin;
- Insulin syringes;
- Diabetic supplies; and
- Contraceptives, as described in the next subsection.

Federal Legend drugs are any medicinal substances that must be labeled "Caution - Federal Law prohibits dispensing without a prescription," as required by the Federal Food, Drug and Cosmetic Act.

Contraceptive Coverage

Generic or single-source oral contraceptives obtained through the Plan's prescription drug program, and that are listed in one of the categories of contraceptives in the Women's Preventive Services Subsection of the Preventive Services Section of the Plan, are covered without cost-sharing, as provided in the Schedule of Benefits. Brand-name or multi-source contraceptives are subject to the appropriate coinsurance or copayment listed in the Schedule of Benefits; however, if a generic equivalent is not available, or if your attending provider determines that the brand-name or multi-source contraceptive is medically necessary, then the brand-name or multi-source contraceptive will be covered without cost-sharing. This coverage is provided for women of all ages with reproductive capacity who are covered by the Plan, including the employee, employee's spouse and employee's covered dependents.

If your attending provider determines that a brand-name or multi-source contraceptive is medically necessary, it will need to be reviewed and approved by the Fund's Pharmacy Benefit Manager prior to obtaining the prescription.

Other FDA-approved contraceptive methods, as listed in the Women's Preventive Services Subsection of the Preventive Services Section of the Plan, are covered by the Plan as preventive services, as provided in the Schedule of Benefits.

Generic medication – by law, both generic and brand-name medications must meet the same standards for safety, purity and effectiveness – and generic medications generally cost less.

Whenever possible, use a generic equivalent when filling prescriptions. This saves you and the Fund money.

Preferred and non-preferred brand-name medications – These are brand-name medications that are listed by the pharmacy benefit manager as either preferred or non-preferred. For a listing of these medications, you may contact the Fund office or the pharmacy benefit manager, or visit the Fund's website listed on your ID card or in the Schedule of Benefits.

Prescription Drugs Requiring Pre-Authorization

Certain prescription drugs, along with a treatment plan, must be pre-authorized before they are covered under the Plan.You should contact the pharmacy benefit manager listed on your ID card or in your Schedule of Benefits to determine whether your medication must be preauthorized.

Prescription Drugs Excluded from Coverage

The following prescription drugs are not covered by the Plan's Prescription Drug Card Program:

- Non-Legend drugs other than insulin;
- Therapeutic devices or appliances, support garments and other non-medical substances;
- Drugs intended for use in a physician's office or another setting other than home use;
- Experimental or Investigative drugs (defined below), including compounded medications for non-FDA approved use;
- Prescriptions that an eligible person is entitled to receive without charge under any workers' compensation law or any municipal, state or federal program;
- Contraceptive devices, which are covered under the medical benefits portion of the Plan and not under the Plan's prescription drug benefit;
- Topical Rogaine.

Experimental or Investigative means equipment, treatments, procedures, or supplies:

- ☑ **not yet recognized as "accepted medical practice" by the general medical community in the state where the services are provided, or**
- ☑ **not covered by any government agency or subdivision, including as provided in the Medicare Coverage Issues Manual.**

It also means devices, drugs or medications that have not yet received required governmental approval. Experimental treatment is a trial procedure or protocol performed on a minimal number of patients to establish data for a rate of cure or improvement in the quality of life.

The Plan Administrator or the Plan Administrator's designee has the discretion to determine whether treatment is Experimental or Investigative.

DENTAL BENEFITS

Dental benefits are provided for you and your covered eligible dependents if you are eligible for, and have elected dependent coverage. If covered, a percentage of your covered dental expenses will be paid, depending on the dental work, as shown in your Schedule of Benefits.

A maximum benefit per calendar year that is listed in your Schedule of Benefits will apply to your total covered dental expenses under Coverages A, B and C, except that it does not apply to coverage A expenses for enrollees under age 19. Orthodontia care for your eligible dependent children is paid up to the maximum amount per lifetime per child that is listed in your Schedule of Benefits. Dental benefits are counted toward your annual maximum dental benefit under the Plan, and toward your medical benefit deductible and out-of-pocket maximum.

Covered Dental Expenses

Covered dental expenses are those you or your eligible dependents incur for necessary dental care and treatment performed by a dentist or dental hygienist. The expenses are paid at the allowable charge. The four types of dental expenses covered under the Plan are:

- **Coverage A** – Routine Oral Examinations;
- **Coverage B** – Basic Dental Care;
- **Coverage C** – Restorations, Crowns and Prosthetics; and
- **Orthodontia Care**.

A dentist is a doctor of dentistry duly licensed and registered to practice his or her profession.

A dental hygienist is licensed to practice dental hygiene and works under the direction and supervision of a dentist.

Routine exams and cleanings are paid at the percentage listed in your Schedule of Benefits of the allowable charge.

The level of Plan payment varies for each type of coverage. You should refer to your Schedule of Benefits for information on the amount of the Plan's coverage.

Coverage A – Routine Oral Examinations

Routine oral examinations help you prevent dental disease from starting or help you detect problems early. Benefits are payable under **Coverage A** at the percentage listed in your Schedule of Benefits of the allowable charge for the following services:

- Charges for routine periodic oral examinations, up to two in a calendar year.
- Diagnostic X-rays as required.
- Full mouth X-rays, routine x-rays (including bite-wing x-rays), panoramic x-rays, limited to once per calendare year.
- Prophylaxis (routine preventive care) including necessary scaling and polishing twice in a calendar year.
- Topical fluoride applications, twice in a calendar year (no age restriction).

Coverage B – Basic Dental Care

Benefits are payable under **Coverage B** at the percentage listed in your Schedule of Benefits of the allowable charge up to the maximum benefit shown in your Schedule of Benefits for you and each of your eligible dependents.

Covered services included under Coverage B are:

- Emergency treatment for relief of pain.
- Restorative services, including inlays and onlays, using amalgam, synthetic porcelain and plastic filling material.
- Periodontic services for treatment for the diseases of the gums.
- Endodontic services including pulpal therapy and root canal filling.
- Extractions and other oral surgery, including pre-and post-operative care.
- Treatment for the disturbance of the temporomandibular joint.
- Implant posts.
- Occlusal guard.

Coverage C – Restorations, Crown and Prosthetics

Coverage C provides benefits for dental repair of your natural teeth or dentures. The Plan pays for restorative dental services under **Coverage C** at the percentage listed in your Schedule of Benefits of the allowable charge up to the maximum benefit shown in your Schedule of Benefits.

Restorative dental services included under Coverage C are:

- Precious metal restorations when the teeth cannot be restored with another filling material payable under **Coverage B**.
- Crowns and jackets when the teeth cannot be restored with a filling material.
- Prosthetics including bridges, partial and complete dentures and crowns required for implants.
- Crown, prosthetic and denture replacement benefits. When professionally indicated, benefits are payable based on the usual, customary and reasonable charge for the replacement that is not the result of theft or loss of a previous denture. Benefits will not be paid for crown, prosthetic, denture, inlay/onlay, veneers, and implant replacements made less than five years after the immediately preceding crown, prosthetic, denture, inlay/onlay, and veneers placement or replacement.

Restoration or Restorative Treatment is a broad term applied to any crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue.

Orthodontia Care

Plan benefits are payable for orthodontia expenses incurred by your eligible dependent children up to the age listed in your Schedule of Benefits. Benefits at the percentage listed in your Schedule of Benefits of the allowable charge are payable under orthodontia care for treatment or correction of malposed teeth including the initial installation of orthodontic appliances. The lifetime maximum benefit amount for orthodontia care payable for each of your eligible dependent children is listed in your Schedule of Benefits.

Benefits under orthodontia care will be paid in the following payment schedule:

- If the proposed treatment is expected to last two years or more, one eighth of the total eligible charges will be considered as incurred on the first day of treatment and the Plan payment will be made. The remaining Plan payments, equal to one-eighth of the total eligible payment, will be made on a quarterly basis from the date of the first treatment for a maximum of two years.
- If the proposed treatment is expected to last less than two years, the total eligible Plan payment will be divided by the number of three-month periods in the treatment schedule. This pro-rated amount will be paid on a quarterly basis with the first payment made as of the date of the first treatment.

Calendar Year Maximum

The maximum benefit per person per calendar year for all benefits combined under Coverages A, B and C is listed in your Schedule of Benefits. If your covered dental expenses under Coverages A, B and C exceed the calendar year maximum benefit, the excess will not be considered an eligible expense in the following year. Any benefits paid towards the lifetime maximum amount for orthodontia care for any of your eligible dependent children will not apply to this calendar year maximum benefit for Coverages A, B and C.

Treatment by More than One Dentist

If you should change dentists in the middle of a course of treatment, benefits will be provided as if you had stayed with the same dentist until treatment was complete. There will be no duplication of benefits.

Coverage after Termination

If your coverage terminates while your covered eligible dependent or you are receiving dental treatment (i.e. example, root canal) that was started while you were eligible for benefits, benefits will continue to be paid for such treatment if completed within 30 days after the date of your termination of coverage. Coverage for benefits after termination will only be continued for treatment that was started while covered. The benefits are subject to all the conditions and limitations of the program.

Pre-Treatment Plan

You may ask your dentist to submit a pre-treatment plan to the Welfare Fund office when your dental expenses are expected to equal or exceed $250.

A pre-treatment plan will help you avoid surprises because it lets you and your dentist know the amount the Plan will cover in advance. Here’s how it works:

- The dentist completes a treatment plan describing the proposed course of treatment by itemizing the services and charges on a standarized claim form. A treatment plan is a written report showing the recommended treatment of any dental disease, defect or injury, prepared by your dentist, as a result of an examination.
- The Plan then determines the amount payable under the Plan and informs you and the dentist of the amount the Plan will cover. You and your dentist should discuss the result before the work is done.

Dental Exclusions – What Is Not Covered

Dental benefits are not payable for the services listed below. The amount of any charges for the following will be deducted from your covered dental expenses before benefits are determined.

- Charges for services that are more than the allowable charge.
- Work done while you or your eligible dependent is not covered under this Plan, except as provided under the Coverage after Termination section as defined above.
- Charges for treatment or service due to a sickness that is covered by a Workers' Compensation Act or other similar legislation, or due to an injury arising out of or in the course of employment for wages or profit.
- Charges for services that are provided by any federal, state or provincial government agency, or are provided without cost to you or your eligible dependent by any municipality, county or other political subdivision or community agency.
- Charges for prescription drugs (prescription drugs are covered under your Prescription Drug Program, see page 50).
- Charges for completion of forms, including the pre-treatment plan.
- Charges for speech therapy.
- Charges for lost or stolen appliances.
- Charges for services for which you or your eligible dependent would have no obligation to pay in the absence of this coverage.
- Surgical correction of congenital or developmental malformation.
- Relative analgesia.
- Hypnosis.
- Pre-medication.
- Treatment solely for cosmetic reasons (see page 45 for a definition of cosmetic reasons).
- Orthodontia care for you or your spouse.
- Treatment started before your eligibility begins, including orthodontia care for eligible dependent children.
- Sterilization charges.
- Oral cancer screening with blue-white light devices.

VISION CARE BENEFITS

The vision care benefit is designed to pay a portion of eye examinations and lenses for eligible employees and for covered eligible dependents if you are eligible for and have elected dependent coverage. If you have covered vision care expenses while you are eligible for benefits, the Plan will pay the benefits shown in your schedule of benefits.

Covered Vision Care Expenses

Covered vision care expenses include charges for:

- A complete eye examination including dilation of pupil and relaxing of focusing muscle by drops, refraction for vision and examination for pathology by a legally qualified ophthalmologist or optometrist; and
- New or replacement frames and/or lenses (including contact lenses) prescribed by an ophthalmologist or optometrist.

Generally, vision examinations are paid once per individual in a 24-month period. A vision care expense will be considered incurred on the date you receive the vision care service or on the date vision supplies are ordered. For persons diagnosed with medical conditions requiring more frequent examination, vision examinations will be covered once per calendar year, up to the limit stated in your schedule of benefits, and as specified for enrollees under age 19.

Vision Care Exclusions - What Is Not Covered

No payment will be made under this vision care benefit for any of the following expenses:

- More than one eye examination, one frame or one pair of lenses during any 24-consecutive month period (an exception is explained above).
- Charges for services or supplies that are covered in whole or in part under any other portion of the Plan.
- Expenses for treatment or service due to a sickness that is covered by a Workers' Compensation Act or other similar legislation, or due to an injury arising out of or in the course of employment for wages or profit.
- Special procedures, such as orthoptics or vision training and special supplies, including non-prescription glasses or sunglasses.
- Services or supplies not shown in your Schedule of Benefits. Vision expenses related to disease or injury are covered under the medical benefit section of the Plan.
- Lens tinting, or scratch-resistant coating.
- Cosmetic contact lenses.
- Services by out-of-network vision care providers

Routine vision care that is provided by an ophthalmologist or optometrist is covered under your vision care benefits only and not under your medical benefits. Be sure to contact your vision care provider rather than your medical care provider to determine whether a provider is a preferred provider and when choosing an ophthalmologist or optometrist for a routine vision exam.

See your schedule of benefits for the amount of your coverage or contact the Welfare Fund office at 314-835-2700 in the St. Louis area or call toll free in Missouri outside St. Louis or in Illinois at 866-565-2700 for information about network vision care providers.

