PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Issued for Covered Employees and Dependents of

GAC CHEMICAL CORPORATION
HDHP PLUS PLAN

Provided through ICWUC/UFCW LOCAL 650-C

by

UFCW National Health and Welfare Fund

September 1, 2022

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UFCW NATIONAL HEALTH AND WELFARE FUND

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TABLE OF CONTENTS

SECTION		PAGE
I.	Introduction	1
II.	Schedule of Benefits	2
III.	Special Provision for Network Hospitals, Providers and Facilities	5
IV.	Definitions and Restrictions	5
V.	Qualified Medical Child Support Orders and Administrative Procedures	15
VI.	Change In Family Status	16
VII.	Eligibility	17
VIII.	Comprehensive Major Medical Benefits	19
IX.	Certification for Hospital Admissions	20
X.	Hospice Care Expenses	21
XI.	Medical Services Requiring Prior Authorization	22
XII.	Newborns' and Mothers' Health Protection Act of 1996	22
XIII.	Women's Health and Cancer Rights Act	23
XIV.	Deductibles	23
XV.	Financial Obligations	23
XVI.	Emergency Services	24
XVII.	Exclusions	24
XVIII.	Subrogation and/or Reimbursement	28
XIX.	Prescription Drug Benefits	31
XX.	Coordination of Benefits	34
XXI.	Termination of Eligibility	35
XXII.	Continuation of Coverage Rights under COBRA	36
XXIII.	Family and Medical Leave	41
XXIV.	Leave for Military Service	43
XXV.	General Provisions	44
XXVI.	Notice and Proof of Claim	44
XXVII.	Claims Review and Appeal Procedure	45
XXVIII.	Payment of Benefits	53
XXIX.	Examination and Investigation of Claims	53
XXX.	Recovery of Overpayment	53
XXXI.	ERISA Information	54
XXXII.	Additional Information	56
XXXIII.	Documentation of Health Coverage	58

I. INTRODUCTION

Dear Participant:

The UFCW National Health and Welfare Fund (Fund) is a joint labor-management Employee Benefit Trust Fund, financed by contributions fixed by Collective Bargaining or other written agreements, and administered by an equal number of Trustees designated by the contributing Employers and by the Union pursuant to an Agreement and Declaration of Trust, which may be amended from time to time. The Fund is separate from a Local Union, International Union or any Employer's association. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted this Plan of Benefits described in this Summary Plan Description (SPD). Under the Trust Agreement and this SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Plan and this SPD, and all determinations on benefit claims and appeals, are subject to the discretion of the Board of Trustees and/or its Claims Review Committee, whose determinations are final and binding.

This Summary Plan Description (SPD) describes all benefits provided by your Welfare Fund. This SPD also serves as the Plan document.

The type of Plan benefits that you are entitled to depends upon certain requirements, which are described generally in this SPD and specifically in the Schedule of Benefits.

This is a Non-Grandfathered Plan. Please note that the Plan applicable to you and your dependents provides only those benefits, which are specifically shown in the Schedule of Benefits.

This SPD is designed to explain in non-technical language the operation of your Plan.

The Trustees are very pleased that these important benefits are available to the Fund participants. While the Trustees of the UFCW National Health and Welfare Fund expect the Plan to continue, they reserve the right to change or discontinue the Plan and/or these benefits, in whole or in part, at any time and for any reason.

If, after reading this SPD, you still have questions, please feel free to contact the Fund office.

Sincerely yours,

THE BOARD OF TRUSTEES

II. SCHEDULE OF BENEFITS

HDHP PLUS PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	 $6,550 $13,100	 $13,100 $26,200
Coinsurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum (Includes deductibles and copays) Individual Family	 $7,000 $14,000	 $14,000 $28,000
Physician Office Visits and Other In-office Services		
Primary Care Physician	20% coinsurance, after deductible	40% coinsurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc)	20% coinsurance, after deductible	40% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening urine tests, chest, x-ray, EKG & mammography)	No Charge	20% coinsurance, after deductible
Diagnostic Tests (X-rays and blood tests)	20% coinsurance, after deductible	40% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% coinsurance, after deductible	40% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Waived if admitted)	20% coinsurance, after deductible	20% coinsurance, after deductible

HDHP PLUS PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Urgent Care Services	20% coinsurance, after deductible	20% coinsurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi-Private and other allowable expenses	20% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient Surgery Center (Includes ambulatory surgery centers)	20% coinsurance, after deductible	40% coinsurance, after deductible
-Physician & Surgeon Fees	20% coinsurance, after deductible	40% coinsurance, after deductible
Mental and Substance Use Disorder		
-Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
-Outpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Home Health Care	20% coinsurance, after deductible	40% coinsurance, after deductible
Hospice Care Services	No Charge	20% coinsurance, after deductible
Skilled Nursing Facility	20% coinsurance, after deductible	40% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	40% coinsurance, after deductible
External Prosthetic Devices -Wigs, toupee or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenetic alopecia-male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	40% coinsurance, after deductible, and any amount over $350 maximum

HDHP PLUS PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Breast Pumps	No Charge and any amount up to a maximum of $250	40% coinsurance, after deductible and any amount up to a maximum of $250
Physical, Occupational and Speech Therapy (Limited up to 60 combined visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Chiropractic Care Services (Limited to 30 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Vision Benefits		
Eye Exam (Once every year)	No Charge	No Charge
Prescription Corrective Eyeglasses or Contact Lenses (Every year)	Up to $100	Up to $100

HDHP PLUS PLAN

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$5 copay	20% coinsurance, after deductible
Preferred Brand Name Drugs	$50 copay	20% coinsurance, after deductible
Non-Preferred Brand Name Drugs	$60 copay	20% coinsurance, after deductible
Mail-Order 90-Day Supply		
Generic Drugs	$15 copay	Not Covered
Preferred Brand Name Drugs	$150 copay	Not Covered
Non-Preferred Brand Name Drugs	$180 copay	Not Covered

III. SPECIAL PROVISION FOR NETWORK HOSPITALS, PROVIDERS AND FACILITIES

If you or your dependent is confined to or receives care at or from a network hospital provider or facility, the Fund will pay the network charges so long as the Fund determines that the network charges are reasonable, customary, usual, represent fair market value and are otherwise payable under this Summary Plan Description. All other provisions of this SPD, including the requirement that such services be necessary and appropriate, and the Fund's decision to determine the propriety of the charges and level of benefits payable will apply.

Your UFCW National Health and Welfare Fund identification cards incorporate a network for eligible In-Network services. Be sure to carry your I.D. card with you and show it to your health care providers so that any claims processed for you will have the correct information.

To find a participating physician, you may call the number on your I.D. card. You may also call the Fund office for assistance at 1-888-773-8329.

IV. DEFINITIONS AND RESTRICTIONS

"Allowable Expense" means all or a portion of any necessary, reasonable, customary, usual, fair market valued item of medical expense incurred by an eligible individual that is deemed to meet the medical necessity definition of the Plan found below and is not excluded or limited by the Plan.

"Annual Deductible" means the amount, which the patient must pay each calendar year for covered expenses before the Fund becomes liable for its share of such expenses.

"Annual Out-of-Pocket Limit" means the total amount of all reasonable, customary, usual, fair market value covered expenses incurred in a calendar year which was not reimbursed for which the patient was responsible and which was eligible to be credited toward the Annual Out-of-Pocket Limit. When the annual deductible and co-insurances add up to the Out-of-Pocket Maximum, the Plan pays 100% of the reasonable, customary, usual, fair market valued expense for the rest of the calendar year.

The following do not count toward the Annual Out-of-Pocket Limit:

- Costs incurred when you or your dependent fail to obtain the necessary approvals.
- Costs incurred when you or your dependent uses emergency facilities and the Fund determines emergency treatment was not required.
- Charges by a Non-Preferred Provider in excess of the usual, reasonable, customary, and fair market value charge.
- Charges for covered benefits in excess of any applicable maximum benefit limit.

- Charges for non-covered benefits.

- Charges deemed to be above the Fund's reasonable, customary, usual, fair market value limits.

Once you and each of your dependents has paid the per person Out-of-Pocket maximum amount, or once any combination of you and your dependents has paid the per family Out-of-Pocket Maximum amount, the Fund will begin to pay 100% of the usual, reasonable, customary, and fair market value charge for the remainder of the calendar year.

"Claim Edits" The Fund uses several resources to edit claims during claim processing. A claim edit finds services or supplies that are ineligible based on Fund rules, and/or national industry standards from sources such as CMS (Centers for Medicare & Medicaid Services), NCCI (National Correct Coding Initiative) and AMA (American Medical Association). In this way the Fund can utilize correct coding methodologies to control improper coding leading to inappropriate payment.

"Co-Insurance" means the percentage of the usual, reasonable, customary, and fair market value expense that a covered person must pay.

"Copayment" means a specific dollar amount that a patient must pay for certain services before the Fund will be financially liable for covered expenses.

"Custodial Care" means the care comprised of services and supplies, including room and board and other institutional services, which are provided to a person, whether disabled or not, primarily to assist that person in the activities of daily living. Such services and supplies are custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

"Dependent" as used in this SPD includes a member of an Employee's family for whom any applicable contribution has been made and who meets the following eligibility requirements:

1. The participant legal spouse of the Employee.

2. Any child of the Employee until the end of the month upon the attainment of age 26.

   The above age limitations specified above, will be extended for an indefinite period in the case of any dependent child of the Employee who becomes incapable of self-sustaining employment by reason of physical or mental infirmity prior to age 19, provided such child remains unmarried, incapable of self-sustaining employment, wholly dependent upon the Employee for support and covered by the UFCW National Health and Welfare Fund or other health coverage from the onset of the infirmity;

   Provided further that the Employee will be required to submit to the UFCW National Health and Welfare Fund, evidence of such incapacity in the manner and form prescribed by the Fund.

3. The term "Child of the Employee" as used herein means natural children of the Employee or the Employee's legal spouse and all other children residing with the Employee and for whom the Employee has been appointed legal guardian or adoptive parent by a court of law and who are totally dependent upon the Employee for support. The term "Dependent" does not include the spouse after divorce or legal separation from the Employee. A child who is adopted or placed for adoption before age 18 under ERISA is treated under the same terms and conditions as are applied in the case of natural dependent children under this Plan.

4. Upon receipt by the Fund of a Medical Child Support Order, the Fund will send notification of the procedures for determination of the qualification of the order, in accordance with its administrative procedures.

"Disability or Disabled" means you are unable to perform the usual duties of your job as a result of an illness or an injury. Provided your dependent's condition is certified by a doctor, he or she will be considered disabled if he or she is unable to perform his or her usual daily activities.

"Durable Medical Equipment" means equipment which:

A. Is designed for repeated use;
B. Is mainly and customarily used for medical purposes.
C. Is not generally of use to a person in the absence of an illness or an injury.
D. Includes, but is not limited to, such items as:

    1) A hospital bed;
    2) A wheelchair;
    3) Brace(s); and
    4) Crutch(es).

E. Durable Medical Equipment does not include and is not limited to the exclusion of such items as:

    1) Air conditioners and purifiers;
    2) Heating lamps and pads;
    3) Bed boards;
    4) Orthopedic shoes or corrective devices for use in shoes;
    5) Gravity traction devices;
    6) Exercise bicycles;
    7) Weight lifting equipment; and
    8) Specially equipped vehicles.

F. Total rental not to exceed purchase price.

"Eligible Expense" means the lesser of the reasonable, customary, usual, fair market value charge for a covered service or the provider's actual charge.

"Eligibility Date" means the date a person becomes an "Eligible Individual".

“Eligible Individual” means you and/or your dependents, if applicable, who are eligible for the benefits provided by the Plan.

“Emergency” means Emergency health services are covered services that are provided in the case of a bona-fide emergency. This is defined as a sudden, serious, acute, life threatening illness within 12 hours of onset and which is demonstrated 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 health in serious jeopardy,
- serious impairment of bodily functions or
- serious dysfunction or any bodily organ or part.

This does not include elective or routine care or care of a minor illness such as treatment of a sore throat, ear pain, colds, flu or toothache.

“EmpiRx” means EmpiRx Health, LLC, a Pharmacy Benefit Manager and National Pharmacy Network. This is the National Fund’s current Pharmacy Benefit Manager (PBM).

