UNITED FOOD AND COMMERCIAL WORKERS UNION AND EMPLOYERS CALUMET REGION INSURANCE FUND

Summary Plan Description

2020 EDITION

UFCW

a VOICE for working America

United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund

Summary Plan Description

Effective January 1, 2020

Message from the Board of Trustees

Dear Participant:

The Board of Trustees is pleased to provide this Summary Plan Description of the benefits available through the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund. This booklet replaces any and all booklets that were previously issued. Please read this booklet and keep it in a safe place for future reference. Please share this information with your spouse (if you are married).

Your Health Plan features a cost-effective preferred provider arrangement that allows you to receive health care at lower rates when you use Hospitals and Doctors that belong to the BlueCross BlueShield of Illinois Network. See page 25 for a complete description of how using the network can help you save money on your out-of-pocket costs for health care.

Although this booklet provides essential information about your Health Plan, it is not a complete description. The Health Plan provisions are contained in the Plan document and related documents. If there is ever a conflict between the wording in this Summary Plan Description and the Plan documents, the applicable Plan documents will govern.

The Benefits Fund Office can answer any questions you may have about your benefits. You may call the Benefits Fund Office from 8:30 a.m. to 4:30 p.m., Monday through Friday, at 800-621-5133.

The Board of Trustees

United Food and Commercial Workers
Union and Employers
Calumet Region Insurance Fund
18861 90th Avenue, Suite A
Mokena, Illinois 60448-8467

Important Information

BlueCross BlueShield Participating Provider Option (PPO)

The Health Plan has made arrangements with certain Doctors, Hospitals, and immediate care centers to provide health care to you and your eligible dependents at lower rates than they would normally charge. In addition, the Plan pays a greater percentage of your Hospital expenses when you use BlueCross BlueShield participating Hospitals. This arrangement helps you save money on your out-of-pocket costs for health care and reduces the Health Plan's costs, as well.

To locate a provider, visit www.bcbs.com or call 800-810-2583.

Tobacco Use Affidavit

Effective January 1, 2020, if you are enrolled in a Calumet Health Plan, the Fund will apply a tobacco surcharge if you use tobacco products or have used tobacco products within six months prior to enrolling in the Plan. Tobacco products are defined as tobacco or tobacco-like products intended for human consumption, and when used orally or inhaled, produce smoke or smoke-like vapor. This includes but is not limited to cigarettes, cigars, loose tobacco smoked via pipe or hookah, chewing tobacco, snuff, dip, electronic cigarettes and vaporizers.

Tobacco Surcharges are not imposed on Eligible Employees under Classification G1 who have declined coverage. Weekly tobacco surcharges as follows are determined by the Trustees in their sole discretion and may change from time to time:

Effective 1/1/2020: $30.00 per week
Effective 1/1/2021: $40.00 per week

Outside of your open enrollment period, you are only eligible to remove the tobacco surcharge after certifying that you have been tobacco-free for the prior six months.

Note: If you complete a tobacco cessation program, you may avoid the tobacco surcharge.

Spousal Coverage

Effective January 1, 2019, if you are an Employee who is receiving benefits through the Plan, your spouse will not be eligible for coverage under this Plan if they have alternative coverage available to them, or if there is not a completed spousal coverage application on file with the Benefits Office.

If your spouse is eligible for other health care coverage through an employer plan, regardless of the cost to your spouse, he or she must take that coverage or he or she will not be covered under the Plan. If your spouse's employer does

not offer health care coverage or if your spouse is not eligible for the coverage offered, you need to complete and submit the Election and Payroll Deduction Authorization Form for Health Benefits Coverage. Failure to complete and submit the

form will result in the Fund denying claims. Any election of family coverage must have a completed "Working Spouse" section of the form.

If your spouse is employed, there may be instances where your spouse may prefer to purchase a private insurance policy rather than elect his or her employer's coverage. In these instances, your spouse may elect to purchase private insurance, provided it is comprehensive coverage that is comparable to your spouse's employer's coverage. The Fund will then consider this private insurance policy as your spouse's other coverage and your spouse will continue to be covered under the Plan.

If your spouse has other coverage, either through an employer plan or a private insurance policy, the Fund will pay benefits second, after the other coverage. This provision helps manage the Fund's healthcare costs. While this provision is beneficial in helping the Fund reduce expenses, it is also beneficial for your spouse because your spouse will have coverage through more than one plan.

It is your responsibility to notify the Fund if your spouse has other coverage through an employer or private policy. If the Fund learns that your spouse has other coverage and does not notify the Fund or refuses to take the available coverage, your spouse will no longer be covered under the Fund's Plan.

If your spouse is employed, his or her employer will be required to complete the Fund's Spousal and Dependent Insurance Form and submit it to the Fund Office. If your spouse's employer does not offer health care coverage or if your spouse is not eligible for the coverage offered, the employer will indicate this on the form.

If your spouse is eligible for other coverage and does not enroll for that coverage when eligible, your spouse's coverage under this Plan will generally end as of the date your spouse is eligible for such other coverage. In addition, benefits will be backdated to the date your spouse could have enrolled in the other coverage.

The Fund may rescind or retroactively terminate coverage as permitted by applicable law and as stated in this SPD based upon fraud or a misrepresentation of a material fact.

Claims Administrator(s)

The Fund Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Zenith American Solutions 18861 90th Avenue, Suite A Mokena, IL 60448 800-621-5133 or 312-649-1200 zenith-american.com	• Medical Post-Service Claims • Pre-Service Claims • Mental Health Urgent, Concurrent and Pre-Service Claims • Substance Abuse Urgent, Concurrent and Pre-Service Claims • Income Protection Benefit Claims • Death Benefit Claims • Accidental Death and Dismemberment Claims • Vision Pre-Service and Post-Service Claims • Dental Pre-Service and Post-Service Claims • Hearing Post-Service Claims
Medical Cost Management (MCM) 1-800-367-9938	• Urgent, Concurrent and Pre-service Medical Claims
WellDyneRx 500 Eagles Landing Drive Lakeland, FL 33810 1-888-479-2000 https://members.welldynerx.com	• Pre-service drugs • Post-Service Claims for out-of-network retail drugs

Section 1557 Nondiscrimination Notice

The United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - o Qualified sign language interpreters, and

- Written information in other formats (large print, audio, accessible electronic formats, and other formats).

- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters, and
  - Information written in other languages.

If you need these services, please contact:

Joshua Todd
Fund Administrator
18861 90th Avenue, Suite A
Mokena, Illinois 60448
Phone: (630) 974-4515
jotodd@zenith-american.com

If you believe that the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Joshua Todd
Fund Administrator
18861 90th Avenue, Suite A
Mokena, Illinois 60448
Phone: (630) 974-4515
jotodd@zenith-american.com

You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, Fund Administrator Joshua Todd is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
(800) 868-1019, (800)537-7697(TDD)

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html

- (English) ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-618-233-7978

- (Spanish) ATENCIÓN: si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-618-233-7978

- (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-618-233-7978

- (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-618-233-7978

- (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-618-233-7978

- (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-618-233-7978

- (Serbo-Croatian) OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-618-233-7978

- (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-618-233-7978 번으로 전화해 주십시오.

- (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-618-233-7978

- (Arabic) 1-618-233-7978 تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم حلموظة: إذا كنت

- (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-618-233-7978

- (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-618-233-7978

- (Pennsylvania Dutch) Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-618-233-7978

- (Hindi) □ान द□: य□द आप □हदी बोलते ह□तो आपके □लिए म□ुत म□ भाषा सहायता से□वाएं उपल□ ह।□ 1-618-233-7978 पर कॉल कर□।

- (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-618-233-7978）まで、お電話にてご連絡ください。

- (Persian) 1-618-233-7978 امکان برای مشتریانی که به زبان فارسی گفتگو می‌کنند، خدمات زبانی بصورت رایگان در دسترس است. با شماره

- (Urdu) اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کر 1-618-233-7978 خبردار:

- (Gujarathi) □ચના: જો તમે □જરાતી બોલતા હો, તો નિ:□લ્ક ભાષા સહાય સે□વાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 1-618-233-7978

- (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-233-7978

- (Dutch) AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-618-233-7978

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Summary of Benefits

The following chart highlights key features of your Plan.

Dependent Coverage and the level of certain benefits are provided only to Employees who qualify for their employer's regular full-time contribution.

Income Protection Benefit for You	
Maximum benefit, if full-time	55% of weekly earnings, up to $161 per week
Maximum benefit, if part-time	55% of weekly earnings, up to $49 per week
Maximum payment period	26 weeks
Benefits begin	1st day of an accident 1st day of Hospital confinement 1st day of outpatient surgery 8th day of sickness
Death Benefit for You, if full-time	$5,000
Death Benefit for You, if part-time	$3,000
Accidental Death & Dismemberment for You	Up to $10,000 determined by severity of Injury

Comprehensive Medical Expense Benefit for You (and Your Dependents, if covered)	
Calendar Year Deductible	
Per person	$1,000
Maximum per family	$3,000 (applies if you have eligible Dependents. Each family member must meet their own individual deductible until the overall family deductible is met)
Calendar Year Medical Out-of-Pocket	
Maximum per person	$3,000 per person,
Maximum per family	$9,000 per family (applies if you have eligible Dependents. Each family member must meet their own individual out-of-pocket maximum until the overall family out-of-pocket maximum is met)
Non-PPO Hospital Copay	$550
Non-Compliance Deductible	$100 (applies to each Hospital confinement, surgery, advanced diagnostic testing, or other service where pre-authorization is required but not obtained)

Covered Expenses Payable by the Plan per Calendar Year

Hospital, Emergency Room Care and Surgery	
PPO and Out-of-Area Hospital	Plan pays 90% after deductible*
Non-PPO Hospital	Plan pays 75% of a discounted fee after deductible*
Emergency Room Care	
PPO and Non-PPO	Plan pays 90% after deductible*
Emergency Medical Transportation	
PPO	Plan pays 80% after deductible
Non-PPO Hospital	Plan pays 80% of a discounted fee after deductible
Surgery for which a Second Surgical Opinion is required but not obtained	Plan pays 50% after deductible
Inpatient Rehabilitation	
PPO and Out-of-Area	Plan pays 90% after deductible
Non-PPO	Plan pays 75% of a discounted fee after deductible
Outpatient Surgery	
PPO	Plan pays 80% after deductible*
Non-PPO	Plan pays 80% of a discounted fee after deductible*
Doctor and Urgent Care Services	
Primary Care/Specialist Visit	
PPO	Plan pays Plan pays 80% after deductible
Non-PPO	Plan pays 80% of a discounted fee after deductible
Urgent Care	
PPO	Plan pays Plan pays 80% after deductible
Non-PPO	Plan pays 80% of a discounted fee after deductible
Most other Covered Expenses (unless otherwise noted)	Plan pays 80%
Preventive Care	
ACA-Required Preventive Care (PPO)	Plan pays 100%; not subject to deductible

Preventive Care *(continued)*	
Diagnostic Testing	
PPO	Plan pays 80% after deductible; deductible does not apply to outpatient lab tests.
Non-PPO	Plan pays 75% of discounted fee after deductible; deductible does not apply to outpatient lab tests.

Mental Health and Substance Use Disorder	
Outpatient:	
PPO	Plan pays 80% after deductible
Non-PPO	Plan pays 80% of a discounted fee after deductible
Inpatient	
PPO	Plan pays 90% after deductible*
Non-PPO	Plan pays 75% of a discounted fee after deductible*

Home Health Care	
PPO	Plan pays Plan pays 80% after deductible
Non-PPO	Plan pays 80% of a discounted fee after deductible

Covered Services and Supplies with Benefit Limitations	
Chiropractic Therapy	
PPO	Plan pays 80% after deductible
Non-PPO	Plan pays 80% of a discounted fee after deductible
Calendar Year Maximum	$2,200 per person
Physical Therapy (including prolo therapy and acupuncture), Occupational Therapy or Speech Therapy	Plan covers up to 25 sessions per acute occurrence
PPO	Plan pays 80% after deductible
Non-PPO	Plan pays 80% of a discounted fee after deductible
If not pre-authorized	Plan pays 50% for more than 25 sessions
Cardiac and Pulmonary Rehabilitation	Plan covers up to 30 sessions per acute occurrence
PPO	Plan pays 80% after deductible
Non-PPO	Plan pays 80% of a discounted fee after deductible

Covered Services and Supplies with Benefit Limitations *(continued)*

Nutritional Counseling/Bariatric Treatment and Management/ Bariatric Surgery (pre-authorization required)	
PPO	Plan pays 80% after deductible*
Non-PPO	Plan pays 80% of a discounted fee after deductible*
Nutritional Counseling Calendar Year Maximum	Plan covers up to 4 visits per person
Bariatric Treatment and Management Calendar Year Maximum	Plan covers up to 6 Doctor visits per person if Body Mass Index (BMI) is 30 or greater and when part of a comprehensive treatment plan
Durable Medical Equipment	
PPO	Plan pays 80% after deductible*
Non-PPO	Plan pays 80% of a discounted fee after deductible*
Skilled Nursing Care & Hospice	
PPO	Plan pays 80% after deductible
Non-PPO	Plan pays 80% of a discounted fee after deductible
If in residential care center or Hospital	Pre-authorization required
Pain Management Treatment	Plan covers up to 25 sessions per acute occurrence
PPO	Plan pays 80%
Non-PPO	Plan pays 50%
IV sedation	Pre-authorization required for IV sedation in conjunction with outpatient epidural or other pain management interventional injections or procedures
Hearing Aid	Plan pays 80% for up to $500 per person in any 5-consecutive year period
Intentionally Destructive Act	Plan pays 50% (except if act caused by or related to an underlying health condition)
Hospital Expenses for Dental Surgery	Plan pays 50% of covered expenses
Treatment of Varicose Veins (if medically necessary)	$2,200 per leg per lifetime
Voice Communication Machine	$7,500 per lifetime

Prescription Drug Benefit for You (and Your Dependents, if covered)	
Out-of-Pocket Maximum	$4,850 per person/$7,200 per family
Dispensing Limitation	30-day supply (retail); 90-day supply for maintenance drugs (retail and mail order) and for all other drugs (mail order)
Co-payment for 30-day supply:	
Tier Zero—Designated ACA Drugs and Supplies	$0
Tier One—Preferred Generic Drugs	$10
Tier Two—Most Generic Drugs	$21
Tier Three—Preferred Brand Name Drugs	$40
Specialty Drugs	$40
Co-payment for 90-day supply of a Maintenance Drug:	
Tier Zero—Designated ACA Drugs and Supplies	$0
Tier One—Preferred Generic Drugs	$12
Tier Two—Most Generic Drugs	$36
Tier Three—Preferred Brand Name Drugs	Not Covered
Specialty Drugs	Not Covered

Vision Benefit for You (and Your Dependents, if covered)	
Individuals age 19 and over (for one exam and glasses; or one exam and contact lenses)	Plan pays 100% up to $100 per person once per Calendar Year
Individuals under age 19 (for one exam and glasses; or one exam and contact lenses)	Plan pays 100% per Calendar Year

Dental Benefit for You (and Your Dependents, if covered)	
Individuals age 19 and older	Plan pays 100% up to $150
Individuals under age 19 (for one exam, two cleanings, filling and x-rays)	Plan pays 100% per Calendar Year

* Subject to the Non-Compliance Deductible
** Deductible does not apply to outpatient lab tests

Eligibility Provisions

Many employers and the United Food and Commercial Workers Local Union 881 have entered into Collective Bargaining Agreements or labor contracts that require the employer to contribute to the Fund on behalf of its eligible Employees. You are also required to contribute weekly to receive benefits from the Plan.

To become covered, you must elect coverage and agree to a weekly contribution made by payroll deduction. If you elect coverage, the weekly payroll deduction will be made under an Internal Revenue Code Section 125 "Cafeteria" Plan that your employer has adopted. Under the Plan, no federal or state tax is withheld from or due on your contribution amount.

To receive single or family coverage, you must sign an election and payroll reduction agreement pursuant to the Cafeteria Plan authorizing your employer to reduce your weekly pay by the amount equal to your coverage election amount. Election and payroll reduction agreements are to be executed before the start of the year.

The Trustees of the Fund determine the plan of benefits that applies to the eligible Employees of each employer. You and your eligible dependents become covered after you satisfy the eligibility requirements that are described in this section.

Initial Eligibility

NOTE: No benefits can be paid unless you elect coverage and provide the Fund with enrollment information.

Eligibility for Plan coverage differs for Employees who are subject to rate-per-hour contributions or flat-rate contributions made by their Contributing Employers pursuant to the applicable Collective Bargaining Agreement. In addition, coverage may differ for Employees who are required to make self-contributions. Generally,

- If you are subject to rate-per-hour contributions, you will be eligible for all benefit coverages (except for the Income Protection Benefit) if you have worked an average of at least 12 hours per week during the weeks that end in each of two full consecutive months, and if your employer has made contributions for the aforementioned two full consecutive calendar months.