IF YOU BECOME DISABLED

You will be eligible for the weekly disability income benefit if you are unable to work because of a non-occupational sickness or injury and you have satisfied the Plan's requirements for eligibility. Benefits are payable as shown in your Schedule of Benefits. Unit 2 Employees are not eligible for this benefit.

Unit 2 Variable Hour Employees:

Although you do not receive a weekly disability income benefit if you are covered under the Plan as a Unit 2 Variable Hour Employee, you should notify the Welfare Fund office of time off due to disability to arrange for continuation of your Part-Time benefits.

To qualify, you must:

- Be wholly and continuously (totally) disabled because of a non-occupational injury or sickness. It is not necessary that you be confined to your home in order to collect benefits, but you must be under the care and treatment of a legally qualified physician;
- Be eligible for benefits at the onset of your disability; and
- Have lost wages that would have been otherwise payable from your contributing employer as a direct result of missing available work because of such sickness or injury.

You must visit a physician within the first three days of disability onset in order for benefits to be payable (except that this provision does not apply to pregnancy). Disability will be considered to be due to sickness unless it is the direct result of and begins within 48 hours after an accidental bodily injury.

Weekly disability income payments cannot begin until you, your employer and your physician complete the claim form and return it to the Welfare Fund office. You will be required to supply the Welfare Fund office with proof of continuing disability as needed.

The weekly disability income benefit is payable for a maximum of 13 weeks during any one period of disability. A new period of disability cannot begin until you return to active, full-time work and you have worked the minimum weekly hours required for eligibility (your average weekly hours prior to disability at the minimum required number of hours listed in your Schedule of Benefits).

Weekly Disability Income Benefit

The amount of the weekly benefit, as shown in your Schedule of Benefits, is a percentage of the average base pay you received during the four weeks immediately before the date your disability began. Average base pay includes vacation or sick pay paid by your employer but does not include any commissions, overtime or bonuses that you may have received during the four week period immediately before your disability onset. Weekly benefits will not exceed the maximum shown in your Schedule of Benefits.

As required by Federal Law, the amount of your share of Social Security (FICA) and income taxes will be deducted from each disability benefit check. The taxes deducted from each disability check will be included in the W-2 form provided by your employer.

Return to work:

When you have a period of disability and return to work, a new period of disability cannot start until you have returned to active, full-time work and you have worked the minimum weekly hours required for eligibility (your average weekly hours prior to disability at the minimum required number of hours listed in your Schedule of Benefits).

Amount of the benefit:

If you were receiving weekly disability income benefits, returned to work, and then had another period of disability, your benefit amount for the second disability period will be based on the following:

- If you have been back to work for less than four weeks after a period of disability, then the benefit payable during your subsequent disability will be the same benefit amount that you were receiving during the prior disability period.
- If you have been back to work for four weeks or more after a period of disability, then the benefit payable during your subsequent disability will be based on your most recent four weeks' salary.

WHEN YOUR DISABILITY INCOME BENEFITS BEGIN	
If you are disabled for this reason	**Your benefits begin on the**
Accidental bodily injury	First day of disability
Sickness, including ☑ Pregnancy ☑ Physical illness ☑ Mental Health Disorder	Fourth day of disability

Exclusions

The weekly disability income benefit will not be paid for:

- Any day of disability during which you are not under the care or treatment of a physician;
- Any disability that is due to a sickness that is covered by a Workers' Compensation Act or other similar legislation, or due to an injury arising out of or in the course of employment for wages or profit;
- Any injury or illness not covered under the Plan guidelines.

IN THE EVENT OF YOUR DEATH

Life Insurance Benefit

The Life Insurance benefit is payable to your beneficiary if you die while you are covered under the Plan. The amount of your Life Insurance benefit is determined by your length of employment and Unit coverage and is shown in your Schedule of Benefits. This is an insured benefit that is provided by the Plan under a policy of group insurance. This description is a summary of the provisions of that policy. Contact the Welfare Fund office for a complete copy of the policy of insurance.

Your Beneficiary

Your beneficiary is any person or persons you named on your enrollment form that you completed and sent to the Welfare Fund office. You may change your beneficiary at any time by filing a new enrollment form with the Welfare Fund office. Such a change will be effective only if it is received by the Welfare Fund office prior to a claim.

If you do not name a beneficiary or your beneficiary dies before you do, the life insurance benefit will be paid in the following order:

1. To your legal surviving spouse, provided you are not divorced or legally separated; or
2. To your children, equally; or
3. To your parents, equally; or
4. To your brothers and sisters, equally; or
5. To your estate.

How Benefits Are Paid

Benefits will be paid to your beneficiary in a lump sum after the Welfare Fund office receives proof of your death. However, the Insurance Company does provide optional forms of payment. Your beneficiary must notify the Welfare Fund office if an optional form of payment is desired.

The Life Insurance Policy provided by the Plan does not have a cash surrender value.

Life Insurance Continues when You Become Totally Disabled

If you become totally disabled prior to age 60, as defined under the terms of the Life Insurance policy, and are no longer able to work, your eligibility for the Life Insurance benefit will be continued until age 65. To qualify, you must remain totally disabled and comply with the Insurance Company's rules regarding proof of your disability. You must have been eligible for the Life Insurance benefit immediately before the onset of total disability in order to continue Life Insurance coverage during your disability.

You will be required to submit proof of your total disability during the twelve-month period following the date you became totally disabled. The Life Insurance benefit will not be payable if you do not submit written proof of your total disability to the Welfare Fund office within 12 months after the date your disability begins. You may be required annually to submit proof that you remain totally disabled.

If you die while you are totally disabled, the Life Insurance benefit will be paid to your beneficiary. The amount of the Life Insurance benefit is the same amount for which you were eligible when your total disability began.

Totally disabled means that you are completely unable to perform the duties of any occupation or employment as a result of a non-work-related injury or sickness.

Accelerated Benefit

If you have a terminal condition, you may apply for an accelerated benefit from the life insurance coverage provider under the Plan. A terminal condition means that you have a condition caused by sickness or accident that results in your having a life expectancy of twelve months or less, as determined by your physician and approved by the insurance company.

The accelerated benefit amount will be 50% of the amount of life insurance benefit for which you are eligible (see your Schedule of Benefits), less any administrative charge. It will be paid to you in a lump sum. Any amount paid to you as an accelerated benefit will reduce the remaining amount of your life insurance benefit, but will not affect your accidental death and dismemberment benefit amount, if you are also eligible for that benefit.

Contact the Welfare Fund office for additional information about this benefit and how to apply for it. You should keep in mind that receipt of the accelerated benefit may affect your eligibility for public assistance programs and may be taxable. You should consult your personal tax advisor before requesting this benefit.

Termination of Life Insurance Coverage

Your life insurance coverage under the Plan will be terminated on the earliest of the following:

- The date the Policy is terminated;
- The date timely premiums are not paid for your coverage;
- The date you no longer meet the Plan's eligibility requirements for coverage under the Plan;
- The date you enter the armed forces of any country.

Life Insurance benefits may be continued if you:

- ☑ **Become disabled while covered; or**
- ☑ **Convert your coverage to an individual policy.**

Conversion Privilege

You have the right to convert to an individual policy of insurance you pay for if: your eligibility for life insurance ends because your employment in a class of employees eligible for life insurance ends; because the insurance policy is terminated or amended to exclude your eligibility (if you have been covered for the required minimum number of years); or because you recover from a disability during which your life insurance was extended. The amount of the converted policy will vary depending on the reason your eligibility ended. You must request the conversion policy in writing within 31 days from the date your eligibility ends. If you delay applying for an individual life insurance policy until after the 31-day period, you will no longer be eligible to convert your group life insurance to an individual policy. If you die during the 31-day period during

which you are eligible to convert your life insurance, your beneficiary will be paid the amount of life insurance you were entitled to convert, whether or not you had applied for conversion.

The premium for an individual life insurance policy will be based on your attained age when you apply for conversion. You must forward the premium to the insurance company within 31 days following the date your eligibility ends. The individual life insurance policy will begin on the 32nd day following the date your eligibility for group life insurance ends. Write or call the Welfare Fund office for additional information about the conversion privilege.

Accidental Death and Dismemberment Insurance Benefit

The accidental death and dismemberment insurance benefit provides benefits if you die or experience one of the losses listed below as the result of an accident, either on or off the job. This is an insured benefit that is provided by the Plan under a policy of group insurance.

In order for benefits to be paid, your loss must occur:

- Within 365 days following the date of the accident; and
- While you are eligible for benefits under the Plan.

If you die as the result of an accident, the maximum benefit will be paid to your beneficiary in a lump sum. Your beneficiary is any person or persons you name on your enrollment form that you filed with the Welfare Fund office. You may change your beneficiary by filing a new enrollment form with the Welfare Fund office, naming your new beneficiary. A change of beneficiary will not be effective unless it is received in the Welfare Fund office and sent to the Insurance Company prior to a claim.

The benefit amount for the accidental death and dismemberment insurance benefit varies according to your Unit coverage and the length of your employment, and is shown in your Schedule of Benefits. You will receive all or part of the accidental death and dismemberment insurance benefit amount listed in your Schedule of Benefits, depending on the extent of your loss.

No more than the benefit amount will ever be paid for all losses due to one accident.

The following definitions apply for purposes of this benefit:

Loss means:

- Severance of a hand or foot at or above the wrist or ankle joint;
- Total and irrecoverable loss of sight;
- Total and irrecoverable loss of audible speech communication;
- Total deafness in both ears, which cannot be corrected to any functional degree by any aid or device.

Quadriplegia means the complete and irreversible paralysis of both upper and both lower limbs.

Paraplegia means the complete and irreversible paralysis of both lower limbs.

Hemiplegia means the complete and irreversible paralysis of upper and lower limbs on one side of the body.

Uniplegia means the total paralysis of one limb.

Felonious Assault means a physical attack by another person resulting in

bodily harm. A physical attack is any willful or unlawful use of force or violence with the intent to cause bodily injury. The attack must be considered a felony or misdemeanor in the jurisdiction in which it occurs, and must not be a moving violation as defined under the applicable state's motor vehicle laws, or an act of an immediate family member or person residing in the same household.

Limitations and Exclusions

The Accidental Death & Dismemberment loss must occur within 365 days after the date of the accident and be a direct result of bodily injury sustained from that accident, independent of other causes. Benefits will not be payable for a loss caused by an accident that occurs after your eligibility under the Plan ends.

Unless prohibited by state law, the accidental death and dismemberment insurance does not include payment for any loss which in any way results from or is caused by or contributed to by:

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- infection, other than infection occurring in an external accidental wound;
- suicide or attempted suicide;
- intentionally self-inflicted injury;
- service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determine by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
- any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight except for self preservation;
  - by or for any military authority; or for travel or designed for travel beyond the earth's atmosphere;
- committing or attempting to commit a felony;
- the voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is: taken or used as prescribed by a Physician, or an "over the counter" drug, medication or sedative, taken as directed;
  - alcohol in combination with any drug, medication, or sedative;or
  - poison, gas, or fumes;
- war, whether declared or undeclared; or act of war, insurrection, rebellion, riot;
- driving a vehicle or operating another device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or other device was being operated.

FILING CLAIMS

WHERE TO SEND CLAIMS	
Type of Claim	**Mail to**
☑ Plan participant-filed claims (weekly disability, accidental death and dismemberment and life insurance claims) ☑ Paper claims filed by dental provider	United Food & Commercial Workers Union Local No. 655 Welfare Fund 13537 Barrett Parkway Drive, Suite 100 Manchester, Missouri 63021
☑ Claims filed by medical, vision, or mental health provider ☑ Electonic claims filed by dental provider	See the address on your Medical ID card

One-year deadline. You must submit a completed claim form accompanied by acceptable proof no later than one year following the date that the expenses were incurred.

Claim forms are not required when you receive services from a network provider, unless the claim is due to an injury.

When filing your claim, attach itemized bills for services not shown on the claim forms. Be sure the bills clearly identify the patient, the dates and nature of treatment or service and the amount of the charge.

File all claims promptly. The PPO providers will file the claim for you. You must provide written notice of the claim to the Welfare Fund office within 90 days after the loss or the date you received the services or supplies. In addition, you must file a proof of claim that contains all the required information, whether you are using network or out-of-network services or supplies within one year immediately following the date you received the services or supplies. If not, the claim will be denied.

If you are prevented from filing a claim within these time frames because of circumstances beyond your control, the Trustees may, in their discretion, accept your claim later than one year after the date you received the services.

The Welfare Fund will pay benefits only when it receives written proof that is satisfactory to the Board of Trustees. The proof will be considered satisfactory if you include itemized bills showing the:

- Diagnosis;
- Services and supplies provided;
- Charges for each item;
- Date or dates each charge was incurred; and
- Name and credentials of persons and or facility providing the service.

When the Welfare Fund office receives notice of your claim, it will notify you if any information is missing or if additional information is required. You must supply the additional information promptly.

The Welfare Fund office will only accept your claim after the 90-day period or accept additional information to verify the proof of claim during the one-year period immediately following the date or dates the loss occurred if:

- Due to extenuating circumstances, it is not reasonably possible to furnish the notice of claim and/or proof of loss on time;

- The notice of claim and/or proof of loss are furnished as soon as reasonably possible; and
- The Board of Trustees approves such claim.