“Employee” as used in this Summary Plan Description (SPD) means a person who meets all eligibility requirements, who has been employed by an Employer, who has executed a Participation Agreement, Schedule of Contributions and Benefits or other written agreement acceptable to the Fund adopting the Agreement and Declaration of Trust of the UFCW National Health and Welfare Fund and for whom contributions are made to the UFCW National Health and Welfare Fund. Where applicable, "Employee" can also mean a full-time official of a Union or full-time Employees of the Fund.

“Employer” means an Employer who qualifies as an Employer under the terms and provisions of the Trust Agreement.

“Expense Incurred” means the amounts regularly and customarily charged in a particular geographical area for the medical services and/or supplies generally furnished for conditions of comparable nature and severity. An expense is considered to have been incurred on the date the service and/or supply is rendered or obtained.

“Experimental or Investigative” means a drug, device, medical treatment or procedure that:

A. It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

B. If the informed consent document utilized with the drug, device, medical treatment or procedure was reviewed and approved by the treating facility’s Institutional Review Board or other body serving in a similar function or if Federal law requires such review and approval; or

C. Is the subject of ongoing Phase I or Phase II clinical trials; is the subject of research, experimental, study or investigational arm of ongoing Phase III clinical

trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

D. The prevailing opinion among experts regarding the drug, device, medical treatment or medical procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

The fact that a doctor has prescribed, ordered, recommended or approved the treatment, service or supply does not in and of itself make it eligible for payment nor will it affect on the manner in which the Plan pays expenses incurred and/or the Plan's stated maximums.

"Fair Market Value" The charge, as determined by the Fund, that would represent a fair value for the services rendered at the time and in the area that the services were rendered. The Fund would take into consideration the charge for the same or similar services by same or similar providers.

"Home Health Agency" means a public or private organization, or a subdivision of such an agency or organization, which meets all of the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients;
B. It has policies, established by a group of professional personnel associated with the agency or organization, governing the services it provides;
C. It provides for the supervision of its services by a doctor or R.N.;
D. It maintains clinical records on all of its patients;
E. It is licensed according to the applicable laws of the state in which the eligible individual receiving the treatment resides and of the locality in which it is located or provides services; and
F. It is eligible to participate in Medicare.

"Hospice Care" means a program of palliative care and supportive services of an individual certified as "terminally ill" and the medical prognosis of the individual's life expectancy is 6 months or less, if the illness runs its normal course.

"Hospital" means an institution that meets fully every one of the following tests:

1. It is primarily engaged in providing, for compensation and on an inpatient basis, facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons under the supervision of a staff of physicians;
2. It continuously provides 24-hour a day R.N. service; and
3. It is not other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

"In-Network Benefits" means the benefit payment level applied to a covered service that is provided by a Preferred Provider.

"Medical Expense Benefits" means those benefits payable under the Rules and Regulations of the Plan for specified expenses incurred in the treatment of a bodily injury or sickness.

"Medically Necessary" means services, tests, medicines or supplies rendered, supervised or ordered by a hospital, skilled nursing facility, doctor or other provider required to treat an illness or injury and customarily recognized within the medical profession as appropriate in the care and treatment of the diagnosed condition in the opinion of the Fund, subject to the Claims Review and Appeal procedures of this SPD.

Coverage is provided only for a service or supply, which is necessary for the diagnosis, care, or treatment of the physical or mental condition involved. It must be widely accepted professionally in the United States as effective, appropriate, and essential based upon recognized standards of the health care specialty involved.

In no event will the following be considered to be necessary:

1. Those services rendered by a provider that do not require the technical skills of such a provider;

2. Those services and supplies furnished mainly for the personal comfort or convenience of the person, any other person who cares for the person or any other person who is part of the person's family;

3. Those services and supplies furnished to a person solely because the person is inpatient on any day which the person's physical or mental condition could safely and adequately be diagnosed or treated while not confined; and

4. That part of the cost, which exceeds that of any other service or supply that would have been sufficient to safely and adequately diagnose or treat the person's physical or mental condition.

"Medicare" means the Health Insurance for the Aged program under Title XVIII of the Social Security Act and the Social Security Amendments of 1965 as this program is currently constituted and as it may be amended from time to time.

"Mental or Nervous Disorder" means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

"Non-Occupational Injury" is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an injury that does.

> Note: If you and/or your dependents are self-employed or are engaged in self-employed activities, no benefits are available from this Plan for injuries or illnesses resulting from those activities. Examples of self-employed activities include, but are not limited to: construction, farming, ranching, sales, housekeeping, or hair-styling.

If you and/or your dependents are engaged in any self-employed activities, it is your responsibility to determine your own personal needs and secure proper coverage outside of this Plan for those exposures.

“Non-Preferred Provider” means a doctor, hospital, medical facility or other provider of health care, which is out of the network, which has been designated by the Fund to render health related services to Fund participants.

“Orthodontic Treatment” means any medical or dental service or supply furnished to prevent, diagnose, or correct a misalignment of the teeth, bite, jaws or jaw joint relationships, whether or not for the purpose of relieving pain. It does not include the installation of a space maintainer or a surgical procedure to correct malocclusion.

“Out-of-Network Benefits” means the benefit payment level applied to a covered service that is provided by a Non-Preferred Provider, as determined by the Fund.

“Out-Patient Surgical Center Facility” means a surgical facility which meets all of the following requirements:

a) It is a health care facility operated for the primary purpose of performing surgery on an outpatient basis and to which a patient is admitted and discharged within 24 hours;
b) It must be regularly licensed as an out-patient surgical facility by the government or other agency which has the responsibility for such licensing;
c) It must be supervised by a full-time Doctor;
d) Any Doctor performing a surgery on the premises must also be allowed to perform surgery in a local Hospital;
e) It must employ a licensed anesthesiologist and an RN;
f) It must maintain central medical and clerical records on all of its patients;
g) It must have at least two operating rooms and a recovery room;
h) It must be equipped to handle medical emergencies;
i) It must have an arrangement with a local Hospital to treat patients who develop complications.

“Participant” means any Employee who is eligible for the benefits provided by the Fund under this Plan.

“Payer Matrix” is a Specialty Drug Cost Containment Company to help mitigate the financial risk and growing liability related to specialty drug costs. It has partnered with the National Fund’s PBM, EmpiRx Health for this program.

“PBM (Pharmacy Benefit Manager)” is a company that administers the prescription drug benefit program for your employer or health plan. Whether plan members access their prescriptions by mail or in a retail pharmacy, PBMs process and pay the prescription drug claims and they are responsible for creating and updating your health plan’s drug formulary list.

"Physician" means a person who is licensed to practice medicine or surgery as a Doctor of Medicine (MD) or as a Doctor of Osteopathy (DO) while acting in the scope of his or her license or other such practitioners of the healing arts as may be determined by the Fund. To the extent that benefits are provided, a doctor also includes a person licensed to practice as a/an podiatrist, chiropractor, optometrist, psychologist and/or a dentist who is licensed to perform oral surgery to the extent that the services provided are directly or indirectly related to any jaw surgery or treatment. "Doctor" does not include you, one of your dependents or any person who is the spouse, parent, child, brother or sister of you or one of your dependents.

The Fund will also consider as eligible, charges for services performed by a Nurse Practitioner, Physician Assistant and Registered Nurse First Assistant who is legally authorized by the State in which the services are furnished to practice in accordance with State law and is certified by a recognized national certifying body that has established standards for such a practitioner, if the services are the type that are considered physician services if furnished by a doctor of medicine or osteopathy (MD/DO) and are performed in collaboration with an MD/DO as required by the law of the State in which the services are performed or, in the absence of a State law governing collaboration, include documentation of the active involvement of the physician in the decision-making process by co-signing and dating the patient's medical records on the date the services are rendered. Services by Certified Nursing Assistants are not covered.

"Plan" means the UFCW National Health and Welfare Fund Plan of Benefits.

"Preferred Provider" or **"Network Provider"** means a doctor, hospital, medical facility or other provider of health care which is included in a network which has been designated by the Fund to render health related services to Fund participants.

"Qualified Domestic Partner" (If Applicable) means the following:

a.) An opposite sex domestic partnership must meet the requirements of their state of residence.

b.) A same sex domestic partnership arrangement must meet the following requirements:

1) Both parties must have reached the age of majority.
2) Both parties are competent to make contracts.
3) Neither party is already married or engages in another domestic partnership.
4) Both parties intend that the domestic partnership be of unlimited duration.
5) Both parties must reside in the same household and not be blood related.
6) The parties must share financial responsibilities, as evidenced by jointly-owned property, or will or pension beneficiary designations.
7) An affidavit must be submitted to the plan administrator affirming domestic partner status.

"Reasonable and Customary Charge" The reasonable, customary, usual, fair market value is only that part of a charge which is covered. The reasonable, customary, usual, fair market value charge for a service or supply is the lower of the provider's usual charge for furnishing it or the charge the Fund determines to be the reasonable, customary, usual,

fair market value charge level made for the service or supply in the geographic area where it is furnished. The Fund may use a nationally recognized database purchased from an independent supplier to assist in the determination of an eligible charge.

In determining the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, the Fund may take into account factors, such as:

1. The complexity;
2. The degree of skill needed;
3. The type or specialty of the provider;
4. The range of services or supplies provided by a facility;
5. The prevailing charge in other areas; and
6. The fair market value of the services provided.

In most cases, the cost of a Non-Preferred Provider's services will be eligible. However, on occasion, a non-preferred provider may charge amounts in excess of the Fund’s reasonable, customary, usual, fair market value charge. In these instances, you will be financially responsible for the difference between what the provider charges and what the Fund allows. Additionally, the Fund will pay network charges so long as the Fund determines that the network charges are reasonable, customary, usual, represent fair market value and otherwise payable under the Summary Plan Description.

“Room and Board Charge” means the institution's charges for room and board and other necessary services and supplies made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

“Semi-Private Rate” means the charge for room and board, which an institution applies to the greatest number of beds in its semi-private rooms containing two or more beds. If the institution has no such rooms, the Fund will determine the rate. It will be the daily room and board rate most commonly charged for semi-private rooms with two or more beds by similar institutions in the area. The term area means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

“Sickness” as used in this SPD, means sickness or disease resulting in loss covered by this SPD, provided such loss begins while the SPD is in effect and which does not arise out of or as a result of any employment for wage or profit. The term "Sickness" as used in this SPD also includes pregnancy or the complications thereof.

“Skilled Nursing Facility” means a nursing facility, regardless of what is called, that:

A. Is an institution, or a distinct part of an institution, which has a transfer agreement with one or more Hospitals;
B. Is primarily engaged in providing in-patient skilled nursing care and related services for Eligible Individuals who require medical or nursing care;
C. Is duly licensed by the appropriate governmental authorities;
D. Has one or more Doctors and one or more Registered Nurses (RNs) responsible for the care of in-patients;
E. Requires that every patient be under the supervision of a Doctor;
F. Maintains central clerical records on all of its patients;

G. Provides 24-hour-a-day nursing services;
H. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; and
I. Has a utilization review plan in effect.

"Treatment Facility" means an institution (or distinct part thereof) for the treatment of alcoholism or drug abuse, which meets fully every one of the following tests:

1. It is primarily engaged in providing, for compensation from its patients, a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse;
2. It provides all medical detoxification services on the premises, 24 hours a day;
3. It provides all normal infirmary-level medical services required during the treatment period, whether or not related to the alcoholism or drug abuses. Also, it provides, or has an agreement with a hospital in the area to provide any other medical services that may be required;
4. At all times during the treatment period, it is under the supervision of a staff of physicians and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse;
5. It prepares and maintains a written individual Plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the Plan is under the supervision of a physician; and
6. It meets any applicable licensing standards established by the jurisdiction in which it is located.

"Treatment of Alcoholism or Drug Abuse" means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and meets either of the following:

1. The physician certifies that a follow-up program has been established which includes therapy by a physician, or group therapy under a physician's direction, at least once per month; or

2. It includes attendance at least twice a month at meetings or organizations devoted to the therapeutic treatment of alcoholism or drug abuse, whichever condition is being treated.

Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the after effects of a specific episode of drinking or drug abuse. Maintenance care consists of the providing of an environment without access to alcohol or drugs.