  You will be eligible for the Income Protection Benefit if you work an average of at least 12 covered hours per week during each month, and an average of at least 28 hours per week during the weeks that end in two of the three preceding calendar months. Your employer must also make contributions for two of the aforementioned full consecutive calendar months.

- If you are subject to flat-rate contributions, you will be eligible for coverage if you work the minimum number of hours within the period

of time required by the applicable Collective Bargaining Agreement for either a full-time or part-time Employee. Your employer must also make contributions for the number of hours within a period of time required by the Collective Bargaining Agreement.

- If you are a Plan Classification G1 Employee, you are subject to a flat-rate contribution and you must elect coverage and pay a weekly self-pay contribution via payroll deduction. The weekly self-pay contribution payroll deduction amount will be established by the Trustees.

To further clarify when you and your Dependents will be eligible for coverage, note that:

- If your employer makes a full-time contribution on your behalf, your Dependents are eligible for coverage.
- If your employer makes a part-time contribution on your behalf, your dependents are not covered (only you are eligible).
- If a contribution is not made on your behalf, you and your dependents are not eligible.
- If you do not elect to make a required contribution, you and your dependents are not eligible.

You and your dependents, if covered, first become eligible on the first day of the month for which your employer makes the required monthly contribution on your behalf.

NOTE: For Group G1 (IGG employees covered by Local 881 Collective Bargaining Agreement requiring payroll deductions), an Election for Family coverage with the appropriate payroll deduction is required.

Continuing Eligibility

Generally, your coverage continues if you work the required number of hours per week, you continue to make contributions, and your employer continues to make the required monthly contribution on your behalf.

Your eligible dependents' coverage generally continues as long as you remain eligible and both your and your employer's contributions are made.

Termination and Reinstatement of Eligibility

Your eligibility for all benefits will end when either your or your employer's contributions are no longer made. Coverage is reinstated when you again meet the eligibility requirements.

You may be eligible to make self-payments to continue coverage under COBRA. See COBRA Continuation Coverage beginning on page 14 for more information.

Special Enrollment Periods

If you, or any of your dependents, lose eligibility under another group health plan (or if an employer stops contributing toward your or your dependent's other coverage), you may be eligible for a special enrollment period. However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your eligible dependent(s). However, you must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption. If you fail to enroll a newly eligible dependent or provide evidence of your dependent's eligibility on time, coverage begins on the first of the month following the day you sufficiently complete the enrollment (coverage is not retroactive to the date of birth, marriage, adoption or placement for adoption). In addition, the Plan is not responsible for any bills or charges incurred prior to the coverage effective date.

Two additional circumstances allow for a special enrollment period:

- Your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent become eligible for a subsidy under Medicaid or CHIP.

In either of these circumstances, you must enroll yourself or your eligible dependent within 60 days after you or your dependent are terminated from, or determined to be eligible for, such assistance.

To request a special enrollment period or obtain more information, contact the Fund Office. You are responsible for advising the Fund Office of any changes in address, beneficiaries or dependents.

Termination of Coverage

Your coverage will terminate on the earliest of the following dates:

- the last day of the month in which you stop being actively employed or cease working the hours required to qualify for employer contributions for coverage;
- the first day of the month in which any self-payment is due and unpaid;
- the last day of the month in which you are no longer disabled, if an extension of coverage due to disability is provided for in the Collective Bargaining Agreement;
- 31 days after the date you enter full-time military service;

- the date your employer ceases to participate in the Plan; or
- the date the Plan ends.

(Note: If your employer fails to make contributions due for 90 days after their due date, the Trustees may, by resolution, terminate your participation in the Plan.)

Your dependents will lose coverage on the earliest of the following dates:

- the last day of the month in which you become ineligible for coverage; or
- the first day of the month for which your contribution is not made;
- the first day of the month for which a full-time employer contribution is not made on your behalf; or
- the last day of the month in which your dependent fails to meet the definition of an eligible dependent (as listed below); or
- the last day of the month in which you and your spouse divorce (coverage for your spouse ends on the date of your divorce). It is your responsibility to advise the Fund Office when a divorce occurs. If the Plan continues to provide benefits after a divorce because you did not notify us, you may be liable for reimbursing the Plan for any such benefits paid.

You may be eligible to make self-payments to continue coverage under COBRA, for both you and your eligible dependent(s). See *COBRA Continuation Coverage* for more information.

Eligible Dependents

Your eligible dependents are:

- your lawful spouse, unless that spouse has alternative coverage available to him or her; and
- your children through the end of the month in which they turn age 26.

Your children include:

- your natural children;
- your legally-adopted children or those for whom adoption proceedings have been started and who have been placed in your home by a licensed placement agency for the purpose of adoption, or those who have been living in your home as foster children for whom foster care payments are being made and a petition for adoption has been filed; and
- your stepchildren.

A child who has reached age 26 but is unmarried and incapable of self-sustaining employment because of intellectual disability or physical handicap is covered provided:

- the incapacity began before the child attained age 26,
- the child resides with you and is permanently and regularly dependent upon you for more than one-half of the year or lives in a treatment center and is primarily dependent upon you for more than on-half of their financial support and maintenance, and
- you provide satisfactory proof of the child's incapacity after the child reaches age 26. Subsequent proof of continuing incapacity may be required by the Fund.

Legal documentation of your dependent's status, such as by an original registered marriage certificate, certified government-issued birth certificate or divorce decree, may be required by the Benefits Fund Office.

If both spouses are eligible as full-time Employees, their dependent children are covered as dependents under each spouse.

You should complete and return a "Dependent Coverage Registration Form" as soon as you receive it from the Benefits Fund Office. This will help to ensure that your dependents can be considered for all health benefits for which they are eligible.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order that requires a participant to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation, or a paternity dispute. Coverage will be provided to a child identified as an alternate recipient under a QMCSO, even if that child was not covered under the Plan due to custody-related issues.

The Benefits Fund Office will notify affected participants and alternate recipients if a QMCSO is received. If you, your child or the child's custodial parent or legal guardian would like a copy at no charge of the Plan's written procedure for QMCSOs, or have any questions, please contact the Benefits Fund Office.

Disability

If you become disabled because of Illness or Injury, your eligibility may continue, as provided by the terms of your Collective Bargaining Agreement. When you return to work, you will be eligible for the same coverage that you had immediately prior to the date of your disability.

Special Rules for Continuing Eligibility

You may remain eligible for benefits under the Plan when your eligibility would otherwise end if you qualify under one of the following conditions.

Military Service

If you are inducted into the armed forces of the United States or if you enlist in military service, your eligibility and your dependents' eligibility will end. However, coverage for you and your dependents may be continued if you satisfy the eligibility criteria of the Uniformed Service Employment and Reemployment Rights Act of 1994, as amended (USERRA).

If you are called into uniformed service for fewer than 31 days, your medical, prescription drug, dental, and vision coverage during that leave period will be continued, provided you pay your share of the premium as established by the Trustees from time to time. Contact the Benefits Fund Office to determine the amount you must contribute to continue your coverage during a leave of fewer than 31 days.

If you are called into uniformed service for 31 or more days, you can continue your coverage for up to 24 months after your coverage under the Plan would otherwise terminate (termination provisions are described on pages 7 and 8). If you fail to provide advance notice of your uniformed service, you will not be eligible to continue coverage unless the failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees determine that your failure to provide advance notice is excused, you may then elect to continue coverage and pay all amounts required to continue coverage in accordance with the COBRA election and payment procedures described on page 17. Your continuation coverage will then be effective retroactive to the date you lost coverage due to your leave of absence to perform uniformed service.

If the Benefits Fund Office has been notified that you are entering the uniformed service, you shall have the option of continuing the same class of coverage under the Plan. Election, payment and termination of this USERRA continuation coverage will be governed by the election, payment and termination rules for COBRA Continuation Coverage, described beginning on page 14, provided the COBRA rules do not conflict with USERRA.

COBRA and USERRA coverage run concurrently. This means that if you are not simultaneously eligible for COBRA and USERRA, then you will be entitled to the more generous benefit provisions under each law for periods in which you remain eligible for both forms of continuation coverage. If you fail to follow the COBRA rules when electing and paying for USERRA coverage, you may lose the right to continue coverage under USERRA. Once lost, the right to USERRA continuation coverage cannot be reinstated.

However, if circumstances make it otherwise impossible or unreasonable for you to timely elect and pay for USERRA continuation coverage, the Trustees may, in their sole discretion, reinstate your right to USERRA continuation coverage, provided you pay all amounts required for such continuation coverage.

If you are discharged from the uniformed service under honorable conditions and have USERRA reemployment rights, eligibility for you and your eligible dependents may be reinstated on the date you return to work in Covered Employment or make yourself available for work in Covered Employment, provided your return to work is within 90 days from the date of your discharge or such shorter or longer period required by law if you serve less than 180 days or are Hospitalized when your military service is terminated.

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993, you may qualify to take up to 12 weeks of unpaid leave for a serious Illness, to care for your newborn child or newly adopted child, to care for your seriously ill spouse, parent or child, or for a spouse, parent or child who is notified of an impending call to active duty.

You may qualify to take up to 26 weeks of unpaid leave to care for a spouse, parent, child or nearest blood relative who is recovering from an Illness or Injury sustained while on active duty.

If the Family and Medical Leave Act applies to your employer (small employers are exempt), it requires your employer to maintain your health coverage for the length of your leave (up to 12 weeks) as if you were actively at work. The Act also states that if you take a Family and Medical Leave, you cannot lose any benefits accrued before the leave.

The Fund will grant eligibility for a Family and Medical Leave and will maintain your current eligibility status for the duration of the leave, provided your employer properly grants the leave of absence under the federal law and makes the required contributions to the Fund on your behalf.

If you do not return to work after your leave and you are no longer eligible to continue health coverage under the Plan, COBRA Continuation Coverage may become available.

Contact your employer if you believe you may be entitled to a leave under the Family and Medical Leave Act.

Rescission of Coverage

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you and/or your eligible dependent(s) should not have been covered by the Plan.

The Plan may rescind your or your dependent's health coverage (but not your Income Protection benefit) for fraud or intentional misrepresentation of a material fact after the Plan provides you and your eligible dependent(s) with 30 days' advance written notice of that rescission of coverage. There are certain situations wherein the Plan will not be required to give you 30 days' advance written notice. You can contact the Benefits Fund Office at 800-621-5133 for further information.

However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days' advance written notice:

- When the Plan terminates an Eligible Employee and/or his or her Eligible Dependent's coverage retroactive to the date that Eligible Employee and/or Eligible Dependent loses eligibility for coverage, if there is a delay in administrative recordkeeping between the date that Eligible Employee and/or Eligible Dependent loses eligibility and the date the Plan is notified of that Eligible Employee and/or Eligible Dependent's loss of eligibility;

- When the Plan retroactively terminates an Eligible Employee and/or his or her Eligible Dependent's coverage because that Eligible Employee and/or Eligible Dependent fails to make timely self-payments for his or her coverage; or

- When any unintentional mistakes or errors result in an Eligible Employee and/or his or her Eligible Dependent(s) being covered by the Plan when that Eligible Employee should not have been covered, the Plan will cancel that Eligible Employee and/or his or her Eligible Dependent's coverage prospectively–for the future–once the mistake is identified.

COBRA Continuation Coverage

In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Plan offers you and your eligible dependents the opportunity to continue medical, prescription drug, dental, and vision coverage by making self-payments when coverage would otherwise end.

You may elect to continue coverage for Medical, Dental, Prescription Drug and Vision Benefits.

Death, Accidental Death and Dismemberment, and Income Protection Benefits cannot be continued.

Qualifying for COBRA

To qualify for COBRA coverage, you or your eligible dependent must experience a qualifying event that would otherwise cause your coverage to end.

A qualifying event for you is:

- a reduction in the number of hours worked; or
- a termination of employment for any reason (including retirement) other than gross misconduct.

For an eligible dependent, a qualifying event may be:

- your death;
- a reduction in the number of hours you work;
- termination of your employment (including retirement) for any reason other than gross misconduct;
- your divorce;
- your entitlement to Medicare; or
- the loss of dependent status.

If you or your eligible dependent have a qualifying event, you need to notify the Benefits Fund Office in writing within 60 days of the loss of coverage. Even though a notice is required from your employer, the Plan recommends you contact the Fund Office as soon as possible if you (or a dependent) have a qualifying event.

If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA coverage is in effect, you may add this child to your coverage if you were eligible for Dependent Coverage when you elected COBRA coverage. Any dependent

child added to your coverage during a period of COBRA continuation coverage will have his or her own right to elect COBRA continuation coverage.

You must submit an original, certified birth certificate issued by the appropriate governmental agency. In the case of adoption, you must submit legal documentation indicating the initiation and/or finalization of the adoption process.

If you get married while your COBRA coverage is in effect, you may add your spouse to your coverage if you were eligible for Dependent Coverage when you elected COBRA coverage. A copy of your marriage license may be required by the Benefits Fund Office. A spouse added to your coverage during a period of COBRA continuation coverage will not have his or her own right to elect COBRA continuation coverage.

Proof of good health is not required to obtain COBRA coverage.

Continuation Coverage Period

The COBRA coverage period depends on the type of qualifying event that caused loss of eligibility under the Plan.

Generally, COBRA coverage will remain in effect for a period of 18 months (or up to 29 months for disabled individuals, as described below) if the qualifying event is:

- a reduction in the number of hours you work; or
- termination of your employment (including retirement) for any reason other than gross misconduct.

COBRA coverage will continue for a maximum period of 36 months if the qualifying event is:

- your death;
- divorce;
- your entitlement to Medicare; or
- the loss of dependent status.

Extension of Coverage Period for a Second Qualifying Event

If your family experiences a second qualifying event while receiving 18 months of COBRA coverage because of a reduction in the number of hours you work or termination of employment, your eligible dependents can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Benefits Fund Office.

This extension is available to your eligible dependents if one of the following events occurs and would have caused the eligible dependent to lose coverage under the Plan if the first qualifying event had not occurred:

- your death;
- divorce;
- your entitlement to Medicare; or
- the loss of dependent status.

Coverage for Disabled Individuals

If you or any of your eligible dependents are disabled (as determined by Social Security) at the time or within 60 days of the date your employment ends or your hours are reduced, COBRA coverage can be extended an additional 11 months, to a maximum period of 29 months. The extension applies to the disabled person and any other covered family members. For coverage to continue, the Benefits Fund Office must be notified:

- before the 18-month period ends; and
- within 60 days of the date of disability.

Any period of extended coverage during disability provided at no cost will reduce the period allowed for COBRA coverage by a period equal to the extended coverage.

Proof of disability must be given. The premium payment for this extended coverage may be higher than that for COBRA coverage.

The Benefits Fund Office must also be notified within 30 days of any subsequent determination by Social Security that the disabled individual is no longer disabled.

Termination of COBRA Coverage

Once COBRA coverage is elected, it will stay in effect until the earliest of the following:

- the date you or your eligible dependent complete the maximum period of COBRA coverage for which you or your eligible dependent are eligible;
- the date a self-payment is not paid on time;
- the date after your COBRA election date that you or your eligible dependent become covered under any other group health plan;
- the date after your COBRA election date that you or your eligible dependent(s) become entitled to Medicare;

- the date the Plan terminates; or
- the date your employer ceases to provide any group health plan to any Employee.

COBRA Premium Payments

After the Benefits Fund Office receives your form electing COBRA coverage, you will be mailed a statement showing the amount due. You will then have 45 days from the date of election to pay the full amount due. COBRA coverage will not be effective until full payment is made.

When you elect COBRA coverage, you must make your COBRA payments on time in order to keep your coverage in effect. If you are late with your payments, your coverage will be terminated. You will receive more information regarding premium amounts and due dates after you experience a qualifying event.

Premium payments must be sent to the Benefits Fund Office at: 18861 90th Avenue, Suite A, Mokena, Illinois 60448-8467.

The Benefits Fund Office has the capability to collect your monthly COBRA payment directly from your bank account through electronic transfer. You may wish to consider this option. Don't let a late or lost COBRA check jeopardize your coverage.

Contact the Contribution Accounting Department at the Benefits Fund Office to request the *Authorization Agreement for Electronic Transfer of Payments for COBRA*.

COBRA Notice Procedures

General Notice of Continuation Coverage. An initial general notice describing COBRA rights will be given to you (and your spouse, if you are married) when you become covered under the Plan and will contain the information required by COBRA. The Benefits Fund Office may provide this notice in a summary plan description ("SPD") furnished in accordance with the paragraph below.

The general notice will be provided no later than 90 days after you become covered under the Plan. If, on the basis of the most recent information available to the Benefits Fund Office, you and your spouse reside at the same location and your spouse becomes covered under the Plan on or after the date you become covered (but not later than the date on which the notice required by this section is required to be provided to the Participant), the Benefits Fund Office may mail you and your spouse a single notice or SPD.

Notice of Qualifying Events. If the qualifying event that occurs is the termination of employment or reduction of hours of employment, your death or entitlement to Medicare benefits, the employer must notify the Benefits Fund Office of the qualifying event. However, you or another family member should

notify the Benefits Fund Office if any of these qualifying events occurs to assure that you receive COBRA election materials as soon as possible.