Physical Examinations

The companies administering and/or insuring life insurance benefits and health and welfare benefits and the Board of Trustees reserve the right to have a physician that they designate examine you or your eligible dependent as often as is reasonable to process the claim for benefits.

Lawsuits

You may not bring an action at law or in equity to recover a loss under the Plan before you have exhausted all of the claims and appeals procedures provided by the Plan, unless, effective September 1, 2012, the Plan fails to follow its procedures (other than a de minimis violation). After you have exhausted the claims and appeals procedures provided by the Plan, you have the right to file a civil action under Section 502(a) of ERISA if you are unhappy with the Trustees' decision regarding your appeal. You must file any such action no later than one year after the date the Trustees issue their final decision on your appeal. If you do not file the action within that one-year period, you will lose your right to do so.

Assignment of Benefits

All or a portion of benefits payable under the Plan may be, at the Board of Trustees' option, paid directly to the hospital or provider that rendered the services being claimed.

Claim Forms for Life Insurance, Accidental Death and Dismemberment and Disability

Here are a few things to remember about filing claims for:

- **Life Insurance—**The Life Insurance Benefit is payable to your designated beneficiary after the Welfare Fund office receives:
  - → A certified copy of the original death certificate; and
  - → A completed Life Insurance claim form.
- **Accidental Death and Dismemberment Insurance—** The accidental death and dismemberment insurance benefit covers accidents that occur on the job as well as those off the job. There will be a minimum waiting period between the date the Welfare Fund office receives the completed proof of loss and the date benefits are paid. Contact the Welfare Fund office for more information about the waiting period.
- **Weekly Disability Income Benefit—** Weekly disability income payments cannot begin until you, your employer and your physician complete the claim form and return it to the Welfare Fund office. You will be required to supply the Welfare Fund office with proof of continuing disability.

CLAIM REVIEW AND APPEAL PROCEDURES

In General

The claim review and appeal procedures outlined here are designed to afford you a full, fair and fast review of the claim to which the procedures apply. This section describes the claim review and appeal procedures.

Health Care Claims

Generally, all health care benefits will be paid as soon as administratively possible. You will be notified of an initial decision within certain timeframes.

Types of Health Care Claims

There are four basic types of health care claims:

Pre-Service. A pre-service claim is a claim for benefits where prior authorization is required. The services that require prior authorization include hospitalizations and inpatient treatment of mental health disorders and chemical dependency. The Plan will not deny benefits for these procedures or services if:

- It is not possible for you to obtain prior authorization; or
- The prior authorization process would jeopardize your life or health.

Urgent Care. An urgent care claim is a type of a pre-service care claim. An urgent care claim is a claim for medical care or treatment that:

- Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a physician with knowledge of your condition.

Post-service. A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim. A claim regarding rescission of coverage will be treated as a post-service claim.

Concurrent Care. A concurrent care claim is a claim that is reconsidered after it is initially approved and the reconsideration results in:

- Reduced benefits; or
- A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment.

If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, you will be given written notice of a decision about your claim.

The deadlines differ for the different types of claims as shown in the following paragraphs:

- **Urgent Care Claims.** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally as soon as possible, but no later than 72 hours and then will be confirmed in writing within three days after the oral notice. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 24 hours after receipt of your claim. You will then have up to 48 hours to respond. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible, but no later than 24 hours after the earlier of the receipt of the information or the end of the period of time allowed to you in which to provide the information.
- **Pre-Service Claims.** An initial benefit determination will be made within 15 calendar days from receipt of your pre-service claim. If additional time is necessary to make a benefit determination on your pre-service claim due to matters beyond the control of the Plan, the Plan may take up to 15 additional calendar days to make a benefit determination. You will be informed of the extension within the initial 15-day deadline. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 15 days after receipt of your claim. You will have up to 45 days to provide the requested information. You will then be notified of the Plan's benefit determination on the pre-service claim as soon as possible, but no later than 15 days after the earlier of the receipt of the information, or the end of the 45-day time period allowed to you in which to provide the information.
- **Post-Service Claims.** An initial benefit determination will be made within 30 calendar days from receipt of your post-service claim. If additional time is necessary to make a benefit determination on your post-service claim due to matters beyond the control of the Plan, the Plan may take up to 15 additional calendar days to make a benefit determination. You will be informed of the extension within the initial 30-day deadline. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 30 days after receipt of your claim. You will have up to 45 days to provide the requested information. You will then be notified of the Plan's benefit determination on the post-service claim as soon as possible, but no later than 30 days after the earlier of the receipt of the information, or the end of the 45-day time period allowed to you in which to provide the information.
- **Concurrent Care Claims.** While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a previously approved claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request in the same manner as urgent care claims.

Authorized Representative

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a Health Care Professional. Under this Plan you do not need to designate in writing that the Health Care Professional is your authorized representative if that Health Care

Professional is part of the claim appeal.

The Plan requires a written statement from you that you have designated an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a plan participant) along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form to the Welfare Fund office.

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (e.g. notarized power of attorney for health care purposes, court order of guardianship/ conservatorship or is your legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not to you. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form to the Welfare Fund office.

Authorized representative forms and change of authorized representative forms are available upon request from the Welfare Fund office.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Payment of Claims

Generally, when providers submit the claims, payment is made directly to the provider. Providers handle all the paperwork for you. However, if you submit the claim, payments are generally made directly to you, unless you assign benefits to the provider.

Weekly Disability Income Benefit

A weekly disability income benefit claim is a claim for benefits under the Plan on which the Plan conditions availability of the benefit on proof of your disability. Generally, you will receive written notice of a decision on your initial claim as soon as possible and no later than within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. The Plan may extend this 45-day period for up to two additional 30-day periods. If a determination is not made within the first 45 days, you will be notified that an additional 30 days is necessary and if the determination is not made within 75 days, you will be notified that an additional 30 days is necessary.

In some instances the Plan may require additional information from you to process and make a determination on your claim. If such information is required, the Plan will notify you as soon as possible, but no later than 45 days after receiving your claim. You then have up to 45 days in which to submit the additional information. You will then be notified of the Plan's benefit determination on the weekly disability income benefit claim as soon as possible, but no later than 30 days after the earlier of the receipt of the information, or the end of the 45-day time period allowed to you in which to provide the information.

Life and Accidental Death and Dismemberment Insurance Benefit Claims

A life insurance or accidental death and dismemberment (AD&D) claim is a claim for benefits under the Plan on which the Plan conditions availability of the benefit on proof of your death or proof of accidental dismemberment. Generally you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

Examination

The Trustees have the right:

1. To employ a physician to examine the person whose illness or injury is the basis of a claim hereunder when and so often as they may reasonable require during the pending of a claim hereunder;
2. To examine any and all hospital and medical records relating to a claim under this Plan; and
3. To request and have an autopsy performed in case of death, provided an autopsy is not forbidden by law.

If a Claim is Denied

Adverse Benefit Determination

For the purpose of the initial and appeal claims processes, an adverse benefit determination as defined under Department of Labor guidance as a denial, reduction, or termination of a benefit, or a failure to provide or make payment in whole or in part for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in the Plan;
- A determination that a benefit is not a covered benefit;
- Any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is experimental, investigative or not medically necessary or appropriate; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except for the following situations:

    → The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.

    → The Plan retroactively terminates your coverage because of your failure to timely pay the required premiums or contributions for your coverage.

    → The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

If you receive an adverse benefit determination, meaning your claim is denied (in whole or in part), you will receive a written notice that will:

- Provide you with certain information about your claim; and
- Notify you of the denial of your claim within certain timeframes.

Information Requirements

When the Plan notifies you of its initial denial of your claim, it will provide:

- Identification of the claim involved, including date of service, provider, claim amount and statement with denial codes, and their respective meanings;
- The specific reason or reasons for the decision, and any Plan standards used in denying the claim;
- The statement that you may request, without charge, the diagnosis code and its corresponding meaning, as well as the treatment code and its corresponding meaning;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A copy of the Plan's internal review procedures and time periods and information needed to appeal your claim, and external review processes for health care claims;
- A statement of your right to bring a civil action under ERISA following an adverse benefit determination of your claim on review; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act of 2010 to assist individuals with the internal claims and appeals and external review processes for health care claims.

In addition, for health care and weekly disability income benefit claims, you have the right to request:

- A copy of any internal rule, guideline, protocol or similar criteria that was relied on in making the decision to deny your claim, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that it is available to you at no cost upon request, if your claim is denied due to medical necessity, experimental treatment, or similar exclusion or limit.

If your appeal is due to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

The Plan must also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan can issue an adverse benefit determination on review based on a new or additional rationale, you must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Appealing a Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Board of Trustees at the Welfare Fund office as soon as possible. For urgent care claims, your appeal may be made orally by calling the Welfare Fund office. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days from the date of a decision for health care or weekly disability income benefit claims; or
- 60 days from the date of a decision for life or AD&D insurance benefit claims.

You should send your appeal to the Welfare Fund office at the address on the inside front cover of this booklet. For urgent care claims, you may call the Welfare Fund office at the number listed on the inside front cover of this booklet.

When filing or appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Welfare Fund office authorizing this representative. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal, you may:

- Submit additional materials, including comments, statements or documents; and
- Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
  - → Was relied upon by the Plan in making the decision;
  - → Was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon); or
  - → Demonstrates compliance with the claims processing requirements.

Appeal Decisions

If you file your appeal on time and follow any applicable required procedures, a new, full and independent review of your claim will be made and the decision will not be deferred to the initial benefit decision maker. An appropriate fiduciary of the Plan, in this case, the Board of Trustees, will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on appeal within the timeframes set forth under the different types of claims. However, notice of a determination on your urgent care claims may be provided to you in an expedited manner and may be provided orally.

Appeal Timeframes

The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

Health Care Claims

- Urgent Care Claims. A determination will be made as soon as possible, but not later than 72 hours from receipt of your appeal.
- Pre-Service Claims. A determination will be made within 30 calendar days from receipt of your appeal if the appeal process has one level. If the appeal process has two levels, the determination will be made within 15 calendar days from receipt of your appeal for each level.
- Post-Service Claims. A determination will be made at the Board of Trustees' next quarterly meeting if your appeal is received at least 30 days before that meeting. If your appeal is received within 30 days of the Board of Trustees' next quarterly meeting, the determination will be made at the second quarterly meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.
- Concurrent Care Claims. A determination will be made before the termination of your benefit.

Weekly Disability Income Benefit

A determination will be made at the Board of Trustees' next quarterly meeting if your appeal is received at least 30 days before that meeting. If your appeal is received within 30 days of the Board of Trustees' next quarterly meeting, the determination will be made at the second quarterly meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Life and AD&D Insurance Benefit

A determination will be made at the Board of Trustees' next quarterly meeting if your appeal is received at least 30 days before that meeting. If your appeal is received within 30 days of the Board of Trustees' next quarterly meeting, the determination will be made at the second quarterly meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and

- Was not consulted (or is not subordinate to the person who was consulted) in connection with the initial denial of your claim.

You have the right, upon request, to be advised of the identity of any medical experts consulted in making a determination of your appeal.

Appeal Information Requirements

When the Plan notifies you of its determination on your appeal, it will provide:

- Identification of the claim involved, including date of service, provider, claim amount and a statement with denial codes, and their respective meanings;
- The specific reason or reasons for the decision, and any Plan standards used in denying the claim;
- Reference to the Plan provisions on which the decision was based;
- A statement that you may request, without charge, the diagnosis code and its corresponding meaning, as well as the treatment code and its corresponding meaning;
- A statement notifying you that you have the right to request a free copy of all documents, records and other information relevant to your claim;
- Information relating to external review processes for health care claims, and any voluntary appeal procedures offered by the Plan;
- A statement of your right to bring a civil action under ERISA; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act of 2010 to assist individuals with the internal claims and appeals and external review processes for health care claims.

In addition, for health care and weekly disability income benefit claims the notice will include:

- A copy of any internal rule, guideline, protocol or similar criteria that was relied on in making the decision to deny your claim, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that it is available to you at no cost upon request, if your claim is denied due to medical necessity, experimental or investigative treatment, or similar exclusion or limit.

External Review of Claims

This External Review process is intended to comply with the Patient Protection and Affordable Care Act of 2010 (PPACA) external review requirements as set forth in federal regulations and other guidance issued in connection with the implementation of the PPACA.

If your appeal of a health care claim, whether pre-service, post-service or urgent care claim, is denied, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

If your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan, external review is not available. You are eligible for external review if your initial claim determination or your adverse appeal claim determination involves medical judgment or rescission of your coverage under the Plan as defined on page 70.

External Review of Standard Claims

Your request for external review of a standard (not urgent) claim must be submitted, in writing, within four (4) months of the date that you receive notice of an initial claim determination or adverse appeal claim determination. For convenience, such a determination is referred to below as an "Adverse Determination," unless it is necessary to address the determination separately.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course external review of standard claims will only be available for appealed claim determinations.