"Treatment of Mental or Nervous Disorders or Conditions" includes only the treatment of a mental or nervous disorder or condition not related to, accompanying or resulting from the person's alcoholism or drug abuse. The treatment of any such related, accompanying or resulting disorder or condition will be considered to be treatment of the alcoholism or drug abuse.

"Trust Agreement" means the UFCW National Health and Welfare Fund Trust Agreement as amended and restated.

“Trustees and Board of Trustees” means those persons who are named according to the provisions of the Trust Agreement and who have the authority to control and manage the operation and administration of the Plan.

“Union” means a union that qualifies as a “Union” under the Plan’s Trust Agreement.

“Utilization Management” is used to manage patient utilization and maximize the use of the safest, most cost effective drug by ensuring the proper use, selection and amount of medication is being provided. In order to accomplish this, the Pharmacy Benefit Manager (PBM) will use the following methods:

1. **“Prior Authorization”** to ensure clinically appropriate use of medications. The PBM will work with your physician to accomplish this benefit.

2. **“Step Therapy”** Step Therapy (also called Step Protocol) is a practice of beginning a specific drug therapy for a medical condition with the most cost effective and safest drug therapy. If a patient does not respond satisfactorily, progressively more costly, risky or different therapy is prescribed as needed. Step Therapy allows the Plan to define a logical sequence of therapeutic alternatives. The aims are to control costs and minimize risks.

3. **“Drug Quantity Guidelines”** aligns dispensing quantity with FDA-approved dosage guidelines and other supportive evidence.

Thus, communication may occur between your physician and/or pharmacist to assist in complying with the provision of “Utilization Management”.

V. QUALIFIED MEDICAL CHILD SUPPORT ORDERS AND ADMINISTRATIVE PROCEDURES

According to Federal law, a Qualified Medical Child Support Order, or QMCSO, is an order of a court or state administrative agency resulting from a divorce or legal separation that has been received by the Plan and that:

- Designates one parent to pay for a child’s health Plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO; Contains a reasonable description of the type of coverage to be provided under the designated parent’s Health Care Plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each Health Care Plan to which the QMCSO applies.

The QMCSO may not require that a Plan provide any benefit that is not otherwise provided under the Plan, but, if the Employee is a Plan participant and provides coverage for dependent children, the QMCSO may require that Plan to provide coverage for the Employee’s dependent children and to accept contributions for that coverage from a parent who is not a Plan participant.

The QMCSO may also require the Plan to pay benefits on account of expenses incurred by or on behalf of the dependent children either to the health care provider who rendered the services or to the custodial parent of the dependent children. If the Fund office or its designee determines that it has received a QMCSO, and if coverage of the dependent children is provided by the Plan, it will pay benefits on account of expenses incurred by or on behalf of the dependent children as required by that QMCSO.

If the Employee and spouse are divorced, and if a court or state administrative agency has issued an order with respect to health care coverage for any of the Employee's dependent children, the Fund office or its designee will determine if the court or administrative agency order is a Qualified Medical Child Support Order (QMCSO) as defined by Federal law, and that determination will be binding on the Employee. Coverage of a dependent child under a QMCSO will terminate when coverage of the employee terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA continuation coverage if that right applies.

Whenever a medical child support order is received by the Fund, the Fund office will promptly notify the participant and the children) recognized under the order as having the right to enrollment under the Fund with respect to that participant of the receipt of the order and enclose a copy of this Administrative Procedure. The order will then be sent to the Fund's Benefits Consultant and Counsel to determine whether it meets the requirements to be considered qualified. Within a reasonable period of time, the Fund office will then determine whether the order is qualified, and notify the participant and the child(ren). The child(ren) may designate a representative for receipt of copies of any such notice. The Fund will use the addresses included in the order. Any payment of benefits to a child or the child's custodial parent or legal guardian under a qualified order will be made directly to the child, custodial parent or legal guardian. Participants and beneficiaries can obtain, without charge, a copy of this procedure from the Plan Administrator.

VI. CHANGE IN FAMILY STATUS

You are required to **notify the Fund office within 30 days** of the event when you have a change in family status and/or want to change your life insurance beneficiary. A failure to notify the Fund may delay eligibility until your Employer's open enrollment period or, in absence of an open enrollment period, until the anniversary of the renewal of the Fund's contract with your Employer. A change in family status occurs when:

- You get married, divorced or your marriage is annulled.
- Birth or adoption of a child, or a child placed for adoption.
- Death of a dependent.

Other Changes

You should notify the Fund office promptly when any of the following occurs:

- You change your name.

- Your dependent child reaches the Plan's limiting age of 26, or becomes physically or mentally handicapped.
- You or your eligible dependent becomes enrolled in or loses coverage under Medicare.
- You or your eligible dependent becomes enrolled in or loses coverage under other medical or applicable coverage.
- Social Security Disability Benefits are awarded or terminated for you or your eligible dependent.

VII. ELIGIBILITY

If you are otherwise eligible for benefits, eligibility starts at your Employer's open enrollment period or in the absence of an open enrollment period, the anniversary of the Fund's agreement with the Employer, currently June 1st.

A. If you were working on the effective date on which your Employer adopted the Agreement and Declaration of Trust of the UFCW National Health and Welfare Fund and you were covered for benefits at that time, you shall be eligible for benefits in the Fund. Thereafter a full-time regular Employee or other classification of employees (as defined by the Collective Bargaining Agreement and agreed to by the UFCW National Fund) and his or her eligible dependents, if applicable, will first become eligible for the benefits provided by the Fund on the first day of the month that your Employer makes a contribution to the Fund as specified above or in the relevant agreements. In any event, dependent coverage will not be effective prior to the day the Employee's coverage is effective. The spouse of an Employee or participant in this Plan will become eligible for benefits under this Plan according to the relevant agreement between the parties.

B. If you have seniority with your Employer but you were not at work on the effective date on which your Employer adopted the Agreement and Declaration of Trust of the UFCW National Health and Welfare Fund, your eligibility for benefits starts on the first day of the calendar month you return to work.

C. If you have become eligible for benefits and eligibility becomes terminated or suspended by reason of temporary layoff, temporary leave of absence, or absence from work because of strike or lockout, you shall again be eligible for all benefits on the first day of the calendar month in which you return to work with the same or a different Employer or when your eligibility is specified in relevant agreements and documents. If you have once become eligible for benefits and eligibility shall have terminated because you were discharged, resigned, retired or for any other reason lost seniority, you shall be eligible for benefits under this SPD in accordance with paragraph "D" following.

D. If you do not become eligible for benefits in accordance with paragraphs "A, B or C" above, you shall be eligible for all benefits, on the first day of the calendar month after the expiration of the probationary period as specified or when your eligibility is specified in the relevant agreements and documents."

E. You shall not be required to serve more than one eligibility period, except as provided in paragraph "C" above.

F. Your dependents shall become eligible for the Comprehensive Major Medical Benefits and Prescription Drugs Benefits described in this SPD on the date you become eligible for the benefits set forth herein.

G. If your contract allows and you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you lose that coverage through no fault of your own and you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you do not notify the Fund within 30 days, your request for eligibility will be considered a Late Enrollment; you then will be eligible at your Employer's open enrollment period or at the annual anniversary period of the Fund's agreement with your Employer.

H. For purposes of eligibility (including continued eligibility) of any individual to enroll for benefits, no health factor that relates to the individual or a dependent of the individual, will be taken into account and absence from work due to any health factor (such as being absent from work on a sick leave approved in writing up to the time limits specifically provided in the applicable Collective Bargaining Agreement but no longer than one year or an approved Worker's Compensation absence benefit period, or an approved Family and Medical Leave Act leave) is treated as being actively at work in accordance with Section 702 of ERISA and applicable federal regulations. However, in all cases, coverage will only be provided so long as the Fund receives the full contribution for benefits. If your Employer provides benefits to you for a specific period of time other than in the circumstances described above, the Fund will continue benefits to you under and in accordance with COBRA, subject to the full required COBRA premium being paid, whether the COBRA premium is paid for by the Employer or by the Employee, and for the maximum period of time provided under COBRA.

I. Your Employer may have rules and procedures on enrollment for Fund coverage with which you must comply as a condition of Fund coverage. Please contact your Employer for these rules and procedures to assure coverage for you and your eligible dependents. In any case, Fund coverage is contingent upon timely receipt by the Fund of full contributions and coverage information.

J. As a condition of coverage, the Fund requires receipt of the full contribution required by your Employer's Participation Agreement or Schedule of Contributions and Benefits with the Fund, as well as its Collective Bargaining Agreement or other written agreement providing for contributions. You may be required to pay a portion of contributions and you should consult with your Employer or the Collective Bargaining Agreement to determine the amount you are required to remit to the Employer. In any case, full contributions must be remitted to the Fund as a condition of coverage for any eligible participant, dependent or beneficiary.

K. If you enter active military service in the armed forces of the United States for more than 31 days, you may continue the Fund-provided health care coverage for yourself and your dependents, if applicable, during the period of the leave (up to a maximum of 18 months) provided you make the required continuation contributions (see the section titled "Continuation of Coverage (COBRA) under the provisions of the Uniformed Services Employees Re-Employment Rights Act (USERRA).

   In addition, your eligibility will be preserved until you are discharged from the Armed Forces, provided you either return to work or are available for work for a contributing Employer within 90 days following your discharge. If the above requirements are not met, you will lose your eligible status.

   If you comply with the above provisions, you will have the benefits provided by the Fund reinstated as soon as your eligibility is established.

   This provision applies to the initial enlistment period only. If you re-enlist, you will forfeit your eligibility for the benefits provided by the Fund.

L. The UFCW National Health and Welfare Fund shall not take back a plan of coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or of coverage.

VIII. COMPREHENSIVE MAJOR MEDICAL BENEFITS

The UFCW National Health and Welfare Fund will pay Comprehensive Major Medical Benefits, specified in your Schedule of Benefits, for expenses incurred by you or your dependent covered under this SPD. Such benefits will be subject to the provisions shown in your Schedule of Benefits.

Covered services will include room and board charges rendered by a legally operated hospital for ward or semi-private accommodations, provided that if you or your dependent occupies a private room that portion of the charge incurred which is equal to the usual charge of the hospital for a semi-private room will be regarded as a covered service. Any other hospital services necessary to the diagnosis, cure and treatment of any condition will be regarded as a covered service to the extent that they are directed or ordered by a licensed physician.

Covered services will include those rendered by a licensed physician for the diagnosis, cure or treatment of any conditions as well as medications which are obtainable only by written prescription, insulin/insulin needles or syringes, contraceptive drugs or devices, equipment employing the use of radiological or radioactive materials, transportation to a place of medical treatment, provided such transportation is furnished by a bona-fide ambulance or vehicle generally used for the transportation of those in need of medical care and is deemed medically necessary, and services performed by a registered nurse when such services are a necessary part of treatment prescribed by a physician.

The Fund will also consider as eligible, charges for services performed by a Nurse Practitioner, Physician Assistant and Registered Nurse First Assistant who is legally authorized by the State in which the services are furnished to practice in accordance with State law and is certified by a recognized national certifying body that has established standards for such a practitioner, if the services are the type that are considered physician services if furnished by a doctor of medicine or osteopathy (MD/DO) and are performed in collaboration with an MD/DO as required by the law of the State in which the services are performed or, in the absence of a State law governing collaboration, include documentation of the active involvement of the physician in the decision-making process by co-signing and dating the patient's medical records on the date the services are rendered. Services by Certified Nursing Assistants are not covered.

Payment may be made to the physician or physician group (Employer) for Nurse Practitioners, Physician Assistants or Registered Nurse First Assistants. All benefit payments may be subject to your deductible and Plan co-insurance. In the absence of a contracted rate for payment, the Fund will pay 85% of the Medicare physician fee schedule allowance or, if the Medicare fee schedule allowance is not available, 25% of the reasonable, customary, usual, fair market value charges for covered services by a Nurse Practitioner, Physician Assistant or Registered Nurse First Assistant. To receive direct payment for independent professional services, providers are required to submit claims with their own billing identification numbers.

Covered services will include only those charges necessarily incurred by or on behalf of you or your dependent, which are medically necessary and deemed to be reasonable, customary, usual, and represent fair market value for the services and supplies to which the charges relate. If the charges incurred are in excess of these charges, no payment will be made with respect to such excess.