If you or your eligible dependent have a qualifying event or second qualifying event that is a divorce or a dependent child's loss of eligibility for coverage as a dependent, you need to notify the Benefits Fund Office in writing within 60 days. You may be asked to provide verification in the form of a copy of your divorce decree, certified copy of your marriage certificate, etc. You or your eligible dependent will be ineligible for COBRA coverage or extended COBRA coverage (in the case of a second qualifying event) if you or your dependent fail to timely notify the Benefits Fund Office.

You must promptly notify the Benefits Fund Office if you and your spouse become divorced. If you fail to do so and your former spouse continues to claim or receive benefits under the Plan, you and your spouse can be subject to loss of benefits, lawsuits and criminal charges. In addition, it is your responsibility to understand your marital status and to inform the Benefits Fund Office when a qualifying event has occurred.

As noted above, you must also notify the Benefits Fund Office of a disability determination before the 18-month period ends and within 60 days of the date of disability. In addition, the Benefits Fund Office must be notified within 30 days of any subsequent determination by Social Security that the disabled individual is no longer disabled.

The notice of a qualifying event or disability determination must be in writing and must include sufficient information to enable the Plan Administrator to determine the following information:

- the Plan;
- the covered Participant and qualified beneficiaries;
- the type of qualifying event or disability determination; and
- the date on which the qualifying event occurred or the disability determination was made.

A notice that does not contain all of the required information will not be considered notice of a qualifying event. If you do not timely provide all of the information necessary to meet the content requirements, you will lose the right to elect or extend continuation coverage.

Notice of Right to Elect COBRA Coverage. Once notified, the Benefits Fund Office will mail you the necessary forms to enable you to elect the COBRA coverage. When you receive the forms, you will have 60 days from the date of the Benefits Fund Office's notification letter in which to elect or decline COBRA coverage. You or your eligible dependent will be ineligible for COBRA coverage if you do not timely elect COBRA coverage.

This notice will be written in a manner calculated to be understood by the average Plan participant and shall contain the information required by COBRA. The notice will be provided by first class mail no later than 14 days after the Benefits Fund Office receives notice that a qualifying event has occurred.
If, on the basis of the most recent information available to the Benefits Fund Office, you and your spouse reside at the same location, the Benefits Fund Office may provide a single notice addressed to both you and your spouse.

The Benefits Fund Office may provide notice to a dependent child by furnishing a single notice to you or your spouse if, on the basis of the most recent information available, the dependent child resides at the same location as the parent to whom the notice is provided.

Address Changes

To protect your family's rights, you should keep the Benefits Fund Office informed of any changes to the addresses of family members.

More Information

This notice may not contain all information about your rights under the Plan. If you have any questions or need more information, contact the Benefits Fund Office.

Cost Containment Features of the Health Plan

Your Health Plan includes programs designed to manage your costs for health care and ensure that you get the most out of the benefits available to you and your family.

The *Pre-Authorization Review Program* provides pre-authorization review services for Hospital admissions, surgeries, advanced testing and home health care through Medical Cost Management (MCM). The use of this program lets you be assured that your medical treatment is covered under the Plan and received in an appropriate and cost-effective manner.

The *Second Opinion Program* helps to determine whether a proposed surgery is Medically Necessary or whether an effective alternative approach exists.

The Plan also offers you further opportunity to save on your out-of-pocket costs for health care through the *BlueCross BlueShield of Illinois Participating Provider Network*. Participants in this network of Hospitals and Doctors agree to provide medical services at a lower rate than they normally charge. This means that your share of the cost for covered services is automatically reduced.

The ultimate decisions regarding your medical care must be made by you or your Doctor. The Pre-Authorization and Second Opinion Programs only determine the medical necessity of a service or supply according to the Plan's benefits and provisions.

The Plan and the Board of Trustees do not express opinions regarding the quality of care or services rendered by a Participating Provider.

Pre-Authorization

Your Health Plan requires pre-authorization of certain expenses. If you do not obtain the required pre-authorization, the expense may not be covered, benefits may be reduced and an additional $100 Non-Compliance Penalty may be applied.

Treatment Type	When to Contact Medical Cost Management (MCM)
Scheduled Hospital admission	Two weeks before you are admitted to the Hospital (Non-Compliance Penalty applies)
Emergency Hospital admission	As soon as possible or within 48 hours of the admission (Non-Compliance Penalty applies)

Admission for childbirth (this is considered a scheduled admission) unless the Hospital admission is less than 48 hours postpartum for a vaginal delivery or less than 96 hours postpartum for delivery by caesarian section	Any time during pregnancy (must be before admission) (Non-Compliance Penalty applies without pre-authorization after 48 hours for vaginal delivery and 96 hours for caesarian delivery)
Surgery, inpatient or outpatient	Two weeks before you are scheduled for surgery (Non-Compliance Penalty applies)
Skilled nursing facility care Rehabilitation therapy Home health care Hospice care Durable medical equipment (No coverage unless pre-authorized)	Before care or before purchase or rental of equipment
Advanced diagnostic tests such as MRI or CT scans or Thallium stress tests (Non-Compliance Deductible applies)	Before care
Ultrasound guidance for outpatient arthrocentesis for therapeutic joint injections (Non-Compliance Deductible applies)	Before care
IV sedation utilized in conjunction with outpatient epidural or other pain management interventional injections or procedures (Non-Compliance Deductible applies)	Before care

When to Notify Medical Cost Management (MCM)

Pre-authorization must be done by MCM at the Benefits Fund Office, not by BlueCross BlueShield—you or your Doctor should speak directly with MCM.

Inpatient Hospital Admission. You must contact MCM at least two weeks before the start of the Hospital stay. If you do not pre-authorize your Hospitalization, an additional $100 Non-Compliance Deductible will be applied. This penalty does not apply to maternity stays that are less than 48 hours postpartum for a vaginal delivery and less than 96 hours postpartum for delivery by caesarian section.

Emergency Care. When emergency care is required that results in you or an eligible dependent being admitted to the Hospital, contact MCM within 48 hours of the admission. If you do not contact MCM, an additional $100 Non-Compliance Penalty will be applied.

Surgery. You must contact MCM at least two weeks before a scheduled inpatient or outpatient surgery. If you do not pre-authorize the surgery, an additional $100 Non-Compliance Deductible will be applied before any benefits are paid. If you do not pre-authorize expenses for bariatric surgery, it will not be considered Medically Necessary and the Plan will not cover the expenses.

Second Opinion Surgery. You may be required to obtain a Second Opinion. The types of surgeries that require a Second Opinion include but are not limited to:

- artery and vein surgery
- back surgery
- breast surgery
- coronary artery bypass
- exploratory surgery
- eye surgery
- foot surgery if it is anticipated that the surgeons' fees will be $2,000 or more for any one surgery or for a series of surgeries
- genital surgery
- hysterectomy (removal of the uterus)
- intestinal surgery
- joint surgery/joint replacement
- nose surgery
- penile implant
- prostatectomy or transurethral resection

If you have surgery without obtaining a Second Opinion when required, the Plan will pay 50% of covered expenses related to the surgery. You will be responsible for the remaining expenses. The additional amount you pay will not count towards your out-of-pocket maximum.

If the second medical opinion does not agree with the recommended procedure or surgery, then a third medical examination and opinion is also necessary.

If the majority of doctors do not agree that the procedure or surgery is Medically Necessary or if a required third examination is not performed, no benefits will be payable.

Advanced Diagnostic Testing. It is required that you contact MCM (*not* BlueCross BlueShield) before undergoing advanced testing such as magnetic

resonance imaging (MRI) scans, computerized tomography (CT) scans, positron emission tomography (PET) scans, Thallium stress tests, sleep studies, nerve conduction studies, or echo Doppler tests. If you do not pre-authorize the expense for advanced testing, an additional $100 Non-Compliance Penalty will be applied.

The pre-authorization must be done by MCM, not by BlueCross BlueShield—you or your Doctor should speak directly with MCM.

Durable Medical Equipment. Before purchasing or renting durable medical equipment, contact MCM for approval. If the expense is not approved, it will not be considered Medically Necessary and the Plan will not cover it.

Weight Loss Treatment. Before incurring expenses for weight loss treatment, including surgery, contact MCM. If certain conditions are not met and if the expense is not approved, it will not be considered Medically Necessary and the Plan will not cover it.

Nutritional Counseling. Expenses for nutritional counseling sessions are covered if the sessions are ordered by your Doctor as part of a comprehensive treatment plan and if approved by MCM at the Benefits Fund Office. If the expense is not approved, it will not be considered Medically Necessary and the Plan will not cover it.

Skilled Nursing Facility Care, Rehabilitation Therapy, Home Health Care and Hospice. Before incurring expenses for care in a skilled nursing facility, for rehabilitation therapy, for home health care, or for care in a hospice, you must contact MCM for approval. If the expense is not approved, it will not be considered Medically Necessary and the Plan will not cover it.

Physical Therapy. Physical therapy is limited to 25 sessions per Illness or Injury. Additional benefits may be payable for treatment of certain conditions. These additional benefits must be pre-authorized by MCM or payment will be limited to 50% of covered expenses.

Occupational Therapy. Occupational therapy is limited to 25 sessions per Illness or Injury. Additional benefits may be payable for treatment of certain conditions. These additional benefits must be pre-authorized by MCM or payment will be limited to 50% of covered expenses.

Note: Remember, the Non-Compliance Penalty does not apply to Durable Medical Equipment (DME) and Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, occupational therapy, and physical medicine services ordered by a qualified doctor in excess of twenty-five (25) sessions per Acute Occurrence.

If Durable Medical Equipment (DME) is not pre-authorized, it will not be covered. If Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, occupational therapy, and physical medicine services ordered by

a qualified doctor in excess of twenty-five (25) sessions per Acute Occurrence are not pre-authorized, 50% of the Usual and Customary Charges for the Covered Expense are payable.

How to Notify Medical Cost Management (MCM)

You may contact MCM directly at:

Medical Cost Management (MCM)
1-800-367-9938

See your Insurance Card instructions for additional details.

Second Opinion

You must obtain a Second Opinion before undergoing certain surgeries. A list of these surgeries begins on page 22. Contact MCM for information on obtaining a second opinion. If you do not obtain a required Second Opinion, covered expenses will be payable at 50%.

BlueCross BlueShield of Illinois Participating Provider Network

BlueCross BlueShield has made arrangements with certain Doctors, Hospitals and immediate care centers to provide health care to you and your eligible dependents at lower rates than normally charged.

Simply by choosing a Hospital and Doctor in the network and showing your Health ID card when you receive medical care, you will receive a discount on your medical bill. The amount of the discount is the difference between the Hospital's or Doctor's regular charge and the negotiated fee contracted by BlueCross BlueShield. Discounts vary and may change from time to time. In addition, the Plan will pay a greater portion of your expenses when you use a PPO Hospital and Doctor.

You save three ways when you use the BlueCross BlueShield Participating Provider Network:

1. your percentage is applied to a discounted fee;
2. your percentage is smaller; and
3. you avoid the extra deductible amount and coinsurance that applies when you use an out-of-network Hospital.

You can find a participating provider by visiting the BlueCross BlueShield website at bcbs.com. Click on "Find a Doctor or Hospital" and follow the instructions from there. Or call BlueCross BlueShield at 800-810-BLUE (2583).

Comprehensive Medical Benefits

Your Plan pays a significant portion of your covered medical expenses and protects you and your family from financial hardship in the event of serious Illness or Injury. The Plan covers non-occupational Illnesses and injuries only.

This benefit provides coverage for many common medical needs after you satisfy the Annual Deductible. Certain medical expenses are paid with no deductible required if you use a PPO provider. A list of covered medical expenses starts on page 27.

Dependent Coverage is provided only to Employees who qualify for their employer's regular full-time contribution.

Calendar Year Deductible

The Calendar Year Deductible is the amount of covered medical charges that you and your family pay each Calendar Year before the Plan's medical benefits begin to pay for any covered charges.

The Plan has both an *individual* ($1,000) and a *family* ($3,000) Calendar Year Deductible requirement. For most covered medical expenses, you must pay the first $500 of any covered expenses you incur each Calendar Year before the Plan begins to pay benefits on your behalf. Once you meet your individual deductible, no further deductible will be required from you for the remainder of that Calendar Year. The Plan will pay the percentage specified in the Summary of Benefits for the cost for any covered medical expenses you incur. You will be responsible for any difference.

If you have covered dependents, each family member must meet their own deductible until the overall family deductible is met.

Separate deductibles apply when you receive Hospital services from a non-PPO network Hospital and when you do not have certain services pre-authorized, as explained later in this section. Refer to the Cost Containment section for more details.

Certain covered medical expenses are not subject to the Calendar Year Deductible and may be covered at 100%, as described on page 27.

Non-PPO Hospital Deductible

If you or your dependent are admitted to a non-PPO Hospital and it is not an emergency, you must pay a $550 Non-PPO Hospital Deductible. This is in addition to the Calendar Year Deductible.

Non-Compliance Penalty

If you or your dependent(s) are admitted to a Hospital, have a scheduled surgery (either inpatient or outpatient) or have advanced diagnostic testing done without having the admission, surgery or testing expenses pre-authorized by MCM, you will be required to pay an additional $100 Non-Compliance Penalty. The additional $100 Non-Compliance Penalty also applies to emergency care that results in Hospital admission if MCM is not contacted within 48 hours of the admission.

Out-of-Pocket Maximum

The Plan has imposed an out-of-pocket maximum in order to minimize the amount of money you will pay out-of-pocket for the expenses you will incur during a Calendar Year.

The out-of-pocket maximum is the most you could pay in a year for covered services. If you have other family members in this Plan, they have to meet their own out-of-pocket maximum until the overall family out-of-pocket maximum has been met. After you have paid the annual out-of-pocket maximum toward covered expenses, the Plan will pay 100% of those covered expenses for the remainder of that Calendar Year.

Expenses that do not count toward the out-of-pocket maximum are:

- charges that exceed the Usual and Customary Charge (see page 76);
- amounts you are required to pay because you failed to pre-authorize your Hospital stay or surgery, or otherwise failed to follow the Plan's Cost Containment Program;
- amounts you pay to satisfy the Non-PPO Hospital Deductible;
- the balance of charges that the Plan pays at 50%;
- amounts paid for out-of-network prescription drugs; and
- any other charges that are not covered by the Plan.

The annual medical out-of-pocket maximum is:

- $3,000 per person ($9,000 per family). This amount includes the $1,000 (or $3,000) Calendar Year Deductible.

A separate out-of-pocket maximum applies for prescription drugs, as follows:

- $4,850 per person ($7,200 per family).

PPO Providers—BlueCross BlueShield of Illinois

You have access to a Preferred Provider Organization (PPO) network that consists of Hospitals, Doctors and ancillary providers. PPO providers offer discounts on services to you and your dependents. When you use a PPO Hospital, the Fund is charged a discounted rate. When you use a PPO Doctor, you receive treatment at an agreed upon, discounted rate. The Fund shares these savings with you by reducing your out-of-pocket costs. The Fund also pays a higher percentage of your expenses when PPO Hospitals are used.

Please note that charges by a non-PPO facility may be substantially in excess of the Plan's Usual and Customary Charges. These excess charges are not covered under the Plan. Additionally, certain surgeries have limited benefits payable if performed at a non-PPO facility—see the next section. Refer to page 76 for a definition of "Usual and Customary Charge."

To locate a provider, visit www.bcbs.com or call 800-810-2583.

Surgery at Non-PPO Facility

When certain surgeries are performed at a non-PPO facility, benefits will be limited to the Plan's defined Usual and Customary Charge (see page 76).

Covered Medical Expenses

The Plan provides coverage for the following medical expenses, provided you are under the care of a licensed Doctor and the covered services and supplies are Medically Necessary.

