UNITED FOOD AND COMMERCIAL WORKERS
UNION LOCAL 655 WELFARE FUND

To All Eligible Employees:

The Board of Trustees is pleased to present you with this new booklet describing the benefits of the United Food and Commercial Workers Union Local 655 Welfare Fund (the Plan).

The Schedule of Benefits Grid that is enclosed with this booklet is a part of this Summary Plan Description. It describes the ways that medical benefits are provided to you through the Plan. You have the choice of receiving medical benefits through in-network providers or out-of-network providers.

In-Network benefits are provided through a network of physicians and hospitals that has contracted with the Plan to offer discounted services. You may choose from the options listed on your Schedule of Benefits the way you wish to receive service at the time you need it. This is referred to as a Point of Service (POS) Plan. This means that you may choose the in-network option (or options) listed on your Schedule of Benefits or you may choose the out-of-network option.

The difference in your choices is outlined in your Schedule of Benefits. Choices may include services offered through physicians and hospitals in a Preferred Provider Organization (PPO), which offers medical care at discounted rates.

You may also obtain care from an Out-of-Network physician or hospital. A Non-Network physician or hospital is one that does not belong to a PPO.

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

People Resources provides you with assistance if you need treatment for mental health concerns or chemical dependency. You will be provided with free counseling by telephone when you call the member assistance division of People Resources at 800-765-9124. If your condition requires additional treatment, People Resources must authorize your care and a counselor will assist you in choosing a course of treatment within your provider network and benefit plan. See your Schedule of Benefits and page 26 for additional information.

Please read this booklet carefully so that you can fully understand your benefits. If you are married, show this booklet to your spouse and let your spouse know where you keep it filed. If you have any questions about the Plan, call the Welfare Fund Office at 314-835-2700 in the St. Louis area or toll free in Missouri or in Illinois at 866-565-2700.

Sincerely,

Board of Trustees
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INTRODUCTION

The Local 655 Health and Welfare Plan (Plan) offers health care coverage to help you and your dependents stay healthy and to provide financial protection against catastrophic medical expenses. If you qualify for benefits, the Plan provides:

- Medical benefits;
- Prescription drug benefits;
- Dental benefits;
- Vision care benefits;
- Life insurance benefits;
- Accidental Death and Dismemberment (AD&D) benefits; and
- Weekly Disability Income benefits.

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

Rules about Plan interpretation. Only the Board of Trustees is authorized to interpret the Plan. The Board has full discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of benefits payable to you. Individual Trustees, employers or union representatives do not have the authority to interpret the Plan on behalf of the Board or to act as agents of the Board. The Board also has the discretion to determine the facts of any claim you make for Plan benefits.

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

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

Changes in your family’s status and other events in your life. You may have a change in your family’s status or you may experience other events in your life that affect your benefits while you are covered by this Plan. In that case, you should consult the chart beginning on the next page for a handy reference of steps you should take with regard to your benefits.

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

- Be covered under a bargaining unit contract or participation agreement that requires your employer to make contributions on your behalf; and
- Meet the eligibility requirements to qualify for the benefits described in this booklet.
# TABLE OF BENEFITS INFORMATION FOR EVENTS IN YOUR LIFE

For Forms and Information, contact the:
UFCW Local 655 Welfare Fund Office
13537 Barrett Parkway Drive, Suite 100
Manchester, Missouri 63021

Telephone: In the St. Louis Area:
314-835-2700
In Missouri Outside St. Louis or in Illinois, call Toll-Free: 1-866-565-2700

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### INFORMATION YOU AND YOUR DEPENDENTS CAN USE WHEN THESE EVENTS OCCUR WHILE YOU ARE COVERED

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<th>If this happens to you or a covered Dependent:*</th>
<th>You may…</th>
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…Choose your level of service: PPO or Out-of-Network | 29 and your Schedule of Benefits | –Your Doctor  
–The contact listed on your ID card | –Your Identification Card for PPO Providers  
–Medical Claim Form for Out-of-Network Providers |
| You need hospitalization                        | …Determine whether the care is covered or excluded by the Plan  
…Choose your level of service: PPO or Out-of-Network  
…Notify the network provider at the number listed on your medical ID card of hospitalization | 29 and your Schedule of Benefits | –Your Doctor | –Your Identification Card for PPO Providers  
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| You need prescription drugs                    | …Determine whether the prescription drugs are covered or excluded by the Plan and whether your pharmacy is listed | 39 and your Schedule of Benefits | –Pharmacy | –Your Identification Card |
| You need dental care                            | …Determine whether the care is covered by the Plan, and the level of coverage  
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| You need vision care                            | …Determine whether the care is covered by the Plan  
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| Adding a child*                                 | …Add your new dependent to existing coverage*  
…Change Beneficiary | 5 | –Welfare Fund Office | –Birth Certificate or Court Document |
| Your covered child reaches age 19 but is younger than 23 and is a full-time student | …Dependent can continue coverage* | 10 | –Welfare Fund Office | –Proof of full-time student status |
| Your covered child reaches age 19 if NOT a full-time student, or reaches age 23 if a full-time student | …Your dependent child may apply for COBRA continuation coverage* | 15 | –Welfare Fund Office | –Notify the Welfare Fund Office within 60 days  
–COBRA election form within 60 days  
–Timely payment for COBRA coverage |
| Marriage                                        | …Add Spouse to existing coverage*  
…Change Beneficiary | 5 | –Welfare Fund Office | –Copy of Marriage License |
### INFORMATION YOU AND YOUR DEPENDENTS CAN USE WHEN THESE EVENTS OCCUR WHILE YOU ARE COVERED

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* Only Unit 1 employees can have covered dependents. If your spouse is employed and your spouse’s employer pays any part of the cost of an employee health plan, your spouse must enroll in that plan in order to be covered by this Plan (see page 9).
ELIGIBILITY FOR BENEFITS

Enrolling in the Plan

When you become eligible to participate in the United Food and Commercial Workers Union Local 655 Welfare Fund, you will receive an enrollment package from the Welfare Fund Office that contains an enrollment form and questionnaire. You must complete this form and questionnaire and return it to the Welfare Fund Office. After the Welfare Fund Office receives your completed information, the Plan will begin providing benefits on your behalf. You must use an enrollment form to:

• Sign up as a new plan participant;
• Add or drop coverage for your spouse;
• Add or drop a dependent child;
• Change your address; or
• Change your beneficiary.

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

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

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

You will receive your medical insurance card within two weeks of your initial eligibility date. The medical insurance card provides information about notification of hospitalization and referrals for mental health and substance abuse treatment. The treatment that requires notification and referral is listed in your Schedule of Benefits. The telephone numbers for notification and referral are listed on your insurance card.
Who Is Eligible for Benefits under the Plan

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

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

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

How You Earn Initial Eligibility

The number of hours you work and your employer’s written agreement with the Union determine what types of benefits you receive. You earn eligibility for Welfare Plan benefits through your hours of work each week or each month for which your employer reports your hours and makes contributions to the Welfare Fund on your behalf.

Level of Coverage

Your employer has made an agreement with the appropriate Union to provide a certain level of coverage under this Plan. You will be covered by the Plan as a Unit 1 or Unit 2 employee when you have met the Plan’s eligibility requirements. The specific eligibility requirements that you must meet are outlined in the Schedule of Benefits that is provided to you with this booklet. Your eligibility is based on the number of hours you work, the date you started working for your employer and when your employer starts making contributions to the Plan on your behalf.

Unit 1 – Hourly. You are eligible for Unit 1 benefit coverage after you have been credited with an average of the required number of contribution hours each week for a calendar month and after you are enrolled in the Plan.

See your Schedule of Benefits Grid enclosed with this booklet for the required number of hours you must work to be eligible for Unit 1 Hourly benefits and for examples of how you become eligible for benefits.

The definition of a week varies according to your employer’s payroll practices. If your payroll period ends on a Saturday, your week runs from Sunday to Saturday. If your payroll period ends on a Monday, your week runs from Tuesday to the following Monday. If the end of the week (payroll period) falls in a calendar month, then all hours for that week are included in that month. This is true even if some of that week falls in the previous month. A month excludes any week for which the end of the week falls in the next month.

As an example, if the employer’s payroll period ends on a Saturday which falls on May 2, then all hours worked in the week beginning with the previous Sunday are counted in May even though most of the week falls in the preceding month of April. None of those hours are counted in April.
Your eligibility for Unit 1 benefits begins on the first day of the second month following the month in which contributions are received. This means that your benefits begin on the first day of the third month in which your employer makes contributions to the Welfare Fund on your behalf. You will not be covered under the Plan if your employer fails to make contributions.

**EXAMPLE:** Julie begins working on October 1, 2004 and her employer begins making contributions on that date. Julie is credited with an average of the required number of contributions hours during each week from October 1 through October 28, 2004. Julie’s Unit 1 benefits begin on December 1, 2004.

**Unit 2 – Hourly.** You are eligible for Unit 2 benefit coverage if you have been credited with an average of the required number of contribution hours each week for a calendar month.

See your Schedule of Benefits Grid enclosed with this booklet for the required number of hours you must work to be eligible for Unit 2 Hourly benefits and for examples of how you become eligible for benefits.

Your eligibility for Unit 2 benefits begins on the first day of the second month following the month in which contributions were received. This means that your benefits begin on the first day of the third month in which your employer makes contributions to the Welfare Fund on your behalf. Contribution hours are counted in the same way as they are for Unit 1 – Hourly employees. You will not be covered under the Plan if your employer fails to make contributions.

**EXAMPLE:** Richard begins working in January and the collective bargaining agreement requires his employer to make contributions on his behalf after six months. Richard’s employer will start making contributions July 1. Richard will be eligible on September 1, provided he worked the required number of hours in July.

However, if Richard’s employer is not required to begin making contributions on his behalf until the following January, he will be eligible on the first day of the following March, provided he has worked the required hours to qualify for Unit 1 - Hourly or Unit 2 - Hourly benefit coverage during the month of January.

**Contributions Generally Do Not Start Immediately**

Most collective bargaining agreements and participation agreements do not require contributions until you have been employed for a certain length of time. If you are a Unit 1 – Hourly or Unit 2 – Hourly employee working under a collective bargaining agreement or participation agreement that requires contributions to begin after a specified time period, you will be eligible for benefit coverage based on contributions received. Benefits begin on the first day of the third month in which your employer makes contributions to the Welfare Fund on your behalf, provided you have worked the hours required for coverage.

**EXAMPLE:** Richard begins working in January and the collective bargaining agreement requires his employer to make contributions on his behalf after six months. Richard’s employer will start making contributions July 1. Richard will be eligible on September 1, provided he worked the required number of hours in July.

However, if Richard’s employer is not required to begin making contributions on his behalf until the following January, he will be eligible on the first day of the following March, provided he has worked the required hours to qualify for Unit 1 - Hourly or Unit 2 - Hourly benefit coverage during the month of January.
Unit 1 Monthly. Your benefit coverage may be determined on a monthly basis rather than an hourly basis if the collective bargaining agreement or participation agreement your employer signed with the United Food and Commercial Workers Union requires monthly contributions. You may contact the Welfare Fund Office to determine whether your employer is required to make monthly contributions to the Welfare Fund for Unit 1 benefits.