Covered services will include routine physical examinations, routine eye examinations performed by a Medical Doctor, and additional preventive services at regular intervals unless otherwise stated in this summary.

Medical justification is required for certain existing drugs. In the event that the Food and Drug Administration (FDA) approves new prescription drugs, the Fund reserves the right to review and limit reimbursement as deemed appropriate.

IX. CERTIFICATION FOR HOSPITAL ADMISSIONS

The member must contact the Fund's pre-certification provider as listed on your I.D. card at least ten working days prior to a non-emergency hospital, skilled nursing facility, rehabilitation facility, or any other inpatient facility admission and not later than one working day following emergency admissions.

X. HOSPICE CARE EXPENSES

Eligibility: To be eligible to elect hospice care under the UFCW National Health and Welfare Fund Plan of Benefits, an individual must be certified as terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course.

Certification: Certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or the individual's attending physician, if he/she has one, regarding the normal course of the individual's illness and may be completed up to 15 days before the hospice care is elected in writing. Written certification must include:

1. The statement that the individual's medical prognosis is that their life expectancy is 6 months or less, and
2. Specific clinical findings and other documentation supporting a life expectancy of 6 months or less; and
3. The signature of the physician, date signed and the period of time being certified or re-certified.

No one other than a licensed medical doctor or doctor of osteopathy can certify or re-certify a terminal illness. Predicting of life expectancy is not always exact. The fact that an individual lives longer than expected in itself is not cause to terminate benefits

Election: An individual (or his/her authorized representative) must elect hospice care to receive it. The first election is for a 90-day period and a subsequent 90-day period is available. For the first 90-day period of hospice coverage, the hospice must obtain oral or written certification of the terminal illness by the medical director of the hospice or the individual's attending physician no later than 2 calendar days after the hospice care is initiated. The attending physician is a doctor of medicine or osteopathy or a nurse practitioner and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and deliver of the individual's medical care.

Hospice Discharge: The hospice benefit is available only to individuals who are terminally ill; therefore, a hospice may discharge a patient if it discovers that the patient is not terminally ill. A patient may elect to revoke the hospice benefit at will, as it is the patient's choice rather than the hospice choice. There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations would include issues where patient safety or hospice staff's safety is compromised. All efforts by the hospice to resolve the problem(s) must be documented in detail and the patient's individual physician must be informed.

XI. MEDICAL SERVICES REQUIRING PRIOR AUTHORIZATION

The Fund requires pre-certification for inpatient hospital confinements. The member must contact Conifer Health Solutions by calling 1-866-292-8090 to obtain pre-certification before inpatient hospital confinement.

Certain services and medical procedures require prior authorization through the Fund. Providers must call 1-888-773-8329 to obtain prior authorization before the medical procedure or service is actually performed. The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or substitute for the medical judgment of the attending physician or other health care provider.

The following medical services require pre-certification by Conifer Health Solutions:

- Inpatient hospital confinement
- Organ Transplants
- Private Duty/Skilled Nursing
- Home Health Care

The following medical services require prior authorization by the Fund:

- Outpatient Magnetic Resonance Imaging (MRIs)
- Computed Axial Tomography (CT or CAT scans)
- Electromyograms (EMGs, nerve tests and studies)
- Sleep Apnea (studies, treatment, devices, test, surgery or any services related to sleep disorders)

If the particular course of treatment or medical service is not certified/authorized, it means that the Plan will not consider that course of treatment as appropriate for reimbursement under the Plan. Failure to obtain pre-certification/prior authorization for the required medical services and procedures listed will result in a denial of benefits when your claim is received for processing.

XII. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

XIII. WOMEN'S HEALTH AND CANCER RIGHTS ACT

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

XIV. DEDUCTIBLES

Comprehensive Major Medical benefits become payable when expenses incurred for covered services exceed the deductible amount specified in your Schedule of Benefits.

XV. FINANCIAL OBLIGATIONS

The amount you or your dependents must pay toward covered services depends on whether you receive services from:

- A Preferred Provider or
- A Non-Preferred Provider

Preferred Providers

When you or your dependents receive services from Preferred Providers, In-Network benefits are paid. You are only financially responsible for the specified deductibles, co-payments and co-insurance amounts. Preferred Providers have agreed to accept the Plan's payment, less any applicable deductibles, copayments and co-insurance amounts, as payment in full.

Additionally, the Fund will pay network charges so long as the Fund determines that the network charges are reasonable, customary, usual, represents fair market value, and otherwise payable.

Non-Preferred Providers

When you or your dependents receive services from Non-Preferred Providers, eligible Out-of-Network benefits are paid. The Fund or its designated network does not have special agreements or contracts with the Non-Preferred Providers.

In most cases, the cost of a Non-Preferred Provider's services will be eligible. However, on occasion, a non-preferred provider may charge amounts in excess of the Fund's reasonable, customary, usual, fair market value charge. In these instances, you will be financially responsible for the difference between what the provider charges and what the Fund allows.

XVI. EMERGENCY SERVICES

Emergency health services are covered services that are provided in the case of a bona-fide emergency. This is defined as a sudden, serious, acute, life threatening illness within 12 hours of onset and which is demonstrated 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 health in serious jeopardy,
- Serious impairment of bodily functions, or
- Serious dysfunction of any bodily organ or part.

This does not include elective or routine or follow-up care or care of a minor illness such as treatment of a sore throat, ear pain, colds, flu or toothache.

XVII. EXCLUSIONS

No benefits will be paid under this Summary Plan Description for:

1. Any drug not requiring a prescription, experimental drugs, therapeutic or other prosthetic devices, appliances, supports, and other non-medical products, immunization agents, drugs prescribed for the treatment of a non-covered service or condition, drugs prescribed primarily for cosmetic purposes, drugs that are not medically necessary, and drugs that have not completed the full range of clinical testing usually required for approval of new drugs.

2. Unless otherwise stated in the Coordination of Benefits Section, any service for which you or your dependent is insured under other group insurance or for which you are covered under a Plan supported by a federal, state or other governmental jurisdiction or for any service for which no enforceable charge is levied against you or your dependent.

3. Unless otherwise stated in this summary, oral or dental treatment (including hospital care), examination and diagnostic procedures, operations and devices, including orthodontics, root canals, crowns, dentures, bridges, oral surgery, treatment of impacted teeth, preventive dental care.

4. Any loss resulting from injury, illness or death, which is the result of suicide, attempted suicide or suicidal ideation. Any voluntary act of alcoholic intoxication or the ingestion of any drug or foreign or controlled substance taken without a physician's direction or in a manner not directed by a physician, except if the injury results from an act of domestic violence or a medical condition (including both

physical and mental conditions) with documentation of causative medical/psychological sources of injury.

5. Any medical services in connection with a hospital confinement or hospital outpatient day surgery that is not certified, whether all or in part by the Fund's pre-certification provider. Failure to fully comply with the requirements of any hospital pre-admission or utilization program implemented by the Fund, the member's out-of-pocket expenses may be higher.

6. Charges for services or losses received as a result of injury or sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.

7. Charges for services and supplies not necessary as determined by the Fund, for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended or approved by an attending physician or dentist, or which any provider, organization or school system is required to provide under any law.

8. Charges for care, treatment, services or supplies that are not prescribed, recommended, and approved by the person's attending physician.

9. Charges for procedures, services, drugs and other supplies that are, as determined by the Fund, experimental or still under clinical investigation by health professionals.

10. Charges for services of a resident physician or intern rendered in that capacity.

11. Charges to the extent they are not reasonable, customary, usual, and represent fair market value as determined by the Fund.

12. Charges that are made only because there is health coverage.

13. Charges that a covered person is not legally obligated to pay.

14. Treatment of obesity, weight control programs or charges relating to commercial diet plans and weight loss clinics, or any physician services or laboratory tests required which are rendered in conjunction with such plans and diet foods or drinks, except for surgical procedures for obesity documented by clinical records, whether or not they relate to an illness. The Fund utilizes the Milliman Care Guidelines, including specially-revised Clinical Indications for Bariatric Surgery, and may also utilize other guidelines or protocols. Additionally, the Fund requires approval and preauthorization for gastric bypass surgery for morbid obesity, and limits charges for approved and preauthorized gastric bypass surgery for morbid obesity to the charges of a Center of Excellence specializing in the procedure. The Fund's guidelines require a BMI threshold of 50 as one of the criteria for surgical intervention. This is reduced to a BMI of 40 when there are significant co-morbidities.

15. Charges for outpatient medical supplies (such as bandages, disposable items, etc.).

16. Charges for examinations specifically for the purpose of obtaining a marriage license, employment or insurance, or examinations precedent to engaging in recreational activities, travel, or attending school.

17. Charges to the extent allowed by the law of the jurisdiction where the Plan is delivered for services and supplies: Furnished, paid for, or for which benefits are provided or required under any law of a government (This does not include a Plan established by a government for its own employees or their dependents or Medicaid). An example is benefits provided, to the extent required by law, under "No-Fault" auto insurance law.

18. Charges for hearing aids including any charges made for the fitting of these appliances or their supplies for children over the age of 12 years of age.

19. Charges for education, special education or job training whether or not given in a facility that also provides medical treatment.

20. Charges made for treatment, service or supplies by a relative of the patient or participant.

21. Charges for plastic surgery, reconstructive surgery, weight control, cosmetic surgery or other services and supplies, which improve, alter or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

    a. Improve the function of a part of the body that; is not a tooth or structure that supports teeth; is malformed: as a result of a severe birth defect; this includes harelip or webbed fingers or toes; as a direct result of disease; or surgery performed to treat disease or injury; or

    b. Repair an injury, which occurs while the person is covered under the Plan. Surgery must be performed within one year of the original accident.

22. Charges for reversal of a sterilization procedure.

23. Charges for or in connection with marriage, career, pastoral or financial counseling.

24. Radial keratotomy (RK), photo refractive keratectomy (PRK), automated lamellar keratoplasty (ALK), lasik surgery, intra corneal rings and similar procedures used to correct near sightedness and other visual abnormalities are not covered.

25. Charges without preauthorization from the Fund for outpatient MRIs, CT scans or EMG testing, except when ordered by surgeon prior to back surgery. Charges for any services for studies, treatment devices, test, surgery or related to sleep apnea.

26. Other than for an ambulance, if applicable, transportation and/or travel, including room or board charges incurred in connection with such transportation and/or travel.

27. Unless otherwise elsewhere specifically covered by the Plan, dental prosthetic appliances, including any charges made for the fitting of these appliances unless the service or supply was rendered or obtained as a result of an accidental injury that occurred while the eligible individual was covered under this Plan.

28. Any Treatments and/or consultations with a social worker unless the social worker is working under the direct supervision of a doctor.

29. Any type of custodial care. Custodial care means care designed primarily to assist an eligible individual in meeting the activities of daily living and applies to all such care regardless of the level of service or how it is described.

30. While an eligible individual is confined in an institution, which is primarily a place of rest, a place for the aged or a nursing home.

31. For education, training or room and board in an institution, which is primarily a school or institution of learning or training.

32. Any physical therapy or occupational therapy, if either the prognosis or history of the eligible individual receiving the treatment or therapy does not indicate a reasonable chance of improvement.

33. Any charges made by a doctor or other provider of services for the completing of claim forms and forms required by the Plan for the processing of claims.

34. Any charges for care and/or treatment when the eligible individual has already received Plan benefits totaling any maximum amount stated in the Summary and/or Explanation of Benefits.

35. Service or supply to diagnose or treat infertility, including:

    A. Artificial insemination;
    B. In-vitro fertilization or other procedures involving the eggs and sperm;
    C. Implantation of an embryo developed in vitro;
    D. Drug therapy;
    E. Ovulation induction therapy; and
    F. Monitoring laboratory, radiology and ultrasound studies.

36. Any charges arising out of or in the course of an eligible individual's employment or self-employment. The Plan provision excludes payment for any injury or disease sustained while doing any act or thing pertaining to any occupational employment for remuneration of profit. In addition, it applies to any expense for which a covered person is entitled to benefits under any Workers' Compensation Law (even if the covered individual has waived participation in Workers' Compensation) occupational disease law or other law of the United States, and/or a state or subdivision of the United States.

37. Any treatment, care, service, supply or hospital confinement that is not rendered for the treatment or correction of or in connection with a specific illness, accidental injury or congenital defect.