Preliminary Review Procedures

1. Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;
    c. You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeal process under the federal interim final regulations (which involve certain limited exceptional circumstances); and
    d. You have provided all of the information and forms required to process an external review.
2. Within one (1) business day of completing its preliminary review, the Plan will send you a notice in writing as to whether your request for external review meets the threshold requirements for external review.
3. If your request for external review is complete but not eligible for external review, the notice will include the reasons for the request's ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
4. If your request for external review is not complete, the notice will describe the information or materials needed to make the request complete, and you will be allowed to perfect your request for external review within the four (4) month filing period or within a 48-hour period following receipt of the notification, whichever is later.

Review By Independent Review Organization

If your request for external review meets the threshold requirements for external review, the Plan will assign the request to an IRO. The IRO will be assigned in accordance with the Plan's rules, which provide an assignment or rotation method that ensures independence and against a bias towards the Plan. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.

Once the claim is assigned to an IRO, the following procedures will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you must submit in writing to the assigned IRO within ten (10) business days following the date you receive the notice from the assigned IRO, additional information that the IRO will consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten (10) business days.
2. Within five (5) business days after the date of assignment to the IRO, the Plan will provide to the IRO any documents and any information considered in making its' Adverse Determination. Failure by the Plan to provide documents cannot delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or the final adverse internal appeal determination. Within one (1) business day after making the decision, the IRO will notify you and the Plan.
3. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
4. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
5. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
6. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives your request for external review.
7. The assigned IRO's decision notice will contain:
8. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
9. The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

10. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
11. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
12. A statement that the IRO's determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
13. A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
14. A statement that judicial review may be available to you; and
15. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not yet been discharged from a facility.

Preliminary Review

Upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request as soon as possible to determine whether the request meets the reviewability requirements set forth in the Preliminary Review Procedures section above. The Plan will send you a notice as soon as possible informing you as to whether your request for review meets the threshold requirements for external review, along with other information described in the Preliminary Review Procedures on page 73.

Review By Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the

terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth for standard reviews, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will provide coverage or payment for the reviewed claim as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or Federal law.

The IRO will maintain records of all claims and notices associated with the eternal review process for a minimum of six (6) years. An IRO will make such records available for examination by you, the Plan, or State or Federal government oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

Coordination of Benefits

In many families, especially those where both husband and wife work, members of the family may be covered for health care under more than one plan. Benefits from each of the different group plans are payable but are coordinated so that the total payment will not be more than 100% of the allowable expenses. Allowable expenses means any allowable charge for services or treatment covered in whole or in part under at least one of the plans covering the patient.

A full technical description of the COB rules is provided in Appendix B. This is a simplified version of Appendix B and if there are any discrepancies between the two, the rules in Appendix B control. Under these rules, one group plan has primary responsibility and pays first. The other plan has secondary responsibility and considers any additional benefits.

If one plan does not have COB rules, that plan is automatically primary. If both plans have COB rules, the following chart shows which plan is designated as primary or secondary in the case of a husband and wife who work for different employers and also have a child eligible for dependent coverage:

PRIMARY AND SECONDARY PLANS UNDER COB RULES		
Patient	**Primary Plan**	**Secondary Plan**
Husband	Husband's	Wife's
Wife	Wife's	Husband's
Child	Child's or Parent's whose birthday falls first in the calendar year*	Parent's whose birthday falls second in the calendar year*

* If both parents have the same birthday, the plan covering the parent for the longer period of time will pay first. If the child has coverage, the parent whose birthday falls first in the calendar year will pay second and the parent whose birthday falls second in the calendar year will pay third.

Generally, if the other plan uses another method to coordinate benefits between children and parents, the other plan determines which plan is primary.

Other Plan means any other plan, whether insured or uninsured, that provides benefits or services for hospital, dental, or medical care treatment, including:

- ☑ **Group, group type blanket or franchise insurance coverage.**
- ☑ **Group service plan contracts, individual practice, group practice, and other prepayment coverage, including HMOs.**
- ☑ **Coverage under labor - management trusteed plans, union welfare plans, employer organization plans or any other arrangement of benefits for individuals of a group.**
- ☑ **Coverage under governmental programs and any coverage required or provided by any statute**.

Divorce Situations – Who Covers the Dependent Children

If the parents of a dependent child are divorced or legally separated, the plan of the parent who has financial responsibility as determined by court decree for that dependent is the primary plan.

If there is no decree establishing financial responsibility, the plan that covers the child as a dependent of the parent with custody is the primary plan. The other parent's plan is secondary.

If there is no financial decree and the parent with custody remarries, that parent's plan remains primary and the step-parent's plan is secondary. The plan of the natural parent without custody pays third.

Other Situations

For an adult dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the plan that has covered the dependent child for the longer period of time is primary. In the event that the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits is be determined by applying the birthday rule to the dependent child's parent(s) and the dependent child's spouse.

If a person's eligibility under this Plan is continued under COBRA or USERRA, this Plan is secondary if that person's coverage by another plan is not COBRA or USERRA continuation coverage.

If the above rules do not establish the order of payment, the plan that has covered the patient for the longer period of time will be primary. Any other plan pays any remaining benefits up to the maximum allowable expenses.

A dependent spouse who declines subsidized coverage (as explained on page 12) will not be covered by this Plan at all, so there will be no coordination of benefits.

Remember to Notify Both Plans

It is also important to know how to file claims when coordination of benefits is involved in order to maximize benefits and speed claims processing. The following guidelines explain how to file when multiple coverage exists.

If an employee is the patient:

1. File under the United Food and Commercial Workers Union Local 655 Welfare Fund first.
2. File under the other plan second.

If the spouse or dependent with other coverage is the patient:

1. File under the other plan first.
2. File under the United Food and Commercial Workers Union Local 655 Welfare Fund second.

If a dependent without his or her own coverage is the patient and the parents are not separated or divorced:

1. File under the plan of the parent whose birthday falls first in the calendar year first.
2. File under the plan of the parent whose birthday falls second in the calendar year second.

When submitting a claim under a multiple coverage situation, you need to send the first plan's explanation of benefits (EOB) to the second plan's carrier or claims administrator. Be sure to keep copies of all items for your records. In cases in which claims are filed for you by the hospital, physician or laboratory, it is important that you notify them that more than one plan is involved and instruct them to file with both plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Welfare Fund office may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Welfare Fund office need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give any facts it needs to apply those rules and determine benefits payable. However, this Plan will comply with all privacy legislation when obtaining or releasing information.

Method of Payment

A payment made under any other Plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount is then treated as though it were a benefit paid under this Plan. The Plan does not have to pay that amount again. The term "payment" includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

SPECIAL NOTES

If your eligible dependent is covered by a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) and voluntarily elects not to use the HMO or PPO's services or follow their referral guidelines, no benefits will be payable from this Plan.

In certain situations, this Plan may not honor another plan's COB rules. For instance, if the other plan has a COB provision designed to minimize its responsibility whenever there is other coverage, that provision will not be recognized by this Plan. Instead, this Plan will coordinate with the other plan as if the other plan was primary.

Summary of Plan's Subrogation, and Reimbursement Rights

The Plan will exercise its rights to subrogation and reimbursement when the Plan pays or is obligated to pay benefits for an injury or illness for which another person or entity may be responsible. A full description of the Plan's subrogation and reimbursement rights is outlined in Appendix C. If there are any discrepancies between this brief summary and Appendix C, the language in Appendix C will control.

If you or a covered eligible dependent incurs claims as a result of an injury or illness for which another party is responsible, and the Plan pays benefits with respect to that injury or illness, this Plan has the same rights as you or your eligible dependent to recover from the responsible party and from any other person or entity that must pay you or your eligible dependent because of that injury or illness. Further, if you or your eligible dependent recovers any monies from the party who caused the injury or illness, you or your eligible dependent must reimburse the Plan the lesser of the benefits paid by the Plan or the amount recovered with respect to that injury or illness.

You or your eligible dependent will be deemed to be holding such recovery in trust for reimbursement to the Plan.

Subrogation rules are given in detail in Appendix C. The rules in Appendix C control the Plan's right to recover expenses it pays on your behalf.

Plan's Right to Recover Overpayments or Mistaken Payments

If the Plan finds that a payment for a claim filed by or for you or one of your eligible dependents is more than the amounts payable under the terms of the Plan or was made in error, then the Plan may request a refund of the excess or erroneous payment.

In addition, the Trustees may take whatever action they deem necessary to recover the overpaid or mistakenly paid amounts, including, but not limited to:

- Reducing benefits payable for future claims filed by or for you or your eligible dependents to offset the overpaid or mistakenly paid amounts; or
- Bringing a legal action against you to collect the overpayment.

If it is necessary for the Trustees on behalf of the Plan to institute legal proceedings to collect an overpayment and they prevail, you will be responsible for paying the reasonable attorney's fees and costs incurred in connection with such action.

IMPORTANT INFORMATION ABOUT THE PLAN

The following information is provided to help you identify this Plan and the people who are involved in its operation:

Name of Plan. This Plan is known as United Food and Commercial Workers Union Local 655 Welfare Fund.

Board of Trustees. A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of employer and union representatives, selected by the employers and local unions that have entered into collective bargaining agreements related to this Plan. If you wish to contact the Board of Trustees, you may use the address and telephone number below:

Board of Trustees
United Food and Commercial Workers
Union Local 655 Welfare Fund
13537 Barrett Parkway Drive, Suite 100
Manchester, Missouri 63021
Telephone: 314-835-2700 or 1-866-565-2700

As of January 1, 2018 the Trustees of this Plan are:

PLAN TRUSTEES AS OF JANUARY 1, 2018	
Employee Trustees	**Employer Trustees**
Mr. David Cook United Food and Commercial Workers Union Local 655 300 Weidman Road Ballwin, Missouri 63011	**Mr. Larry Hunt** Schnuck Markets 11420 Lackland Road St. Louis, Missouri 63146-6928
Mr. Steve Powell United Food and Commercial Workers Union Local 881 10400 W. Higgins Road Rosemont, Illinois 60018	**Mr. Alan Kehrer** Shop N Save 10041 Manchester Rd Kirkwood, Missouri 63122
Ms. Karen Settlemoir-Berg United Food and Commercial Workers Union Local 655 300 Weidman Road Ballwin, Missouri 63011	**Mr. Tracy McDonald** SuperValu 7075 Flying Cloud Drive Eden Prairie, MN 55344
Mr. Robert Spence United Food and Commercial Workers Union Local 655 300 Weidman Road Ballwin, Missouri 63011	**Mr. Nancy Meyer** Dierbergs Markets 16690 Swingley Ridge Road Chesterfield, Missouri 63017
Mr. Garry Torpea United Food and Commercial Workers Union Local 655 300 Weidman Road Ballwin, Missouri 63011	**Mr. Don Schaper** Schnuck Markets 11420 Lackland Road St. Louis, Missouri 63146-6928

The Board of Trustees is both the Plan Sponsor and the Plan Administrator. The Board has delegated administrative responsibilities to a Fund Administrator.

Identification Numbers. The plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is 23-7401847.

Agent for Service of Legal Process. Ms. Cathy Sanderson, Fund Administrator, is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon Ms. Sanderson at the Welfare Fund office or upon any individual Trustee.

Source of Contributions. The benefits described in this booklet are provided through employer contributions. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements of the United Food and Commercial Workers Union (Locals 655, 881, 534, 700).

Identification of Insurance Companies and Network Providers. Life and accidental death and dismemberment insurance benefits are provided under a policy of group insurance issued by MetLife, Metropolitan Life Insurance Company, 200 Park Ave, New York, New York. Disability, medical, and dental benefits are self-funded and administered directly by the Welfare Fund office. The medical, prescription, and dental network arrangements are provided through contracts between the Fund and the networks. The medical network of benefit providers is provided through a contract between the Fund and Coventry/Aetna. The prescription drug network of benefit providers is provided through a contract between the Fund and LDI Integrated Services. The dental network of benefit providers is provided through a contract between the Fund and Anthem of Missouri PPO. The vision benefit network is provided through a contract between the Fund and VSP.

Welfare Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Welfare Fund's assets and reserves are invested by professional managers selected by the Trustees. The Fund is governed by the revised Amendment and Declaration of Trust establishing the United Food and Commercial Workers Union Local 655 Welfare Fund dated September 1, 2011.

Plan Year. The records of the Plan are kept separately for each Plan Year. The Plan Year begins on September 1 and ends on August 31.

Type of Plan. This Plan is maintained for the purpose of providing life, accidental death and dismemberment, disability, medical, dental and vision benefits. Self-funded benefits are paid from the assets of the Plan. The Plan benefits are summarized in your Schedule of Benefits and throughout this booklet.

Collective Bargaining Agreement. The Plan is established and maintained pursuant to collective bargaining agreements, a copy of which may be obtained by written request to the Welfare Fund office. Such collective bargaining agreements are also available for examination by plan participants and beneficiaries at the Welfare Fund office. If for any reason, you wish to review a collective bargaining agreement, please contact the Welfare Fund office to make an appointment.

You may receive from the Welfare Fund office, upon written request, information as to whether a particular employer or labor organization sponsors the Plan and, if so, you can receive the address of the employer or employee organization.

Payment of Benefits Provision. The Trustees may determine that a person covered under the Plan is legally incapable of giving a valid receipt for any payment due. If no guardian has been appointed, the Board of Trustees may, at its option, make the payment to the individual or individuals whom the Trustees believe have assumed the care and principal support of such person.