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

**EXAMPLE:** Patrick is credited with a monthly contribution for work in January. His eligibility for Unit 1 benefits is effective March 1, which is the first day of the second month following his employer’s monthly contribution on his behalf.

How You Continue Your Unit 1- Hourly or Unit 2 - Hourly Eligibility

Unit 1 – Hourly and Unit 2 – Hourly. Once enrolled, you will remain covered for either Unit 1 – Hourly or Unit 2 – Hourly benefits if you work the required average number of contribution hours each month. Your continued eligibility for Unit 1 or Unit 2 benefits requires that you be credited with an average of the required number of contribution hours each week during a calendar month. See your Schedule of Benefits Grid enclosed with this booklet for the required number of hours you must work to continue eligibility for Unit 1 or Unit 2 Hourly benefits and for examples of how you continue to be eligible for benefits.

Average contribution hours per week are determined on a monthly basis as described in the Eligibility Example in your Schedule of Benefits Grid enclosed with this booklet. Weeks vary according to your employer’s payroll practices. If the employer’s weekly payroll period ends on a Saturday, then hours worked in each week count for the month in which the Saturday occurs.

How You Change Eligibility Between Unit 1- Hourly and Unit 2 - Hourly

If your eligibility is based on hourly contributions and your average number of weekly contribution hours changes, your eligibility for Unit 1 or 2 may change. Changes between Unit 1 and Unit 2 coverage are allowed as follows:

**From Unit 1 to Unit 2.** Your eligibility will change from Unit 1 to Unit 2 coverage if you are covered for Unit 1 benefits and your average number of contribution hours per week in a calendar month is reduced to the required number of Unit 2 contribution hours per week, as shown in your Schedule of Benefits, for Unit 2 benefits. Your eligibility for Unit 2 coverage begins on the first day of the second month following the month in which your average number of contribution hours per week was less than the required number of hours for Unit 1 coverage, but met the minimum average number of hours per week required for Unit 2 coverage.
From Unit 2 to Unit 1. If you are covered for Unit 2 benefits and the average number of contribution hours credited to you in a calendar month increases to the required number of contribution hours per week for Unit 1 coverage, your eligibility will change from Unit 2 to Unit 1 coverage. Your eligibility for Unit 1 coverage begins on the first day of the second month following the month in which you average the required number of Unit 1 contribution hours or more per week.

For examples of how you may meet the hourly eligibility work requirements and how your eligibility may change from Unit 1 to Unit 2 or from Unit 2 to Unit 1, see your Schedule of Benefits enclosed with this booklet.

How You Continue Your Unit 1 Monthly Eligibility

Unit 1 Monthly. Your eligibility for Unit 1 Monthly benefits will continue for as long as you work the required average number of hours each month and you are credited with a monthly employer contribution.

Covering Your Dependents

If you are eligible and enrolled under Unit 1, your dependents will become covered under the Plan on the same day your own coverage begins if they are enrolled at the same time. If you acquire a dependent after you become eligible, that dependent will become eligible on the date he or she becomes your dependent. **No coverage is available for dependents if your eligibility is under Unit 2.** Your dependents must be listed on your enrollment form. Until your dependents are listed on the enrollment form, they will not be covered. You must complete a new enrollment form to add them to your coverage before they will be covered.

Coverage of Your Spouse

If your spouse is employed and your spouse’s employer pays any part of the cost of an employee health plan, your spouse must enroll in that plan in order to be covered by this Plan. This means that if your spouse has other health coverage available through his or her employer and your spouse’s employer pays any portion of the cost of that coverage, your spouse must elect coverage under that employer’s plan. **If your spouse has other subsidized coverage available and does not enroll in that coverage, your spouse will not be covered by this Plan.**

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

This requirement applies only to your spouse. Eligibility requirements for dependent children are described in the next section. If your spouse can elect coverage only during a specific enrollment period, under the spouse’s plan, this Plan will provide coverage up to the date of the open enrollment. If your spouse needs a certificate of creditable coverage to enroll for coverage under his or her employer’s plan, please contact the Welfare Fund Office.

Your legal spouse is a person of the opposite sex to whom you are legally married in a lawful ceremony, under the laws of the state in which you reside. **This Plan does not recognize common law marriages. The Plan may require proof of the legal marital relationship. Your legally separated spouse or divorced former spouse is not an eligible spouse under this Plan.**
You must complete and return a *Spousal Coverage Verification Form* if you are married. The form is your certification of your spouse’s employment situation that informs the Plan whether your spouse is eligible for coverage under a subsidized plan of his or her employer. The Fund will not pay claims incurred by your spouse until you complete and return this form to the Fund Office. This form will also help the Fund Office coordinate benefits for your spouse and confirm your spouse’s eligibility for coverage under this Plan.

**Your Eligible Dependent Defined**

If you are eligible under Unit 1, your eligible dependents include the following individuals, provided they are either citizens of the United States or residents of the United States, Canada, or Mexico (with certain exceptions for adopted children, as provided in the Internal Revenue Code):

- Your legal spouse.
- Each of your unmarried children from birth to 19 years of age who are dependent on you for more than one-half of their support and maintenance and who have a principal place of residence with you for more than one-half of the calendar year.
- Your unmarried dependent child between the ages of 19 and 23 years of age, if the child:
  - Attends an accredited high school, college, university or vocational school full-time, as defined by the institution the child is attending; and
  - Continues to rely on you for more than one-half of his or her financial support and maintenance; and
  - Maintains a principal place of residence with you for more than one-half of the calendar year.
- Your unmarried dependent child at any age, if the child becomes physically or mentally disabled before eligibility under the Plan would otherwise end due to age, and meets one of the two following requirements.
  - The child is a dependent disabled child of yours. The child is a dependent disabled child of yours if:
    - He or she is totally dependent on you for financial support, and
    - Maintains his or her principal place of residence with you for more than one-half of the calendar year,
  OR
  - The child is a qualifying relative of yours. The child is a qualifying relative of yours if:
    - You provide over one-half of the child’s support for the calendar year, and
    - The child is not a qualifying child, as defined in the Internal Revenue Code, of yours or of anyone else during the calendar year.

Physically or mentally disabled means that the child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more.

The term child includes:
- A natural born child; or
- A legally adopted child; or
- A child placed in your home for adoption; or
- A step-child; or
- A foster child, which means a child who is legally in your physical custody pursuant to a court order or state placement, provided the foster child does not have healthcare coverage provided by a state or state agency.
In order to continue coverage under the Plan for a physically or mentally disabled child, you must submit medical evidence of the handicap to the Welfare Fund Office within 31 days of the date your dependent's eligibility would normally end. The Board of Trustees may request continuing proof of existence of the handicap from time to time. When the Board of Trustees receives the proof of incapacity, it has the right to have a Physician of the Board’s choice examine the child. The Board may require such an examination as often as it believes is reasonable.

If a child does not live with you after a divorce or separation, the child will be a dependent child, provided that:

- The child's parents:
  - Are divorced or legally separated under a decree of divorce or separate maintenance; or
  - Are separated under a written separation agreement; or
  - Live apart at all times during the last six months of the calendar year;

- The child’s parents provide over one-half of the child’s support during the calendar year; and

- The child is in the custody of one or both of his or her parents for more than one-half of the calendar year.

**Qualified Medical Child Support Orders**

The Plan provides coverage for your children that are required to be covered by a Qualified Medical Child Support Order (QMCSO). A QMCSO is generally a court order that directs a medical plan covering a parent to provide benefits to the parent’s children. The Plan will provide benefits in accordance with such an order. A child covered by a QMCSO is called an alternate recipient and is treated as a dependent under the Plan if he or she meets the criteria specified in the law governing QMCSOs. If you think this law may apply to you, you may want to contact your legal counsel.

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

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

A QMCSO is an order entered by a state domestic relations court or agency that requires medical coverage for children affected by the Order.

A QMCSO may not be used to expand the definition of a child eligible for coverage.
When Coverage Ends

When your, or your eligible dependent’s, coverage ends, you or your dependent will be provided with Certification as to the length of Coverage under the Plan. This may help reduce or eliminate any pre-existing condition limitation under a new group plan. See page 69 for additional information.

<table>
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<th>WHEN COVERAGE ENDS</th>
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<td>Unit 1 or Unit 2 Hourly Benefits</td>
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<tr>
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When Your Dependents’ Coverage Ends

Your dependent’s eligibility under Unit 1 ends on the earlier of:

- The date your eligibility under Unit 1 terminates;
- The date of your dependent’s death;
- The date the Plan ends; or
- The date your dependent no longer meets the definition of dependent as stated on page 10.

In the event of your death if you are a Unit 1 employee, your dependents’ coverage will be continued for three months immediately after the end of the month in which your death occurred. The extension of coverage to your surviving dependents is provided by the Plan free of charge if you are covered under Unit 1.

Your dependents’ eligibility for Plan benefits ends three months after the end of the month in which your death occurred unless they elect COBRA continuation coverage as described on page 15. The COBRA continuation period begins after the three-month period.

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

- The date your child’s incapacity no longer exists;
- The date your child fails to submit to any required medical examinations;
- The date you fail to provide required proof of uninterrupted existence of your dependent child’s incapacity; or
- The date your child is no longer either your disabled dependent child or your qualifying relative, as described on page 10.
You May Continue Coverage During Family and Medical Leave

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

- The birth, adoption, or placement with you for foster care, or adoption of a child;
- The care of a seriously ill spouse, parent or child; or
- Your serious illness.

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

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

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

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

Your Family and Medical Leave Act Hours Are Counted

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

Duty of Your Employer

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

Extension of Coverage for Disability

If your average number of contribution hours is reduced because you are absent from work due to a non-work-related sickness or injury and you are under the care of a physician for that sickness or injury, your coverage under Unit 1 or Unit 2 will be extended for up to three months beyond the date it would normally end. You may elect COBRA continuation coverage if you are still absent after this three-month extension. This three-month disability extension is not counted in calculating the amount of your COBRA continuation period. Your COBRA period will begin after the disability extension period.

The extension of your eligibility for three months due to absence from work because of non-work related sickness or injury includes any absence from scheduled work that you take as leave under the Family and Medical Leave Act (FMLA). No additional extension beyond the stated maximum three months will be granted under the FMLA.
If your absence is due to a work-related sickness or injury covered by Workers' Compensation, your eligibility can be extended for up to six months while you are disabled. You may elect COBRA continuation coverage if you are still absent after this six-month extension and the COBRA period will start at the end of the six-month extension. See page 15 for information about COBRA continuation coverage.

Your eligibility will be extended under the same benefits (Unit 1 or 2) for which you were eligible during the month you would have otherwise lost eligibility. To qualify for the Disability Extension of Eligibility, you must present medical evidence to support your disability claim:

- That is satisfactory to the Board of Trustees; and
- That shows you are unable to work due to sickness or injury.