38. Services relating to routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.

XVIII. SUBROGATION AND/OR REIMBURSEMENT

1. If you or your dependent have the opportunity to recover monies in connection with an illness, injury, accident, occurrence, condition or other loss for which Fund benefits are payable, through a claim against any third party the Fund has a lien against, is subrogated to, and has the right to reimbursement from such monies up to the full extent of benefits paid by the Fund. A "Claim against any Third Party" means a claim of any type whatsoever, whether the claim exists or may exist, or the monies are or may be recovered, from a third party through a claim, lawsuit, settlement, insurance policy or pool, uninsured or underinsured motorist or other policy or pool, governmental or private right of recovery, Workers' Compensation or disability award or order, judgment, no-fault program, or personal injury protection, financial responsibility, medical benefit reimbursement insurance coverage not purchased by you, by compromise, or in any other way from any third party, person, agency, organization or fund of money.

2. The Fund is entitled to its full lien and/or its full recovery of the total amount of benefits which are payable, regardless of the amount of monies paid or awarded to you by the third party, even if those monies are less than the full amount which you do seek or could seek against the third party, regardless of whether the monies are or are described as for medical expenses, and regardless of how they are described or what they are for, and regardless of whether full compensation from the third party is obtained or available. No reduction in the Fund's full right to recover the total amount of Fund benefits payable is effective without the Fund's written consent. The Fund retains the sole and final discretion to decide whether and in what case such consent will be granted, if requested. The Fund has a constructive trust over and an equitable right to and lien with regard to any monies received by a participant and/or his or her beneficiary, attorney or representative from a third party.

3. This provision applies to any type of payment, which in any way arises from or in connection with the illness, injury, accident, occurrence, loss or condition, whether or not the payor caused or is legally responsible or liable for it. It is applicable regardless of whether such liability or responsibility is or is not denied or is in dispute.

4. The Fund has sole and final discretion to determine whether to assert its rights under this provision as a lien, through subrogation, or through reimbursement, to advance payments of benefits and require repayment, or through any combination or variation of these methods. The determination of which method(s) will be used in a particular case will be made to protect the interests of the Fund and its

participants, and is in the Fund's sole and final discretion.

5. If any claim exists or may exist by you or your dependent against any third party, you must notify the Fund within 30 days of the date such claim becomes apparent in writing, stating the name, address, telephone number and basis for the claim against the third party, and the name, address and telephone number of the attorney, representative or other agent handling the claim on behalf of you or your dependent. You must also notify the third party and its counsel or representative in writing of the Fund's lien within 30 days of the date you assert your claim against the third party.

6. You, your dependent, and any attorney, representative or agent who is representing you in connection with any claim against any third party, are required to sign and have a written statement provided by the Fund saying that they acknowledge, agree to and will adhere to the Fund's lien, right of subrogation and/or reimbursement and this provision of the Plan. The existing form, which the Fund requires you and any such attorney to complete, includes this entire provision and is set forth below. The Fund may modify this form at any time without further notice, in its sole and exclusive discretion, and will provide you with a copy of any new or revised form to be executed and returned to the Fund within 10 days of notification. The Fund also may, in its sole and final discretion, require you, your dependent and/or any such attorney, representative or agent to execute such other documents the Fund deems necessary, helpful or appropriate to protect the Fund's rights under the provision. You may also be required to permit the Fund to intervene in any proceeding, and you may be required to file a lien or Consent to Lien, assignment or other such forms, to protect the Fund's interests.

7. The Fund may withhold or suspend payment of any or all benefits in case a claim against any third party exists pending reimbursement, pending guaranteed recognition of the Fund's reimbursement, or pending court order, as the Fund may decide in its sole and final discretion. If you, your dependent, attorney, representative or agent fail or refuse to cooperate with this provision and with the Fund's rights by disputing the Fund's lien, failing to advise the Fund of the status of the claim against the third party, withholding necessary information, not executing the Consent to Lien form described above, or in any other way the Fund will withhold, suspend and exclude payment of any benefits which would otherwise be payable under the Plan. Neither you nor your Dependent shall do anything after a loss to prejudice such rights. Prejudicing the Fund’s Subrogation rights may result in the denial of benefits or termination of your participation of the Fund. This is a specific exclusion and limitation of the Plan, and is in addition to any other legal rights, which the Fund may have, or any other action the Fund may take to protect its rights.

8. You, your dependent, your attorney, a representative or agent must advise the Fund as to the status of any claim against any third party, including providing the Fund with information as to the third party, insurers, lawsuits or any other data related to the claim or to the existence of a claim. Such information must be provided at the initiation of the claim, every 12 months thereafter, whenever a settlement is proposed, and whenever requested by the Fund.

9. No claim against any third party may be settled or resolved, and no payment may be accepted from any third party, without the written consent of the Fund. Unless and until the Fund has received full reimbursement, no monies from or through a third party may be distributed to you, your dependent, your attorney, representative or agent without the Fund's written consent, and these monies are, to the extent of benefits payable or paid by the Fund, assets of and debts owed to the Fund. The Fund's decision on whether to grant, or withhold, its consent is a final decision, made in the sole discretion of the Fund.

10. The Fund may, by written notice given to you, require that any other person comply with this provision as well, in order to secure the Fund's rights in the exercise of its sole and final discretion.

11. Full cooperation with this provision is a condition to payment of any benefits under this Plan. In case of any failure of cooperation, or violation of this provision, you, your dependent, attorney, representative or agent will be liable to the Fund for full reimbursement and for its loss, including costs, interests and fees.

12. This provision covers not only you as participant, but also your dependents, spouses, attorneys, representatives, agents and their heirs, guardians, executors, successors and assignees.

13. No other liens may be superior to the Fund's lien or rights under this provision. The Fund may in its discretion and in an appropriate case, agree to a reduction of its lien for the payment of a portion of attorneys' fees and costs of a legal proceeding, if all terms of this provision have been and are being observed.

14. Any disputes arising under or in connection with this Section, including disputes over liens, their amount, reimbursement or withholding of benefits, or reductions or compromises in the Fund's lien shall, if not resolved with the Fund's Claim Department, be taken up in accordance with the procedure for disputed claims contained in this SPD, including review by the Claims Review Committee of the UFCW National Health and Welfare Fund Board of Trustees and appeal to the Board of Trustees as defined in the SPD. Wherever the discretion of the Fund is noted in this Section, it refers to the discretion of the Fund personnel and the Claims Review Committee of the Board of Trustees.

15. Form for lien. The above provisions followed by this language must be executed as described above.

I HEREBY ACKNOWLEDGE, AGREE TO AND WILL BE BOUND BY THE ABOVE "REIMBURSEMENT AND/OR SUBROGATION" PROVISION OF THE PLAN OF BENEFITS OF THE UFCW NATIONAL HEALTH AND WELFARE FUND.

______________________________	______________________________
Name of Participant	Name of Attorney or Agent

Address

Signature Date

Name of Dependent (if applicable)

Address

Signature Date

Address

Signature Date

XIX. PRESCRIPTION DRUG BENEFITS

The Fund provides prescription drug benefits to eligible individuals through EmpiRx Health, LLC (you must show your prescription drug card at the time of purchase) for prescription medications that are purchased from a participating pharmacy.

Prescription Drug Generic Requirement

When a generic drug is available, but the pharmacy is asked to dispense the brand name at the participant's request, the participant will pay the difference between the brand cost and the generic cost, and the participant will have to pay the brand coinsurance if it is different from the generic coinsurance.

Retail 30-Day Supply

1. Generic Drugs. The co-payment for each new or refill prescription for a 30-day supply is $5.00.

2. Preferred Brand Name Drugs. The co-payment for each new or refill prescription for a 30-day supply is $50.00.

3. Non-Preferred Brand Name Drugs. The co-payment for each new or refill prescription for a 30-day supply is $60.00.

Mail Order is suggested for maintenance drugs. You may receive up to a 90-day supply when using the mail order pharmacy. The co-payment for each 90-day supply when using the mail order pharmacy is $15.00 for generic drugs; $150.00 for preferred brand name prescriptions; and $180 for non-preferred brand name prescriptions.

The mail order requirement, in certain cases, where there is a manufacturer's co-pay/discount card applied to prescription plans requiring maintenance medication or long-term medication or specialty medication be obtained through the mail order pharmacy is

deleted.

Step Therapy (also called Step Protocol) is a practice of beginning a specific drug therapy for a medical condition with the most cost effective and safest drug therapy. If a patient does not respond satisfactorily, progressively more costly, risky or different therapy is prescribed as needed. Step Therapy allows the Plan to define a logical sequence of therapeutic alternatives. The aims are to control costs and minimize risks.

Medical justification is required for certain existing drugs. In the event that the Food and Drug Administration (FDA) approves new prescription drugs, the Fund reserves the right to review and limit reimbursement as it deems appropriate.

The Fund has a policy requiring pre-approval for requests for lifestyle drugs, Viagra and other medications for impotence, limiting approval to a maximum of 6 pills per month, and providing that:

a) A letter of medical necessity by the patient's attending physician based on a diagnosis of non-psychological impotence (based on the diagnoses listed by the Fund's Pharmacy Benefits Manager) must be submitted to the Fund's Medical Director for review.

b) The dosage dispensed should not exceed a maximum of 6 pills per month, to be purchased through the Pharmacy Benefits Manager exclusively, so that controls are in place and monitoring can be ongoing. The Fund will request cost and usage reports from the Pharmacy Benefits Manager.

c) This policy will also apply to all drugs present and future for the treatment of organic impotence.

d) Medication is authorized and released when the Fund receives the letter of medical necessity and faxes a prior authorization to the Pharmacy Benefits Manager. The letter must verify that the impotence is due to non-psychological causes such as diabetes or nerve damage.

The Preferred Medication List or Formulary developed by EmpiRx contains an extensive group of medications researched and designed to meet the prescription drug needs of all types of patients. A select group of physicians and pharmacists have agreed, after careful analysis, on what medications should be included on this list. The list is designed for your physician to review and select the appropriate medication for you. However, you will still be covered for whatever medication is prescribed by your doctor, except those already excluded by the Plan.

Specialty Drugs: Cost Avoidance Program through Payer Matrix and EmpiRx

The UFCW National Health and Welfare Fund, has initiated a cost avoidance program coordinated through Payer Matrix for specialty drugs. The goal of the program is helping you avoid any out-of-pocket expense for specialty medications and decrease the cost to the National Fund, if possible. If you are currently taking or have been prescribed most specialty drugs (these are the impacted drugs involved), you are required to apply to participate in the Payer Matrix program. The program will help you enroll in any applicable

alternate funding programs for your eligible drug therapy. If you are eligible to participate in the Payer Matrix program, you will receive a telephone call/and or letter, to your current telephone number/last known address on file with the Fund office, outlining the enrollment process.

As a first step, Plan members or their providers are required to send specialty medication prescriptions to EmpiRx as is the current process. While EmpiRx conducts the clinical prior authorization to ensure the medication is medically necessary for you, Payer Matrix conducts an administrative review to locate an alternate payer for you and the specific specialty medication you need. Payer Matrix and/or your Plan will assist you throughout the process, from enrollment through your receipt and use of your medication.

If you do not apply, or are eligible for a Payer Matrix identified alternate funding program and choose not to enroll in the program, you will be responsible for the full cost of your specialty drug prescription. You will get no benefit from the National Fund, and this expense will not count toward your annual out-of-pocket maximum. If you are not eligible after applying for any alternate funding program through Payer Matrix for any Specialty Drug prescription covered by the Plan, Payer Matrix will work with EmpiRx and you will receive your drugs with all your Plan provisions in force. Your cost would be subject to the standard covered specialty drug copay/coinsurance as outlined by your Plan.

Payer Matrix does not result in any reduction of benefits, increase in co-insurance, co-payment or deductibles, or lower employer contributions or change any annual limits.

Limitations and Exclusions. The Fund will not pay any charges related to the following:

1. Drugs that are lawfully obtainable without a prescription other than injectable insulin.

2. Therapeutic devices and/or appliances including hypodermic needles, syringes, support garments and other non-medical substances regardless of their intended use.

3. Charges for the administration of prescription legend drug or injectable insulin.

4. Drugs and injectable insulin dispensed during hospital confinement including confinement in a rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises a facility for dispensing pharmaceuticals.