Preventive Care for You and Your Spouse. You and your dependent spouse, if covered, are each eligible for the following (not subject to the $1,000 Calendar Year Deductible). Benefits are payable immediately at 100% for the following when services are received from an in-network provider):

- abdominal aortic aneurysm screening (a one-time screening) if you are a certain age and have never smoked
- alcohol misuse screening and counseling services
- anemia screenings, provided on a routine basis while you are pregnant
- annual physical exam with your family physician and/or an ob-gyn physician
- aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, and are not at increased risk for bleeding, have a life expectancy of at least 10 more years, and are willing to take low-dose aspirin for at least 10 years; or in pregnant women after 12 weeks of gestation if you are at high risk for preeclampsia

- bacteriuria urinary tract or other infection screenings you receive while pregnant
- blood pressure screenings
- BRCA risk assessment and counseling for genetic testing, if you are considered high risk
- breast feeding support, supplies, rental of equipment and counseling services
- breast cancer mammography screenings, every one to two years, if you are older than age 40. Periodic screenings are covered for women under age 40 who have an increased risk (i.e., those with a parent, sibling, or child who had or who has breast cancer)
- breast cancer chemoprevention counseling, if you are considered high risk
- breastfeeding interventions to support and promote breastfeeding
- cervical cancer screenings
- cervical dysplasia screenings at 21 years of age
- chlamydia infection screenings, if you are age 24 or younger and sexually active or are over 24 and considered high risk
- cholesterol screenings, if you meet certain age requirements or you are considered high risk
- colorectal cancer screenings, if you are older than age 50
- contraceptive methods and counseling for all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling services
- counseling for sexually transmitted infections (STIs)
- counseling and screening for human immunodeficiency virus (HIV)
- depression screenings
- diet counseling, if you are considered high risk for chronic disease
- fall prevention physical therapy and vitamin D supplements, if you are age 65 or older, you are living in a community dwelling, and you are at risk for falls
- folic acid supplements, if you may become pregnant
- Gonorrhea screenings, if you are under age 24 and sexually active or over age 24 and considered high risk

- Hepatitis B screening, if you are considered high risk or at your first prenatal visit, if you are pregnant
- Hepatitis C screenings, if you are considered high risk or you were born between 1945 and 1965
- HIV screening, if you are considered high risk or pregnant
- Human papillomavirus (HPV) testing, once every three years beginning at age 30
- immunization vaccines, including the following (doses, recommended ages and recommended populations vary):
    - Haemophilus influenzae type b;
    - Hepatitis A;
    - Hepatitis B;
    - Herpes zoster;
    - Human papillomavirus;
    - Influenza;
    - Measles, mumps, rubella;
    - Meningococcal;
    - Pneumococcal;
    - Tetanus, diphtheria, pertussis; and
    - Varicella
- lung cancer screening, provided through low-dose computed tomography, up to one each year if you are between the ages of 55 and 80, you have a 30-pack per-year smoking history, and you currently smoke or have quit in the last 15 years
- obesity screening and counseling services
- osteoporosis screenings, if you are older than age 60, depending on risk factors
- preeclampsia screening if you are pregnant
- preeclampsia prevention low-dose aspirin, provided as a preventative medication after 12 weeks of gestation, if you are considered high risk for infection
- Rh incompatibility screenings, if you are pregnant, including follow-up testing if you are considered high risk

- screening and counseling for interpersonal and domestic violence
- screening for gestational diabetes
- tobacco use screening and cessation interventions, including expanded counseling for pregnant tobacco users
- tuberculosis screening, if you are considered high risk
- Type 2 diabetes screenings, if you have high blood pressure
- statin preventive medications, for individuals between the ages of 40 and 75, depending on risk factors
- syphilis screening, if you are considered at high risk or pregnant
- sexually transmitted infection (STI) prevention counseling services, if you are considered high risk.

The Plan pays benefits for the following additional preventive care services for your covered children (generally younger than age 18):

- alcohol and drug use assessments
- anemia screening at 12 months of age
- autism screening for your children between age 18 and 24 months
- behavioral assessments
- bilirubin concentration screening for your newborn
- blood pressure screenings
- blood screening for your newborn
- congenital hypothyroidism screening for your newborn
- critical congenital heart defect screening for your newborn
- depression screening routinely for adolescents
- developmental screenings for your children younger than age three, and surveillance throughout their childhood
- dyslipidemia screenings once between nine and 11 years of age; once between 17 and 21 years of age
- fluoride chemoprevention supplements for your child, if fluoride is not in his or her water source
- fluoride varnish application
- Gonorrhea preventive medication for your newborn

- head circumference and weight for length measurement for infants and young children
- hearing screenings for your newborn and adolescents
- height, weight and body mass index measurements
- hematocrit or hemoglobin screenings
- hemoglobinopathies or sickle cell screening for your newborn
- HIV screening once between 15 and 18 years of age
- immunization vaccines for your children from birth to age 18, including the following (doses, recommended ages, and recommended populations vary):
    - Diphtheria, tetanus, acellular pertussis;
    - Haemophilus influenzae type b;
    - Hepatitis A;
    - Hepatitis B;
    - Human papillomavirus;
    - Inactivated poliovirus;
    - Influenza;
    - Measles, mumps, rubella;
    - Meningococcal;
    - Pneumococcal;
    - Rotavirus; and
    - Varicella
- interpersonal and domestic violence screening for adolescents
- iron supplements for your children, between 6 to 12 months, who are considered at risk for anemia
- lead screening for your children who are considered at risk for exposure
- medical history for your children throughout their development
- obesity screening and counseling services
- oral health risk assessments
- Phenylketonuria (PKU) screenings for this genetic disorder in your newborn

- sexually transmitted infection (STI) prevention and counseling services, and screenings for your adolescent who is considered high risk
- skin cancer behavioral counseling services, including how your child age 10 to 24 who has fair skin can minimize his or her exposure to UV radiation
- tobacco use interventions to prevent initiation of tobacco use in school-aged children and adolescents
- tuberculin testing for your child who is considered high risk for tuberculosis
- vision screenings.

Covered preventive care services may change from time to time based upon the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

Office Visit Coverage

Preventive Services are covered based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for PPO office visits under the Preventive Services benefit. Non-PPO office visits are not covered under the Preventive Services benefit under any condition.

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

  Example: If a person has a cholesterol screening test during an office visit and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge coinsurance for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge coinsurance for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100% when

services are received from an in-network provider. Well woman visits are also treated as Preventive Services and paid at 100% when services are received from an in-network provider.

1. Laboratory Testing: Benefits are payable at 80% for covered laboratory testing (not subject to deductible) if you have the tests conducted by:

   - a stand-alone outpatient laboratory, such as Quest Diagnostics or LabCorp of America; or

   - a Doctor who participates in the BlueCross BlueShield network and processes the tests in his or her office.

   If you have the tests conducted by a non-PPO provider, the Plan will pay 75% of a discounted fee, and 100% of the remaining fee that was not discounted.

   These covered expenses are payable as shown in the Summary of Benefits and are subject to any rules and limitations explained under each item.

2. Hospital services and supplies, including:

   - room and board, up to the standard daily rate for a semi-private room;

   - specialty care unit charges (e.g. intensive care unit, cardiac care unit);

   - other services and supplies furnished by a Hospital; and

   - emergency room charges.

3. Doctor's professional medical and surgical services, including:

   - Hospital, office and home visits;

   - Emergency Services with respect to an Emergency Medical Condition, which means a medical screening examination within the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.

   - services for surgical procedures;

4. Surgery and related charges.

5. Doctor's charges for surgery, radiotherapy procedures or medical services.

6. Outpatient treatment, services and supplies for Illness or Injury.

7. Ambulatory surgical center services.

8. Diagnostic x-ray and laboratory charges.

9. X-ray, chemotherapy, radium and radiation therapy.

10. Anesthetics and their administration.

11. Blood and blood plasma and its administration

12. Oxygen and its administration and the rental of equipment for the administration of oxygen, including the one-time purchase of an oxygen concentrator for portable oxygen tanks.

13. Professional ground ambulance transportation to and from a local Hospital or between local Hospitals. Convenience transfers are limited to $300. Covered air ambulance expenses are limited to $15,000 in North America and $25,000 elsewhere. Air ambulance transportation is covered only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient.

14. Pregnancy. Federal law requires that benefits be provided to the mother and/or newborn child for Hospital confinement of at least 48 hours following a vaginal delivery or at least 96 hours following a cesarean section, unless the mother chooses to leave the Hospital sooner. Your Doctor or Hospital is not required to obtain authorization for a length of stay that does not exceed 48 (or 96) hours.

15. Women's Health and Cancer Rights Act of 1998. Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. If you or a dependent are receiving benefits under the Plan in connection with a mastectomy and elect breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending Doctor and the patient, for:

    - reconstruction of the breast on which the mastectomy was performed;

    - surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    - prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

16. Reconstructive treatment because of an Injury or congenital disease or anomaly that results in a functional defect or deformity from trauma, infection or other disease of the involved body parts or in relation to a mastectomy.

17. Durable medical equipment for therapeutic treatment. Benefits for rental of durable medical equipment cannot exceed the allowable purchase price, as determined by the Trustees.

18. Orthotic appliances. Benefits are payable for the initial appliance, and after five years, one replacement for each five years of continuous use.

19. Prosthetic appliances. Benefits are payable for the initial appliance, and after five years, one replacement for each five years of continuous use. Covered items include:

    - artificial limbs or eyes
    - external breast prosthesis;
    - internal breast prosthesis (implant);
    - cataract or corneal transplant basic lenses; and
    - penile implant, limited to one per lifetime.

    Cochlear implants are not covered.

20. Medical supplies, trusses, braces or supports, casts, splints and crutches. The following supplies are limited to a maximum per Calendar Year of:

    - 4 pairs of surgical stockings;
    - 1 wig, up to a maximum of $150; and
    - 2 bras for a breast prosthesis.

21. Charges made by a registered nurse or licensed practical nurse. Only home health care expenses that are pre-authorized will be covered.

22. Home health care. Benefits are payable for the following services when provided by a Home Health Care Agency:

    - skilled nursing care by, or supervised by, a licensed nurse; home aides are not covered; and
    - administration of IV therapy.

    Covered medical expenses are limited to expenses that are pre-authorized by MCM. Each visit by a member of the home health team will count as one visit.

23. Skilled nursing facility care, rehabilitation therapy and hospice care. Expenses for Medically Necessary care in a skilled nursing facility, rehabilitation therapy and hospice care are covered if pre-authorized by MCM. The Plan will not consider these expenses Medically Necessary and will not cover them if you do not receive pre-authorization for them.

24. Chiropractic care. Benefits are payable for up $2,200 per Calendar Year for charges by a chiropractor for treatment of the back, neck, spine or vertebra for conditions due to non-work-related subluxations, strains, sprains and nerve root problems.

25. Physical therapy, acupuncture, and prolo therapy. Benefits are payable for up to 25 sessions per acute occurrence. A session includes an evaluation

and no more than three medically-appropriate modalities or other services for up to one hour per day.

Additional benefits may be payable for treatment of more than one musculoskeletal, neurological, digestive, genitourinary or skin systems or for loss of any special senses function. These additional benefits must be pre-authorized by MCM or payment will be limited to 50% of covered expenses.

26. Occupational therapy. Benefits are limited to 25 sessions per Illness or Injury. A session includes an evaluation and no more than three medically-appropriate modalities or other services for up to one hour per day.

    Additional benefits may be payable, but must be pre-authorized by MCM, or payment will be limited to 50% of covered expenses.

27. Speech therapy. Benefits are limited to 25 sessions per Illness or Injury. A session includes an evaluation and treatment provided on a single day not to exceed one hour.

    Additional benefits may be payable, but must be pre-authorized by MCM, or payment will be limited to 50% of covered expenses.

28. Cardiac and pulmonary rehabilitation. Benefits are limited to 30 sessions per event. A session is a supervised rehabilitation service of no more than one hour per day and may further include one low level stress test per event.

29. Pain management treatment for chronic pain. Benefits are payable for treatment provided by a practitioner in the Pain Management Provider Network established by the Fund.

30. Transplant expenses, except that no benefits are payable for donor-related expenses.

31. Varicose vein treatment. Except for ulcerated conditions, benefits are limited to a lifetime maximum of $2,200 per leg.

32. Nutritional counseling. Expenses for up to four nutritional counseling sessions per Calendar Year will be covered if the following conditions are met:

    - the patient must have a known history of diabetes, renal failure, hepatic insufficiency, morbid obesity, or a genetic metabolic disorder requiring diet modification;

    - the counseling must be ordered by a Doctor as part of a comprehensive treatment plan and the expense must be pre-authorized by MCM; and

    - the counseling must be provided by a Registered Dietician or a comparably credentialed professional.

33. Weight loss treatment. Benefits are payable for the following services for persons with a known history of morbid obesity:

    - nutritional counseling—Up to four counseling sessions per Calendar Year with a Registered Dietician (or a comparably-credentialed professional) when ordered by your Doctor as part of a comprehensive treatment plan and the expenses are pre-authorized by MCM;

    - bariatric treatment and management—Up to six visits per Calendar Year with a Doctor (MD or DO) when part of a comprehensive treatment plan and the expenses are pre-authorized by MCM; and

    - bariatric surgery—The patient must be enrolled in a Fund-approved multi-discipline, Doctor-supervised nutrition and exercise program of at least six months in duration. Any recommended surgery must be pre-authorized by MCM and must be performed at a Fund-approved Bariatric Surgery Center of Excellence.

    Contact MCM for additional details and for referrals to a Fund-approved program.

34. Mental health or substance use disorder treatment expenses except when provided as an inpatient in a residential care facility that does not meet the Plan's definition of a Hospital (see page 74). Eligibility for all inpatient and outpatient therapy will be subject to all Plan Provisions, including, but not limited to, a determination that the therapy is Medically Necessary and Appropriate. Expenses for treatment by a residential care center must be pre-authorized in writing by the Benefits Fund Office.

    The residential care center must:

    - be accredited by the Joint Commission or other similar credentialing entity acceptable to the Plan;

    - comply with all federal, state, and local requirements, including required licensing; and

    - be an PPO provider unless a PPO facility is unavailable, in which case, the alternative facility must be pre-authorized in writing by the Benefits Fund Office.

35. Injury to oral/facial structures, including, but not limited to, jaw and facial bone fractures and Injury to sound and natural teeth.

36. Hospital Expenses for Dental Surgery. Benefits are payable for Hospital expenses for covered dental surgery. To be covered, the expenses must be pre-authorized by MCM.

    Other expenses, including professional fees of any kind, for dental care, anesthesia, diagnosis, treatment or supplies, are not covered under the Comprehensive Medical Expense Benefit. Such expenses may be covered under the Dental Benefit.

37. Voice communication machines. The Plan pays up to $7,500 per person, per lifetime.

38. Hearing aid. Benefits are payable at 80% up to $500 per person in a five-consecutive-year period for covered expenses for a hearing examination and hearing aid.

    Covered expenses include the following:

    - an otologic examination performed by a Doctor;
    - an audiologic examination performed by a Doctor or a licensed audiologist;
    - the hearing aid (monaural or binaural) prescribed as a result of an examination. This generally includes ear mold(s), the hearing aid instrument, the initial batteries, cords and other necessary ancillary equipment; and
    - a follow-up consultation within 30 days following the delivery of the hearing aid;

    The following expenses are not covered:

    - expenses for more than one hearing examination without a hearing aid being obtained;
    - replacement batteries; and
    - charges for repairs, servicing and alterations.

39. IV sedation utilized in conjunction with outpatient epidural or other pain management interventional injections or procedures, when pre-authorization is received through MCM.

Approved Clinical Trials

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

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

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

- satisfy the protocol prescribed by the Approved Clinical Trial provider; and
- either:
    - o the individual's PPO provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or
    - o the individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

Excluded Expenses include:

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

What is Not Covered

Expenses that are not covered under the Comprehensive Medical Benefit include, but are not limited to, the following:

- custodial care, except when provided by a hospice;
- cosmetic treatment or complications thereof, except as otherwise permitted (e.g., reconstructive surgery following a mastectomy);
- immunizations, except as required by the ACA
- routine examinations or screenings, except as required by the ACA or otherwise noted;
- routine foot care such as the cutting and trimming of toenails;
- naturopathic or homeopathic services and substances;
- personal hygiene, comfort or convenience items such as air conditioners and humidifiers or physical fitness equipment;

- over-the-counter supplies, drugs and medicines unless otherwise noted, except for certain over-the-counter drugs that are permitted to be obtained under the prescription drug benefit with a Doctor's prescription;
- foods and nutritional supplements including, but not limited to, home meals, formulas, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided through a feeding tube as sole nutrition;
- marriage counseling or treatment for anti-social behavior that is not the result of a mental health or of a substance use disorder;
- gender reassignment surgery or any associated pharmacotherapy;
- hormone therapy, artificial insemination or any other direct attempt to induce or facilitate fertility or conception;
- expenses related to a surrogate pregnancy;
- genetic testing, except for amniocentesis, government-mandated neonatal testing, testing for the purpose of determining the medical appropriateness of therapy for newly diagnosed breast cancer, and testing for the purpose of definitively determining future treatment of individuals with a high probability of having a BRCA (breast cancer) mutation, and any preventive services benefits provision as required by the ACA;
- breast reduction surgery except for reconstruction due to breast cancer;
- wigs or toupees except when made necessary due to loss of hair resulting from treatment of a malignancy or permanent loss of hair from an Injury; hair transplants, hair weaving or any drug if such drug is used in connection with baldness;
- expenses for home health care that have not been pre-authorized by MCM;
- skin or fat removal surgery for any reason;
- services or supplies for weight reduction by diet control or behavior modification, with or without drugs, except as provided under Weight Loss Treatment
- donation of an organ or tissue;
- routine circumcision of newborns;
- blood storage charges except for use for an anticipated covered medical condition for a period not to exceed six months;
- blood donated by family members or others specifically for another patient's use;
- expenses for home blood pressure monitoring or home uterine monitoring equipment for any reason;

- muscle stimulators in excess of $500;
- cochlear implants;
- snoring cessation and snoring correction devices for any reason;
- repair of, or operating supplies for, durable medical equipment, including more than one tank for portable oxygen when an oxygen concentrator is leased or purchased;
- services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes except for tumors or cysts or unless resulting from an accidental Injury to sound and natural teeth;
- eye refractions, eye examinations, frames and lenses (including contact lenses) or their fitting except as provided under the vision benefit;
- procedures for surgical correction of myopia and/or other refractive errors;
- vision therapy;
- vitamins, including vitamins requiring a written prescription, Except as required by the ACA preventive services benefit that include prenatal prescription vitamins covered under the Prescription Drug Program;
- shoes for any reason (including orthopedic shoes);
- transportation expenses other than local ambulance service and covered air ambulance;
- expenses for and related to travel for you, a covered family member or a Doctor;
- charges for infection control and medical waste disposal;
- more than one medical office visit, Hospital room, or wound-care facility charge billed on the same day by the same Provider will not be covered; and
- anything excluded under the General Exclusions and Limitations listed beginning on page 56.