**Extension of Certain Benefits for Total Disability**

If an employee becomes totally disabled while covered under this Plan, and coverage is terminated while treatment is in progress, coverage for some benefits for the disabled employee will be continued beyond the date coverage would otherwise end. Limited coverage will be continued under the medical plan only.

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

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

The extension applies:

- Only to the charges related to treatment of the disabling condition that existed on the eligibility termination date.
- Only if the employee has not received the maximum benefits under this Plan.
- If COBRA is elected this provision applies after COBRA is exhausted.

If the employee is covered under the extension of benefits provision and becomes eligible under another group plan as an employee, the extension of benefits will end on the date the employee becomes covered or would have become covered under the other plan.

**You May Continue Coverage During Military Service**

Your health care coverage (either the Unit 1 or Unit 2 benefits for which you are covered) will continue if you serve in the Uniformed Services of the United States (active duty or inactive duty training) for up to 31 days. If you serve for more than 31 days, you may continue your coverage at your own expense for up to 24 months (18 months if you elected continuation coverage because of military service before December 10, 2004) under COBRA and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). See the next section for more information about COBRA continuation coverage. You may also continue coverage for your dependents if they were covered under the Plan at the time you entered military service.

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

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

*Special Note. The extension of benefits covers only the disabling condition. If you want to be covered for other medical conditions, or beyond the extension time period, you must elect COBRA continuation coverage within 60 days (see page 15). You will not be given the opportunity to elect COBRA continuation coverage when the extension of benefits ends.*

*Generally Uniformed Services means service in the United States Army, Navy, Marine Corps, Coast Guard, National Guard or Commissioned Corps of the Public Health Service.*
If you leave contributory employment to enter the Uniformed Services, you may use up your remaining earned eligibility while you are in the Uniformed Services or you may choose to save that already earned eligibility to cover you when you return to contributory employment. For example, if you had been steadily employed for 40 hours a week for a year prior to entering the Uniformed Services on May 31 of 2006, you would have already earned coverage for June and July of 2006. You could use that eligibility in June and July or you could save it and have two months of eligibility when you return to work in contributory employment. If when you return to contributory employment, you do not have any remaining already earned eligibility, you may pay for your benefits (at COBRA rates) until you have requalified for coverage under the Plan based on your contribution hours.

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

- The date of your death;
- The date you or your dependents do not make the required payments within 30 days of the due date;
- The date the Plan or Welfare Fund Office no longer provides any group health benefits;
- The date you reinstate your eligibility for coverage under the Plan; or
- The last day of the 24th consecutive month of coverage (18 consecutive months of coverage if you elected continuation coverage because of military service before December 10, 2004) or the last day of any extension of the coverage period allowed under the COBRA or USERRA rules.

For more information about paying for your own coverage under USERRA, contact the Welfare Fund Office at 314-835-2700 in the St. Louis area or call toll free at 1-866-565-2700 in Missouri outside St. Louis or in Illinois.

You May Continue Coverage Through COBRA

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

This means that if you were a Unit 1 employee, you would be given the option to continue your Unit 1 coverage. You may choose to continue either only Medical benefits or Medical plus Dental and Vision benefits. If you were a Unit 2 employee, you would be given the option to continue your Unit 2 coverage. You may choose to continue either only Medical benefits or Medical plus Vision benefits. Life, Accidental Death and Dismemberment and Weekly Disability coverage is not available through COBRA.

If you lose eligibility for Unit 1 benefits and become eligible for Unit 2 benefits, you will only have the option of electing the Dental benefits because that is the only benefit covered under COBRA for which you will lose coverage. However, because your dependent children and spouse would lose all coverage if you change from Unit 1 to Unit 2 benefits, they will be given the choice of continuing Medical benefits only or Medical plus Dental and Vision benefits.

Only Unit 1 employees who lose eligibility for Unit 1 benefits and become eligible for Unit 2 benefits will be permitted to self-pay for only Dental benefits through COBRA.
EXAMPLES: Charlie works full time as a Unit 1 employee. When he loses eligibility for all Plan benefits his COBRA self-pay choice is between:
• Medical; or
• Medical plus Dental and Vision.

He cannot choose:
• Only Dental and Vision without choosing Medical; or
• Medical with only Dental; or
• Medical with only Vision.

John, on the other hand is a part-time Unit 2 employee. When he loses eligibility for all Plan benefits his COBRA self-pay choice is between:
• Medical; or
• Medical plus Vision.

He cannot have Dental coverage because he was not eligible for that coverage as an active employee. He cannot choose Vision alone without electing Medical benefits.

If Charlie, in the first example above, loses eligibility for Unit 1 benefits, but not Unit 2 benefits, his COBRA self-pay choice is Dental only because he is covered for all other active employee benefits under Unit 2.
If Charlie is married, however, his spouse and dependents (if any) will have a COBRA self-pay choice between:
• Medical; or
• Medical plus Dental and Vision benefits.
They have this choice because they would lose coverage when Charlie changes from Unit 1 coverage to Unit 2 coverage, which does not cover dependents.

Your continuation coverage will be identical to the coverage you had under the Plan, as that coverage may change from time to time. You will not be eligible to continue coverage for the Life Insurance, Weekly Disability Income or Accidental Death & Dismemberment Insurance (AD&D) benefits.

You Must Have a Qualifying Event

You do not have to show that you are insurable for COBRA continuation coverage. It is offered to you if you lose coverage and, to your dependents, if they lose coverage, if loss of coverage is the result of certain circumstances known as qualifying events. To be eligible for continuation coverage, you and your dependents must be covered by the Plan at the time of the qualifying event. These qualifying events and the length of coverage are shown in the Length of Coverage chart on page 17.

Each covered individual who loses eligibility for health care benefits due to one of the qualifying events described on pages 16 and 17 is a “qualified beneficiary.” Each qualified beneficiary has an independent right to elect COBRA coverage. However, one qualified beneficiary can elect COBRA coverage on behalf of all of the qualified beneficiaries who lost coverage due to the same qualifying event.

If you are eligible to continue Unit 1 coverage and you have a newborn child, adopt a child, have a child placed with you for adoption (for whom you have financial responsibility), add a spouse through marriage or otherwise add a dependent while
your COBRA continuation coverage is in effect, you may add that dependent to your coverage. You must give the Welfare Fund Office written notice of the birth, adoption, placement of a child with you for adoption or addition of a spouse in order to have the dependent added to your coverage. Newborn or newly-adopted children who are added while your COBRA coverage is in effect will have the same COBRA rights as if they were qualified beneficiaries covered by the Plan before the event that triggered COBRA continuation coverage. Any other dependents who are added to your coverage will not be treated as qualified beneficiaries. As with qualified beneficiaries, you must make continuous COBRA payments on time to keep uninterrupted coverage for dependents you add.

If your dependents are entitled to 18 months of COBRA coverage and then experience another qualifying event that would have resulted in a loss of coverage if it occurred while you were actively working, your dependents may extend the length of coverage.

The extension:

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

## LENGTH OF COVERAGE

<table>
<thead>
<tr>
<th>If This Qualifying Event Occurs While You and Your Dependents Are Covered by the Plan</th>
<th>COBRA Coverage Is Available For</th>
<th>The Maximum Length of Coverage from the Qualifying Event Is</th>
</tr>
</thead>
</table>
| End of your employment (for reasons other than gross misconduct) | • You and dependents covered by Unit 1 | • 18 months  
• 29 months if you or your dependent is disabled* |
| Reduction in your hours so that you no longer meet eligibility requirements | • You and dependents covered by Unit 1 | • 18 months  
• 29 months if you or your dependent is disabled* |
| Your death** | • Dependents covered by Unit 1 | • 36 months |
| Your entitlement to Medicare within 18 months prior to your termination or reduction in hours | • Dependents covered by Unit 1 | • 36 months from the date of entitlement to Medicare |
| Your entitlement to Medicare during the first 18 months of COBRA | • Dependents covered by Unit 1 | • 36 months only if it would have resulted in a loss of coverage if it occurred while you were an active Employee |
| Divorce or legal separation | • Dependents covered by Unit 1 | • 36 months |
| Children no longer qualify as eligible dependent | • Dependents covered by Unit 1 | • 36 months |

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

** See also the section entitled Continuation of Dependents’ Medical Benefits After Your Death on page 51.
Additional Coverage for Disability: As noted in the Length of Coverage chart above, in cases of disability, coverage for you and your dependents may continue for a total of 29 months (an additional 11 months) after your employment ends or you have a reduction in your hours. This additional coverage is available to all qualified beneficiaries, whether or not the disabled person elects COBRA coverage. To qualify, you or one of your dependents must be Totally Disabled (as determined by the Social Security Administration) either:

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

You must notify the Welfare Fund Office of your determination of Disability by the Social Security Administration within 60 days of the decision and no later than the end of the 18-month initial COBRA period. Your dependents may elect the additional coverage even if you do not elect it. If you or your dependents do not notify the Welfare Fund Office within 60 days of the Social Security disability determination, the right to elect the additional coverage is lost.

You Must Notify the Welfare Fund Office

You, your dependent or representative must inform the Welfare Fund Office in writing within 60 days of the date you legally separate, divorce or your child loses dependent status under the Plan. If you do not notify the Welfare Fund Office in writing within 60 days of such an event, you lose your right to elect COBRA continuation coverage.

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

You Must Elect COBRA Continuation Coverage

When the Welfare Fund Office is notified that one of these events has occurred, you and your dependents will be notified of your right to elect COBRA coverage. Once you receive a COBRA notice, you have 60 days to respond if you wish to elect COBRA continuation coverage. Even if you do not elect coverage, your dependents have the opportunity to elect coverage independently from you if they were covered under Unit 1 benefits. If a COBRA election is not made and returned within the 60 days, the right to COBRA coverage is lost.

Contact for COBRA Questions

If you or a dependent has any questions regarding this Plan’s COBRA continuation coverage, call or write:

COBRA Coordinator
UFCW 655 Welfare Fund
13537 Barrett Parkway Drive, Suite 100
Manchester, Missouri  63021-5866
(314) 835-2700
You Must Pay for COBRA Continuation Coverage

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

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

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

Coverage During Election Period and Payment Periods

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

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

Things to Consider When Deciding Whether to Take COBRA Coverage

The decision to elect or reject COBRA can have an effect on the individual’s future rights regarding health benefits under federal law. First, under federal law, if a person has had health coverage continuously for 12 (or in some cases 18) months, and has less than a 63-day gap in health coverage when he or she becomes covered under another group health plan, that next group health plan cannot limit coverage for any pre-existing conditions that person may have. Taking COBRA coverage may help the individual complete 12 (or 18) months of coverage under this Plan and may help him or her to avoid a 63-day gap in coverage.