5. Any drug labeled “Caution – Limited by Federal Law to Investigational Use” or any experimental drugs.

6. Any prescription filed in excess of the number specified by the doctor or any refill dispensed after one year of the doctor’s order.

7. Any prescription for which an eligible individual is entitled to receive reimbursement under any Workers’ Compensation Act or similar law or is entitled to receive reimbursement of such prescription legend drug without charge from a municipality, state, or Federal program, including Title XVIII of the Social Security

Act unless otherwise required by law.

8. Drugs dispensed due to accidental injury or sickness arising out of an in the course of an eligible individual's employment of self-employment.

9. Prescription drugs, which may be properly received without, charge under local, state or Federal programs unless required by law.

10. Fertility medications.

11. Medications for cosmetic purposes.

12. Retin-A if over age 24 with prior authorization.

13. Vitamins, except prenatal.

14. Anti-obesity drugs.

15. Amphetamines.

XX. COORDINATION OF BENEFITS

All claims for covered expenses shall be subject to Coordination of Benefits in that the liability of the UFCW National Health and Welfare Fund shall be reduced to the extent by which you or your dependents are entitled to benefits under any other group Plan with respect to the same expenses.

When expenses are covered under more than one Plan, Coordination of Benefits is the method used to determine which Plan has primary responsibility to pay Plan benefits for such expenses and which Plan has secondary responsibility. A Plan without a coordinating provision is always primary. If all Plans have such a provision: (1) the Plan covering the patient as the Employee, rather than, an Employee's dependent, is primary and the other is secondary, except that an active Plan is always primary over a Retiree Plan regardless of whether the patient is covered as an Employee or dependent of said active Plan; (2) if a child is covered under both parents' Plans, the Plan of the parent whose birthday occurs first in the calendar year is the primary Plan.

When the parents are separated or divorced, their Plans pay in this order: (1) if a court decree has established financial responsibility for the child's medical expenses, the Plan of the parent with this responsibility; (2) the Plan of the parent with the custody of the child; (3) the Plan of the step-parent married to the parent with custody of the child; (4) the Plan of the parent not having custody of the child.

If your spouse received any economic inducement, incentive, reward or benefit for waiving coverage available to your spouse by your spouse's Employer Group Health Plan (whether in cash, a flexible spending or benefit account, additional or other benefits, insurance or vacation, or in any other form), the Fund will consider your spouse to be entitled to coverage under your spouse's Employer Group Health Plan for purposes of

the Fund's Coordination of Benefits provision.

If your spouse is not required to pay any amount to receive coverage for your spouse and/or dependent children under your spouse's Employer Group Health Plan and waives coverage, the Fund will consider your spouse to be entitled to coverage under your spouse's Employer Group Health Plan for purposes of the Fund's Coordination of Benefits provision.

If your spouse is required to pay any amount to receive coverage for your spouse and/or dependent children under your spouse's Employer Group Health Plan and waives coverage, the Fund will not consider your spouse to be entitled to coverage under your spouse's Employer Group Health Plan for purposes of the Fund's Coordination of Benefits provision (even if your spouse receives an inducement for waiving available coverage as defined above).

When you continue in active employment at age 65 and beyond, the benefits under this Plan will be primary. Likewise, if you are under age 65, but your spouse is over age 65 and you are actively employed, this Plan will be primary for your spouse. In both cases, Medicare will be considered secondary and pay only limited supplementary benefits.

Please note that enrollment in Medicare Part A is automatic in most cases. You must always enroll in Part B for which you pay a monthly premium to the Federal Government.

XXI. TERMINATION OF ELIGIBILITY

A. Eligibility for benefits for you and your dependents, as contained in this SPD, shall automatically terminate at the end of the last day of the calendar month in which:

1. You cease active employment. Active employment has ceased when you:

   (a) Become laid off or become absent because of a strike or lockout,
   (b) End a sick leave approved in writing up to the time limits specifically provided in the applicable Collective Bargaining Agreement or Summary Plan Description but no longer than one year, a Short Term Disability benefit period provided by the Fund, an approved Worker's Compensation absence benefit period, or an approved Family and Medical Leave Act leave, during which required contributions are being made to the Fund,
   (c) Are retired
   (d) Are discharged,
   (e) Have resigned, or

2. The Agreement and Declaration of Trust between the Employer and the Union is finally terminated, or

3. The UFCW National Health and Welfare Fund is discontinued, or

4. The Employer contributions or your payments to the UFCW National Health and Welfare Fund cease.

B. Eligibility for your dependent's benefits under this SPD will automatically cease at the end of the last day of the calendar month in which the person covered as a dependent ceases to be a dependent as defined herein or at the end of the last day of the calendar month in which your eligibility ends, whichever is earlier.

C. The Plan Administrator may also terminate any covered person's coverage for Cause. "Cause" means the covered person's willful engagement in misconduct that is materially injurious to the plan or plan participants, dishonesty by the covered person in connection with the provision of benefits under the plan, fraudulent or unethical conduct by the covered person relating to or affecting the provision of benefits under the plan, the covered person's being indicted or charged with any crime constituting a felony, or the covered person's failure to repay any amounts due and owing to his or her Employer or the Fund.

D. Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The continuing person must pay the entire cost (plus a reasonable administration fee). Coverage will end if the covered individual fails to make timely payment of contributions or premiums (within a maximum of 45 days for initial premium/contribution payments and 30 days thereafter). This law is referred to as "COBRA", which stands for the Consolidated Omnibus Reconciliation Act of 1985.

XXII. CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer sponsoring the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to the UFCW National Health and Welfare Fund’s Eligibility Department.

Electing COBRA after a Leave under FMLA

If you take a leave of absence under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you will be entitled to elect COBRA if:

- You were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and

- You will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment or reduction of hours. (See “How is COBRA continuation coverage provided?” below).

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Paying for COBRA Continuation Coverage

You must pay the cost of COBRA continuation coverage. The cost of coverage is determined by the Board of Trustees and is subject to change periodically as the actual cost of providing benefits changes.

Generally, the amount of the premium for COBRA coverage will not exceed 102 percent of the cost of providing benefits to a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will not exceed 150 percent of the cost of coverage.

Your first payment must be made within 45 days of the date that the COBRA election was made. After the initial payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be cancelled retroactively to the first day of the month for which no payment was received and all COBRA rights are forfeited.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

Your continuation coverage may be shortened for any of the following reasons:

a. the Plan no longer provides group health coverage to any of its participants;

b. the premium for your continuation coverage is not paid;

c. you become covered under another group health plan that does not have a pre-existing condition limitation. Even if the other plan's coverage is less valuable than the continuation coverage, continuation coverage will cease;

d. If the other group health plan has a pre-existing condition limitation, coverage will not end provided the beneficiary provides evidence of the pre-existing limitation from the other group health plan's policy, document or Summary Plan Description.

e. you become eligible for Medicare;

f. for any reason the Plan would terminate coverage of a participant not receiving continuation coverage (such as fraud).

g. in the case of extended COBRA coverage due to disability:

- after Social Security determines that you are no longer disabled; or
- when you become eligible for Medicare (even if it is before the 29 months has expired).

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/benefits.cfm.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

The Fund Office is responsible for the administration of COBRA Continuation Coverage and can be reached at the address below:

UFCW National Health and Welfare Fund
Department of COBRA Administration
66 Grand Avenue
Englewood, NJ 07631-3545
Telephone: 201.569.8801

XXIII. FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 (the Act) requires covered Employers to provide up to 12 weeks of unpaid leave to eligible Employees for certain family and medical reasons.

Employees are considered eligible for this leave if:

a. The Employee has worked for the covered Employer for at least one 1 year;
b. The Employee has worked 1,250 or more hours over the previous 12 months; and
c. There are at least 50 Employees within 75 miles of your workplace. Unpaid leave may be granted to an eligible Employee for any of the following reasons:

    - To care for the Employee's child after birth, or placement for adoption or foster care;
    - To care for the Employee's spouse, son or daughter, or parent, who has a serious health condition; or
    - For a serious health condition that makes the Employee unable to perform the Employee's job.

Note*:* At the Employer's option, certain kinds of paid leave may be substituted for or used prior to using unpaid leave (i.e., accrued vacation or sick leave). If the Employer does not require the use of the unpaid leave, the Employee retains the option of choosing to use paid leave prior to any unpaid leave.

The Employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if the following requirements are not met:

a. The Employee ordinarily must provide 30 days advance notice when the leave is "Foreseeable".

b. An Employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the Employees expense) and a fitness for duty report to return to work.

The Family and Medical Leave Act also provides job and benefit protection to Employees by mandating certain administrative compliances. For example:

a. For the duration of the approved leave, the Employer must maintain the Employee's health coverage under any "Group Health Plan". If the Employee normally makes contributions toward the cost of the "Group Health Plan", the Employer may require the Employee to continue to make the contributions while on leave. The method and timing of these contributions will be determined by mutual agreement between the Employer and Employee.

b. Upon return from the approved leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

c. The use of the approved leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

d. The Family and Medical Leave makes it unlawful for any Employer to:

    1. Interfere with, restrain, or deny the exercise of any right provided under the Act;
    2. Discharge or discriminate against any person for opposing any practice made unlawful by the Act or for involvement in any proceeding under or relating to the Act.

The U.S. Department of Labor is authorized to investigate and resolve complaints of violations under the Act. An eligible Employee may bring a civil action against an Employer for violation.

This Act does not affect any Federal or State law prohibiting discrimination, or supersede any State or Local law or Collective Bargaining Agreement, which provides greater family, or medical leave rights.

For Additional Information: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, or the Office of the Plan Administrator.

XXIV. LEAVE FOR MILITARY SERVICE

In accordance with the requirements of the Uniformed Services Employment and Re-Employment Rights Act of 1994, if you go into active military service for up to 31 days, you will continue your coverage, up to 31 days. If you go into active military service for more than 31 days, you may be able to continue your coverage at your own expense for up to 18 months. See the information on Continuation of Coverage (COBRA) for a full explanation of when and how these circumstances may apply to your coverage.

You will not retain coverage for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility will be reinstated on the day you return to work with an Employer that is participating in the Plan's Collectively Bargained Agreement, provided that you return to employment within:

1. Ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or

2. Fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days; or

3. At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

Questions regarding your entitlement to this leave should be referred to your Employer. Questions regarding the continuation of coverage should be referred to the Plan office.

XXV. GENERAL PROVISIONS

This SPD is provided in accordance with and subject to the terms, conditions, rules and regulations of the Board of Trustees of the UFCW National Health and Welfare Fund.

No person is authorized to:

(a) Change or amend this SPD,
(b) Waive any condition or restriction contained in this SPD,
(c) Extend the time for making any contribution or payment, or
(d) Bind the Trustees by any statement or promise.

No change in this SPD will be valid unless authorized by the Board of Trustees of the UFCW National Health and Welfare Fund and thereupon endorsed hereon over the signature of the Chairman.

Nothing contained in this SPD shall limit the broad discretion of the Trustees to interpret and apply the provisions of this SPD or the terms of the Plan.

The UFCW National Health and Welfare Fund is not under the supervision of the Department of Banking and Insurance of the state of New Jersey, nor any similar department of any other state or governments, except to the extent that employee benefit plans may be regulated by law.

None of the benefits provided by this plan are “Vested” or guaranteed in any way. Nothing in this booklet is meant to interpret or change in any way the provisions expressed in the Rules and regulations of the UFCW National Health and Welfare Fund. The Trustees reserve the right to amend, modify or discontinue all or part of this plan, whenever in their sole discretion conditions so warrant. If you do not understand English and have questions about the benefits or the rules of the plan, contact the Fund Office to find out how to obtain such help.

Si no habla o entiende inglés y tiene preguntas de los beneficios o reglamentos de plan, pongase en contacto con nuestra oficina para obtener ayuda e informacíon.

XXVI. NOTICE AND PROOF OF CLAIM

A. Written "Notice" of injury or sickness upon which claim may be based must be given to the UFCW National Health and Welfare Fund within 30 days after the date of the event upon which claim may be based.

B. Written “Proof” of Loss must be given to the UFCW National Health and Welfare Fund, within 90 days after the date of such loss, except in the case of death, within one year after such death.