In determining the existence, identity or any other facts relating to any person and any question of entitlement to payment in accordance with this Section, the Board of Trustees may rely solely on any affidavit or other evidence deemed satisfactory to the Board of Trustees. Any payment or payments made by the Board of Trustees in reliance on such proof will fully discharge the Board of Trustees from liability under the Plan, to the extent of such payment.

Trustee Interpretation of Plan Provisions and Decisions Regarding Benefits. Under the Plan and the Trust Agreement creating the Welfare Fund, the Trustees have broad discretion and sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Benefits under the Plan will be paid only if the Trustees decide, in their discretion, that the applicant is entitled to them. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be given the most deferential standard of judicial review.

Future of the Plan. The Board of Trustees intends to continue the United Food and Commercial Workers Union Local 655 Welfare Fund indefinitely. However, the Board of Trustees retains the right to amend the Plan at any time, in accordance with the terms of the Trust Agreement and the Employee Retirement Income Security Act of 1974, as amended. If the Plan is amended, you will be notified in writing of the amendment. The Board of Trustees also retains the right to terminate the Plan and Welfare Fund in part or in whole at any time, if all contributing employers are no longer obligated through collective bargaining agreements to make required contributions. The monies of the Welfare Fund will be applied to all existing benefit obligations in effect on the date of termination of the Plan and Welfare Fund. No benefits will be payable after the Welfare Fund has terminated.

Any balance of the Welfare Fund that cannot be applied as above, will be applied to other uses that will best serve the intentions of the Plan, in the opinion of the Board of Trustees. Upon the distribution of the entire Welfare Fund, the Welfare Fund will then terminate.

The benefits provided by the Plan are payable only to the extent the Welfare Fund has assets available for such payments. Your benefits under the Plan (including retiree coverage) are not vested, and the Plan may be amended or terminated by the Trustees as noted previously.

Privacy and Security Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of private health information as defined by HIPAA's regulations. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice is available from the Fund Administrator.

In accordance with HIPAA, this Plan and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information" or "PHI"), except as necessary for treatment, payment, health

plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information for employment- related actions and decisions or in connection with any other benefit or Employee benefit plan. The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan also will require all of its business associates to agree to observe HIPAA's privacy rules. See Appendix E for more detailed information about the Plan's use of protected health information. Further, the Plan will take all steps required by HIPAA and its regulations to protect the security of your PHI that is stored or transmitted electronically.

Under HIPAA, you will have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Welfare Fund office if:

1. You need a copy of the Privacy Notice;
2. You have questions about the privacy of your health information; or
3. You wish to file a complaint under HIPAA.

Security Rule

The Plan complies with the HIPAA Security Rule, which addresses the security of electronically maintained protected health information. While security measures have always been in place, the Security Rule requires that certain safeguards be documented in Plan documents. Accordingly, the Trustees have implemented the following measures:

1. Administrative, physical, and technical safeguards have been implemented that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information the Trustees created, received, maintained, or transmitted on behalf of the Plan;
2. There is adequate separation (or firewall) between the information that is received from the Plan and other employment information and decisions, and this separation is supported by reasonable and appropriate security measures;
3. Any agent, including any subcontractor, to whom the Plan provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and
4. The Trustees will report to the Plan any security incident of which it becomes aware.

Breach Notification

The Plan will comply with the Health Information Technology for Economic and Clinical Health (HITECH) Act breach notification rules. In the unlikely event that your protected health information is breached, as that term is defined under the new HITECH law, the Plan will provide you with written notice of the breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information:

1. A brief description of what happened, the date of the breach if known, and the date of discovery;
2. The type of PHI involved in the breach;
3. Any precautionary steps you should take;
4. What the Plan is doing to mitigate the breach and prevent future breaches; and
5. How you may contact the Plan to discuss the breach.

The Plan will also report the breach to the U.S. Department of Health and Human Services as required under HITECH.

Patient Protection Notice

Federal regulations require us to advise you that the United Food and Commercial Workers Local 655 Welfare Fund generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Welfare Fund office at 314-835-2700.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the United Food and Commercial Workers Local 655 Welfare Fund or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Welfare Fund office at 314-835-2700.

YOUR RIGHTS UNDER ERISA

As a participant in the United Food and Commercial Workers Local 655 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the office of the Plan Administrator and at other specified locations, such as worksites and union halls, all documents governing the Plan. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These documents include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, your spouse, or eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the

control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted the claims procedures under the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), 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, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. For single copies of publications, contact the Employee Benefits Security Administration Brochure Request Line at 1-800-998-7542 or contact the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices at the EBSA's website at http://www.dol.gov/dol/ebsa/.

ERISA gives you rights to:

- ☑ **Receive copies of Plan information.**
- ☑ **Continue coverage;**
- ☑ **Eliminate waiting periods; and**
- ☑ **Bring a lawsuit to enforce your rights.**

The information in this section gives you more details about those rights.

GENERAL PROVISIONS

Severability Clause; Conformity with Law

Should any provision of the Plan, this document, or any amendment thereto be deemed or held to be unlawful, or unlawful as to any person or instance, such facts will not adversely affect the other provisions, or the application of those provisions to any other person or instance, unless such illegality makes the functioning of the Plan impossible or impracticable.

To the extent permitted by law, the Trustees will not be held liable for any act done or performed in pursuance of any provisions of the Plan prior to the time that such act or provision is held unlawful by a court of competent jurisdiction.

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Workers' Compensation Not Affected

This Plan is not in lieu of and does not affect any requirement for coverage under Workers' Compensation Act or Occupational Diseases Act or similar law.

Governing Law

All questions pertaining to the validity and construction of the Trust Agreement, the Plan, and of the acts and transactions of the Trustees or of any matter affecting the Fund will be determined under Federal law where applicable Federal law exists. Where no applicable Federal law exists, the laws of the State of Missouri will apply.

Fraudulent Claims

Notwithstanding any other provisions of the Plan, the Trustees may, in their sole discretion, determine whether a covered individual willfully and knowingly defrauds the Fund in any manner. In such case, the covered individual:

1. Shall forfeit all rights to benefits paid or payable to the covered individual, any assignee, any eligible dependent or to any other beneficiary, in connection with the claim or claims to which the subrogation and reimbursement agreement, deceit, theft or fraud relates and shall reimburse the Plan for any benefit payments already made by the Plan and the Plan's attorney's fees and costs incurred in recovering said benefit payments, all upon such terms and conditions as the Trustees in their sole discretion shall determine; and
2. If the complying plan would be the secondary plan under the rules set out here, it will pay or provide its benefits first, but the amount of benefits payable will be determined as if the complying plan were the secondary plan. In such a situation the payment will be the limit of the complying plan's liability;
3. If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan will assume that the benefits of the non-complying plan are identical to its own, and will pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it will adjust payments accordingly;
4. If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non- complying plan paid or provided its benefits as the primary plan,

and governing state law allows the right of subrogation set forth below, then the complying plan will advance to the covered person or on behalf of the covered person an amount equal to the difference; and

5. In no event will the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan will be subrogated to all rights to reimbursement of the covered person against the non-complying plan. The advance by the complying plan will also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation and reimbursement rights.
6. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans will immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan will be required to pay more than it would have paid had it been the primary plan.
7. If the other group plan, which is sponsored, maintained, or contributed to by an eligible person's employer, contains a provision which: (1) excludes the eligible person from eligibility under the other group plan due to coverage under another plan; or (2) has the effect of either: shifting coverage liability to this Plan in a manner designed to avoid any liability under the other group plan; or avoiding the customary operation of this Plan's coordination of benefit rules; this Plan will consider such provision to have no force or effect. This Plan will coordinate benefits payable under this Plan with benefits which would have been payable under the other group plan if such provision had not existed.

It shall be considered fraud if a covered individual willfully and knowingly fails to report the existence of any other available coverage or the covered individual's rights against a third party or insurance company in connection with a claim filed for benefits under this Plan.

Headings

The headings of sections and subsections are included solely for convenience of reference, and if there is any conflict between such headings and the text of this Plan document, the text shall control.

Gender and Number

The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender and the singular shall be deemed to include the plural, unless the context clearly indicates to the contrary.

APPENDIX A: DURABLE MEDICAL EQUIPMENT

The criteria for coverage (rental or purchase) of durable medical equipment is that the item must be medically necessary and prescribed by a physician for an illness or injury.

Covered Expense

Alternating pressure point pads
Apnea monitor
Automatic blood pressure monitor
Bed pans, autoclave hospital-type if bed-confined
Bedside commode
Bi-osteogen system
Blood glucose monitor
Blood pressure cuff, if pre-authorized
Bone growth stimulator, if pre-authorized
Braces and splints
Breast pumps
Cane (with prescription)
Case boot/shoe
Catheter
Cervical collar
Continuous passive motion machine
CPAP (continuous positive airway pressure)
Corrective shoes (child up to 6 years old)
Cranial helmet (for infants)
Crutches
Dialysis machine
Ear molds
Electro larynx
Glucose monitor or accuchek
Hair prosthesis, $150 maximum (if needed following any medical diagnosis)
Hearing aid
Home nebulizer
Hospital bed/mattress
Infusion pump
Insulin infusion pump
IPPB (intermittent positive pressure breathing)machines, if patient's ability to breathe is severely impaired
Lambs wool pads
Lifts, if pre-authorized
Lumbosacral corset
Lymphedema pumps
Muscle simulators
Nebulizer
Nerve simulators
Orthopedic shoes (see Corrective shoes)
Orthotic devices (also see Non-Covered Expense)
Oxygen, including rental of equipment to administer it
Pavlik harness
Percussors
Postural drainage boards
Prosthetics, other than dental
Pulse oximeter
Pulse tachometer
Respirator/ventilator
Spinal pelvic stabilizer
Stoma unit
Suction machine
Surgical bra

Surgical stockings
Tens unit
Traction equipment
Trapeze bars
Ultra violet equipment for treatment of psoriasis or skin disorder
Urinals, autoclavable hospital-type
Uterine monitor, if high risk pregnancy
Ventilators
Walker
Wheel chair, including cushion & battery
Wrist gauntlet

Non-Covered Expense

Bathroom equipment
Batteries, other than for wheelchair
Bed baths
Bed lifters
Bedboards
Beds, lounge-type or oscillating-type
Biofeedback equipment
Blood glucose analyzer
Blood pressure cuff
Braille teaching texts
Cervical pillow
Chairs/recliners
Colonic irrigation units
Communication devices
Diabetic shoes
Diathermy machines
Ear plugs
Elastic stockings, support hose
Elevators
Emesis basins
Environment equipment including:
- Air cleaner
- Air conditioner
- Air filter
- Dehumidifier
- Electrostatic machines
- Heaters, portable room heaters
- Heating and cooling plants/pads/packs
- Humidifier
- Precipitator

Esophageal dilator
Exercise equipment
Fabric supports
Facial masks, surgical
Food blender
Hair prosthesis (also see Covered Expense)
Hand rails/grab bars
Heart pulse rate monitor
Heat and massage foam cushion pad
Heat lamps
Heating pad
Hot tub
Incontinent pads /diapers/depends
Insulin injectors irrigating kit
Massage devices
Nocturnal enuresis devices
Orthopedic shoes (patient over 6 years old)

Orthotic devices for feet such as:
- Arch support
- Heel cups
- Heel lifts
- Heel pads

Over-bed table
Palatal plastic devices relating to temporomandibular joint syndrome
Paraffin bath units
Parallel bars
Polar/cold therapy unit
Portable whirlpool pumps
Preset oxygen units
Pressure leotards
Raised toilet seats
Sauna baths or beds
Scooters
Sitz baths
Sleep warm electric comfort units
Spare oxygen tanks
Standing tables
Telephone arms
Treadmill exerciser
Treadmill walker
Vaporizers
Water piks
Whirlpool equipment

This is a partial list of durable medical equipment. If you have any questions regarding coverage of a specific item not included on this list, please call the Welfare Fund office at 314-835-2700 in the St. Louis area or call toll-free in Missouri outside St. Louis or in Illinois at 1-866-565-2700. The Trustees have the discretion of paying for such items.

APPENDIX B: COORDINATION OF BENEFITS RULES

These coordination of benefits (COB) rules apply when a person has health care coverage under this Plan and one or more Other Plans as defined below.

The order of benefit determination rules in this Appendix B determine which plan will pay as the Primary Plan. The Primary Plan pays first without regard to the possibility another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

These rules do not require the Plan to pay more than it would otherwise have to pay if the other plan did not exist.

If you are covered by more than one health benefit plan, you should file all your claims with each plan.

Definitions

As used in this appendix, these words and terms have the following meanings, unless the context clearly indicates otherwise:

A. **Allowable expense**, except as set forth below or where a statute requires a different definition, means any health care expense that is covered in full or in part by any of the plans covering the person, including coinsurance or copayments and without reduction of any applicable deductible.

1. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
2. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.
3. The following are examples of expenses that are **not** allowable expenses:

    a. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

    b. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

    c. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

    d. If a person is covered by one plan that calculates its' benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment

will be the allowable expense used by the secondary plan to determine its benefits.

4. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
5. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

    a. Because the covered person does not comply with the plan provisions concerning second surgical opinions or pre-certification of admissions or services; or

    b. Because the covered person has a lower benefit because the covered person did not use a preferred provider.

B. **Birthday** refers only to month and day in a calendar year and does not include the year in which the individual is born.