Second, federal law generally requires that insurance companies offer individual health insurance policies with no pre-existing condition limitations to individuals who have exercised their rights to take COBRA continuation coverage from group health plans for the maximum period. If a person does not take COBRA, he or she will lose this protection.
Finally, under the federal law, an individual has the special right to enroll in any other group health plan for which he or she may be eligible (such as a plan sponsored by a spouse’s employer) within 30 days after his or her regular coverage under this Plan terminates due to a qualifying event. The individual will not have to wait until that other plan’s next open enrollment period. If that individual elects COBRA continuation coverage under this Plan, he or she will have that same special right to enroll in another group health plan at the end of the COBRA coverage if he or she keeps the COBRA coverage for the maximum period it is available.

You Can Lose Your COBRA Coverage

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

• You or your dependents do not make the required COBRA payments within 30 days of the due date;
• The Plan stops providing any group health benefits;
• After the Qualifying Event you or your dependents become covered under another group health care plan that does not contain any exclusions or limitations concerning any pre-existing conditions which apply; or
• You or a qualified beneficiary becomes entitled to Medicare.

When COBRA coverage ends, certification of length of coverage under this Plan will be given. This may help reduce or eliminate any pre-existing condition limitation under a new group medical plan. (See page 69 for additional information regarding your rights under ERISA.)

Special COBRA Rules for Individuals Eligible For Trade Adjustment Assistance

The Trade Act of 2002 provides that certain workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may be determined by the United States Department of Labor or other government agency to be eligible for “trade adjustment assistance” or “TAA.” In connection with COBRA coverage, the Trade Act provides special election periods, special rules regarding starting dates and pre-existing condition rules, and possible help in paying for COBRA. If you are determined to be eligible for trade adjustment assistance, contact the Welfare Fund Office. Also if you have questions about trade adjustment assistance you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information is available online at: www.doleta.gov/tradeact.

Keep Welfare Fund Office Informed of Addresses

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

The Early Retirement Incentive Program (ERIP) provides coverage for you and your covered dependents until your 65th birthday, if you retire prior to your 65th birthday and meet certain criteria determined by the Board of Trustees. Generally, you will be eligible for ERIP coverage if you are receiving a pension from a UFCW Pension Fund, you retire before reaching age 65 and you have 20 pension credits under the Local 655, Local 881 and/or the Local 534 Pension Plan. To meet the pension credit requirement, you will receive credit for years of eligibility in the Local 655 Health & Welfare Plan if contributions were made to this Plan on your behalf for a period of employment for which you would have earned pension credits if you had been working for an employer that was required to contribute to a UFCW Pension Plan.

Your employer’s collective bargaining agreement may require your employer to contribute to the Plan for your coverage under the ERIP. Generally, this means that your employer, you and the Plan will each pay some percentage of the cost of your coverage under the Plan. However, if your employer is not required by a collective bargaining agreement to contribute for your coverage under the ERIP, you may self-pay the employer’s share in addition to your share to obtain coverage under the ERIP if you are otherwise eligible for coverage. If your employer is paying a portion of your ERIP and files for bankruptcy after your retirement, the Fund will pay a percentage of the cost of your coverage under the ERIP and you will pay a percentage. You should contact the Welfare Fund Office for information about eligibility and the self-payment rates for ERIP coverage. The Trustees reserve the right to modify or discontinue the provisions of the Early Retirement Incentive Program at their discretion.

If you retired prior to January 1, 2005, contributions under the ERIP program will be governed by the relevant collective bargaining agreement. If you retire on or after January 1, 2005, you must pay one-half of the COBRA rate for ERIP coverage and the Fund will pay the remainder of the cost, regardless of the inclusion of the ERIP program in the collective bargaining agreement.

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

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

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

To continue coverage, your spouse and dependents must:

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

Your spouse may continue coverage until:

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

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

Rejecting Plan Coverage

You have the right to reject Welfare Plan coverage if you are Medicare eligible. If you are married and you reject Plan coverage, your spouse must sign an acknowledgement agreeing that he/she will not have coverage under the Plan. Contact the Welfare Fund Office for more information.

Reinstatement of Eligibility

Your eligibility will be reinstated for benefits under Unit 1 or 2:

- If you meet the contribution requirements described in the continued eligibility sections (see page 8 and your Schedule of Benefits);
- Beginning on the first day of the second month following the month in which you were credited with the required employer contributions.

Reinstatement of Eligibility after Leaves of Absence

If your coverage ends while you are on an approved leave of absence or while you are on family medical leave under the Family and Medical Leave Act (FMLA) that exceeds 12 weeks or that is not approved by your employer, your coverage will be reinstated on the first day of the second month following the month in which employer contributions are received on your behalf, subject to all eligibility guidelines and hours requirements listed on your Schedule of Benefits and all accumulated annual and lifetime maximums that were in effect before the leave of absence. This provision is not effective if you were terminated and rehired. See the section explaining FMLA leave on page 13.

If your coverage ends while you are on an approved leave of absence for military service in the Uniformed Services or while you are on an approved family medical leave under the Family and Medical Leave Act (FMLA), your coverage will be reinstated, without evidence of good health, as required by Federal law (see pages 13-15).

Reciprocity Agreements

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

Your Plan includes programs designed to manage your costs for health care. Some Plan benefits have certain restrictions or limitations. See your Schedule of Benefits, the list of Covered Medical Expenses on page 29 and the list of Limitations and Exclusions on page 36 for more information. In order to maximize your Plan benefits, please read the following provisions carefully.

Your Choice

This Plan is designed to provide you with maximum freedom to choose how your health care is handled. You decide, at the time you need medical service, if you will receive care from:

- A doctor or hospital in a Preferred Provider Organization network; or
- An Out-of-Network doctor or hospital.

With this Plan of medical care, your choice determines the level of benefits you will receive. The level of network or out-of-network benefits is explained in your Schedule of Benefits.

Certain networks (or groups) of physicians and hospitals have agreed to provide services at negotiated fees. Out-of-network physicians and hospitals do not have contracts to provide services at specified fees.

The network includes a great number of physicians and hospitals throughout your geographic area. “Out-of-network” refers to all other licensed physicians and hospitals that do not belong to the network.

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

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

If you receive treatment from an out-of-network physician or in an out-of-network hospital you will generally be required to satisfy an annual deductible that is higher than the deductible when you use network providers. The deductible amount for out-of-network providers includes any deductible amount you satisfied when treated by a network provider.

After you satisfy your deductible, the Plan will pay a percentage of your medical expenses, but the percentage is lower than the percentage the Plan pays when you use network providers. This means that the amount you pay for treatment by an out-of-network physician or in an out-of-network hospital is higher than when you are treated by network providers.
Once you reach your out-of-pocket maximum, the Plan will pay 100% of your eligible expenses. You should refer to your Schedule of Benefits that accompanies this booklet for the deductible amount and the percentage the Plan pays for out-of-network providers.

Copayments you make do not count against the network or the out-of-network deductibles or out-of-pocket maximums. For information about how to file claims for reimbursement of your covered out-of-network expenses, see How to File Claims on page 53.

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

**Schedule of Benefits**

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

**Pre-Authorization of Hospitalization**

Pre-authorization is the process of notifying the Plan of your hospitalization. When a network physician recommends a hospital confinement, your network physician will call your provider network to notify the network of the hospitalization. When an out-of-network physician recommends a hospital confinement, either you or your physician must call your provider network at the number listed on your Schedule of Benefits and your insurance card to notify the network of the hospitalization.

If you receive out of network care that could have been provided on an outpatient basis, the Plan will not cover any charges related to that confinement.
**Annual (Calendar Year) Deductible**

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

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

- Copayments;
- Dental expenses;
- Vision expenses;
- Prescription drug expenses; and
- Charges that are not covered expenses.

**Coinsurance**

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

**Copayment**

Your copayment is a specific dollar amount that you pay to the network provider for a certain service. Copayments are listed in your Schedule of Benefits. The term “copay” that is used on the Schedule of Benefits has the same meaning as copayment.

**Out-of-Pocket Maximum**

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

- Your deductible;
- Copayments you make for visits to network physicians;
- Mental health and chemical dependency treatment you receive if treatment was not referred by an assessor or case manager under the People Resources program;
- Charges you must pay for treatment received from an out-of-network physician or hospital that is over the reasonable and customary charge recognized by this Plan, and
- Charges that are not covered expenses.

Generally, to receive the highest benefits, you should use network doctors and hospitals. By using network providers, you avoid paying an annual deductible; and charges over the reasonable and customary charge set by the Plan because the Plan considers the contract fee of the network provider to be reasonable and customary.
Lifetime Maximum

The lifetime maximum is the maximum amount that the Plan will pay in medical care benefits over your lifetime or over the lifetime of your dependent while covered under the Plan. The lifetime maximum for you and each of your dependents is listed in your Schedule of Benefits. Certain benefits are subject to lower lifetime maximum amounts, as listed in your Schedule of Benefits.

Medically Necessary Treatment

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

- Necessary and appropriate to treat the condition; and
- Non-experimental or non-investigational; and
- Not in conflict with accepted medical standards.

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

Reasonable and Customary Charge

The reasonable and customary charge for medical care and treatment is an amount determined to be consistent with the prevailing charge for comparable treatment or service made by most physicians or providers with similar training and experience in the same geographic location where the treatment or service is furnished. This determination is made using current available data about prevailing charges. Treatment you receive from a network physician or hospital is at negotiated rates that are guaranteed to be consistent with the reasonable and customary charge recognized by this Plan. The determination by the Trustees as to what is a reasonable and customary charge is final.

Mental Health and Chemical Dependency Care and Referral Requirement

People Resources is a managed mental health and chemical dependency program built around an independent network of certified specialists. The program provides services and referrals for treatment of mental health and chemical dependency problems. People Resources is not an agent of the Plan and the Plan is not responsible for their actions or errors. To receive benefits under the program, you must first contact a People Resources program assessor (case manager) at 800-765-9124.

Program assessors are licensed mental health professionals – physicians, psychologists and masters-prepared licensed professional counselors – who are experienced in total mental health assessment. The program assessors are available 24 hours a day by telephone. The number is listed above and on your Schedule of Benefits and your Insurance Card. When you or your dependents need treatment, the assessor will refer you to a network provider.
Covered Expenses under the Program

*If care is provided by a program network provider,* the Plan pays eligible expenses (see your Schedule of Benefits Grid), up to your lifetime maximum medical benefit. There is a lifetime limit of ten programs of in-network treatment for chemical dependency, including alcoholism. The Plan pays a percentage of the charges for covered services as described in the Schedule of Benefits after referral by *People Resources.*

*Treatment for mental health disorders and chemical dependency, including alcoholism, that is not referred by People Resources is not covered.* If care is provided without a referral from People Resources, the Plan will not pay for any of your expenses, and you must pay for all treatment.

Emergency Services

When medically necessary, emergency services for mental health or chemical dependency treatment are covered, whether the care is received inside or outside the program network. Whenever emergency care is received, a program assessor must be notified within 48 hours following the start of that care. If you do not notify a program assessor within 48 hours of such care it will not be covered.