Prescription Drug Benefit

The Prescription Drug Benefit provides coverage for most drugs that require a Doctor's prescription, for certain over-the-counter medications when prescribed by a Doctor and for some diabetic supplies.

For "short-term" prescription drug needs, you should have your prescription filled at a participating pharmacy (explained below).

For drugs that are used on a long-term or on-going basis, you must use the Mail Order Program to fill your prescription—see page 45.

Dependent Coverage is provided only to Employees who elect to participate, make their contributions and who qualify for their employer's regular full-time contribution.

Prescription Drug ID Card

You will receive an ID card when you become eligible for benefits. When you use your ID card at a participating pharmacy to fill prescriptions, you pay only the applicable co-payment. You do not have to complete any claim forms.

If you need a replacement card or an additional card, contact Customer Service at the Benefits Fund Office at 800-621-5133.

Participating Pharmacy Program

The Prescription Drug Benefit is managed by WellDyneRx, a prescription benefit manager with a large network of pharmacies, called "participating pharmacies." You receive the highest level of benefits when you fill your prescription at a participating pharmacy.

Many, but not all, large chain pharmacies and small independent pharmacies are participating pharmacies. Should you have any problem locating a participating pharmacy, please contact WellDyneRx at 888-479-2000.

Prescription Drug Out-of-Pocket Maximum

The annual prescription drug out-of-pocket maximum is the most you pay out of your own pocket for eligible expenses each year. Once you meet the maximum, the Plan pays 100% of all eligible expenses for the rest of the year. This means that the Plan pays benefits for covered prescription drug services until you reach the prescription drug out-of-pocket maximum. Then, the Plan pays 100% of your eligible expenses for the remainder of the Calendar Year.

Note: Your prescription drug out-of-pocket maximum is separate from your medical out-of-pocket maximum.

Covered Drugs

The Plan covers the following:

- most drugs that require the written or oral prescription of a licensed Doctor or dentist under federal or state law, up to a 30-day supply maximum per prescription or refill;
- exceptions to the 30-day supply maximum are non-specialty (see page 45) maintenance drugs that are used on a long-term or on-going basis to treat chronic conditions. You can receive up to a 90-day supply of these drugs when you fill the prescription through the Mail Order Program;

Contact WellDyneRx Customer Service at 888-479-2000 for specific information on maintenance drugs and for instructions on using the Mail Order Program.

- certain over-the-counter (OTC) drugs when prescribed by a Doctor. Currently, OTC Omeprazole (Prilosec) and OTC Loratadine (Claritin) are covered;
- injectable insulin, blood glucose testing strips and lancets;
- needles and syringes to administer injectable insulin; and
- needles and syringes for any other use, up to a 30-day supply.

Drugs That Require Pre-Approval

Some drugs require pre-approval before your prescription can be filled under the Prescription Drug Benefit. For example, drugs that may require pre-approval include narcotics, amphetamines, anabolic steroids and protein pump inhibitors (stomach drugs) when more than one tablet per day is taken.

The Fund Administrator, in consultation with the Fund's Medical Consultant and with the approval by the Trustees, periodically makes changes regarding which drugs require pre-approval.

Contact WellDyneRx at 888-479-2000 for information on which drugs currently require pre-approval and how to obtain the pre-approval.

Generic Equivalents and Brand-Name Drugs

If you or your eligible dependent request a brand-name drug when a generic equivalent is available (and medically appropriate), you will be responsible for paying the difference in cost between the generic and the brand-name drug, in addition to the brand-name co-payment amount.

In general, using generic drugs usually helps to control the cost of health care while providing quality drugs—and can be a significant source of savings for you and the Plan. Your Doctor or pharmacist can assist you in substituting generic drugs when appropriate.

Specialty Drugs—Require Purchase by Mail

Specialty drugs are medications that may require special storage, handling or administration (such as injection or infusion) or are for conditions where it may be beneficial to monitor the drug therapy or an underlying medical condition.

Examples of such drugs are Atripla, Enoxaparin, Humira, Enbrel, Truvada.

The Fund Administrator, in consultation with the Fund's Medical Consultant and with approval by the Trustees, periodically identifies which drugs are specialty drugs. Inquiries as to whether any drug is on the current specialty drugs list should be directed to the Benefits Fund Office.

Under the Prescription Drug Benefit, specialty drugs can be obtained only by mail through US Specialty Care. Specialty drugs are not covered if obtained at a local pharmacy.

To obtain your specialty drug:

- your doctor must contact US Specialty Care at 800-641-8475 and provide any required Physician Information and Clinical Information; and
- Note that you may use your UFCW ID # instead of your Social Security number on the form;
- you or your doctor may also fax a completed request to US Specialty Care at 800-530-8589. Or you may mail it to US Specialty Care, PO Box 4517, Englewood CO 80155-4517.

A professional from US Specialty Care will call you to confirm when and where you would like your prescription drugs delivered (along with any needed supplies). Drugs are packaged in unmarked, temperature-controlled containers and can be delivered to any secure location of your choice.

US Specialty Care pharmacists and staff are available to answer any questions. They can give you detailed instructions and support for how and when to take your drugs. They also offer refill reminder calls.

You can reach US Specialty Care at 800-641-8475, FAX at 800-530-8589, or by mail at PO Box 4517, Englewood CO 80155-4517.

Co-Payments

Co-payments are based on tiers established by the Trustees to encourage cost-effective use of the Prescription Drug Benefit.

You will also be responsible for paying the difference in cost between the generic and the brand-name drug if you request a brand-name drug when a generic drug is available and medically appropriate.

Prescriptions Filled at a Participating Pharmacy

When you fill your prescription at a participating pharmacy using your ID card, you'll pay the following:

30-Day Supply	Co-Payment
Tier Zero—Designated ACA Drugs and Supplies	$0
Tier One—Preferred Generic Drugs	$10
Tier Two—Most Generic Drugs	$21
Tier Three—Preferred Brand Name Drugs	$40
Specialty Drugs	$40

Prescriptions Filled through the Mail Order Program

You must use the Mail Order Program when you need to have a prescription filled for a maintenance drug. Maintenance drugs are drugs that are used on a long-term or on-going basis to treat chronic Illnesses.

If you obtain a maintenance drug at a retail pharmacy instead of through the Mail Order Program, your prescription will be limited to a 30-day supply (instead of 90-day) and the co-pay will be the 90-day co-payment amount.

When you order by mail, you will pay the following:

Maintenance Drug (90-Day Supply)	Co-Payment
Tier Zero—Designated ACA Drugs and Supplies	$0
Tier One—Preferred Generic Drugs	$12
Tier Two—Most Generic Drugs	$36
Tier Three—Preferred Brand Name Drugs	N/A
Specialty Drugs	N/A

* Tier Three and Specialty Drugs are not covered through mail order.

Contact WellDyneRx at 888-479-2000 for information on which drugs are preferred drugs and for instructions on using the Mail Order Program.

Current Tier 0 medications include Simvastatin, Lovastatin and Omeprazole.

Remember, you will always pay the lowest of the designated co-pay, contracted price or actual selling price of a covered drug.

What is Not Covered

Expenses for the following are not covered:

- drugs or medications that are payable under any other benefit provided by the Plan;

- non-Legend or over-the-counter drugs, except as otherwise specifically noted;
- drugs or medications that require pre-approval when you did not obtain approval before they were dispensed to you;
- the difference in cost if you request a brand-name drug when a generic drug is available and medically appropriate, except for certain medical conditions as determined from time to time by the Trustees;
- specialty drugs when dispensed by a retail pharmacy instead of by mail through US Specialty Care;
- drugs consumed at the time and place of prescription;
- drugs that are considered experimental or not approved by the U.S. Food and Drug Administration for the condition, dose, rate or frequency prescribed;
- research drugs;
- appliances and devices;
- blood and blood plasma, immunization agents and biological sera;
- fertility drugs;
- lifestyle drugs, including drugs to treat sexual dysfunction or inadequacy;
- drugs used for cosmetic purposes;
- drugs to promote hair growth;
- drugs used as an aid to weight loss;
- non-drug items including nutritional supplements, regardless of intended use;
- vitamins, except prescription pre-natal vitamins;
- erectile dysfunction drugs;
- any prescription order or refill for which the pharmacist's Usual and Customary Charge is less than the co-pay amount;
- drugs that will be covered by any Workers' Compensation law, Medicare, or similar governmental program, or any other prescription program or group plan unless prohibited by federal law;
- drugs in excess of the quantity specified in the prescription order;
- drugs that will be payable under a governmental program or a pharmaceutical industry co-pay assistance program unless such payments are approved by and coordinated with the Health Plan;

- any prescription order or refill filled outside the United States, except for emergencies; and
- drugs intended for any purpose other than the manufacturer's published use or drugs prescribed in quantities in excess of the dosage recommended by the manufacturer.

Other drugs, as determined by the Trustees from time to time, may be excluded from coverage.

Use of Non-Participating Pharmacies

You receive the highest level of benefits when you fill your prescription using your ID card at a participating pharmacy. If for some reason you cannot use a participating pharmacy or your ID card, you may submit a "Direct Reimbursement" claim form to request reimbursement. Contact the Benefits Fund Office to obtain a Direct Reimbursement claim form.

Creditable Coverage Under Medicare

The prescription drug benefit provided by the Health Plan has been determined to be "creditable coverage" under Medicare. This means that if you are eligible for Medicare, you may defer electing Medicare Part D Prescription Drug Coverage while you remain covered under the Plan and you will not be penalized if you then elect it at a later date. For more detailed information, refer to Appendix C: Prescription Drug Creditable Coverage—Medicare Part D beginning on page 113.

Vision Benefit

Vision Benefits help you pay for the cost of Medically Necessary eye examinations, frames and lenses for you and your eligible dependents. You must use a licensed ophthalmologist, optometrist or optician to receive benefits under the Plan.

Covered Vision Expenses

Your Vision Benefit covers examinations, lenses and frames, or contact lenses, and is simple to use. The Plan pays 100% of the covered expenses, up to a maximum benefit of $100 per person per Calendar Year.

For individuals under age 19, the Plan pays 100% for an exam and glasses once per Calendar Year.

What is Not Covered

The following expenses are not covered:

- any expense that exceeds the maximum amount during any Calendar Year;
- any lenses which do not require a prescription; or
- radial keratotomies or other procedures for surgical correction of myopia and/or refractive errors.

Dental Benefit

Your dental coverage pays a portion of the cost of covered dental services. The Plan pays only for services that are provided by a licensed dentist or dental hygienist, including any required supplies.

How the Plan Pays Benefits

The Plan pays 100% of charges for covered dental expenses up to a maximum of $150 per person per Calendar Year for individuals aged 19 or older.

For individuals under age 19, the Plan pays 100% for oral exams (one per Calendar Year), cleanings (two per Calendar Year), fillings, and x-rays.

Covered Dental Expenses

The following services and supplies are covered under the Dental Benefit.

Diagnostic and Preventive Services:

- oral examination, if performed by a dentist;
- prophylaxis (teeth cleaning), if performed by a dentist or dental hygienist, limited to twice per Calendar Year;
- necessary x-rays—complete series, including bitewings, and panoramic are limited to once per Calendar Year;
- fluoride treatments;
- fillings, including silver amalgams, silicate and acrylic restorations; and
- sealants.

Other Services:

- tooth extractions;
- amalgam and resin-based composite filling restorations for decaying or broken teeth;
- onlays and crowns;
- space maintainers;
- oral surgery, including extractions and surgical procedures;
- periodontal treatment (treatment of the gums and bones), including, but not limited to, periodontal scaling and periodontal maintenance procedures;
- endodontic treatment, including root canal therapy; and
- initial fitting and replacement of complete and partial dentures and bridges; replacements will be payable once every five years.

What is Not Covered

Expenses not covered under the Dental Benefit include the following:

- services or supplies provided or paid for by any other employer's medical or dental coverage, mutual benefits association, labor union or similar organization under provisions governing the coordination of benefits;
- cosmetic treatment;
- panoramic x-rays more often than once each Calendar Year;
- orthodontic treatment; and
- anything excluded under the General Exclusions and Limitations listed beginning on page 56.

Income Protection Benefit

This benefit provides you with a basic level of income if you become disabled and cannot work at any occupation because of a non-occupational Illness or Injury. Disability benefits are payable only to active, eligible Participants.

Benefit Amount

The Plan pays 55% of your weekly earnings, up to

- $161 per week, if full time; or
- $49 per week, if part time,

for up to a maximum period of 26 weeks for each period of non-occupational Illness or Injury.

Benefits start on the:

- 1st day of an accident
- 1st day of Hospitalization
- 1st day of outpatient surgery
- 8th consecutive day of sickness

When your coverage otherwise ends, you may elect to continue coverage by making self-payments under COBRA; a description of COBRA Continuation Coverage begins on page 14.

Successive Periods of Disability

Successive periods of disability due to the same or related causes are considered one period of disability, unless separated by a return to active, full time work for four consecutive weeks. Successive periods of disability due to entirely different and unrelated causes are considered one period of disability, unless separated by at least one day of active, full time work.

What Is Not Covered

Benefits are limited to one 26-week period for disability due to any one Injury and two 26-week periods for disability due to a single or related Illness/Injury.

Benefits are not payable for:

- disability resulting from Illness or Injury for which you are not under the regular care of a Physician;
- disability arising out of or in the course of any occupation, employment or self-employment; or for which you have a right to payment under any Workers' Compensation law or occupational disease law; Illness or loss

for which you are entitled to benefits or reimbursement under any motor vehicle insurance plan, insurance settlement, or any third party settlement or agreement;

- disability resulting from a loss, problem, complaint, pain or ailment which did not arise from an objectively determined and documented medical impairment;
- disability incurred by owner-operators, non-Employee operators, proprietors, owner-Employees, partners, commission-only Employees or non-bargaining unit Employees or any person participating on a voluntary basis;
- periods for which you receive remuneration from any employer or any source for work or services performed; or
- periods after a Contributing Employer closes all stores in the geographical area of the Plan's operation or ceases to be a Contributing Employer.

Death Benefit

Your Death Benefit helps to protect your family from a sudden loss of income in the event of your death. If you die from any cause while you are an eligible active Employee, the Death Benefit will be paid in a lump sum to your beneficiary.

Benefit Amount

For you:	
if full time	$5,000
if part time	$3,000

Note: The Plan's Death Benefit is self-insured, which means that benefits are provided through the assets of the Plan, rather than through the purchase of insurance. Proceeds from self-insured Death Benefits are considered taxable benefits and any amounts paid on your behalf will be added to your beneficiary's taxable income.

Naming a Beneficiary and Payment of Benefit

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time. To name a beneficiary or to change your beneficiary, complete a "Designation of Beneficiary for the Death Benefit" form (available from the Benefits Fund Office) and return it to the Benefits Fund Office. The designation or change will be effective when the completed form is received at the Benefits Fund Office.

If you choose to name a former spouse as a beneficiary, you must specifically identify that person as an ex-spouse under "Relationship" on the "Designation of Beneficiary for the Death Benefit" form. Plan provisions prohibit the benefit from being paid to a former spouse unless you specifically indicate the relationship is "ex-spouse."

If you do not designate a beneficiary, or if your designated beneficiary is not living at the time of your death, the Death Benefit will be paid to your estate, or at the option of the Trustees, to your surviving spouse or if not surviving, in equal shares to your surviving children, or if none survive, to your parents equally or the survivor, or if neither survives, in equal shares to your brothers and sisters who survive you.

The Trustees have the right to pay benefits to any organization or person as needed to properly carry out the provisions of the Plan. Those payments that are made in good faith are considered benefits paid under the Plan.

Filing a Claim

Upon notification that your death has occurred, the Benefits Fund Office will send the proper forms to your beneficiary, estate administrator or survivor. Benefits cannot be paid until a completed claim form has been received by the Benefits Fund Office.

Accidental Death & Dismemberment (AD&D) Benefit

Accidental Death & Dismemberment (AD&D) benefits are payable if you sustain an accidental Injury resulting in the loss of your life, a limb, or your eyesight within 90 days after the accident.