C. **Claim** means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

    1. Services (including supplies);
    2. Payment for all or a portion of the expenses incurred;
    3. A combination of paragraphs (1) and (2); or
    4. An indemnification.

D. **Closed panel plan** means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

E. **Consolidated Omnibus Budget Reconciliation Act of 1985** or **COBRA** means coverage provided under a right of continuation pursuant to federal law and includes the right to continuation coverage provided under the Public Health Service Act and the Uniformed Services Employment and Reemployment Rights Act (USERRA).

F. **Coordination of benefits** or **COB** means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

G. **Custodial parent means:**

    1. The parent awarded custody of a child by a court decree; or
    2. In the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

H. **Group-type contract** means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

I. **High-deductible health plan** has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended.

J. **Hospital indemnity benefits** means benefits not related to expenses

incurred. The term hospital indemnity benefits does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

K. **Plan** means a form of coverage with which coordination is allowed. The definition of plan in the contract must state the types of coverage that will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group that are provided through separate contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB with the separate parts of the plan. For example, if an employer-provided plan of medical benefits is made up of a base plan and a major medical plan, this Plan will treat those two components as a single coordinated plan for purposes of these COB rules.

1. "Plan" may include:

    a. Group and non-group insurance contracts and subscriber contracts;
    b. Uninsured arrangements of group or group-type coverage;
    c. Group and non-group coverage through closed panel plans;
    d. Group-type contracts;
    e. The medical care components of long-term care contracts, such as skilled nursing care;
    f. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts; and
    g. Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph #2(h) or (i). That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

2. "Plan" does not include:

    a. Hospital indemnity benefits or other fixed indemnity coverage;
    b. Accident only coverage;
    c. Specified disease or specified accident coverage;
    d. Limited benefit health coverage, as defined under state law;
    e. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;
    f. Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
    g. Medicare supplement policies;
    h. A state plan under Medicaid; or
    i. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

L. **Policyholder** means the primary insured named in a non-group insurance policy.

M. **Primary plan** means a plan whose benefits for a person's health care

coverage must, under this Plan, be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

1. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this provision; or

2. All plans that cover the person use the order of benefit determination rules required by this provision, and under those rules the plan determines its benefits first.

N. **Secondary plan** means a plan that is not a primary plan.

Rules for Coordination of Benefits

A. When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan will pay or provide its benefits as if the secondary plan or plans did not exist.
2. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for Emergency Services or authorized referrals that are paid or provided by the primary plan.
3. When multiple contracts providing coordinated coverage are treated as a single plan under this provision, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan will be responsible for the plan's compliance with this provision.

B. If a person is covered by more than one secondary plan, the order of benefit determination rules of this provision decide the order in which the secondary plans' benefits are determined in relation to each other. Each secondary plan will take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this provision, has its benefits determined before those of that secondary plan. A plan that does not contain order of benefit determination provisions that are consistent with this provision is always the primary plan.

C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this provision, it is secondary to that other plan. If another plan is the primary under this Plan's rules, and the other plan contains a provision that has the effect of capping its benefits for an individual covered under this Plan and of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of this Plan's coordination of benefits rules, this Plan shall not be liable to provide benefits until the other plan provides as primary plan its customary benefits determined without regard to such cap or the existence of this Plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

1. Non-dependent or dependent

a. Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and

the plan that covers the person as a dependent is the secondary plan.

b. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

   i. Secondary to the plan covering the person as a dependent; and

   ii. Primary to the plan covering the person as other than a dependent (e.g. a retired Employee),

   then the order of benefits is reversed so that the plan covering the person as an Employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

2. Dependent Child Covered Under More Than One Plan: Unless there is a court decree stating otherwise, plans covering a dependent child will determine the order of benefits as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

      ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

   b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan;

      ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph will determine the order of benefits;

   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph will determine the order of benefits; or

   d. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      i. The plan covering the custodial parent;

      ii. The plan covering the custodial parent's spouse;

      iii. The plan covering the non-custodial parent; and then

      iv. The plan covering the non-custodial parent's spouse.

   e. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of

benefits will be determined, as applicable, under subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

f. For an adult dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the plan that has covered the dependent child for the longer period of time is primary. In the event that the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits is be determined by applying the birthday rule to the dependent child's parent(s) and the dependent child's spouse.

3. Active Employee or Retired or Laid-Off Employee

a. The plan that covers a person as an active employee that is, an Employee who is neither laid off nor retired or as a dependent of an active Employee is the primary plan. The plan covering that same person as a retired or laid-off Employee or as a dependent of a retired or laid-off Employee is the secondary plan. An individual who is in the 12-month extension of coverage for total disability, described on pages 16-17 of this booklet, is not an active Employee.

b. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the rule in Paragraph D (1) can determine the order of benefits.

4. COBRA or State Continuation Coverage

a. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an Employee, member, subscriber or retiree or covering the person as a dependent of an Employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the rule in Paragraph D (1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage

a. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

b. To determine the length of time a person has been covered under a plan, two successive plans will be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

c. The start of a new plan does not include:

i. A change in the amount or scope of a plan's benefits;

ii. A change in the entity that pays, provides or administers the plan's benefits; or

iii. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

d. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the allowable expenses will be shared equally between the plans.

Calculating Benefits as the Secondary Plan and Paying a Claim

If this Plan is the secondary plan on a claim, it will calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under this Plan that is unpaid by the primary plan. This Plan may, as the secondary plan, reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim. In addition, this Plan, as the secondary plan, will credit any amounts paid by the primary plan on the claim toward this Plan's deductible, if any. When the primary plan is a plan containing a sub-plan/no loss or similar provision, this Plan will not pay as the secondary plan until the primary plan has exhausted its benefits without regard to any such provision.

Miscellaneous Coordination of Benefits Provisions

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision will be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

B. A plan with order of benefit determination rules that comply with this provision (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this provision (non-complying plan) on the following basis:

1. If the complying plan would be the primary plan under the rules set out here, it will pay or provide its benefits first;
2. If the complying plan would be the secondary plan under the rules set out here, it will pay or provide its benefits first, but the amount of the benefits payable will be determined as if the complying plan were the secondary plan. In such a situation, the payment will be the limit of the complying plan's liability;
3. If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan will assume that the benefits of the non-complying plan are identical to its own, and will pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it will adjust payments accordingly;
4. If the non-complying plan reduces its benefits so that the covered

person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan will advance to the covered person or on behalf of the covered person an amount equal to the difference; and

5. In no event will the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan will be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan will also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation and reimbursement rights.

C. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans will immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan will be required to pay more than it would have paid had it been the primary plan.

D. If the other group plan, which is sponsored, maintained, or contributed to by an eligible person's employer, contains a provision which: (1) excludes the eligible person from eligibility under the other group plan due to coverage under another plan; or (2) has the effect of either: shifting coverage liability to this Plan in a manner designed to avoid any liability under the other group plan; or avoiding the customary operation of this Plan's coordination of benefit rules; this Plan will consider such provision to have no force or effect. This Plan will coordinate benefits payable under this Plan with benefits which would have been payable under the other group plan if such provision had not existed.

Rules for Coordination of Benefits with Medicare

A. Entitlement to Medicare Coverage: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

B. Medicare Participants May Retain or Cancel Coverage Under This Plan: If you, your covered spouse or eligible dependent child becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan. If you and/or any of your eligible dependents are covered by both this Plan and by Medicare, as long as you remain actively employed, this Plan will continue to provide the same medical expense benefits, and your contributions for those benefits will remain the same. In that case, this Plan will pay first and Medicare will pay second.

Note: An individual in the 12-month extension of coverage for total disability described on pages 16-17 of this booklet, or an individual covered by COBRA, is not considered actively employed for purposes of this paragraph.

If you are covered by Medicare and you cancel your coverage under this Plan, coverage of your spouse and/or your eligible dependent child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of your eligible dependents are covered by Medicare and you cancel that eligible dependent's coverage under this Plan, that dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is yours, and yours alone. Neither this Plan nor your employer will provide any consideration, incentive or benefits to encourage you to cancel coverage under this Plan.

C. Coverage Under Medicare and This Plan, (Including COBRA Continuation Coverage) When You Have End-Stage Renal Disease: If, while you are actively employed, you or any of your covered eligible dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second. By definition, ESRD means kidney failure that requires a regular course of dialysis or a kidney transplant.

D. Coverage under Medicare Part D and This Plan: If you or one of your eligible dependents who is covered under this Plan also has Medicare Part D coverage, this Plan continues to provide the same prescription drug benefits to that person and pays its benefits before Medicare, provided that person continues to be covered under the Plan and you continue to be actively employed. Your contributions for coverage under this Plan will remain the same. However, if you are not actively employed, then Medicare pays first and this Plan pays second. If you or your covered eligible dependent enrolls in Medicare Part D and then later drops Medicare Part D coverage, the Plan will continue to provide prescription drug benefits to that person, provided the person remains eligible for benefits under this Plan.

Rules for Coordination of Benefits and Medicaid

The Plan honors any Medicaid assignment of rights made on behalf of a participant. The Plan also honors any subrogation and reimbursement rights that a state may have by virtue of payment of Medicaid benefits for expenses covered by the Plan. In addition, the Plan will not consider Medicaid eligibility or medical assistance proved by Medicaid in determining Plan benefits or eligibility.

Effect on the Benefits of this Plan

When this Plan is secondary, it reduces its benefits so that the total benefits paid by all plans for a claim do not exceed 100% of the total allowable expenses.

APPENDIX C: SUBROGATION AND REIMBURSEMENT

Plan's Right to Subrogation and Reimbursement

The Plan shall be entitled to subrogation and reimbursement to the extent of any benefits the Plan has paid or may be obligated to pay including accidental death and dismemberment ("the claim") in connection with an illness or injury, sickness, accident, condition or death (collectively for purposes of this Appendix C "incident") to all rights of recovery of an employee, eligible dependents, spouse, representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of a covered person (collectively, for purposes of this Appendix C "individual") against any person organization or other entity in connection with the claim and/or the incident (the "source"). A source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility, any employer of the individual under the provisions of a Worker's Compensation or Occupational Disease Law, and an individual policy of insurance maintained by the individual, which may also include uninsured and/or underinsured insurance coverage. (However, a source does not include the payor under a health, hospitalization or disability policy that covers the individual. Such payments are subject to the Plan's coordination of benefit rules). The Plan's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery received by or payable to or on behalf of the individual from any source, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the individual is made whole, and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as for medical expenses or as amounts other than for medical expenses and regardless of whether liability is admitted by the source. Once the Plan makes or is obligated to make payments on behalf of an individual on account of the claim, the Plan is granted, and the individual consents to, an equitable lien by agreement or a constructive trust for the benefit of the Plan in the identifiable amount on the proceeds of any payment, settlement or judgment received by the individual from any source. Such benefits are paid on the express condition that the individual must reimburse the Plan from the proceeds of any settlement or (recovery) for the benefits it paid out if the individual recovers any amounts from any source.

The description or characterization of any recovery from any source does not affect the Plan's right to reimbursement. By accepting benefits from the Plan, the individual acknowledges the Plan's right to subrogation and reimbursement and agrees to hold any recovery received from a source in trust for the Plan, to the extent of the amount of benefits the Plan has paid or may be obligated to pay in connection with the Incident. The individual must reimburse the Plan in full for benefits it has paid or will pay in connection with the Incident before any other amounts are deducted from the recovery from the source. Such reimbursement must be made within thirty (30) days after the individual receives any monies from any source.

The Trustees of the Plan, in their sole and absolute discretion, based on all of the circumstances, including the total amount of the recovery by the individual may determine it is in the best interests of the Plan to reduce their claim for reimbursement.

Action Required of an Individual

The individual must complete a Subrogation and Reimbursement Agreement ("Agreement") prior to payment of any benefits by the Plan. If the Agreement is not executed by the individual(s), at the Plan's request, or if the Agreement

is modified in any way without the consent of the Plan, the Plan may suspend all benefit payments. However, in its sole discretion, if the Plan advances claims in the absence of an Agreement, or if the Plan advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to reimbursement or subrogation. If the individual is a minor or incompetent to execute the Agreement, that person's parent, the individual (in the case of a minor eligible dependent child), the individual's spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Plan. An individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Plan. In this regard, the individual agrees that out of any source, as described above, the identified amount that the Plan has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Plan's benefit and the Plan shall have an equitable lien by agreement which shall be enforceable under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Plan's subrogation and reimbursement rights shall apply regardless of whether the individual executes a subrogation and reimbursement agreement. In accepting benefits from the Plan, the individual agrees that any and all amounts recovered by settlement, judgment or otherwise will be applied first to reimburse the Plan. In addition, if requested in writing by the Trustees or their authorized representative, an individual shall take such action as may be necessary or appropriate to recover payments made or to be made by the Plan from any source and shall hold in trust for the benefit of the Plan that portion of the total recovery from any source which is due for payments made or to be made and shall be paid to the Plan immediately upon recovery thereof. If an individual fails or refuses to take such action, the Plan shall be entitled and reserves the right to do so in the individual's name against any source liable therefor.

The individual shall not do anything to release, impair, discharge or prejudice the rights referred to in this Appendix C. The individual shall assist and cooperate with representatives designated by the Plan to recover all amounts to which the Plan is entitled and shall do everything that may be necessary to enable the Plan to exercise its subrogation and reimbursement rights described herein.