You must notify a program assessor with 48 hours:

*Emergency Services are medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:*

- The patient’s life or health would be placed in serious jeopardy.
- There would be a serious dysfunction or impairment of a bodily organ or part.
- In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons. A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods.
COVERED MEDICAL EXPENSES

The Plan will cover the following expenses for you and your dependents if they are eligible for coverage under the Plan. In order to be covered, the expenses described below must be medically necessary (see page 26), except that those routine preventative services and health promotion services specifically described below are also covered. In all cases the amount of the charges must be reasonable and customary (see page 26) or must be at the rate negotiated with the network provider. Expenses are subject to the limitations and exclusions contained in this Summary Plan Description, including the Schedule of Benefits.

REMEMBER: You are responsible for any expense over the amount that the Plan determines is reasonable and customary if you receive treatment from an out-of-network physician or in an out-of-network hospital.

Hospital Expenses

Hospital expenses include:

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

Surgery

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

Physician’s Services

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

Vaccination for Food Handlers

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

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

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

Chiropractic Services

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

Diagnostic X-rays and Laboratory Tests

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

Prescription Drugs

Drugs and medicines prescribed by a physician while you are confined in a hospital or skilled nursing facility are covered by the Plan. Other prescription drugs are covered under the Prescription Drug Card Program described on page 39 and your Schedule of Benefits.

Surgical Supplies, Aids and Prostheses

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

Durable Medical Equipment

Subject to the limitations in the Schedule of Benefits, durable medical equipment is covered if it is listed in Appendix A. The cost may not exceed the rental cost or purchase price of the amount listed in your Schedule of Benefits. Hearing aids are subject to additional limitations as explained in your Schedule of Benefits and on page 35. The Board of Trustees has the discretion to pay for durable medical equipment in excess of the limitations in the Schedule of Benefits. Contact the Welfare Fund Office for more information.

Occupational and Physical Therapy

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

- Your physician orders the therapy;
- Therapy is provided by a registered physical therapist or a registered or state-licensed occupational therapist; and
- Therapy is prescribed for short-term (20 visits or less), non-maintenance restoration of a physical disability that is reasonably expected to improve.

Maintenance care or treatment for developmental delay is not covered.

Pregnancy and Maternity Care

Maternity care is provided for you and your eligible spouse, if your spouse is covered under the Plan.
Under the Plan and as required by Federal law, hospital stays for mothers and newborns in connection with childbirth are not less than:

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

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

**Mastectomy Medical and Surgical Benefits**

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

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

**Anesthesia, Blood and Oxygen**

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

**Ambulance**

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

**Accidental Injury to Teeth or Jaw**

The services of a dental surgeon or dentist are covered by the medical Plan to repair damage to the jaw or natural teeth that is the direct result of an accident. Services must be provided within six months of the accident.

**Mental Health Care and Chemical Dependency Treatment**

Treatment for mental health and chemical dependency (including alcoholism) is covered as explained in the section on Mental Health Care on page 26 and in your Schedule of Benefits.

**Organ Transplants**

Covered medical expenses for a human organ or tissue transplant for the recipient of a covered organ transplant (transplant of the pancreas, cornea, kidney, liver, skin, bone marrow or heart) up to the maximum amount per transplant shown in your Schedule of Benefits. Organ transplant expenses must be pre-approved by the Welfare Fund Office and are subject to the lifetime maximum benefit under the Plan.
To qualify, for coverage of a transplant, the recipient must provide the Welfare Fund Office with two medical written opinions that the transplant is medically necessary. Each written opinion must:

1. be given by a physician who is acceptable to the Plan and who is a board certified specialist in the relevant involved field of medicine or surgery; and

2. must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the patient’s condition.

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

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

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

If two or more transplants are performed in a single operation, the maximum benefit payable is equal to the highest allowable amount plus 50% of the maximum allowed for the other transplants. In such cases, only one transplant period will be recognized under this Plan.

Home Health Care

Home health care is provided, up to the maximum number of visits listed in your Schedule of Benefits. A home health care visit is defined as the shorter of either four hours of home health aide services or an actual visit by a member of a Home Health Care Agency team.

Home health care includes the following when administered in the patient’s home:

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

Skilled Nursing Facility

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

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

**Hospice Care**

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

**Emergency or Urgent Care Center Services**

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

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

**Emergency Room Care**

Emergency room care is covered by the Plan, subject to the limitations in the Schedule of Benefits. The required copayment listed in your Schedule of Benefits is waived if the patient is admitted that day to the hospital as a result of the illness that required the emergency care.

**Voluntary Sterilization**

Charges for voluntary sterilization procedures are covered by the Plan for self or spouse only, but charges for procedures to reverse sterilization are not covered.

**Eye Surgery**

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

The Plan covers the initial refraction and first pair of eyeglasses or contact lenses purchased within six months after eye surgery. The eye surgery must be covered by the Plan and be the cause for the change in the lens prescription. The expense for the initial refraction and first pair of eyeglasses or contact lenses is limited to the maximums provided under Vision benefits as outlined in your Schedule of Benefits. However, they will be provided in addition to regularly scheduled Vision Care Benefits.
If Vision Benefits are not provided on your Schedule of Benefits, this benefit will not be provided.

**Physical Examinations**

Physical examinations are covered when performed by a physician in your PPO network only and are limited to one examination per calendar year.

**Well Child Care**

Well child care is provided for your covered children, including children of your spouse, as provided in your Schedule of Benefits.

**Speech Therapy**

The Plan covers charges for the services of a speech pathologist or audiologist certified by the American Speech Language - Hearing Association and the state's Board of Registration. Such services include speech or language evaluations, hearing evaluations and necessary services to gain or regain speech, language or hearing.

When speech therapy is provided:

- To correct a speech impediment such as stuttering or the inability to pronounce certain letters, benefits are subject to a separate lifetime maximum benefit listed in your Schedule of Benefits; or
- For a speech problem that is the direct result of a documented illness or injury, benefits are subject to the general (20 visits per calendar year) maximum benefit listed in your Schedule of Benefits.

**Hair Prosthesis**

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

**Smoking Cessation Programs**

Charges for smoking cessation programs are covered up to the calendar year maximum and lifetime maximum amounts listed in your Schedule of Benefits after successful completion of a professional behavior intervention program. No expenses will be reimbursed until you submit an official certificate of completion from the program to the Welfare Fund Office.

**Second Surgical Opinions**

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

**Pre-Admission Tests**

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

**Attention Deficit Disorder and Hyperkinetic Syndrome**

The Plan covers care provided by a physician for treatment of the physical components of Attention Deficit Disorder and Hyperkinetic Syndrome, payable as a medical benefit. Psychotherapy used to treat these conditions is subject to the restrictions under the Mental Health and Chemical Dependency Care program described on page 26.

**Weight Loss Treatment**

Office visits and consultations by a physician and drugs requiring a prescription from a physician for weight loss and/or obesity are covered if pre-approved by the Welfare Fund Office, subject to the list of general limitations and exclusions listed beginning page 36 and subject to the lifetime maximum weight loss benefit amount listed in your Schedule of Benefits. In addition to office visits and consultations, prescription drugs are also subject to the lifetime maximum weight loss benefit amount listed in your Schedule of Benefits.

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

**Cardiac Rehabilitation Phase I and II**

Cardiac Rehabilitation Phase I and II is covered by the Plan. Contact the Welfare Fund Office for more information and see the exclusions and limitations beginning on page 36.

**Infertility Treatment**

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

**Dietary Consultations**

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

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

**Hearing Exam/Hearing Aids**

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

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

- Any charges that exceed the reasonable and customary charge or charges for services or supplies that are not medically necessary.
- Charges for maintenance care. Maintenance care is care provided after your condition has plateaued, has ceased to improve or is only minimally improving. For example, spinal manipulations/adjustments and physical therapy are considered maintenance care if your condition is not improving significantly.
- Charges for treatment of dependent children for mental or physical developmental delay. Treatment of developmental delay includes diagnosis and treatment of learning disorders.
- Services or supplies done while you or your dependent is not covered under this Plan, except as provided under the Continuation of Coverage provisions.
- Charges incurred before you or your dependent is covered under the Plan.
- Charges incurred after coverage ends.
- Charges for chiropractic treatments that exceed the Plan limitations in your Schedule of Benefits.
- Charges for chiropractic X-ray and lab charges in excess of the amount listed in your Schedule of Benefits.
- Charges for treatment or service due to a sickness that is covered by a Workers’ Compensation Act or other similar legislation, or due to an injury arising out of or in the course of employment for wages or profit.
- Charges for any treatment or service that is paid for or furnished by any federal, state or local government or agency thereof.
- Services and supplies necessary for the treatment of any condition caused by any act of war, declared or undeclared, except to the extent exclusion of such is prohibited under Federal law.
- Services and supplies for treatment of an injury or illness that arose or was exacerbated while the patient was engaged in military, naval or air service of any country, except to the extent exclusion of such is prohibited under Federal law.
- Any treatment for cosmetic reasons, unless directly related to recovery from an accident. Treatment for cosmetic reasons includes surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation/breast reduction, elimination of redundant skin of the abdomen, treatment of varicose veins or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. Breast reconstruction in connection with a mastectomy is a covered expense, as explained on page 31.

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

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

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

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

The Plan Administrator or the Plan Administrator’s designee has the discretion to determine whether treatment is experimental or investigative.
• Any charges related to equipment, treatment, procedures, supplies, devices, drugs or medications that, with respect to the condition being treated, are experimental or investigative.

• Any charges incurred for custodial care or care while confined in a custodial care institution that is primarily a place of rest, a place for the aged or a nursing home. Custodial care is care that does not require the services of a registered nurse or a licensed practical nurse. When a caregiver or family member can be safely and effectively taught to provide certain care, that care is considered custodial. For example, your program does not provide benefits if you only need help taking your medications, or help with eating, bathing, dressing, toileting or walking.

• Charges for services for which you would not be obligated to pay in the absence of this coverage.

• Medical care received outside the geographic area of this Plan unless:
  – Comparable services are not available within the geographical area of the Plan; or
  – Such care is a medical emergency requiring immediate attention (see page 31 for a definition of emergency care).

• Any charges or services not prescribed by a Physician.

• Charges to complete forms required by the Welfare Fund Office.

• Charges that exceed the maximums shown in your Schedule of Benefits or elsewhere in this booklet.

• The difference between the charge for a private room and the hospital’s most common semi-private room charge if you elect a private room in a hospital that has both semi-private and private rooms.

• Any treatment or services by a dentist or dental surgeon, unless that treatment or service is (1) necessary to treat an injury to the jaw or natural teeth that is the result of an accident and (2) rendered within 6 months of the accident.

• Non-invasive treatments for temporomandibular joint syndrome are covered under the Dental Benefit.

• Charges incurred for an employment exam, including lab tests and immunizations.

• Charges that are incurred for services or treatments rendered in connection with weight loss and/or obesity, except for weight loss treatment and dietary consultations described on page 35. Non-medical charges for services and supplies such as diet food supplements are not covered, even when directed or prescribed by a physician, unless they are described under Weight Loss Treatment on page 35.