Benefit Amount

If you suffer more than one of the losses listed below in any one accident, payment will be made only for the loss for which the largest amount is payable. Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint, respectively. Loss of sight means the total and irrecoverable loss of sight.

Type of Loss	Benefit Amount
Life	$10,000
Both hands or both feet or sight of both eyes	$10,000
One hand and one foot	$10,000
One hand and the sight of one eye	$10,000
One foot and the sight of one eye	$10,000
One hand or one foot	$5,000
Sight of one eye	$5,000

Note: The Plan's Accidental Death & Dismemberment (AD&D) Benefit is self-insured, which means that benefits are provided through the assets of the Plan, rather than through the purchase of insurance. Proceeds from self-insured AD&D benefits are considered taxable benefits and any amounts paid on your behalf will be added to your beneficiary's taxable income.

Who Receives Benefits

Benefits for loss of your life are payable to your Death Benefit beneficiary (see page 53). Benefits for any other loss are payable to you.

Filing a Claim

Upon notification that your death or dismemberment has occurred, the Benefits Fund Office will send the proper forms for completion. Benefits cannot be paid until a completed claim form has been received by the Benefits Fund Office.

What is Not Covered

No benefit is payable under the AD&D benefit if death or any loss is caused directly or indirectly by:

- bodily or mental Illness, infirmity or disease of any kind;
- ptomaine or bacterial infections (except infections caused by pyogenic organisms that occur with and through an accidental cut or wound) or hernia;
- suicide or intentional self-destruction or self-inflicted Injury;
- participation in the commission of a felony;
- war or an act of war; or
- operating or riding in any aircraft, except:
    - as a passenger in a commercial aircraft that is on a regularly scheduled passenger flight;
    - as a passenger or pilot of a chartered flight; and
    - as a passenger or pilot of a licensed aircraft operated by a licensed pilot, including student licensees.

General Exclusions and Limitations

This Plan contains some general exclusions and limitations that apply to all benefits provided by the Plan.

No benefits are payable under the Plan for the following:

- Illness or Injury arising out of or in the course of any occupation or employment, or which is compensable under any Workers' Compensation or Occupational Disease Act or Law, except in the case of Death and AD&D benefits (pages 54 and 55).
- Services, supplies or treatments that are not Medically Necessary and appropriate.
- Services or supplies that are experimental or investigational or do not meet accepted standards of medical practice.
- Expenses incurred while coverage is not in force.
- Illness or Injury caused by war or any act of war, declared or undeclared, or by participating in a riot, or as the result of the commission of a felony.
- Examinations or treatment ordered by a court in connection with a legal proceeding or obtained for the purpose of receiving favorable consideration by a court or similar body, unless such examinations or treatment would otherwise qualify as a covered expense.
- Any expenses that exceed the Usual and Customary Charge (see page 76).
- Any expenses that are over the maximum benefit amounts.
- Any deductible or co-pay amounts.
- Expenses that you would not have been charged had there been no coverage.
- Expenses for which there is no legal obligation to pay.
- Physical examinations or medical certificates required for employment.
- Any service, supply or treatment that you or your covered dependent are entitled to receive from the Uniformed Services medical care facilities or under any program of the Veterans' Administration (VA), except when services are provided to a veteran for a disability that is not service-connected.
- Any expense for government-provided services given to a person under any plan or program established under the laws or regulations of any government or of any political subdivision.

- Any service, supply or treatment that is not recommended and approved by a legally-qualified Doctor or surgeon.
- Any service, supply or treatment that is received outside the United States or Canada, except for emergency care.
- Diagnosis, testing or treatment of infertility.
- Reversal of a surgical procedure.
- Services provided by a person who normally resides in your household or who is a parent, spouse, child, brother or sister of the eligible Employee-Member or his or her dependent.
- Educational services (except nutritional counseling as described on page 23), supplies or equipment, including but not limited to, computers, software, printers, books, tutoring and visual aids even if they are required because of an Illness or Injury.
- Dental services, except as provided under the Dental Benefit, and except for removal of tumors, treatment of fractures, direct surgery on the temporomandibular joint itself or surgery to correct a malocclusion of the jaw due to a skeletal deformity.
- Expenses for which the Fund has not received complete documentation of the claim, including medical reports and records if needed.
- If you are employed by more than one employer participating in this Fund, the benefits provided to you will be no greater than if you were employed by only one employer.
- Expenses payable by another group medical plan under the Plan's Coordination of Benefits provision.
- For failure to keep a scheduled visit, phone calls or completion of a claim form or routine supplemental report.
- Expenses billed for the same day by the same provider for more than one medical office visit, Hospital room, or wound-care facility charge.
- More than one medical office visit, hospital room, or wound-care facility charge billed on the same day by the same Provider.
- Long-term care.
- Private-duty nursing.
- Weight-loss programs, except as required by the health reform law.
- Anything excluded under any other provision of the Plan.

Preventive Services Coverage Limitations and Exclusions

- Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Service covered for diagnostic reasons are covered under the applicable plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the Participant or dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

- Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.

- The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.

- Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.

- Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

- Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

    - o when required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

    - o when related to judicial or administrative proceedings;

    - o when related to medical research or trials; or

    - o when required to maintain employment or a license of any kind.

- Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

- Services related to a man's reproductive capacity, such as vasectomies and condoms.

Self-Audit Program

The Self-Audit Program provides you with a cash incentive to discover and arrange for the recovery of overcharges made on your inpatient Hospital bills. The program pays 25% of the actual amount of the overcharge that the Hospital agrees is valid. Reimbursement is subject to a maximum of $500 per Calendar Year. Payment for typographical errors is limited to $250.

Following is a detailed description of the Self-Audit Program including guidelines to assist you in reviewing the services received at a Hospital. Remember, always request an itemized bill in order to review the services rendered.

Self-Audit Program Guidelines

For purposes of the cash incentive, only Hospital expenses that the Plan covers, not telephone bills, television rental, newspapers, etc., shall be considered in determining the amount payable to you under this program. Claims involving coordination of benefits will be eligible only if this Plan is primary (that is, this Plan is required to pay benefits first for you or your dependents).

Proof of eligibility for a cash incentive must be submitted in the form of a copy of the initial itemized bill with the overcharges circled, and a copy of the adjusted bill showing that the Hospital dropped these charges. Such proof must be submitted to the Benefits Fund Office within 45 days following the date of discharge from the Hospital. Within 30 days after receipt of proof and verification that the overcharge has been recovered, the Fund will issue a check to you for 25% of the amount of the overcharge.

The Trustees and administrative staff of the Fund will not get involved in any differences between you and the Hospital with respect to disputed charges. You are solely responsible.

The Trustees have the sole right at any time to amend or modify these guidelines or terminate the Self-Audit Program entirely.

Suggestions for Reviewing Your Itemized Bills

- Before leaving the Hospital, make sure the Hospital provides or arranges to send an itemized bill.
- Either during your Hospital stay or immediately after discharge, list the events of your stay. Match this list against your actual Hospital bills to detect any overcharges.
- Check your bill carefully for charges that represent any treatments, services, or supplies that were not received. Follow this or a similar checklist.
- Determine if you were billed for the correct number of days; and for the correct type of room occupied (private, semi-private, ward).

- If intensive care was required, determine if you were billed for the correct number of days.
- Determine if you were charged for the day that you were discharged even though you left before the day's charges began.
- Determine if you were charged for only the tests or x-rays that you actually received.
- Determine if you were charged for medication, injections, dressings, supplies, etc., that you did not receive or for quantities in excess of what you remember.
- Determine if medication ordered by your Doctor for a specified period was billed to you for your entire Hospital stay.
- Determine if you were billed for purchases that you were not allowed to take home—for example, humidifiers, bedpans, admission kits, etc.
- If you received physical, radiation, inhalation, and/or occupational therapy, determine if you were charged for the correct type of treatment and for the correct number of hours.
- If you received a blood transfusion, determine if you were charged for blood that a donor, blood bank or a Red Cross family or community assurance program replaced.
- If admitted to the maternity wing, determine if you were billed for a labor room that may not have been used due to swift delivery.
- Ask for an explanation of specific terms used in your bill—for example, miscellaneous charges.

When an Overcharge is Discovered

- Circle any overcharges on your bill.
- Report the overcharges to the Hospital's billing department and request a corrected bill. If errors are properly identified in the Hospital bill, the Hospital must drop these charges, unless there is evidence in the medical file to the contrary.
- A copy of the adjusted bill is considered proof that the Hospital acknowledged and dropped the charges.

A Self-Audit Program payment is considered income to you and should be reported to the Internal Revenue Service.

Filing a Claim and Claim Information

Many health care providers will submit your claims for you. Be sure to show your ID card so your provider knows where to submit your claim. If your provider does not submit your claim for you, it is then your responsibility to do so. For prompt processing of your claims, please follow the detailed information in Appendix A, beginning on page 80.

Please submit your claims to the Benefits Fund Office as soon as possible. If you do not file a claim for benefits within 12 months of the date the service is received, the claim will not be processed and no benefits will be paid. You have up to 180 days to appeal a denied or partially denied claim.

Claim Forms

Claim forms are available by contacting the Benefits Fund Office. You may request/obtain forms by contacting the Fund:

800-621-5133, FAX 847-384-0197

Send completed forms and all bills, receipts or other documentation to:

United Food and Commercial Workers
Union and Employers
Calumet Region Insurance Fund
18861 90th Avenue, Suite A
Mokena, Illinois 60448-8467

Authorization to Release Personal Health Information

Help us communicate benefits to you and your family. Federal law requires that every adult covered person must give a written authorization before we may disclose personal health information to another person, such as a spouse, about the individual's treatment or coverage. If an authorization is not on file, we can disclose information only to the covered person.

You and any adult covered dependents should complete and return the "Authorization for Release of Personal Health Information" form as soon as you receive it from the Benefits Fund Office. We will then know to whom we are authorized to disclose information regarding health benefits coverage and medical treatment.

Payment or Status of Claims

To obtain the status of your claim, call the Benefits Fund Office. The person who calls must be you or someone you have authorized and should be able to provide the following information:

1. Your name and UFCW ID# or Social Security number.

2. Your current address and phone number.

3. The nature and date of the accident or Illness.

4. The name and location of the Hospital or Doctor.

All benefits under the Plan will be paid shortly after receipt of your proof of loss. Benefits for loss of life are payable to your beneficiary if surviving you, otherwise to your estate. All other benefits are payable to you.

Assignment

You may file a written assignment to have payment made directly to a provider of medical services and supplies. However, the Fund Administrator may reject or override an assignment and refuse to accept future assignments from a medical provider on behalf of you and your eligible dependents pursuant to criteria established by the Trustees.

Coordination of Benefits Provisions

Your Plan contains a coordination of benefits (COB) provision. This provision ensures that if you or an eligible dependent are covered by another group medical plan, you will receive all the benefits to which you are entitled from all plans.

Group Medical Plan

A group medical plan is one that covers medical expenses provided by:

- Group insurance.
- Group BlueCross, group BlueShield, or other prepayment coverage on a group basis, including health maintenance organizations (HMOs).
- Coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans.
- Coverage under governmental programs or coverage required or provided by any statute.
- School or association excess plans.
- Other arrangements of covered or self-covered group coverage.
- Plans for which any employer directly or indirectly has made contributions or payroll-deductions.

If you have a claim that is covered by two or more group medical plans, one plan—the primary plan—pays its benefits first, regardless of the amounts payable under any other plan. The other plans—the secondary plans—will adjust their benefit payments so that the total benefits paid to you do not exceed 100% of the charge for covered expenses.

Determining Which Plan is Primary

A plan without a COB provision is always the primary plan.

If a plan has COB provisions that conflict with the COB provisions of this Plan, the Trustees may in their discretion resolve the dispute by having each plan pay 50% of the allowable charges.

Generally, if the other plans have COB provisions, the following rules apply:

- The plan that covers the person as a non-dependent, such as an Employee, member, subscriber or retiree, pays before a plan that covers a person as a dependent.
- The plan that covers a person as an active Employee shall pay its benefits before a plan that covers the person as a laid-off or retired Employee.
- If this Plan covers the person under the COBRA provisions, it pays second.

- When the person is a dependent of parents who are not separated or divorced and both parents have medical coverage for their eligible dependent children, the plan of the parent whose birthday comes earlier in the Calendar Year will be considered the primary plan. If both parents' birthdays are on the same day, the plan covering the parent for the longer period of time will be primary. If one plan uses the male/female rule and the other plan uses the birthday rule, the plan using the male/female rule pays first.

- If the parents are separated or divorced, their plans will pay medical benefits for eligible dependents as follows:
  - o if no court decree exists and the parent with custody has not remarried, the plan of the parent with custody is primary.
  - o if the parents have joint custody and the divorce decree does not specify that one parent has responsibility for coverage, the birthday rule applies.
  - o if no court decree exists and the parent with custody remarries, the plan of the parent with custody pays first, the plan of the spouse of the custodial parent pays second, and the plan of the parent without custody pays last.
  - o if a court order states that one of the parents is responsible for the child's health care expenses, the health plan covering that parent is primary, provided the plan has knowledge of the court decree.

- If a person is covered by two plans as a non-dependent, the plan under which the person works the greater number of hours pays first.

- If a person is covered by a plan as a non-dependent and that other plan provides that the customary coordination of benefits rules for health insurance are inapplicable or a reduced level of coverage is applicable because the person in question is covered as a dependent under this Plan, then this Plan shall coordinate benefits as if the other plan had paid based upon the customary coordination of benefits rules for health insurance and the other plan's regular plan of benefits that would have applied to the individual but for the reduction in benefits due to coverage under this Plan. If the Plan cannot disregard the other plan's rule that seeks to avoid the result under customary coordination of benefits rules for health insurance and/or that seeks to apply a reduced level of benefits because of the individual's coverage as a dependent under this Plan, then this Plan will limit such individual's coverage under this Plan to a maximum benefit for claims incurred in a Calendar Year to $1,000 per Calendar Year.

- If none of the above rules apply in determining which plan pays first, then the plan covering the person for the longer continuous period of time shall be primary.

- If any plan has a provision that results in lower benefits being paid because of the existence of this Plan, this Plan shall pay as if the other plan had paid its regular benefits that would apply to a covered person based upon the customary coordination of benefits rules.

Primary Plan Procedures Must Be Followed

If you or your eligible dependent are covered under another plan that has primary responsibility for expenses, you must follow all required procedures to obtain treatment and to qualify for all benefits available under your other plan. If, for any reason, you do not follow your primary plan's procedures, this Plan limits coverage to expenses, if any, that would have been payable had the necessary procedures been followed.

Expenses incurred because of a primary plan's refusal for any reason to refer any covered person to any Doctor or type of Doctor or institution, will not be covered under this Plan.

Additionally, if you or your eligible dependent are covered under an HMO or clinic that provides necessary treatment without charge, you or your eligible dependent must obtain the treatment from the HMO or clinic. No benefits will be payable under this Plan for the expense of any treatment that would have been provided by an HMO or clinic without charge.

Coordination of Benefits With Medicare

Benefits from this Plan are coordinated with Medicare. Medicare is a government program that provides health insurance and prescription drug coverage to individuals age 65 and older and to permanently disabled individuals.

Generally, if you work for an employer that has 20 or more Employees, this Plan is primary and will pay benefits before Medicare in the following circumstances:

- you or your eligible dependent are age 65 or older and covered by this Plan due to your current employment status;
- you or your eligible dependent are under age 65 and entitled to Medicare due to Social Security disability and covered by this Plan due to your current employment status; or
- you or your eligible dependent are entitled to Medicare because of End Stage Renal Disease during the coordination period described by the Medicare regulations (currently, the first 30 months).

At all other times, this Plan is secondary to Medicare when allowed by law.

Coordination of Benefits With Automobile and Similar Coverage

Benefits from this Plan will not be paid for the cost of care, treatment, services or supplies that are furnished by or are payable under any motor vehicle or automobile insurance policy or plan or any plan or policy covering loss, liability or damage caused by a third party, including but not limited to, "no fault" or uninsured or underinsured motorist coverage.

Subrogation and Reimbursement Rights

If you receive benefits or are entitled to receive benefits under the Plan as the result of an incident such as an Illness or Injury that may be caused by another party, the Plan has the right to seek repayment of those benefits. For purposes of this section, "you," "your" or "claimant" means Plan participants, their parents and dependents (including minor dependents) or their representatives, guardians or trustees. The Plan's right to seek repayment is often called the right of subrogation or reimbursement. You may be required to sign a subrogation agreement with the Plan if a third party may be responsible for your Illness or Injury.

The Plan has the right to recover from any source of recovery, including, but not limited to, any third party or its insurer, any claim covered by workers' compensation or occupational disease laws, and any insurance policy that covers a claimant, or against which the claimant has or may have a claim, including, but not limited to, "med-pay," "personal injury protection," "financial responsibility," "no fault," "uninsured" or "underinsured" motorist coverage, school insurance, and homeowner policies.