If an individual fails to take any actions required by Appendix C or takes action in contravention of the obligations imposed by Appendix C, the Plan shall suspend benefit payments relating to the claim and may exercise the offset and recoupment rights pursuant to Appendix C.

Disavowal of Common Law Defenses

The Plan specifically disavows any claims that an individual may make under any federal or state common law defense, including, but not limited to, the common fund doctrine, the double recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Plan's subrogation and reimbursement rights apply on a priority, first dollar basis to any recovery of the individual from any source without regard to legal fees and expenses of the individual and the individual will be solely responsible for paying all legal fees and expenses. The Plan shall have a priority, first dollar security interest and a lien on any recovery received from any source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such injury, illness, sickness, accident or condition.

Plan's Enforcement of Rights

The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests under this Appendix C through any appropriate legal or equitable remedy, including but not limited to the initiation of an

recognized cause of action under ERISA section 502(a)(3), including injunctive action to ensure the claim amounts that the Plan has advanced are preserved and not disbursed, or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered by an individual from any source, whether through settlement, judgment or otherwise. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Plan's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the individual, as opposed to the general assets of the individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the individual.

Further, where the individual receives a recovery from any source but does not reimburse the Plan, the Plan shall have the right to reduce future payments due to such individual or the employee or retiree and dependents associated with the individual until the Plan has recovered the full amount paid by the Plan. This right of offset shall not, however, limit the rights of the Plan to recover such monies in any other manner described in this Appendix C.

Payment After Settlement

The individual shall provide the Plan with a copy of any judgment, settlement agreement or other document the individual obtains or executes in conjunction with making any recovery from any source relating to the incident. The Plan will not pay benefits to or on behalf of an individual that relate, directly or indirectly, to any incident following the date an individual receives any recovery from any source in connection with the Incident if the Trustees, in their discretion, determine that the recovery from the source relates to future medical expenses. The Plan will suspend benefits relating, directly or indirectly, to the incident in an amount equal to the recovery the individual receives that is attributable to future medical expenses. The Plan will commence paying benefits for claims relating to the incident when the Trustees, in their discretion, find that the amount of claims suspended equals the amount of the recovery that the individual received that is attributable to future medical expenses.

Offset and Recoupment

In the event an individual makes any recovery from any source in connection with an incident and the Plan is entitled to such monies in accordance with this Appendix C and is not immediately reimbursed the amount it has paid for claims relating to the incident, the Plan shall have the right to reduce future payments due to or on behalf of such individual, including the employee, retiree or other dependents associated with the individual, until the Plan has recovered the full amount to which it is entitled under this Appendix C. The right of offset shall not, however, limit the rights of the Plan to recover such overpayments in any other manner (including, but not limited to, pursuing its rights in a court of competent jurisdiction).

Attorney's Fees

The Plan will not be responsible for an individual's attorneys' fees or costs and there shall be no set off against the Plan's recovery for fees or costs unless the Plan has agreed in writing to discount the Plan's claim by an agreed upon amount of such fees or costs. However, the Plan will reduce the subrogated amount by up to 1/3 of the amount for attorneys' fees that the Plan incurs in asserting its right of recovery, in addition to any other amounts that are deducted from the proceeds.

Trustees Right to Waive

The Trustees of the Plan may waive the above rights to subrogation and reimbursement or any part thereof, if they decide such action is in the best interest of the Plan and its Participants, unless determined to be acting in an arbitrary and capricious manner. Waivers will generally not be granted if the past medical expenses are greater than $500 or if the total judgment or settlement exceeds $5,000.

APPENDIX D: CONTRIBUTING EMPLOYERS

Local 534
Bill's IGA
Capri IGA
Carlyle IGA Market
Dierbergs Market
Harmons IGA
Highland Tru Buy
Kroger
Local 534 Employees
Millstadt IGA
Randy's Mkt
Red Bud IGA
Schnuck Markets Inc.
Schuette Stores
Sinclair Foods South
SuperValu DBA Shop N Save
Tom's Foodland Freeburg
Tom's Supermarket

Local 881
Capri IGA
Dierbergs Market
Dons Hardware
Highland Tru Buy
Kroger
Millstadt Super Mart
Pinnacle Food Group LLC
Red Bud IGA
Russell Furniture Co.
Route 3 Liquors
Rozier Country Market
Schnuck Markets Inc.
Supervalu Inc. DBA Shop N Save
Tom's Foodland Freeburg
Tom's Mad Pricer - W. Frankford
Tom's Supermarket
Vision Care Associates

Local 700
Kroger
Rozier Country Market

Local 655
Cowley Distributing Inc.
Darling International
Dierbergs Central Design
Dierbergs Central Kitchen
Dierbergs Market
Double G Brands Inc.
Edmonds Chile Co.
Elsberry IGA
Fricks Market
Hapstone (Little Debbie)
Holten Meat Inc.
Kroger
Mickelberry Corp.
Mid Towne IGA
Miller Ham Company
Moore Funeral Home

Nestle Inc. DSD
TNT Foods LLC DBA Price Chopper
Rozier Grocery
Schnuck Markets, Inc.
Schnucks Focus on Design
Sika Corp. DBA Greenstreak Plastics
St. Louis Area Maps
St. Louis Labor Council
Ste Genevieve Country Mart
Straubs Markets
Supervalu Inc. DBA Shop N Save
UFCW Union Local 655
UFCW 655 Joint Pension Fund
UFCW 655 Welfare Fund

APPENDIX E: THE PLAN'S USE AND DISCLOSURE AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION

How the Plan Uses and Discloses Your Protected Health Information

The Plan will use your protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). The definition of "protected health information" is set forth in these privacy regulations. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your personal representative or beneficiary. With an authorization, the Plan will disclose PHI to the Retirement Fund, disability plan, reciprocal benefit plans and Workers' Compensation insurers for purposes related to administration of these plans.

This disclosure also is intended to serve as the Plan amendment required under HIPAA to allow the Plan to disclose PHI to the Trustees as Plan Sponsor and also to service as the Plan amendment to ensure that the Trustees reasonably and appropriately safeguard electronic PHI.

Definition of Payment

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);
2. Coordination of benefits;
3. Adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing Employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities, and related health care data processing;
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participants (and their authorized representatives') inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
11. Utilization review, including pre-certification, pre-authorization, concurrent review, and retrospective review;
12. Disclosure to consumer reporting agencies related to collection of

premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number, and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

Definition of Health Care Operations

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
4. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
7. Business management and general administrative activities of the entity, including, but not limited to:

    a. management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

    b. customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;

    c. resolution of internal grievances; and

    d. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and

8. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, SARs and other documents.

The Plan's Disclosure of Protected Health Information to the Board of Trustees

For purposes of this section, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor for the purpose of deciding health claim appeals. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the documents governing the Plan have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description and Plan Document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
4. Not use or disclose the information in connection with any other benefit or Employee benefit plan of the Plan Sponsor unless authorized by the individual;
5. Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make the information available that is required to provide an accounting of disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the group health plan with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

The Plan may disclose summary health information, as defined in 45 C.F.R., Sec. 164.501, to the Plan Sponsor if such information is requested by the Plan Sponsor for the purpose of obtaining bids for providing health care coverage under the Plan, or for the purpose of modifying, amending or terminating the Plan. The Plan may also disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled or has disenrolled from the Plan.

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees will be given access to PHI:

1. The Fund Administrator; and
2. Staff designated by the Fund Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description and Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan

designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

Security Measures

The Plan will reasonably and appropriately safeguard electronic protected health information (ePHI) created, received, maintained, or transmitted to or by the Plan. Accordingly, the Plan has:

1. Implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI it creates, receives, maintains, or transmits;
2. Ensured that there is adequate separation (or firewall) between the information that is received from the Plan and other employment information and decisions, and this separation is supported by reasonable and appropriate security measures; and
3. Ensured that any agent, including any subcontractor, to whom it provides this information, agrees to implement reasonable and appropriate security measures to protect the information.

Breach Notification

Effective September 23, 2009, the Plan was subject to the new HITECH breach notification rules. In the unlikely event that your protected health information is breached, as that term is defined under the new HITECH law, the Plan will provide you with written notice of the breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information:

1. A brief description of what happened, the date of the breach if known, and the date of discovery;
2. The type of PHI involved in the breach;
3. Any precautionary steps you should take;
4. What the Plan is doing to mitigate the breach and prevent future breaches; and
5. How you may contact the Plan to discuss the breach.

The Plan will also report the breach to the U.S. Department of Health and Human Services.

APPENDIX F: NOTICE OF PRIVACY PRACTICES FOR UNITED FOOD & COMMERCIAL WORKERS LOCAL 655 WELFARE FUND

The United Food & Commercial Workers Local 655 Welfare Fund (the Plan) has a duty under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), to outline its legal obligations regarding your private medical information. In general, the Plan is required by this law to maintain the privacy of your health information. The Plan must also provide you with a notice of its legal duties and current privacy practices.

The Plan has the legal obligation to abide by the terms of this notice, but retains the right to change those terms when necessary. Any changes may be effective for any current health information about you and any information that may be obtained in the future. Such changes will be appropriately reflected in this Notice of Privacy Practices. The most recent version of our full notice will always be available to you through our office.

This notice describes how medical information about you may be used and disclosed, how you can get access to this information, and informs you of your rights related to your health information. Review it carefully.

The Plan is required by law to:

1. Maintain the privacy of your health information, which is information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form;
2. Give you this notice of our legal duties and privacy practices with respect to health information about you; and
3. Follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You

We may use your health information, as described in each category below, for treatment purposes, for payment purposes, and for our health care operations. For each of these categories, an example of how your health information might be used is provided below.

Treatment

We may use or disclose your health information to facilitate your health care treatment. For example, we might disclose information to your health care provider to assist them in making a determination on a course of treatment for you.

Payment

We may use and disclose health information about you for purposes related to payment. For example, we may use your health information to obtain premiums or to determine our responsibility for coverage under the Plan. As another example, we may use your health information to coordinate benefits with another health plan.

Health Care Operations

We may use and disclose health information about you in order to carry-out the day to day health care operations of the Plan. For example, we may use

health information in connection with:

- legal services;
- audit services;
- business planning and development; and
- business management of the Plan.

The Plan will not, for purposes of health care operations, including underwriting, use or disclose your genetic health information, which is information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics obtained from genetic testing or which may be inferred from your family medical history.

Other Potential Uses and Disclosures

In addition to the general uses and disclosure of your information discussed above, there may be other special situations where it is necessary, and permissible, for us to use or disclose your health information. These situations are discussed below:

1. **Public Health Activities.**

   For example, we may disclose information to a public health authority for the purpose of preventing or controlling disease.

2. **Reporting Abuse, Neglect or Domestic Violence.**

   For example, circumstances may arise where we need to disclose to appropriate authorities suspected abuse or domestic violence.

3. **Health Oversight Activities.**

   We may disclose health information to a health oversight agency for health oversight activities, including audits, health care fraud investigations, inspections and other oversight activities authorized by law. For example, it may be necessary for us to disclose information pursuant to a Medicare audit.

4. **Judicial or Administrative Proceedings.**

   For example, we may disclose information pursuant to a court order, subpoena, or a discovery request related to a trial proceeding.

5. **Law Enforcement Purposes.**

   For example, it may be necessary for us to disclose information to law enforcement officials regarding the identification or location of suspects, fugitives, or missing persons.

6. **Medical Directors, Coroners, and Funeral Directors.**

   In the event of your death, we may disclose your health information to medical directors, coroners, or funeral directors. For example, disclosure may be necessary for determining a cause of death.

7. **Organ and Tissue Donation.**

   We may disclose your information to organizations handling organ and tissue donation.

8. **Disclosures to Avert a Serious Threat to Health or Safety.**

   For example, we may disclose information to appropriate authorities in order to protect the safety of an individual.

9. **For Specialized Government Functions.**

   We may disclose health information pursuant to certain governmental functions. For example: military or veteran activities; or national security activities.

10. **Workers' Compensation**.

    We may release information in accordance with applicable Workers' Compensation laws.

11. **Disclosures to the Plan Sponsor.**

    The Plan may disclose health information to the Trustees of the Plan in order to carry out plan administration functions.

12. **Research.**

    The Plan may disclose your information subject to certain conditions.

All Other Uses or Disclosures

We may not use or disclose your health information for any other purpose other than described above without your specific written authorization. You may revoke any such authorization in writing at any time. However, any revocation is limited to the extent that the Plan has already taken action in reliance upon your authorization.