• Home health care services:
  – Not provided or coordinated by a home health care agency;
  – Provided during any period in which the patient is not under the continuing care of a physician; or
  – For which benefits are payable under any other provisions of this Plan.
  – Nurse aids are not covered.

Routine physicals and tests are covered as provided in your Schedule of Benefits Grid.
• Hospital charges incurred on Friday or Saturday when the admission is for elective, non-emergency surgery, unless the actual surgery is performed on the day immediately following the date of admission.

• Weekly charges for home health care services that exceed the reasonable and customary weekly charge for inpatient care in a skilled nursing facility.

• Pregnancy or infertility treatment for an eligible dependent child.

• Charges for elective abortions and care related to elective abortions. However, complications of elective abortions are covered by the Plan.

• Treatment of spider veins.

• Pulmonary Rehabilitation Programs. (Pulmonary Rehabilitation refers to a formal program of controlled exercise training and respiratory education under the supervision of qualified medical personnel capable of treating respiratory emergencies, as provided in a hospital outpatient department or other outpatient setting.)

• Cardiac Rehabilitation Phase III.

• Orthotripsy treatment for plantar fasciitis.

• Surgery to correct astigmatism, except as specifically provided on page 33.

• Charges of a physician or other provider who or which is not acting within the scope of his, her or its license.

• Charges for services or care provided by members of your immediate family (parents, spouse, siblings by birth or marriage or children).

• Vision care, except as provided under vision plan.

• Drugs, except as provided in the hospital or under the Prescription Drug Card Program.

• Reversal of sterilization.

• Personal comfort items.

• Injury or illness caused by the act or omission of third party, unless the participant signs the required subrogation agreement.

• Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.

• Wigs or hair prosthesis, except as provided in your Schedule of Benefits.

• Personal blood storage.

• Hypnosis.

• Acupuncture.

• Any charges in excess of the maximums listed in the Schedule of Benefits.
PRESCRIPTION DRUG CARD PROGRAM

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

Prescription drugs that your doctor prescribes while you are confined in a hospital or skilled nursing facility are covered under the Medical Benefits portion of the Plan as described on page 30.

When you are eligible for prescription drug benefits, you will receive a prescription drug identification (ID) card from the Plan’s prescription drug provider. To receive prescription drug benefits, you must visit a participating pharmacy and present your ID card or use the provider’s mail order program.

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

Filling Prescriptions through the Retail Pharmacy Program

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

Filling Prescriptions in an Emergency through a Non-Participating Pharmacy

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

Filling Prescriptions through the Mail Order Program

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

- Ask your doctor to prescribe a 90-day supply of your medications with refills for one year.
- Mail the original prescription along with a completed order form, patient profile and your copayment to the mail order program in the envelope provided with the order form. If you need additional envelopes, you should contact the Welfare Fund Office, call the number on your prescription drug ID card or visit the prescription drug provider’s website listed on your ID card.
- Allow about 14 days from the time you mail in your order to receive your prescription.
- After your first prescription is filled, you can obtain refills online at the website, through the mail or by calling the prescription drug provider. The contact information is on your prescription drug ID card. When you reorder your prescription, have your prescription number, zip code and credit card information ready.

Covered Prescription Drugs

The following prescription drugs are covered by the Plan’s Prescription Drug Card Program:

- Federal Legend prescription drugs;
- Drugs requiring a prescription under the applicable state law;
- Injectable insulin;
- Insulin syringes;
- Diabetic supplies; and
- Oral contraceptives for employees or their spouses who are age 18 and older.

Prescription Drugs Requiring Pre-Authorization

The following prescription drugs along with a treatment plan must be pre-authorized by the Welfare Fund Office before they are covered under the Plan:

- Fertility medications (requires a 50% copayment);
- Smoking cessation products (after completion of a smoking cessation class);
- Weight management medication;
- Topical creams;
- Migraine medication;
- Erectile dysfunction medication;
- Birth control for dependent children;
- Sleep disorder medications.

Prescription Drugs Excluded from Coverage

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

- Non-Legend drugs other than insulin;
- Therapeutic devices or appliances, support garments and other non-medical substances;
- Drugs intended for use in a physician’s office or another setting other than home use;
- Investigational or experimental drugs (as defined on page 36), including compounded medications for non-FDA approved use;
- Prescriptions that an eligible person is entitled to receive without charge under any workers’ compensation law or any municipal, state or federal program;
- Oral contraceptives for dependent children;
- Contraceptive devices;
- Topical Rogaine.

Federal Legend Drugs are any medicinal substances that must be labeled “Caution - Federal Law prohibits dispensing without prescription,” as required by the Federal Food, Drug and Cosmetic Act.
DENTAL BENEFITS

Dental benefits are provided for you and your covered dependents only if you are an employee who is eligible for Unit 1 benefits. If covered, a percentage of your covered dental expenses will be paid, depending on the dental work, as shown in your Schedule of Benefits.

A maximum benefit per calendar year that is listed in your Schedule of Benefits will apply to your total covered dental expenses under Coverages A, B and C. Orthodontia Care for your dependent children is paid up to the maximum amount per lifetime per child that is listed in your Schedule of Benefits. Dental benefits are counted toward your lifetime maximum benefit under the Plan, but not toward your medical benefit deductible or out-of-pocket maximum.

Covered Dental Expenses

Covered dental expenses are those you or your dependents incur for necessary dental care and treatment performed by a Dentist or Dental Hygienist. The expenses must be usual, reasonable and customary. The four types of dental expenses covered under the Welfare Plan are:

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

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

Coverage A – Routine Oral examinations

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

- Charges for routine periodic oral examinations, up to two in a calendar year.
- Diagnostic X-rays as required.
- Full mouth X-rays, limited to once per calendar year.
- Prophylaxis (routine preventive care) including necessary scaling and polishing twice in a calendar year.
- Topical fluoride applications, twice in a calendar year.

Coverage B – Basic Dental Care

Benefits are payable under **Coverage B** at the percentage listed in your Schedule of Benefits of the usual, reasonable and customary charge up to the maximum benefit shown in your Schedule of Benefits for you and each of your eligible dependents.
Covered services included under **Coverage B** are:

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

**Coverage C – Restorations, Crown and Prosthetics**

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

Restorative dental services included under **Coverage C** are:

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

**Orthodontia Care**

Plan benefits are payable for orthodontia expenses incurred by your eligible dependent children. Benefits at the percentage listed in your Schedule of Benefits of the usual, reasonable and customary charge are payable under **Orthodontia Care** for treatment or correction of malposed teeth including the initial installation of orthodontic appliances. The lifetime maximum benefit amount for **Orthodontia Care** payable for each of your dependent children is listed in your Schedule of Benefits.

Benefits under **Orthodontia Care** will be paid in the following payment schedule:

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

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

Treatment by More than One Dentist

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

Coverage after Termination

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

Pre-Treatment Plan

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

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

- The dentist completes a treatment plan describing the proposed course of treatment by itemizing the services and charges on the claim form that you provide. You may obtain the claim form from the Welfare Fund Office. A treatment plan is a written report showing the recommended treatment of any dental disease, defect or injury, prepared by your dentist, as a result of an examination.

- The Plan then determines the amount payable under the Plan and informs you and the dentist of the amount the Plan will cover. You and your dentist should discuss the result before the work is done.
Dental Exclusions – What Is Not Covered

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

- Charges for services that are more than the usual, customary and reasonable charge.
- Work done while you or your dependent is not covered under this Plan, except as provided under the Coverage after Termination section as defined on page 43.
- Charges for treatment or service due to a sickness that is covered by a Workers’ Compensation Act or other similar legislation, or due to an injury arising out of or in the course of employment for wages or profit.
- Charges for services that are provided by any federal, state or provincial government agency, or are provided without cost to you or your dependent by any municipality, county or other political subdivision or community agency.
- Charges for prescription drugs.
- Charges for completion of forms, including the pre-treatment plan.
- Charges for speech therapy.
- Charges for lost or stolen appliances.
- Charges for services for which you or your dependent would have no obligation to pay in the absence of this coverage.
- Surgical correction of congenital or developmental malformation.
- Relative analgesia.
- Hypnosis.
- Pre-medication.
- Treatment solely for cosmetic reasons (see page 36 for a definition of cosmetic reasons).
- Orthodontia Care for you or your spouse.
- Treatment started before your eligibility begins, including orthodontia care for dependent children.
- Sterilization charges.
VISION CARE BENEFITS

The Vision care benefit is designed to pay a portion of eye examinations and lenses for eligible employees and for covered dependents of Unit 1 employees only. If you have covered vision care expenses while you are eligible for benefits, the Welfare Plan will pay the benefits shown in your Schedule of Benefits. Your out-of-pocket expenses for vision care do not count toward your deductible or out-of-pocket maximum listed on your Schedule of Benefits for medical care, but are counted toward your lifetime maximum benefit under the Plan.

Covered Vision Care Expenses

Covered vision care expenses include charges for:

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

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

Vision Care Exclusions - What Is Not Covered

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

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

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

See your Schedule of Benefits for the amount of your coverage or contact the Welfare Fund Office at 314-835-2700 in the St. Louis area or call toll free in Missouri outside St. Louis or in Illinois at 866-565-2700 for information about preferred vision care providers that offer covered services at a discount.
IF YOU BECOME DISABLED

You will be eligible for the Weekly Disability Income Benefit if you are unable to work because of a non-occupational sickness or injury and you have satisfied the Plan’s requirements for eligibility. Benefits are payable up to the maximum rate of pay for your Unit as shown in your Schedule of Benefits. Unit 2 employees are not eligible for this benefit. Benefits are payable for Employees only.

To qualify, you must:

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

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

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

The Weekly Disability Income Benefit is payable for a maximum of 13 weeks during any one period of disability. A new period of disability cannot begin until you return to active, full-time work (your average weekly hours prior to disability at the minimum required number of hours listed in your Schedule of Benefits), for a period of five working days within a seven-day period.

**WHEN YOUR DISABILITY INCOME BENEFITS BEGIN**

<table>
<thead>
<tr>
<th>If you are disabled for this reason</th>
<th>Your benefits begin on the</th>
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<tr>
<td>Accidental bodily injury</td>
<td>First day of disability</td>
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<tr>
<td>Sickness, including</td>
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<td>- Pregnancy</td>
<td>Fourth day of disability</td>
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<td>- Physical illness</td>
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<td>- Mental illness</td>
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</table>
Weekly Disability Income Benefit

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

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

Exclusions

The Weekly Disability Income Benefit will not be paid for:

- Any day of disability during which you are not under the care or treatment of a physician;
- Any disability that is due to a sickness that is covered by a Workers’ Compensation Act or other similar legislation, or due to an injury arising out of or in the course of employment for wages or profit;
- Any days for which you are receiving vacation pay or sick day pay;
- Any injury or illness not covered under the Plan guidelines.
IN THE EVENT OF YOUR DEATH

Life Insurance Benefit

The Life Insurance benefit is payable to your beneficiary if you die from any cause on or off the job while you are covered under the Plan. The amount of your Life Insurance benefit is determined by your Unit coverage and is shown in your Schedule of Benefits. This is an insured benefit that is provided by the Plan under a policy of group insurance issued by Principal Life Insurance Company. This description is a summary of the provisions of that policy. Contact the Welfare Fund Office for a complete copy of the policy of insurance.