C. Failure to furnish "Notice" or "Proof" within the time provided above will not cancel nor reduce any claim if it is shown not to have been reasonably possible to give such “Notice” or “Proof” within the time provided above and that such "Notice" or "Proof" was given as soon as was reasonably possible.

D. The UFCW National Health and Welfare Fund, upon receipt of the Notice required by this SPD will supply to the claimant such forms as are usually supplied for filing Proof of Loss. If such forms are not so supplied within 15 days after the Fund receives such Notice, you shall be considered to have complied with the requirements of this SPD as to Proof of Loss upon submitting, within the time fixed in this SPD for filing Proof of Loss, written Proof covering the occurrence, character and extent of the loss for which claim is made.

XXVII. CLAIMS REVIEW AND APPEAL PROCEDURE

A. Authority of the Fund

The UFCW National Health and Welfare Fund is a joint labor-management employee benefit trust fund, financed by contributions fixed by collective bargaining or other written agreements, and administered by an equal number of Trustees designated by the contributing employers and by the union pursuant to an Agreement and Declaration of Trust (Trust Agreement), which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted a Plan of benefits set forth and described by Summary Plan Description (SPD). Under the Trust Agreement and SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Plan and SPD, and all determinations on benefit claims and appeals, are subject to the discretion of the Board of Trustees and/or its Claims Review Committee, whose determinations are final and binding.

B. Request for Review of Disputed Claims

If you have presented a claim for benefits under this SPD, you may file a request for review of its disposition or adverse benefit determination by appealing to the Claims Review Committee of the Board of Trustees of the UFCW National Health and Welfare Fund in writing, within 180 days after receiving written notice of the Fund's action. Send your appeal to the Fund office and address it to the Claims Review Committee. You will be notified, in writing, of the decision of the Claims Review Committee within 60 days of the date your request for review is received, unless there are special circumstances, in which case you will be so notified and then notified of the decision within 120 days. At any time, the Claims Review Committee may refer a request for review to the Board of Trustees of the Fund.

C. Voluntary Appeal to Board of Trustees

If you are not satisfied with the decision of the Claims Review Committee you may, within 60 days after the date of the Committee's Decision, appeal in writing to the Board of Trustees of the Fund by writing to the Board of Trustees at the Fund office. You will be notified, in writing, of the decision of the Board of Trustees within 60 days after the date the Board of Trustees next meets and decides your appeal after the date your appeal is received, unless there are special circumstances, in which case you will be so notified and then notified of the decision within 120 days. The Fund waives any right to assert

that you failed to exhaust administrative remedies because you did not elect to voluntarily submit your appeal to the Board of Trustees after the Decision of the Claims Review Committee. Any statute of limitations or other defense based on timeliness is tolled during the time that any voluntary appeal to the Board of Trustees from the Decision of the Claims Review Committee is pending. Your decision as to whether or not to voluntarily submit a benefit dispute to the Board of Trustees after the Decision of the Claims Review Committee will have no effect on your right to any other benefits under the Fund. There is no cost to this voluntary level of appeal.

D. Additional Information

If additional information is needed, it will be requested by the Fund, and absent the timely provision of the information, may require the denial of the claim or appeal.

E. Finality

In deciding claims, the Claims Review Committee and the Board of Trustees have broad discretion to interpret and apply the terms of this plan and SPD.

The determination of the Fund will be final and binding if an objection or request for review is not timely filed. The decision of the Claims Review Committee on a request for review will be final and binding if not timely appealed. The decision of the Board of Trustees of the Fund will be final and binding on any appeal timely presented to it.

The Claimant has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act following an adverse benefit determination on review. If your claim involves disability benefits, you and your plan may have other voluntary alternative dispute options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

F. Notification and Right to Comment and to Information

Upon any adverse benefit determination, the Fund will notify the Claimant of this Claims Review and Appeal Procedure and its time limits. A Claimant may review pertinent documents and submit written issues and comments, records or other information relating to the claim. A Claimant shall be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. All comments, documents, records, and other information submitted by the Claimant will be taken into account at any stage of the Claims Review and Appeals Procedure and process. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse benefit determination, such will be stated and a copy will be provided upon request. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request. The Fund will provide for the identification of medical or vocational experts whose advice was relied on in connection with an adverse benefit determination.

G. Urgent Care, Pre-Service and Post Service Claims

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours

Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit in whole or in part, on approval in advance of obtaining medical care. There are, for example, Claims subject to pre-certification or pre-authorization. Please see the cost management section of your summary plan description for further information about Pre-Service Claims if pre-approval of services are applicable under your plan of benefits.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by claimant	45 days

Notification, orally or in writing, of failure to follow the Plan’s procedures for filing a Claim	5 days

Ongoing courses of treatment:

Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by claimant	45 days
Review of adverse benefit determination	60 days

In case of the failure of you or your representative to follow the Plan's procedures for filing pre-service claims, which are described separately in the SPD, you or your representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits, as soon as possible but not later than 5 days (24 hours in the case of a failure to file with respect to a claim involving urgent care) following the failure.

In the case of urgent or concurrent care claims, notification and right to review and appeal shall be in accordance with regulations of the United States Department of Labor, with initial appeal within the procedures and time limits set forth by the Fund's utilization reviewer, which are described separately in the SPD. In the case of an adverse benefit determination concerning an urgent or concurrent care claim, the expedited review process applicable to such claims will be included with the determination. After completing such appeal to the utilization review, the Claimant shall also have a right of appeal within the Fund as described in this Claims Review and Appeal Procedure.

H. <u>Medical Judgments</u>

In deciding any appeal based in whole or in part on a medical judgment, the Claims Review Committee or Board of Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the adverse benefit determination nor the subordinate of any such individual.

I. Two-Step Appeal Procedure in Non-Grandfathered Plan

a. **General**: In accordance with the federal Patient Protection and Affordable Care Act and applicable Regulations, the Fund provides for a two-step Claims Review and Appeals Procedure in a Non-Grandfathered Plan. The first step is an Internal Appeal to the Claims Review Committee and Board of Trustees of the Fund, as set forth above. The second step is an External Appeal to an Independent Review Organization (IRO). The Fund has engaged IROs on behalf of the Fund, and any external appeal shall be assigned to such IROs in accordance with federal law.

b. **External Appeal or Step Two**: The Claimant may file a request for an External Review with the Fund Office within four (4) months after the date of receipt of an adverse Internal Appeal Decision. If there is no corresponding date four (4) months after the date of receipt, i.e. receive on October 30 and there is no February 30, the request must be filed by the first day of the fifth month following the receipt of the notice. If the last filing date falls on a Saturday, Sunday or federal holiday, the filing deadline is extended to the next business day.

c. **Preliminary Review**: Within five (5) business days following the date of receipt of the Claimant's External Review request, the Fund Office must complete a preliminary review of the request to determine whether it is eligible for External Review. In order to be eligible for External Review the following factors must be met:

   A. The Claimant is or was covered under the Plan at the time the health care item, service, or other benefit was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item, service, or other benefit was provided;

   B. The adverse benefit determination or the adverse Internal Appeal determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

   C. The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process under the federal interim final regulations or in accordance with this procedure; and

   D. The Claimant has provided all of the information and forms required to process an External Review.

d. **Notice of Preliminary Review:** Within one (1) business day after completion of the Preliminary Review, the Fund Office will issue a notice in writing to the Claimant. If the request for External Review is complete, but not eligible for External Review, such notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notice will describe the information or materials needed to make the request complete and the Plan shall allow Claimant to perfect the request for External Review within the later of the four-month filing

period or within 48 hours following the receipt of the Notice of Preliminary Review.

e. **<u>Assignment of IRO:</u>** In accordance with federal law, the Fund Office shall assign an accredited IRO to conduct the External Review. The IRO shall be assigned in accordance with the Fund's rules, which provide an assignment or rotation method that ensures independence and against a bias towards the Fund.

f. **<u>IRO Process</u>**: Upon receipt of the External Review, the IRO will:

   A. Utilize legal experts where appropriate to make coverage determinations under the Plan;

   B. Timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days following the date the Claimant receives this notice any addition information that the IRO must 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.

g. **<u>Information to IRO:</u>**

   A. Within five (5) business days after the date of assignment to the IRO, the Fund Office must provide to the IRO any documents and any information considered in making the adverse benefit determination or the adverse Internal Appeal determination. Failure by the Fund Office to provide documents must not delay the External Review. If the Fund Office fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the adverse benefit determination or the adverse Internal Appeal determination. Within one (1) business day after making such decision, the IRO must notify the Claimant and the Fund Office.

   B. Upon receipt of any information submitted by the Claimant, the IRO must within one (1) business day forward such information to the Fund Office. Upon receipt of any such information, the Fund Office may reconsider its adverse benefit determination or adverse Internal Appeal determination that is the subject of the External Review. Any reconsideration by the Fund Office must not delay the External Review. External Review may be terminated if the Fund Office determines during reconsideration to reverse the previous determination and provide coverage or payment as requested by Claimant. The Fund Office will provide written notice to the IRO and the Claimant of its reversal of the previous determination within one (1) business day of such reversal. Thereafter, the IRO will terminate the External Review proceedings.

C. The IRO will review all information and documents timely received and review the claim and all evidence de novo. The IRO is not bound by any decisions or conclusions reached during the initial benefit determination or the Internal Appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, in reaching an External Review decision:

1. The Claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's Treating Provider;
4. The terms of the Plan (unless contrary to applicable law);
5. Appropriate medical practice guidelines, including evidence-based standards;
6. Any applicable clinical review criteria developed and used by the Plan (unless contrary to the Plan or applicable law);
7. The opinion of the IRO's clinical reviewer.

h. **<u>IRO Decision:</u>** The IRO will provide written notice of the final External Review decision to the Claimant and the Fund Office within 45 days after the IRO receives the request for External Review.

A. the IRO's final External Review decision notice will contain:

(i) A general description of the reason for the request for External Review, including: sufficient information to identify the claim (date or dates of service, Provider, claim amount, diagnosis code and corresponding meaning, treatment code and corresponding meaning, and reason for previous denial);

(ii) The date the IRO received the assignment to conduct the External Review;

(iii) The date of the IRO's final External Review decision;

(iv) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;

(v) An explanation of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;

(vi) A statement that the determination is binding except to the extent that other remedies may be available under federal law to either the Plan or the Claimant;

(vii) A statement that judicial review may be available to the Claimant; and

(viii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

i. **Records**: The IRO must maintain records of all claims and notices associated with the External Review for six (6) years. An IRO must make such records available for examination by the Claimant, Plan, or state or federal government oversight agency upon request unless such disclosure would violate state or federal privacy laws.

j. **Expedited External Review:**

A. Expedited External Review shall be undertaken when the Claimant has a medical condition that necessitates Expedited External Review because the time frame for completion of the standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the adverse Internal Appeal determination concerns an admission, availability of care, continued stay, or health care item, service, or other benefit for which the Claimant received emergency services, but has not been discharged from a Provider's facility, or such Claimant qualifies for Urgent Care review.

B. The Fund Office shall immediately upon receipt of the request for the Expedited External Review, perform the Preliminary Review provided in Section 12.4(c)(2) and shall complete such review as soon as possible without regard to the five (5) business days referred to therein. Upon its determination of the Preliminary Review, the Fund Office will immediately send the notice described above.

C. Upon a determination that the request is eligible for Expedited External Review, the Fund Office shall assign an IRO in accordance and transmit or provide all documents and information described above electronically or by telephone or facsimile or by any other available expeditious method.

D. The IRO must provide its final External Review decision and notice of such decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an Expedited External Review. If the notice of the Expedited External Review decision is provided by the IRO other than in writing, then within 48 hours of the date such notice is provided the IRO will provide written confirmation of the decision to the Claimant and the Fund Office.

k. **Reversal of Adverse Determination:** In the event the adverse benefit determination or the adverse Internal Appeal determination is reversed by the Fund or the IRO, respectively, the Fund will provide coverage or payment for the claim in accordance with applicable law and regulations, but reserves the right to pursue judicial review or other remedies available or that may become available to the Fund under applicable law and regulations.