Your Rights Regarding Health Information

Federal law provides you with several rights regarding your health information:

1. **Right to Inspect and Copy Your Health Information.**

   You have the right to inspect and copy the health information that we maintain about you. You must submit any request to inspect or copy your health information in writing. If you request a copy of your information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. All such written requests should be forwarded to:

   United Food & Commercial Workers Local 655 Welfare Fund
   ATTENTION: Privacy Officer
   13537 Barrett Parkway Drive, Suite 100
   Manchester, MO 63021

2. **Right to Amend Your Health Information.**

   You have the right to request an amendment to your health information maintained by our Plan, for as long as the information is kept by our Plan. You may wish to request an amendment to your information if you feel that the information is inaccurate or incomplete. You must make any request for amendment in writing. A request must state the reason you feel the amendment is necessary. Your request should be submitted to:

   United Food & Commercial Workers Local 655 Welfare Fund
   ATTENTION: Privacy Officer
   13537 Barrett Parkway Drive, Suite 100
   Manchester, MO 63021

3. **Right to an Accounting of Disclosures.**

   You have the right to receive an accounting of certain disclosures of your health information made by the Plan. This accounting does not include disclosures made pursuant to treatment, payment, healthcare operations, or your individual authorization. Your request for an accounting should state the time period for which you would like an accounting, which cannot go beyond the six-years prior to the date of your request. You are not entitled to an accounting of disclosures made prior to April 14, 2003. You are entitled to one free accounting within any 12-month period. We may charge you a reasonable fee for any other accounting made within this

same 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred. You must submit a request for an accounting of disclosures in writing to:

United Food & Commercial Workers Local 655 Welfare Fund
ATTENTION: Privacy Officer
13537 Barrett Parkway Drive, Suite 100
Manchester, MO 63021

4. **Right to Request Restrictions.**

   You have the right to request specific restrictions on our uses and disclosures of your health information. For example, you have the right to request that we not disclose any of your health information for treatment purposes. We do not have to agree to a requested restriction. Agreeing to a restriction is within our sole discretion.

5. **Right to Request Confidential Communications.**

   You have the right to request that we communicate specific information to you in a certain manner or at a certain location, if you feel that the communication might otherwise place you in danger. For example, you may request that an explanation of benefits be sent to your work rather than to your home if you feel that this information may put you in danger if sent to your home. Any request for a confidential communication must be made in writing and be accompanied by a statement that the confidential communication is necessary to avoid your personal endangerment. All requests should be submitted to:

   United Food & Commercial Workers Local 655 Welfare Fund
   ATTENTION: Privacy Officer
   13537 Barrett Parkway Drive, Suite 100
   Manchester, MO 63021

6. **Right to a Paper Copy of This Notice.**

   You have the right to receive a paper copy of this notice at any time. To request a paper copy of this notice, please contact the Privacy Officer at the address in the above paragraph.

7. **Breach Notification.**

   If a breach of your unsecured health information occurs, the Plan will notify you.

Revisions to This Notice

We reserve the right to change the terms of this notice. Any changes to this notice will be effective for health information that we maintain about you. Should we revise this notice, we will promptly provide you with a new Notice by mailing you a written copy of the new notice.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. Your privacy rights will not be affected by filing a complaint. Further, you will not be retaliated against in any manner for filing a complaint. To file a complaint with the Plan, contact:

United Food & Commercial Workers Local 655 Welfare Fund
ATTENTION: Privacy Officer
13537 Barrett Parkway Drive, Suite 100
Manchester, MO 63021

APPENDIX G: GLOSSARY

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Allowable charge means:

- With respect to a network provider, the allowable charge is the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility, or organization and the Plan.
- With respect to an out-of-network provider, the allowable charge means the amount as determined by the Board of Trustees for a particular service or supply. The Plan will only pay allowable charges for out-of-network services or supplies that are determined by the Board of Trustees, and not by any provider, facility, or other person or organization.

Ambulatory surgical facility means a freestanding institution where surgery can be performed without an overnight hospital stay. The facility does not have to be part of a hospital, but it must be licensed, permanently equipped and operated primarily to provide surgical services. A physician's office may be considered an ambulatory surgical facility for certain minor operations.

Chemical dependency is another term for Substance Use Disorder/Substance Abuse. See also the definitions of Mental Health Disorder and Substance Use Disorder/Substance Abuse.

Chiropractor means a person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae), who acts within the scope of his or her license, and who is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered employee.

Contributing employer means any employer that has entered into a collective bargaining agreement with the Union, or participation agreement with the Plan, and is required to make contributions to the Fund, and who has not been terminated by the Trustees as a contributing employer because of failure to pay contributions as required by the collective bargaining agreement, participation agreement, and/or Fund rules.

Definition of a week varies according to your employer's payroll practices. If your payroll period ends on a Saturday, your week runs from Sunday through Saturday. If your payroll period ends on a Monday, your week runs from Tuesday through the following Monday. If the end of the week (payroll period) falls in a calendar month, then all hours for that week are included in that month. This is true even if some of that week falls in the previous month. A month excludes any week for which the end of the week falls in the next month.

Dental hygienist means a person who is licensed to practice dental hygiene and works under the direction and supervision of a dentist.

Dentist means a person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her

license; and is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered employee.

Durable medical equipment means equipment that can withstand repeated use, is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness, is not disposable or non-durable and is appropriate for the patient's home. Durable medical equipment includes, but is not limited to, the equipment listed in Appendix A.

Eligible dependent means:

- Your spouse,
- Your children until the end of the month in which they reach age 26; children include:
  - → Your natural born child;
  - → Your legally adopted child;
  - → A child placed in your home for legal adoption;
  - → Your step-child;
  - → Your foster child, as defined by the state in which the child resides;
  - → You must provide the Fund with a copy of the court order or other documentation from a state court or state agency placing the child legally as your foster child.
- A child for whom you have been appointed legal guardian by a court. You must provide the Fund with a copy of the court order or other documentation from a state court appointing you as legal guardian of the child. The child must be dependent on you for more than one-half of his or her financial support and maintain a principal place of residence with you for more than one-half of the calendar year.
- Your eligible dependent child who is age 26 or older and who has become physically or mentally disabled before the child's eligibility under the Plan would otherwise end due to reaching the end of the month in which the child turns age 26; the child's coverage under the Plan will continue for as long as the child remains physically or mentally disabled and is either a dependent disabled child or a qualifying relative of yours. In addition, the child must be totally dependent on you for financial support and maintain his or her principal place of residence with you for more than one-half of the calendar year.

  The child is a qualifying relative of yours if the child is dependent on you for more than one-half of his or her financial support during the calendar year, and the child is not a qualifying child, as defined in the Internal Revenue Code, of anyone else during the calendar year.

  Physically or mentally disabled means that the child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more.

  If the disabled dependent child (age 26 or older) does not live with you after a divorce or separation, the child will qualify as a disabled dependent child, provided that:

  - → The child's parents are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or live apart at all times during the last six months of the calendar year;

- → The child's parents provide over one-half of the child's support during the calendar year;
- → The child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and
- → The child is not the dependent or qualifying relative of any other person during the calendar year, as defined in the Internal Revenue Code.

In order to continue coverage under the Plan for a physically or mentally disabled child, you must submit medical evidence of the disability to the Welfare Fund office within 31 days of the date your eligible dependent's eligibility would normally end. The Board of Trustees may request continuing proof of existence of the disability from time to time. When the Board of Trustees receives the proof of disability, it has the right to have a physician of the Board's choice examine the child. The Board may require such an examination as often as it believes is reasonable. Proof of a disabled dependent child's or a qualifying relative's financial dependency and residency, as applicable, must be submitted to the Welfare Fund office upon request.

- ▸ Your child who is the subject of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice.

Emergency services mean with respect to an emergency medical condition (defined below), a medical screening examination within the emergency department of a hospital including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- ▸ The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver a newborn child (including the placenta).
- ▸ The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
- ▸ The Plan Administrator or the Plan Administrator's designee has the discretion and authority to determine if a service or supply is or should be classified as an emergency medical condition.

Employee means any individual who is employed by a contributing employer for whom the contributing employer has made the required contributions to the Fund for coverage under the Plan.

Experimental or investigative means equipment, treatments, procedures, or supplies:

- ▸ Not yet recognized as "accepted medical practice" by the general medical community in the state where the services are provided, or
- ▸ Not covered by any government agency or subdivision, including as provided in the Medicare Coverage Issues Manual.

It also means devices, drugs or medications that have not yet received required governmental approval. Experimental treatment is a trial procedure or protocol performed on a minimal number of patients to establish data for a rate of cure or improvement in the quality of life.

The Plan Administrator or the Plan Administrator's designee has the discretion to determine whether treatment is experimental or investigative.

Health care facility includes outpatient ambulatory surgical facilities, Mental Health Disorder treatment facilities, birthing centers, Hospices, Skilled Nursing Facilities, sub-acute care facilities and rehabilitation facilities.

Health care provider includes physicians and other providers who are licensed to provide health care. The Plan will not deny payment of covered services to health care providers based on the type of license the provider holds, as long as the health care provider is acting within the scope of the license held.

Hospice means an agency or organization that administers a program of palliative care and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

"Palliative care" refers to care of a patient whose disease is not responsive to curative treatment and includes control of pain and other symptoms along with psychological, social and spiritual support. The Hospice agency must meet one of the following tests:

- It is approved by Medicare, or meets the standards of the National Hospice Organization and any applicable licensing requirements of the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all of the following requirements:

    - Provides 24 hour-a-day, 7 day-a-week service.
    - Is under the direct supervision of a duly qualified physician.
    - Has a full-time administrator.
    - Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
    - The main purpose of the agency is to provide hospice services.
    - Maintains written records of services provided to the patient.
    - Maintains malpractice insurance coverage.

A Hospice that is part of a hospital, as defined in this appendix, will be considered a Hospice for the purposes of this Plan.

Hospital means a class of health care institutions that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which:

- Provides care and treatment by physicians and nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises; and

- Provides diagnosis and treatment on an inpatient basis for compensation; and
- Is approved by Medicare as a hospital.

The facility may also be accredited as a hospital by The Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations). A hospital may include facilities for treatment of Mental Health Disorders and Substance Use Disorders treatment that are licensed and operated according to law.

Any portion of a hospital used as an ambulatory surgical/outpatient surgery facility, birth (or birthing) center, hospice, skilled nursing facility, inpatient rehabilitation facility, subacute care facility/long term acute care facility or other residential treatment facility or place for rest, custodial care, or facility for the aged will not be regarded as a hospital for any purpose related to this Plan.

Hospitalization means an admission to a hospital.

Illness means any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be considered to be an illness only for the purpose of coverage under this Plan. Certain prenatal care expenses are covered under the preventive services benefit, as provided in the appropriate Schedule of Benefits for a female employee, spouse and dependent child.

Injury means any damage to a body part resulting from trauma from an external source.

Medically necessary/medical necessity means:

A medical or dental service or supply that is determined to be medically necessary by the Plan Administrator or the Plan Administrator's designee if it:

- Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it, or dentist if a dental service or supply is involved; and
- Is determined by the Plan Administrator or the Plan Administrator's designee to be necessary in terms of generally accepted American medical and dental standards; and
- Is determined by the Plan Administrator or the Plan Administrator's designee to meet all of the following requirements:

    - → It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
    - → It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
    - → It is an appropriate service or supply given the patient's circumstances and condition; and
    - → It is a cost-efficient supply or level of service that can be safely provided to the patient; and
    - → It is safe and effective for the illness or injury for which it is used.

For purposes of this definition, a medical or dental service or supply will be considered to be appropriate if:

- It is a diagnostic procedure that is called for by the health status of

the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

- It is care or treatment that is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

For purposes of this definition, a medical or dental service or supply will be considered to be cost-efficient if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.

A hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or health care facility or other more costly facility.

The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.

A medical or dental service or supply will not be considered to be nedically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital or health care facility.

Medicare means the Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental health disorder means any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Mental health disorder includes, among other things, depression, schizophrenia, and Substance Abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by mental health practitioners. Certain mental health disorders, conditions and diseases are specifically excluded from coverage as noted in the Exclusions and Limitations on Medical Benefits section of this document. See also the definition of Substance Use Disorder.

Physician means a person legally licensed as a Medical Doctor (MD), Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the

scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered employee.

Plan means the plan of benefits provided under the United Food and Commercial Workers Union Local 655 Welfare Fund, as described in this document.

Plan administrator means the person who has been designated as the Plan Administrator by the Plan Sponsor and who has the responsibility for overall Plan administration.

Prescription drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug:** means a generic version of a brand-name drug (basically a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use). Generic drugs work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA). Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
5. **Specialty drug:** Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken orally or inhaled, may need to be administered by a Health Care Practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Examples of Specialty drugs can include medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer. Specialty drugs may be managed by the Prescription Drug Program under contract to the Plan.

Skilled nursing facility means an institution that operates to provide convalescent and skilled nursing care to inpatients on a 24-hour a day basis and is licensed and Medicare-certified. It employs a medical staff that, in part, consists of full-time registered professional nurses who furnish 24-hour care. A Skilled Nursing Facility is not, other than incidentally, a place for rest or domiciliary or long-term care, or for the aged, home for chemically dependent persons (where treatment is not provided) or a hotel or a motel.

Spouse means your legal spouse, regardless of gender, who is a person to whom you are legally married in a lawful ceremony. This Plan does not recognize common law marriages. The Plan may require proof of the legal marital relationship. Your legally separated spouse or divorced former spouse is not an eligible spouse under this Plan.

Substance use disorder (substance abuse) means a psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Mental Health Disorder and Chemical Dependency.

Totally disabled means that you are completely unable to perform the duties of any occupation or employment as a result of a non-work related injury or illness; it is presumed that you meet this definition if you have been approved for Social Security Disability benefits.

Union means the United Food and Commercial Workers Union Local 655 or one of the Local Unions listed in Appendix D.

Notes

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