If you bring a lawsuit to pursue your claim, benefits payable under the Plan must be included in your claim for relief. The Plan has the right to intervene in the lawsuit or to initiate its own lawsuit. If you hire an attorney, you need to provide the Plan with the attorney's name, address and telephone number as soon as possible. The Plan will not be liable for any expenses related to the lawsuit unless approved in advance by the Plan. The Plan has the right to be reimbursed immediately from proceeds obtained by settlement of a lawsuit, by judgement, or from any other recovery from any source. The Plan's rights apply to partial and full recoveries, regardless whether the recovery is designated for medical claims or whether the claimant is made whole. You must hold that portion of any recovery from any source that is equal to the amount of benefits paid or to be paid by the Plan until the Plan's subrogation and reimbursement rights are satisfied. You will reimburse the Plan immediately upon recovery. You must not do anything to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement. You will assist and cooperate with the representatives designated by the Plan. You will do everything necessary to enable the Plan to enforce its subrogation and reimbursement rights. The Plan's subrogation and reimbursement claim is equal to the benefits it has paid or may be obligated to pay for an Illness or Injury for which a third party may be responsible. A claimant may retain amounts exceeding the aggregate of: (a) the benefit amounts the Plan paid or may be obligated to pay, and (b) the costs, expenses and fees the Plan incurs enforcing its rights.

When a claim is settled or a judgement is obtained by you from any source, you must first reimburse the Plan for all benefits paid by the Plan to you or on your behalf (or that the Plan is obligated to pay) on a first dollar basis. You are obligated to refrain from doing anything that would prejudice the Plan's right of recovery. You may be required to sign and execute documents to secure the

Plan's rights. Benefit payments for new claims may be withheld for you and your dependents by the Plan until full compliance with the Plan's subrogation provision is achieved and any reimbursement owed to the Plan is made. If you have received benefits or recovery from other sources, the Plan may demand reimbursement for the benefits paid by the Plan or may credit the benefits or recovery received from other sources against benefits that the Plan may be required to pay in the future. The Plan may also pursue legal and equitable claims (e.g., imposing constructive trust, filing a claim for equitable lien by agreement) to enforce its rights. Once the Plan makes or is obligated to make payments on your behalf, the Plan is granted, and you consent to, an equitable lien by agreement or constructive trust on the proceeds of any payment, settlement or judgement received by you from any source.

Other Recoveries

Whenever benefit payments in excess of the maximum amount of payment required under the Plan have been made, the Plan has the right to recover such excess payments from any person for whom such payments were made, any insurance company or any other organization.

In the event payment is made to or for an individual who is not entitled to payment, the Plan has the right to suspend or withhold future payments to such person and/or his or her family members participating in the Plan. The reduced amount will equal the amount of the erroneous payment and any amount incurred by the Plan in recovering the overpayment. The Plan may take other actions, including filing a lawsuit. These recovery rights also apply to the Plan's subrogation and reimbursement rights.

Submission of Falsified or Fraudulent Claims

All claims, enrollment forms, and any other information submitted or provided to the Plan must be accurate and complete. If the Board of Trustees finds that false or inaccurate information in support of a claim has been provided to the Plan, whether directly or indirectly, the claim will be denied. Further, the Plan shall offset any amount improperly paid and/or terminate future coverage for the Participant and covered family members.

Claim Appeal Procedure

If you believe you have been improperly denied benefits provided for under the Plan, you are entitled to a full and fair review of your claim.

The procedure to follow to file an appeal is summarized here. For more detailed information, refer to Appendix A, beginning on page 80.

If your initial claim is denied, you will be given a written explanation within the period of time allowed by law. The explanation will provide:

- the specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- an explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;
- if the denial of a health or disability/income protection benefit claim was based on an internal rule, guideline, protocol, standard, or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;
- if the denial of a health benefit claim or disability/income protection claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request;
- with respect to disability/income protection claims, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination; and
- with respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

If you do not agree with the claim denial decision, you may file an appeal within 180 days of the date of the denial. To file an appeal, send a written statement that includes your reasons for appealing the denial decision and any supporting documents not previously furnished. If you need a description of any additional information to assist you in filing an appeal, contact the Benefits Fund Office. Send your appeal to:

Fund Administrator
Claim Appeal
UFCW Union and Employers
Calumet Region Insurance Fund
18861 90th Avenue, Suite A, Mokena, Illinois 60448-8467

The Plan will make its decision within the period of time allowed by law. You will be advised in writing of the decision. The decision(s) that you receive from the Fund Administrator or from the Board of Trustees will be written in a clear and understandable manner and will include a specific reason for the decision.

Statement of Rights Under the Employee Retirement Income Security Act of 1974

As a participant in the United Food and Commercial Workers Union and Employers Calumet Region Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are 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 union halls and worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, a copy of the latest annual report (Form 5500 Series) and a copy of an updated Summary Plan Description. The Plan 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 free of charge.

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 for the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misused the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest field office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website at dol.gov/ebsa.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 866-444-3272 or visit their website at dol.gov/ebsa.

Definitions

The following are definitions of specific terms and words used in this booklet.

Authorized Representative. An individual or entity who has been named in writing by a Plan participant to act on the participant's behalf to submit a claim or file an appeal. Once established, an Authorized Representative may only be dismissed in writing by the participant.

Benefits. Payments made to you and your eligible dependents pursuant to the Plan.

Calendar Year. The twelve month period beginning January 1 and ending the following December 31.

Collective Bargaining Agreements. The written agreement between Contributing Employers and the Union covering wages, hours and other terms and conditions of employment for Employee-Members in the bargaining unit represented by the Union and requiring the Contributing Employer to make contributions to the Fund on behalf of bargaining unit Employee-Members.

Contributing Employer. Any one or more individuals, partnerships, associations, legal representatives, and corporations of every nature that:

- has or will enter into a collective bargaining agreement with the Union covering Employees represented by the Union; and
- adopts and agrees in writing to be bound by the Fund's Agreement and Declaration of Trust and any amendments thereto; and
- makes contributions to the Fund as required by the collective bargaining agreement; and
- are approved by the Trustees for participation.

Contributions. Payments made by the Contributing Employer to the Fund pursuant to a collective bargaining agreement or other written agreement between the Contributing Employer and the Union.

Covered Employment. Services performed as an Employee of a Contributing Employer for which contributions are made to the Fund.

Disability/Total Disability. The inability of an Employee to perform all the duties of his or her employment for which employer contributions are payable to the Fund as a result of an Illness or Injury, or the inability of an eligible dependent to perform the normal activities or duties of a person of the same age and sex. To be considered totally disabled, a person must also be continuously, during the entire period of disability, under the care of a Doctor for treatment consistent with the disability.

Doctor/Physician. A person who is duly licensed by the appropriate state agency of the state in which the services are performed practicing within the scope of his license as:

- a Doctor of Medicine (M.D.);
- a Doctor of Osteopathy (D.O.);
- a Doctor of Dental Surgery (D.D.S.);
- a Doctor of Podiatry (D.P.M.);
- a Doctor of Chiropractic (D.C.); or
- a Doctor of Medical Dentistry (D.M.D.).

Durable Medical Equipment. Equipment that is intended for repeated use and is not a consumable or disposable item and that is used primarily for a medical purpose.

Eligible Dependent. See page 9.

Employee/Employee-Member. An individual who works for a Contributing Employer that pays contributions to the Fund for the individual's work in accordance with a written agreement providing for such contributions.

Fund Administrator. A person or entity employed by the Trustees, charged with any administrative duties of the Fund, such as recordkeeping, reporting and disclosure, processing of applications for benefits, and related functions attendant to the administration of the Plan.

Fund/Health Fund/Trust Fund. The term "Fund" or "Trust Fund" means all cash and other property held by the Trustees under the terms of the Agreement and Declaration of Trust.

Health Care Provider. May include, but not limited to, the institutions or persons listed below legally licensed and/or legally authorized to practice or provides medical care or diagnostic treatment to sick or injured persons under the laws of the state or jurisdiction in which the services are rendered:

- Home Health Agency;
- Ambulatory Care Facility;
- Licensed ambulance service;
- Practitioner;
- Physician;
- Hospital;
- Laboratory;
- Skilled Nursing Facility;
- Hospice;
- Licensed clinical social worker;

- Licensed social worker;
- Licensed clinical professional counselor;
- Occupational, physical, respiratory or speech therapist;
- Certified alcohol and drug counselor;
- Licensed nurse practitioner; and
- Residential treatment facilities.

Hospital. An institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and meets all of the following criteria:

- it is accredited as a Hospital by The Joint Commission.
- Medicare recognizes it as a Hospital.
- it meets all of the following tests:
    - maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Doctors;
    - provides continuous 24-hour-a-day nursing service on the premises by or under the supervision of registered graduate nurses; and
    - is operated continuously with organized facilities on the premises for operative surgery, except for (1) mental/psychiatric Hospitals; (2) drug/alcohol rehabilitation Hospitals; and (3) physical rehabilitation Hospitals.
- it does not include any institution:
    - that is run mainly as a rest, nursing, or convalescent home; or
    - for which any part is mainly for the care of the aged; or
    - that is engaged in the schooling of its patients; or
    - that does not meet all of the above requirements.

Illness. Any marked, pronounced deviation from a normal, healthy state. Illness also includes pregnancy.

Injury. Any damage to the body.

Medically Necessary or appropriate. A medical service, supply, treatment or confinement will be determined to be "Medically Necessary" by the Plan Sponsor if it meets all the following requirements:

- is provided by or under the direction of a Physician or other Health Care Provider who is licensed and authorized to provide or prescribe it;
- is determined by the Plan Sponsor or its designee to be necessary in terms of generally accepted medical standards in the U.S.; and

- is determined by the Plan Sponsor to meet all of the following requirements:
    - it is consistent with the symptoms or diagnosis and treatment of the Illness or Injury;
    - it is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or health care facility;
    - it is an "Appropriate" service or supply given the patient's circumstances and condition;
    - it is the most "Cost-Efficient" supply or level of service that can be safely provided to the patient;
    - it is safe and effective for the Illness or Injury for which it is used; and
    - for Hospital Confinement, it cannot be safely provided on an outpatient basis.

The fact that a Physician or other Health Care Provider orders or recommends a service, supply, treatment or confinement does not in itself make them Medically Necessary.

A medical service, supply, treatment or confinement will be considered to be "Appropriate" if:

- it is a diagnostic procedure that is called for by the health status of the patient, and is:
    - as likely to result in information that could affect the course of treatment as; and
    - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.
- it is care or treatment that is:
    - as likely to produce a significant positive outcome as; and
    - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

Mental or Nervous Disorder. A mental Illness or organic functional nervous disorder that is identified as a mental or nervous disorder in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Conditions included in the DSM for which mental health treatment is received will be considered a mental Illness, regardless of the etiology of the patient's symptoms; i.e., if the symptoms are due to an organic (physical) cause or are considered functional (non-physical) in origin.

Plan. The program of benefits established by the Trustees, the United Food and Commercial Workers Union and Employers Calumet Region Insurance Plan, as amended from time to time.

Trustees. The Trustees signatory to the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund Agreement and Declaration of Trust and their successors who are duly appointed in accordance with the terms of such Trust Agreement as Plan Sponsors and fiduciaries. The Trustees in their collective capacity will be known as the "Board of Trustees of the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund" and may conduct the business of the Trust and execute all instruments in that name.

Union. Any local union affiliated with United Food and Commercial Workers International Union that has or will become a party to the Agreement and Declaration of Trust.

Usual and Customary Charge. With respect to a provider outside of the geographic area served by the PPO, the charge for Medically Necessary services or supplies will be determined by the Plan Sponsor or its designee to be the lowest of:

- the usual charge by the Health Care Provider for the same or similar service or supply; or
- no more than 85% of the "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply; or
- the Health Care Provider's actual charge.

With respect to a PPO provider and any other provider within the geographic area served by the PPO, the Usual and Customary Charge means the charges set forth in the agreement between the PPO provider and the PPO or the Plan.

- The "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Fund Administrator who shall use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity.
- No provision of this Plan requires the Plan to pay benefits based on the charges submitted by a proprietary provider of a medical supply or service.

With respect to Dental Services provided to an individual under the age of 19 or to an individual under the age of 19, the Usual and Customary Charge is the usual charge determined by the standards of generally accepted dental practice made by most Dentists for the same or similar service.

Important Information about the Plan

The Employee Retirement Income Security Act of 1974 (ERISA) requires certain information be furnished to you when you participate in an employee benefit plan. This is your Summary Plan Description. This Plan is maintained pursuant to a collective bargaining agreement.

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

The Fund
United Food and Commercial Workers
Union and Employers
Calumet Region Insurance Fund
18861 90th Avenue, Suite A
Mokena, Illinois 60448-8467

Telephone: 800-621-5133
FAX: 847-384-0197

The Trustees of the Plan* are:

Employer Trustees	Union Trustees
Jeffrey Strack	Bill O'Keefe
Samuel Van Til	Steven M. Powell

The Alternate Trustees of the Plan* are:

Employer Trustee	Union Trustee
Richard Bugajski	Anthony Malito
Derek Kinney	

**as of this printing*

Name of Plan. This Plan is known as the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund.

Board of Trustees. A Board of Trustees is responsible for the operation of this Plan. Except as otherwise stated, the Board of Trustees has discretionary authority to determine eligibility for benefits and to construe the terms of the Plan. A decision by the Board of Trustees shall be final and binding, unless determined by a court of law to be arbitrary and capricious. Benefits will only be paid under the Plan if the Trustees, in their discretion, determine that the applicant is entitled to them. The Board of Trustees also has the right to amend or terminate the Plan or any of its benefits, in whole or in part, at any time. The Board of Trustees consists of an equal number of Employer and Union representatives selected by the Employers and local Union that have entered into collective bargaining agreements that relate to this Plan.

Plan Sponsor. The Board of Trustees is the Plan Sponsor.

Identification Numbers. The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 35-1065816.

Agent for Service of Legal Process. The Plan's agent for service of legal process is the Board of Trustees. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Fund Administrator or upon any individual Trustee at the address of the Benefits Fund Office.

Source of Contributions. The benefits described in this booklet are provided through employer contributions. The amount of employer contributions and the Employees on whose behalf contributions are made, are determined by the provisions of the collective bargaining agreements. The Benefits Fund Office will provide, upon written request, information as to whether a particular employer is contributing to the Fund on behalf of Employees working under the collective bargaining agreement.

Trust Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

Plan Year. The records of the Plan are kept separately for each Plan Year. The Plan Year begins December 1 and ends November 30.

Type of Plan. This Plan is maintained for the purpose of providing death, disability, medical, prescription drug, vision and dental benefits in the event of death, accident or Illness. The Plan benefits are summarized in the Summary of Benefits beginning on page 1.

Eligibility. The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described in the Plan document, and are summarized beginning on page 6.

Claim Procedure. The procedure to follow for filing a claim for benefits is summarized beginning on page 61. If all or any part of your claim is denied, you may appeal that decision within 180 days (see page 68). Also refer to Appendix A beginning on page 80 for detailed information on how to file a claim or how to appeal a claim denial.

Type of Administration. The Fund currently self-insures the medical, dental, prescription drug and income protection benefits provided under the Plan.

Medical PPO Benefit
BlueCross BlueShield
www.bcbs.com
800-810-2583

Prescription Drug Benefit
WellDyneRx
https://members.welldynerx.com
888-479-2000

Tokio Marine HCC. HCC Life Insurance Company provides stop-loss insurance that will reimburse the Fund for certain losses in excess of amounts described in the stop-loss insurance policy. Under the policy, HCC Life Insurance Company has no obligation to pay benefits or make any other payments to any Plan participant.

Continuation of Plan. The Board of Trustees intends to continue the Plan indefinitely. To protect against any unforeseen situations, however, the Trustees reserve the right to change the Plan. In the event the obligations of all employers to make contributions to the Fund shall terminate or the Plan otherwise terminates, the Trustees shall determine the disposition of any assets in the Trust remaining after all expenses of the Fund have been paid, provided that any such distribution shall be made only for the benefit of former participants and for the purposes set forth in the Trust Agreement.

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan document. The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgement, conditions so warrant.

Unless otherwise indicated, the benefits described in the Plan document and in this Summary Plan Description are self-funded by the Plan. The benefits payable are limited to Plan assets available for such purposes.

Appendix A:
Claim Procedures

for Medical, Dental, Vision, Prescription Drug, Income Protection, Death Benefit, and Accidental Death & Dismemberment Claims

Internal Claims and Appeal Procedures

This describes the procedures followed by the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance abuse, dental, vision, hearing aid, prescription drug, income protection, death, and accidental death and dismemberment benefits.