J. **Limitations on Action Against Fund:** No lawsuit shall be brought to recover benefits under this Fund unless:

(i) The Claimant has exhausted the appeal procedure provided by the Plan; and

(ii) Such lawsuit is filed within one year from the date of the Claims Review Committee Decision or, if a timely appealed has been presented to the Board of Trustees, the Board of Trustees Decision or, where applicable, the date of the External Review decision.

XXVIII. PAYMENT OF BENEFITS

ASSIGNMENT OF BENEFITS. Neither this SPD nor the right to benefits under this SPD is assignable, except that:

Benefits, if any, payable for hospital, surgical, medical or Major Medical expenses may be assigned as a convenience to the participant, by written instrument filed with the UFCW National Health and Welfare Fund, to the institution or person providing the service on account of which such benefits become payable.

When payable, if an "Assignment of Benefits" has been made, the provision will be considered as a request to the Fund to pay benefits directly to the Provider. The Participant is financially responsible for any charges not covered and/or not paid by this assignment. The Fund does not guarantee payments to a Provider. If the services were paid for by the Participant or Dependent and are verified to the Fund and eligible for coverage, the payment will go directly to the Participant.

XXIX. EXAMINATION AND INVESTIGATION OF CLAIMS

The UFCW National Health and Welfare Fund shall have the right and opportunity to investigate, at its expense, the person whose injury or sickness is the basis of a claim, when and so often as it may reasonably require during pendency under this SPD.

You or your personal representative or any other claimant must promptly furnish all consents and authorizations upon request of the UFCW National Health and Welfare Fund to permit its designated representatives to examine any and all medical, hospital, and other privileged records and communications relating to any claim filed under this SPD.

XXX. RECOVERY OF OVERPAYMENT

The Fund may recover or recoup the amount of any erroneous payment, with interest, against pending or future benefits in accordance with law and regulations.

XXXI. ERISA INFORMATION

As a participant in the UFCW National Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income and Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest Annual Report (Form 5500 series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's Annual Financial Report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Group Health Plan, if you have Creditable Coverage from another Plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your Group Health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 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 Plan documents or the latest Annual Report from the Plan, if any, and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 courts costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Este libreto contiene un resumen de sus beneficios y sus derechos del plan de UFCW National Health & Welfare Fund. Si tiene dificultad entendiendo cualquier parte de este libreto por favor de contactar al administrador Glenn L. Di Biasi a 66 Grand Avenue, Englewood, New Jersey 07631-3545. Horario de oficina son de 8:30 am a 4:30 pm, Lunes a Viernes. Tambien podra llamar al administrador del plan a (201) 569-8801 para asistencia.

XXXII. ADDITIONAL INFORMATION

The following information is required to be provided under the Employee Retirement Income Security Act of 1974 (ERISA).

1. **Name of Plan:**

   UFCW National Health and Welfare Fund

2. This Plan is maintained pursuant to Collective Bargaining Agreement or other written agreement, is a Collectively-Bargained Plan established by one or more Employers and one or more Employee organizations, and is administered by a joint Board of Trustees. Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or Employee organization is a Sponsor of the Plan and, if the Employer is a Plan Sponsor, the Sponsor's address.

3. **Plan is maintained and administered by and the Plan Administrator is:**

   Board of Trustees
   UFCW National Health and Welfare Fund
   66 Grand Avenue
   Englewood, New Jersey 07631-3545
   (201) 569-8801

4. **Employer Identification Number of the Plan Sponsor:**

   EIN: 22-1458594

5. **Benefit Year**: Calendar Year

6. **Plan Fiscal Year**: October 1 – September 30

7. **Type of Plan and Type of Administration:**

   Welfare Plan and Group Health Plan. Benefits are self-funded and self-insured, except to the extent that certain benefits are insured. The Plan is administered by the Fund.

8. **Source of Contributions to the Plan**

   Assets to provide Plan benefits are accumulated under the provision of the Collective Bargaining Agreement and the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable expenses.

   The sources of contributions are provided through Collective Bargaining Agreements of the various Employers that are insured under the UFCW National Health and Welfare Fund and in accordance with the Collective Bargaining Agreement.

9. **Agent for Service of Legal Process:**

The Board of Trustees has been designated as the agent for the service of legal process. Service of legal process may be made upon a Plan Trustee or the Plan Administrator. The designated agent for service of legal process is:

Board of Trustees
UFCW National Health and Welfare Fund
66 Grand Avenue
Englewood, New Jersey 07631-3545

10. **Circumstances Which May Result in Loss of Benefits and Authority to Terminate or Amend Benefits:**

The Summary Plan Description (SPD) describes circumstances, which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery of benefits.

The UFCW National Health and Welfare Fund (Fund) is a joint labor-management Employee Benefit Trust Fund, financed by contributions fixed by Collective Bargaining or other written agreements and administered by an equal number of Trustees designated by the contributing Employers and by the Union pursuant to an Agreement and Declaration of Trust, which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted this Plan of Benefits described in this Summary Plan Description (SPD). Under the Trust Agreement and this SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Plan and this SPD, and all determinations on benefit claims and appeals, are subject to the discretion of the Board of Trustees and/or its Claims Review Committee, whose determinations are final and binding.

While the Trustees of the Fund expect the Plan to continue, they reserve the right to change or discontinue the Plan and/or these benefits, in whole or in part, at any time and for any reason.

This Plan is intended to comply with all provisions of the Americans with Disabilities Act (ADA), the Family and Medical Leave Act (FMLA) and the 1996 Health Insurance Portability and Accountability Act (HIPAA). Any Provisions of this Plan found to be in conflict with the ADA, FLMA or HIPAA is amended to comply with these Acts.

11. **The Trustees of the Plan are as follows:**

Employer Trustees	Union Trustees
Michelle Lewis	George J. Orlando, Chairman
John Pepe	Robert A. Blair
Geraldine Senack	James E. Blau, CEBS
	Frank J. Runey

12. **Address for Trustees**

66 Grand Avenue
Englewood, NJ 07631-3545
201-569-8801

XXXIII. DOCUMENTATION OF HEALTH COVERAGE

Important Notice of Your Right to Documentation of Health Coverage

Recent changes in Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12 month (or 18 month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an Employer Group Health Plan, a Certificate of Prior Coverage may help you obtain coverage without a pre-existing condition exclusion. Contact your State insurance department for further information.

For Collectively Bargained Group Health Plans, these changes will generally take effect on the last termination date of the Collective Bargaining Agreements related to the Plan, which were in effect on the day HIPAA was enacted.

You have the right to receive a Certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new Plan Administrator to see if your new Plan excludes coverage for pre-existing conditions and if you need to provide a Certificate or other documentation of your previous coverage.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Disclosure and Use of Protected Health Information

What follows is a Notice of Privacy Practices of the UFCW National Health and Welfare Fund (the "Fund"). The Notice establishes the circumstances under which the Fund may share your protected health information with others in accordance with the Health Insurance Portability and Administrative Accountability Act of 1996 (HIPAA) Privacy Rules.

The Fund may use your protected health information ("PHI") for purposes of making or obtaining payment for your care and conducting health care operations. The Fund has established a policy to guard against unnecessary disclosure of your health information.

YOUR PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED IN THE FOLLOWING CIRCUMSTANCES AND FOR THE FOLLOWING PURPOSES:

To Make or Obtain Payment. The Fund may use or disclose your PHI to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Fund may use or disclose PHI for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants and beneficiaries. Healthcare operations includes such activities as:

a. Quality assessment and improvement activities.
b. Activities designed to improve health or reduce health care costs.
c. Clinical guideline and protocol development, case management and care coordination.
d. Contacting health care providers, participants and beneficiaries with information about treatment alternatives and other related functions.
e. Health care professional competence or qualifications review and performance evaluation.
f. Accreditation, certification, licensing or credentialing activities.
g. Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
h. Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
i. Business planning and development including cost management and planning related analysis and formulary development.
j. Business management and general administrative activities of the Fund, including member services and resolution of internal grievances.
k. Certain marketing activities.

For example, the Fund may use your PHI to conduct case management, quality improvement, disease management, utilization review, or to engage in member service and grievance resolution activities.

For Treatment Alternatives. The Fund may use or disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health Related Benefits and Services. The Fund may use or disclose your PHI to provide to you information on health related benefits and services that may be of interest to you.

For Disclosure to Plan Sponsor. The Fund may disclose your PHI to the Plan Sponsor, the Trustees of the Fund, or for plan administration functions performed by the Trustees on behalf of the Fund. In addition, the Fund may provide summary health information to the Trustees so that the Trustees may solicit premium bids from health insurers or modify, amend or terminate the plan. The Fund may also disclose to the Trustees information on whether you are participating in the plan.

Where Required or Permitted by Law. The Fund also may use or disclose your PHI where required or permitted by law. In that regard, HIPAA generally permits health plans to use or disclose PHI for the following purposes: where required by law; for public health activities; to report child or domestic abuse; for governmental oversight activities; pursuant to judicial or administrative proceedings; for certain law enforcement purposes; for a coroner, medical examiner, or funeral director to obtain information about a deceased individual; for organ, eye, or tissue donation purposes; for certain government-approved research activities; to avert a serious threat to an individual's or the public's health or safety; for certain government functions, such as related to military service or national security; or to comply with Workers' Compensation laws.

Authorization to Use or Disclose Protected Health Information
Most uses of and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI can be made only with an individual's consent. By law, the following types and uses and disclosures of PHI generally require your authorization: use or disclosure of psychotherapy notes, use or disclosure of PHI for marketing purposes, and disclosure of PHI selling purposes. Except as stated above, the Fund will not disclose your PHI other than with your written authorization. If you authorize the Fund to use or disclose your PHI, you may revoke that authorization in writing at any time. If the Plan uses or discloses PHI for underwriting purposes, the Plan is prohibited from using or disclosing genetic information for these purposes.

Your Rights With Respect to Your Protected Health Information

You have the following rights regarding your PHI that the Fund maintains:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. You have the right to request a limit on the Fund's disclosure of your PHI to someone involved in the payment of your care. However, the Fund is not required to agree to your request, except if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law or the PHI pertains solely to a health care item or service for which you, or person other than the Fund on your behalf, has paid the covered entity in full. If you wish to make a request for restrictions, please contact the Fund's Privacy Officer (see Contact Person below).

Right to Receive Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your PHI could endanger you. For example, you may ask that the Fund only communicate with you at a

certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing and mail to the Fund's Privacy Officer (see Contact Person below). The Fund will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Protected Health Information. You have the right to inspect and copy your PHI, with some limited exceptions. A request to inspect and copy records containing your PHI must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). If you request a copy of your PHI, the Fund may charge a reasonable fee for copying, assembly and postage, if applicable, associated with your request.

Right to Amend Your Protected Health Information. You have the right to request an amendment to your PHI records that you believe are inaccurate or incomplete. The request will be considered as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The Fund may deny the request if you do not state why you believe your records to be inaccurate or incomplete. The request also may be denied if your PHI records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend includes information you are not permitted to change, or if the Fund determines the records containing your PHI are accurate and complete.

Right to an Accounting. You have the right to obtain a list of disclosures of your PHI made by the Fund for any reason other than for treatment, payment or health care operations, unless you have authorized the disclosure. The request must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The request should specify the time period for which you are requesting the information. The right to an accounting does not extend beyond six (6) years back from the date of your request. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Copy of this Notice. You have a right to obtain and receive a copy of this Notice at any time, even if you have received this Notice previously. To obtain a copy, please contact the Fund's Privacy Officer (see Contact Person below).

Duties of the Fund
The Fund is required by law to maintain the privacy of your PHI as set forth in this Notice, and to provide to you this Notice of its duties and privacy practices, and to notify affected individuals following a breach of unsecured PHI. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice by providing you with a copy of a revised Notice within sixty (60) days of the change and by making the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The Fund

encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint. An individual has the right to be notified when a breach (as defined in regulations) of his or her unsecured PHI has occurred. An individual has the right to be notified when a breach (as defined in regulations) of his or her unsecured PHI has occurred.

Contact Person

The Fund has designated Glenn L. Di Biasi, Fund Administrator as its contact person ("Privacy Officer") for all issues regarding patient privacy and your privacy rights. You may contact this person as follows:

Glenn L. Di Biasi, Fund Administrator
UFCW National Health and Welfare Fund
66 Grand Avenue
Englewood, NJ 07631-3545
Telephone: 201.569.8801
Facsimile: 201.569.1085

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