Your Beneficiary

Your beneficiary is any person or persons you name on your enrollment form that you completed and sent to the Welfare Fund Office. You may change your beneficiary at any time by filing a new enrollment form with the Welfare Fund Office. Such a change will be effective only if it is received by the Welfare Fund Office and forwarded to the Insurance Company before the Insurance Company pays out benefits.

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

- To your legal surviving spouse, provided you are not divorced or legally separated; or
- To your dependent children; or
- To your children who are not dependent on you; or
- To your mother; or
- To your father; or
- To your estate.

Benefits paid to your children will be distributed equally among them.

How Benefits Are Paid

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

Life Insurance Continues when You Become Totally Disabled

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

You will be required to submit proof of your total disability during the twelve-month period following the date you became totally disabled. The Life Insurance benefit will not be payable if you do not submit written proof of your total disability to the Welfare Fund Office within 12 months after the date your disability begins. You may be required annually to submit proof that you remain totally disabled.
If you die while you are totally disabled, the Life Insurance benefit will be paid to your beneficiary. The amount of the Life Insurance benefit is the same amount for which you were eligible when your total disability began.

**Termination of Life Insurance Coverage**

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

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

**Conversion Privilege**

You have the right to convert to an individual policy of insurance you pay for if: your eligibility for life insurance ends because your employment in a class of employees eligible for life insurance ends; because the insurance policy is terminated or amended to exclude your eligibility (if you have been covered for the required minimum number of years); or because you recover from a disability during which your life insurance was extended. The amount of the converted policy will vary depending on the reason your eligibility ended. You must request the conversion policy in writing within 31 days from the date your eligibility ends. If you delay applying for an individual life insurance policy until after the 31-day period, you will no longer be eligible to convert your group life insurance to an individual policy. If you die during the 31-day period during which you are eligible to convert your life insurance, your beneficiary will be paid the amount of life insurance you were entitled to convert, whether or not you had applied for conversion.

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

**Accidental Death and Dismemberment Insurance Benefit**

The Accidental Death and Dismemberment Insurance benefit provides benefits if you die, lose a limb or the sight of an eye as the result of an accident, either on or off the job. This is an insured benefit that is provided by the Plan under a policy of group insurance issued by Principal Life Insurance Company.

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

- Within 90 days following the date of the accident; and
- While you are eligible for benefits under the Plan.

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

**Life Insurance benefits may be continued if you:**

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

**Loss of hand or foot means severance through or above the wrist or ankle joint, respectively. Loss of sight means the complete and irrecoverable loss of sight of the eye.**
The benefit amount for the Accidental Death and Dismemberment Insurance benefit varies according to your Unit coverage and is shown in your Schedule of Benefits. You will receive all or part of the Accidental Death and Dismemberment Insurance benefit amount depending on the extent of your loss as follows:

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

<table>
<thead>
<tr>
<th>Loss</th>
<th>Benefit Amount</th>
<th>Payable to</th>
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<tbody>
<tr>
<td>Your death</td>
<td>Listed on your Schedule Benefits</td>
<td>Your beneficiary</td>
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<tr>
<td>Two of any: hands, feet or sight of an eye</td>
<td>Listed on your Schedule Benefits</td>
<td>You</td>
</tr>
<tr>
<td>One hand, foot or sight of an eye</td>
<td>Listed on your Schedule Benefits</td>
<td>You</td>
</tr>
</tbody>
</table>

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

**Exclusions**

You will not be eligible for the Accidental Death and Dismemberment Insurance benefit if you incur a loss of life or limb after the 90-day period following the date of the accident. Benefits will not be payable for a loss caused by an accident that occurs after your eligibility under the Plan ends.

Unless prohibited by state law, the Accidental Death and Dismemberment Insurance benefit will not be paid for a loss due to any of the causes listed below:

- Self-inflicted injury, or self destruction while sane
- Disease; bodily or mental infirmity, or medical or surgical treatment thereof;
- Insurrection, participation in a riot; police duty as a member of any military, naval or air organization, war or any act of war declared or undeclared;
- Engaging in or participation in any aeronautic operations or activities, except as a passenger; or
- The taking of or the effect of using any illegal drug, narcotic, or hallucinogen unless prescribed or administered to you by a licensed physician.

**Continuation of Dependents’ Medical Benefits after Your Death**

In the event of your death if you are a Unit 1 employee, your dependents’ eligibility will be continued for the three-month period immediately after the end of the month in which your death occurred. The extension of eligibility to your surviving dependents is provided by the Welfare Fund free of charge if you are covered under Unit 1. At the end of the three-month period, your dependents will be eligible for COBRA coverage.

Your dependents should call or write the Welfare Fund Office for information on continuation of their coverage and refer to the information on page 15.
PROCESSING CLAIMS FOR BENEFITS

How to File Claims

Please contact the Welfare Fund Office for forms and filing instructions. Whenever possible, you should obtain a claim form before treatment of an accidental injury so that your physician can assist you with completion of the form.

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

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

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

If you are prevented from filing a claim within these timeframes because of circumstances beyond your control, the Trustees may, in their discretion, accept your claim later than one year after the date you received the services.
The Welfare Fund will pay benefits only when it receives written proof that is satisfactory to the Board of Trustees. The proof will be considered satisfactory if you include itemized bills showing the:

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

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

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

- Due to extenuating circumstances, it is not reasonably possible to furnish the notice of claim and/or proof of loss on time;
- The notice of claim and/or proof of loss are furnished as soon as reasonably possible; and
- The Board of Trustees approves such claim.

**Physical Examinations**

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

**Lawsuits**

You may not bring an action at law or in equity to recover a loss under the Plan before you have exhausted all of the claims and appeals procedures provided by the Plan.

**Assignment of Benefits**

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

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

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

- **Life Insurance** – The Life Insurance Benefit is payable to your designated beneficiary after the Welfare Fund Office receives:
  - A certified copy of the original death certificate; and
  - A completed Life Insurance claim form.
• **Accidental Death and Dismemberment Insurance** – The Accidental Death and Dismemberment Insurance Benefit covers accidents that occur on the job as well as those off the job. There will be a minimum waiting period between the date the Welfare Fund Office receives the completed proof of loss and the date benefits are paid. Contact the Welfare Fund Office for more information about the waiting period.

• **Weekly Disability Income Benefit** – Weekly Disability Income payments cannot begin until you, your employer and your physician complete the claim form and return it to the Welfare Fund Office. You will be required to supply the Welfare Fund Office with proof of continuing disability.

**Claim Review And Appeal Procedures**

**Health Care Claims**

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

For mental health and chemical dependency services, the Plan requires a referral. If a referral is not obtained from People Resources, the Plan will not pay any of your expenses.

It’s not mandatory for you to pre-certify other medical treatments and no penalty will be applied; however, it is recommended that you provide notification to your provider network if you need hospitalization. (See page 24 regarding the importance of getting pre-certification for out-of-network care.)

**Types of Health Care Claims**

There are four basic types of health care claims:

**Pre-Service.** A pre-service claim is a claim for benefits where pre-certification is required. The services that require pre-certification are hospitalization and mental health and chemical dependency care. The Plan will not deny benefits for these procedures or services if:

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

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

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

**Post-service.** A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim.
Concurrent Care. A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification of the number of days of an inpatient mental health Hospital stay) and the reconsideration results in:

- Reduced benefits; or
- A termination of benefits.

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

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

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

- **Urgent Care Claims.** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to 48 hours to respond. The initial 72-hour deadline is suspended for up to 48 hours or until the information is received, if sooner.

  If you improperly file an Urgent Care claim, the Fund Office will notify you as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

- **Pre-Service (initial determination 15 days) and Post-Service Claims (initial determination is 30 days)** An initial determination will be made within 15 calendar days (30 days for Post-Service claims) from receipt of your claim. If additional time is necessary, up to 15 additional calendar days, due to matters beyond the control of the Plan, you will be informed of the extension within this 15-day deadline (30-day deadline for Post-Service claims). In addition, if additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

  If you improperly file a Pre-Service claim, the Fund Office will notify you as soon as possible but not later than five days after receiving your claim, of the proper procedures you should follow in filing a claim. You will only receive notice of an improperly filed Pre-service claim if the claim includes sufficient identification that allows the Fund Office to contact you.

  You must refile the claim properly in order for it to constitute a claim under the Plan.
Generally, when providers submit the claims, payment is made directly to the provider. Providers handle all the paperwork for you. However, if you submit the claim, payments are generally made directly to you, unless you assign benefits to the provider.

**Weekly Disability Income Benefit**

Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. The Plan may extend this 45-day period for up to two additional 30-day periods. If a determination is not made within the first 45 days, you will be notified that an additional 30 days is necessary and if the determination is not made within 75 days, you will be notified that an additional 30 days is necessary.

In some instances, the Plan may require additional information to process and make a determination on your claim. If such information is required, the Plan will notify you within 45 days of receiving your request. You then have up to 45 days in which to submit the additional information. If you do not provide the information within this time, your claim may be denied.

**Life and Accidental Death and Dismemberment Insurance Benefit Claims**

Generally, you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

**If a Claim Is Denied**

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

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

**Information Requirements**

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

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed; and
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim.
In addition, for health care and Weekly Disability Income Benefit claims, you have the right to request:

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

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

**Appealing a Denied Claim**

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

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

- 180 days from the date of a decision for health care or Weekly Disability Income Benefit claims; or
- 60 days from the date of a decision for Life or AD&D Insurance Benefit claims.

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

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

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

- Submit additional materials, including comments, statements or documents; and
- Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
  - Was relied upon by the Plan in making the decision;
  - Was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon); or
  - Demonstrates compliance with the claims processing requirements.
In addition, if your claim is for health care or Weekly Disability Income Benefits and is denied based on:

- An internal rule, guideline, protocol or other similar criteria, you have the right to request a free copy of such information; and
- A Medical Necessity, Experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

**Appeal Decisions**

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

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

**Appeal Timeframes**

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

**Health Care Claims**

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

**Weekly Disability Income Benefit**

A determination will be made at the Board of Trustees’ next quarterly meeting if your appeal is received at least 30 days before that meeting. If your appeal is not received within 30 days of the Board of Trustees’ next quarterly meeting, the determination will be
made at the second quarterly meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

**Life and AD&D Insurance Benefits**

A determination will be made at the Board of Trustees’ next quarterly meeting if your appeal is received at least 30 days before that meeting. If your appeal is not received within 30 days of the Board of Trustees’ next quarterly meeting, the determination will be made at the second quarterly meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

**Medical Judgments**

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

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

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

**Information Requirements**

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

- The specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based; and
- A statement notifying you that you have the right to request a free copy of all documents, records and relevant information;
- Information relating to any additional voluntary appeal procedures offered by the Plan; and
- A statement that you may bring a civil action suit under ERISA.