The Plan's internal claims and appeal procedures are designed to provide an Eligible Employee and his or her Eligible Dependents with full, fair, and fast claim review so that Plan provisions are applied consistently with respect to an Eligible Employee and his or her Eligible Dependents and other similarly situated Participants and dependents. With respect to health benefit claims, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies an Eligible Employee or Eligible Dependent's initial claim for benefits (known as an "adverse benefit determination"), that Eligible Employee or Eligible Dependent has the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, an Eligible Employee or Eligible Dependent may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

General Information

Claims Administrator(s)

The Fund Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Zenith American Solutions 18861 90th Avenue, Suite A Mokena, IL 60448 800-621-5133 or 312-649-1200 zenith-american.com	• Medical Post-Service Claims • Pre-Service Claims • Mental Health Urgent, Concurrent and Pre-Service Claims • Substance Abuse Urgent, Concurrent and Pre-Service Claims • Income Protection Benefit Claims • Death Benefit Claims • Accidental Death and Dismemberment Claims • Vision Pre-Service and Post-Service Claims • Dental Pre-Service and Post-Service Claims • Hearing Post-Service Claims
Medical Cost Management (MCM) 1-800-367-9938	• Urgent, Concurrent and Pre-service Medical Claims
WellDyneRx 500 Eagles Landing Drive Lakeland, FL 33810 1-888-479-2000 https://members.welldynerx.com	• Pre-service drugs • Post-Service Claims for out-of-network retail drugs

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Discretionary Authority of Fund Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Fund Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- a reduction of a benefit resulting from the application of any Pre-Authorization decision, source-of-Injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- a rescission of coverage, whether or not there is an adverse effect on any particular health or disability/income protection benefit. An adverse benefit determination does not include rescissions of coverage with respect to accidental death and dismemberment insurance/death benefits.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a doctor or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Culturally and Linguistically Appropriate Notices

All notices sent to claimants relating to internal claims and appeal review for health and disability/income protection benefits will contain a notice about the availability of Spanish language services. Assistance with filing a claim for internal review in Spanish is available by calling 1-800-621-5133. Notices relating to internal review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-621-5133.

Definition of a Claim

A claim is a request for a Plan benefit made by an Eligible Employee or his or her Eligible Dependent (also referred to as "claimant") or his or her authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits.

There are four categories of health claims as described below:

- ***Pre-Service Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)** – A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for medical, mental health, substance abuse, and prescription drug benefits.

- ***Urgent Care Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- ***Concurrent Claims*** **(applicable to medical, mental health, substance abuse, dental, and prescription drug benefits)** – A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- ***Post-Service Claims*** **(applicable to medical, mental health, substance abuse, dental, vision, hearing aid, and prescription drug benefits)** – A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Income Protection Benefit Claims

An Income Protection Claim is a request for benefits during a period of disability. Income Protection Claims are filed after a Participant suffers a disability and benefits are paid if the Claims Administrator determines that the Participant has suffered a disability as defined by the terms of the Plan.

Accidental Death and Dismemberment Insurance/Death Benefit Claims

An Accidental Death and Dismemberment Insurance/Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the Participant or the death of a covered dependent. A claim for Accidental Death and Dismemberment Benefits may also be filed by a Participant after he or she has provided the Plan with proof of a bodily loss.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- be received by the Fund Administrator or Claims Administrator (as applicable);
- name a specific individual Participant and his/her Social Security Number or Unique ID Number;
- name a specific claimant and his/her date of birth;
- name a specific medical condition or symptom;
- provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- when another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- not made in accordance with the Plan's benefit claims filing procedures described in this section;
- made by someone other than an Eligible Employee, his or her Eligible Dependent, or an Eligible Employee's (or his or her Eligible Dependent's) authorized representative;
- made by a person who will not identify himself or herself (anonymous);
- a casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- a request for prior approval where prior approval is not required by the Plan;
- an eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- the presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, an Eligible Employee or Eligible Dependent may file a claim with the Plan; or

- a request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, an Eligible Employee or his or her Eligible Dependent may file a claim with the Plan.

If an Eligible Employee or his or her Eligible Dependent submits a claim that is not complete or lacks required supporting documents, the Fund Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims should be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than twelve (12) months from the date the charges were incurred.

A claim for the Income Protection Benefit must be submitted within two weeks of the onset of the disability. Subsequent reports confirming care and treatment must be submitted every three weeks thereafter.

Written notice of Illness or Injury upon which a claim for any other benefit may be based must be given to the Benefits Fund Office within 90 days of the date on which an expense was first sustained for an Illness or Injury for which benefits may be claimed.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by an Eligible Employee, his or her Eligible Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be an Eligible Employee or his or her Eligible Dependent's authorized representative.

Health Care Claims – Decision Timeframes

The Plan will provide an Eligible Employee or his or her Eligible Dependent, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give the Eligible Employee or his or her

Eligible Dependent a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, the Eligible Employee or his or her Eligible Dependent will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give the Eligible Employee or his or her Eligible Dependent a reasonable opportunity to respond prior to that date.

- *Pre-Service Claims* (applicable to medical, mental health, substance abuse, and prescription drug benefits)

  Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. An Eligible Employee or his or her Eligible Dependent will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided the Eligible Employee or his or her Eligible Dependent is given written (or electronic, if applicable) notification before the expiration of the initial fifteen (15) day determination period.

  If an Eligible Employee or his or her Eligible Dependent improperly files a Pre-Service Claim, the Claims Administrator will notify the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, the Eligible Employee or Eligible Dependent must re-file a claim to begin the Pre-Service Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will notify the Eligible Employee or his or her Eligible Dependent in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, the Eligible Employee or Eligible Dependent will have 45 days following his or her receipt of the notice to supply the additional information. If the Eligible Employee or Eligible Dependent does not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which the Eligible Employee or Eligible Dependent is permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives the Eligible Employee or Eligible Dependent's response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable).

- *Urgent Care Claims* (applicable to medical, mental health, substance abuse, and prescription drug benefits)

  In the case of an Urgent Care Claim, if a health care professional with knowledge of an Eligible Employee or his or her Eligible Dependent's medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be that Eligible Employee or Eligible Dependent's authorized representative, bypassing the need for completion of the Plan's written authorized representative form.

  The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to the Eligible Employee or Eligible Dependent and his or her health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

  If an Eligible Employee or his or her Eligible Dependent improperly files an Urgent Care Claim, the Claims Administrator will notify that Eligible Employee or Eligible Dependent and his or her health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, the Eligible Employee or Eligible Dependent must re-file a claim to begin the Urgent Care Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will provide the Eligible Employee or his or her Eligible Dependent and his or her health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, the Eligible Employee or Eligible Dependent will have not less than 48 hours following receipt of the notice to supply the additional information. If the Eligible Employee or Eligible Dependent does not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to the Eligible Employee or Eligible Dependent and his or her health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end of the period given for the Eligible Employee or Eligible Dependent to provide this information, whichever is earlier.

- *Concurrent Claims* (applicable to medical, mental health, substance abuse, dental, and prescription drug benefits)

  If a decision is made to reduce or terminate an approved course of treatment, an Eligible Employee or his or her Eligible Dependent will be provided with a written (or electronic, as applicable) notification of

the termination or reduction sufficiently in advance of the reduction or termination to allow that Eligible Employee or Eligible Dependent to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved, the Eligible Employee or Eligible Dependent will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, the Eligible Employee or Eligible Dependent will be notified orally with written (or electronic, as appropriate) notice.

- *Post-Service Claims* (applicable to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug claims)

  Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. An Eligible Employee or his or her Eligible Dependent will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

  The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

  If a claim cannot be processed due to insufficient information, the Claim Administrator will notify the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, the Eligible Employee or Eligible Dependent will have 45 days after his or her receipt of the notice to supply the additional information. If the Eligible Employee or Eligible Dependent does not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which the Eligible Employee or Eligible Dependent is permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date that the Claims Administrator receives the Eligible Employee or Eligible Dependent's written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable).

Disability/Income Protection Claims – Decision Timeframes

Claims for Disability/Income Protection benefits will be decided no later than 45 days after receipt by the appropriate Claims Administrator. An Eligible Employee or his or her Eligible Dependent will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided the Eligible Employee or his or her Eligible Dependent is given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies the Eligible Employee or his or her Eligible Dependent of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided the Eligible Employee or his or her Eligible Dependent is notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify the Eligible Employee or his or her Eligible Dependent in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, the Eligible Employee or his or her Eligible Dependent will have 45 days after his or her receipt of the notice to supply the additional information. If the Eligible Employee or his or her Eligible Dependent does not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which the Eligible Employee or his or her Eligible Dependent is permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives the Eligible Employee or his or her Eligible Dependent's written response to the request for information. The Claims Administrator then has 30 days to make a decision and notify the Eligible Employee or his or her Eligible Dependent in writing (or electronically, as applicable).

Accidental Death and Dismemberment Insurance or Death Benefit – Decision Timeframe

Generally, an Eligible Employee or his or her Eligible Dependent will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator, you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies an Eligible Employee or his or her Eligible Dependent's initial claim, in whole or in part, that Eligible Employee or Eligible Dependent will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- identify the claim involved (and for health benefit claims – include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- give the specific reason(s) for the denial (and for health benefit claims – include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- if the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- reference the specific Plan provision(s) on which the denial is based;
- describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- with respect to health and disability/income protection benefit claims, the opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to an initial claim for benefits;
- provide an explanation of the Plan's internal appeal and external review for health benefit claims processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;
- contain a statement that the Eligible Employee or his or her Eligible Dependent has the right to bring civil action under ERISA section 502(a) following an appeal;
- with respect to health and disability/income protection benefit claims, if the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol or similar criteria that was relied upon will provided to the Eligible Employee or his or her Eligible Dependent free-of-charge upon request;

- if the denial of a health care claim or disability/income protection claim was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to the Eligible Employee or his or her Eligible Dependent free-of-charge upon request;

- with respect to disability/income protection claim, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;

- for Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and

- with respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist the Eligible Employee or his or her Eligible Dependent with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, an Eligible Employee or his or her Eligible Dependent will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to an Eligible Employee or his or her Eligible Dependent and his or her health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

- *Health Care Claims* (applicable to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits)

  If an initial health care claim is denied (in whole or in part) and an Eligible Employee or his or her Eligible Dependent disagrees with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below

in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

- Disability/Income Protection Claims

  If an initial Disability/Income Protection Claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

- Accidental Death and Dismemberment Insurance/Death Benefits

  If an initial accidental death and dismemberment /death benefit claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an appeal. You have 180 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 180-day period.

Internal Appeals Process

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan at the following address:

Board of Trustees
United Food and Commercial Workers
Union and Employers
Calumet Region Insurance Fund
18861 90th Avenue, Suite A
Mokena, IL 60448-8178
1-800-621-5133

Appeal requests involving Urgent Care Claims may be made orally by calling the Board of Trustees at the telephone number listed above.

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- the opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

- the opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

- with respect to health and disability/income protection benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;

- a full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

- with respect to health and disability/income protection benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies;

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- with respect to health and disability/income protection benefit claims appeals, continued coverage during the pendency of the appeal process; and

- in deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

    o consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment;

- is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
- the Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- **Health Care Claims**
  - Pre-Service Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits). A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.
  - Urgent Care Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits). This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).
- **Concurrent Claims *(applicable to medical, mental health, substance abuse, dental, and prescription drug benefits).*** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Board of Trustees. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.
- **Post-Service Claims *(applicable to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits).*** The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing,

an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you in writing (or electronically, as applicable) of the benefit determination no later than five (5) calendar days after the benefit determination is made.

- **Disability/Income Protection Benefit Claims.** The Plan will make an appeal determination no later than the date of the meeting immediately following the Plan's receipt of your written request for an appeal, unless the request for an appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary the Plan must provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you of the benefit determination no later than five (5) calendar days after the benefit determination is made.

- **Accidental Death and Dismemberment Insurance/Death Benefit Claims.** A written (or electronic, as applicable) notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Plan.

Notice of Adverse Benefit Determination upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- the specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;

- reference the specific Plan provision(s) on which the denial is based;

- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;

- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

- an explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;

- if the denial of a health or disability/income protection benefit claim was based on an internal rule, guideline, protocol, standard, or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;
- if the denial of a health benefit claim or disability/income protection claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request;
- with respect to disability/income protection claims, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination; and
- with respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan.

Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a claimant) along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Administrator).

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

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative until the designation is revoked in writing by the Participant, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Fund Administrator.

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

Limitation on When a Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. With respect to health and disability/income protection benefits, the law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.

In addition, with respect to health care claims, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than three years after the end of the year in which services were provided, or, if the claim is for disability benefits, more than three years after the start of the disability.

Elimination of Conflict of Interest

With respect to health and disability/income protection benefits, to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

External Review of Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Culturally and Linguistically Appropriate Notices

All notices relating to external review sent will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling 1-800-621-5133. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-621-5133.

Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- the adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment; and

- the denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

- claims that involve only contractual or legal interpretation without any use of medical judgment.
- a determination that you or your dependent are not eligible for coverage under the terms of the Plan.
- claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.
- claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- claims that relate to benefits other than health care benefits (such as dental/vision benefits that are considered excepted benefits).
- claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- if the Plan waives the requirement that you complete its internal claims and appeals process first;
- in an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal; and
- if the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeals is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain, in writing, why you are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, contact the following:

Fund Administrator
United Food and Commercial Workers
Union and Employers Calumet Region Insurance Fund
18861 90th Avenue, Suite A
Mokena, IL 60448
800-621-5133 or 312-649-1200

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- you are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided;
- the adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage;
- you have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed); and
- your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- your request is complete and eligible for external review;
- your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number

866-444-EBSA (3272).); and

- your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must

provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- the IRO will timely notify you in writing that your request is accepted for external review;
- the IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline;
- within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination;
- if you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review;
- the IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo*, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit;
- to the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other

information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s); and

- in a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- a general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial;
- the date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon;
- a statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
- a statement that judicial review may be available to you; and
- a statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

- you receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; and
- you receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, contact the following:

Fund Administrator
United Food and Commercial Workers
Union and Employers
Calumet Region Insurance Fund
18861 90th Avenue, Suite A
Mokena, IL 60448
800-621-5133 or 312-649-1200

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim *de novo* meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require,

but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made?

If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

Appendix B: Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. The effective date of this notice is September 23, 2013.

The United Food and Commercial Workers Union and Employers Calumet Region Insurance Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures. Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations. The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals

between one or more of your providers. For example, the Plan may disclose to a treating Doctor the name of your treating radiologist so that the Doctor may ask for your x-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, and pre-authorizations). For example, the Plan may tell a treating Doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes. For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and Disclosures that Require that You be Given an Opportunity to Agree or Disagree Prior to the Use or Release. Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or is helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and Disclosures for which Your Consent, Authorization or Opportunity to Object is Not Required. The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

- For treatment, payment and health care operations.
- Enrollment information can be provided to the Trustees.
- Summary health information can be provided to the Trustees for the purposes designated above.
- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

- When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

- The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit pro-grams (for example, to investigate Medicare or Medicaid fraud).

- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

- When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgement.

- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and Disclosures that Require Your Written Authorization. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI. You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request, (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket). You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI. You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2004; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of this Notice upon Request. You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note about Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of an un-emancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard. When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

The Plan Sponsor will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;
- ensure that the adequate separation discussed in Item (d) above, specific to electronic PHI, is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- report to the Plan any security incident of which it becomes aware concerning electronic PHI.

De-Identified Information. This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information. The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach. The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Your Right to File a Complaint with the Plan or with the US Department of Health and Human Services Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at: 18861 90th Avenue, Suite A, Mokena, Illinois, 60448-8467, 800-621-5133.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

Appendix C: Prescription Drug Creditable Coverage— Medicare Part D

The information below can help you decide whether or not you want to join a Medicare drug plan. If you defer enrollment in Part D, you will need this Appendix C (or the similar notice that you will receive each year from the Benefits Fund Office) in order to avoid paying a higher premium (a penalty).

Your Prescription Drug Benefits and Medicare Prescription Drug Coverage

If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is located on page 114.

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

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

When can you join a Medicare drug plan?

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

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

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current UFCW Plan coverage will be affected. Your coverage under the UFCW Plan will be coordinated with your Medicare prescription drug coverage.

If you decide to join a Medicare drug plan and drop your current UFCW Plan coverage, be aware that you and your covered dependents will not be able to get this coverage back until the UFCW Plan's next open enrollment period in November.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

If you are entitled to Medicare and you drop or lose your coverage with the UFCW Plan and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about this Notice or your Current Prescription Drug Coverage

Contact the person listed below for further information. Note: You will receive a notice similar to this Appendix C each year. You will also get it before the next period you can join a Medicare drug plan, and if your UFCW Plan coverage changes. You also may request a copy of the notice at any time.

For More Information about your Options under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

- Visit https;//www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more information about this extra help, visit Social Security on the web at socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 2020
Name of Sender:	UFCW Calumet Region Insurance Fund
Contact:	Joshua Todd, Fund Administrator
Address:	18861 90th Avenue, Suite A Mokena, IL 60448
Telephone Number:	630-974-4515

5869746v7/02964.023

Notes

UFCW CALUMET REGION INSURANCE FUND
18861 90th Avenue, Suite A
Mokena, Illinois 60448