In addition, for health care and Weekly Disability Income Benefit claims the notice will include:

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

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

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

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

<table>
<thead>
<tr>
<th>Patient</th>
<th>Primary Plan</th>
<th>Secondary Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>Husband’s</td>
<td>Wife’s</td>
</tr>
<tr>
<td>Wife</td>
<td>Wife’s</td>
<td>Husband’s</td>
</tr>
<tr>
<td>Child</td>
<td>Parent’s whose birthday falls first in the calendar year*</td>
<td>Parent’s whose birthday falls second in the calendar year*</td>
</tr>
</tbody>
</table>

*If both parents have the same birthday, the plan covering the parent for the longer period of time will pay first.

Generally, if the other plan uses the male/female rule to coordinate benefits, the other Plan determines which plan is primary. Under the male/female rule, the plan that covers a child as the dependent of a male employee pays before the plan that covers child as the dependent of a female employee.

Divorce Situations – Who Covers the Dependent Children

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

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

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

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

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

A dependent spouse who declines subsidized coverage (as explained on page 9) will not be covered by this Plan at all, so there will be no coordination of benefits.

SPECIAL NOTES

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

A dependent spouse who declines subsidized coverage (as explained on page 9) will not be covered by this Plan at all, so there will be no coordination of benefits.

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

Remember to Notify Both Plans

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

If an Employee is the Patient:

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

If the Spouse or Dependent With other Coverage of an Employee Covered for Unit 1 Benefits is the Patient:

1. File under the other plan first.
2. File under the United Food and Commercial Workers Union Local 655 Welfare Plan second.
If a Dependent Without His or Her Own Coverage is the Patient and the Parents are not Separated or Divorced:

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

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

Right to Receive and Release Needed Information

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

Method of Payment

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

Summary of Plan’s Rights to Subrogation, Reimbursement, and Liens

This Plan will exercise its rights to reimbursement, subrogation, and a lien when the Plan provides benefits for an injury or illness for which another person or entity may be responsible. A full description of the Plan’s reimbursement, subrogation, and lien rights is included in Appendix C. If there are any discrepancies between this brief summary and Appendix C, the language in Appendix C will control.

Basically, if you or one of your covered dependents is injured or made ill by another person and this Plan pays out benefits with respect to that injury or illness, this Plan has the same rights as you or your dependent to recover from the person who caused the injury or illness and from any other person or entity that must pay you or your dependent because of that injury or illness. Further, if you or your dependent recovers any monies from the person who caused the injury or illness, you or your dependent must reimburse the Plan, up to the amount you recover, for the amounts the Plan paid out with respect to that injury or illness.

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

Subrogation rules are given in detail in Appendix C. The rules in Appendix C control the Plan’s right to recover expenses it pays on your behalf.
Plan’s Right to Recover Overpayments or Mistaken Payments

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

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

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

If it is necessary for the Trustees to institute legal proceedings to collect an overpayment and they prevail, you will be responsible for paying the reasonable attorney’s fees and costs they incur in connection with such action.
IMPORTANT INFORMATION ABOUT THE WELFARE PLAN

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

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

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

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

As of July 1, 2006 the Trustees of this Plan are:

<table>
<thead>
<tr>
<th><strong>Employee Trustees</strong></th>
<th><strong>Employer Trustees</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Randy Charboneau</td>
<td>Mr. Edward Keady</td>
</tr>
<tr>
<td>United Food and Commercial Workers</td>
<td>Schnuck Markets</td>
</tr>
<tr>
<td>Union Local 655</td>
<td>St. Louis, Missouri 63146-6928</td>
</tr>
<tr>
<td>300 Weidman Road</td>
<td></td>
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<tr>
<td>Ballwin, Missouri 63011</td>
<td></td>
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<tr>
<td>Mr. James Dougherty</td>
<td>Mr. John T. Dougherty</td>
</tr>
<tr>
<td>United Food and Commercial Workers</td>
<td>SuperValu</td>
</tr>
<tr>
<td>Union Local 655</td>
<td>Kirkwood, Missouri 63122</td>
</tr>
<tr>
<td>300 Weidman Road</td>
<td></td>
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<tr>
<td>Ballwin, Missouri 63011</td>
<td></td>
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<tr>
<td>Mr. David Politte</td>
<td>Ms. Denise Haddix</td>
</tr>
<tr>
<td>United Food and Commercial Workers</td>
<td>Shop N Save</td>
</tr>
<tr>
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<td>Kirkwood, Missouri 63122</td>
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<td>300 Weidman Road</td>
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<tr>
<td>Ballwin, Missouri 63011</td>
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<tr>
<td>Mr. Paul Schaefer</td>
<td>Ms. Linda Ryan</td>
</tr>
<tr>
<td>Local 881 UFCW, Suite 102</td>
<td>Dierberg Markets</td>
</tr>
<tr>
<td>#1 Sunset Hills Park</td>
<td>Chesterfield, Missouri 63017</td>
</tr>
<tr>
<td>Edwardsville, Illinois 62025</td>
<td></td>
</tr>
<tr>
<td>Mr. Scott Zlatic</td>
<td>Mr. Don Schaper</td>
</tr>
<tr>
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<td></td>
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<tr>
<td>Ballwin, Missouri 63011</td>
<td></td>
</tr>
</tbody>
</table>
Plan Sponsor and Administrator. The Board of Trustees is both the Plan Sponsor and the Plan Administrator. The Board has delegated administrative responsibilities to a Fund Administrator.

Identification Numbers. The 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 23-7401847.

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

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

Identification of Insurance Companies. Life and Accidental Death and Dismemberment Insurance benefits are provided under a policy of group insurance issued by Principal Life Insurance Company, 2135 East Primrose, Suite A, Springfield, Missouri 65804. Disability, medical, dental and vision benefits are self-funded and administered directly by the Welfare Fund Office.

Welfare Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Welfare Fund’s assets and reserves are invested by professional managers selected by the Trustees. The Fund is governed by the revised Amendment and Declaration of Trust establishing the United Food and Commercial Workers Union Local 655 Welfare Fund dated July 1, 2005.

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

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

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

In determining the existence, identity or any other facts relating to any person and any question of entitlement to payment in accordance with this Section, the Board of Trustees may rely solely on any affidavit or other evidence deemed satisfactory to the Board of Trustees. Any payment or payments made by the Board of Trustees in reliance on such proof will fully discharge the Board of Trustees from liability under the Plan, to the extent of such payment.
Trustee Interpretation of Plan Provisions and Decisions Regarding Benefits.
Under the Plan and the Trust Agreement creating the Welfare Fund, the Trustees have broad discretion and sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be given judicial deference and be upheld unless the decision is determined to be arbitrary or capricious.

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

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

The benefits provided by the Plan are payable only to the extent the Welfare Fund has assets available for such payments.

Privacy and Security Policy

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

In accordance with HIPAA, this Plan and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA (“protected health information” or “PHI”), except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan. The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan also will require all of its business associates to agree to observe HIPAA's privacy rules. See Appendix E for more detailed information about the Plan’s use of protected health information. Further, the Plan will take all steps required by HIPAA and its regulations to protect the security of your PHI that is stored or transmitted electronically.
Under HIPAA, you will have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

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

1. You need a copy of the Privacy Notice;

2. You have questions about the privacy of your health information; or

3. You wish to file a complaint under HIPAA.
YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

You have the right to:

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

Continue Group Health Plan Coverage

You also have the right to:

• Continue health care coverage for yourself, your spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
• Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health Plan if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurer when:
  – You lose coverage under the Plan;
  – You become entitled to elect COBRA continuation coverage; or
  – Your COBRA continuation coverage stops.
You must request the certificate before losing coverage, or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund 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 Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

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

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

You may also find answers to your plan questions and a list of EBSA field offices at the EBSA’s website at http://www.dol.gov/dol/ebsa/.
## APPENDIX A: DURABLE MEDICAL EQUIPMENT

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

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<th>Non-Covered Expense</th>
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<td>Batteries, other than for wheelchair</td>
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<td>Blood pressure cuff, if pre-authorized</td>
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<td>Glucose monitor or accuchek</td>
<td>Environment equipment including:</td>
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<td>Air cleaner</td>
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<td>Hospital bed/mattress</td>
<td>Air conditioner</td>
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<td>Infusion pump</td>
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<td>Insulin infusion pump</td>
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<td>Heart pulse rate monitor</td>
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<td>Heat and massage foam cushion pad</td>
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<td>Heat lamps</td>
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(continued on page 72)
### Covered Expense

- Oxygen, including rental of equipment to administer it
- Pacemakers
- Pavlic harness
- Penile implant
- Percussors
- Postural drainage boards
- Prosthetics, other than dental (breast prosthesis, 1 per calendar year)
- Pulse oximeter
- Pulse tachometer
- Respirator/ventilator
- Spinal pelvic stabilizer
- Stoma unit
- Suction machine
- Surgical bra (2 per calendar year)
- Surgical stockings (2 pair per calendar year)
- Tens unit
- Traction equipment
- Trapeze bars
- Ultra violet equipment for treatment of psoriasis or skin disorder
- Urinals, autoclavable hospital-type
- Uterine monitor, if high risk pregnancy
- Ventilators
- Walker
- Wheel chair, including cushion & battery
- Wrist gauntlet

### Non-Covered Expense

- Heating pad
- Hot tub
- Incontinent pads
- Insulin injectors
- Irrigating kit
- Lifts
- Massage devices
- Nocturnal enuresis devices
- Orthopedic shoes (patient over 6 years old)
- Orthotic devices for feet such as:
  - Arch support
  - Heel cups
  - Heel lifts
  - Heel pads
  - Over-bed table
- Palatal plastic devices relating to Temporomandibular joint syndrome
- Paraffin bath units
- Parallel bars
- Polar/cold therapy unit
- Portable whirlpool pumps
- Preset oxygen units
- Pressure leotards
- Raised toilet seats
- Sauna baths or beds
- Scooters
- Sitz baths
- Sleep warm electric comfort units
- Spare oxygen tanks
- Standing tables
- Telephone arms
- Treadmill exerciser
- Treadmill walker
- Vaporizers
- Water paks
- Whirlpool equipment

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This is a partial list of Durable Medical Equipment. If you have any questions regarding coverage of a specific item not included on this list, please call the Welfare Fund Office at 314-835-2700 in the St. Louis area or call toll-free in Missouri outside St. Louis or in Illinois at 1-866-565-2700. The Trustees have the discretion of paying for such items.
APPENDIX B: COORDINATION OF BENEFITS RULES

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

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

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

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

Definitions

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

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

1. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

2. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

3. The following are examples of expenses that are not allowable expenses:
   a. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
   b. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.
   c. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
   d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement will be the allowable expense for
all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan’s payment arrangement and if the provider’s contract permits, that negotiated fee or payment will be the allowable expense used by the secondary plan to determine its benefits.

4. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

5. The amount of the reduction may be excluded from allowable expense when a covered person’s benefits are reduced under a primary plan:
   a. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or
   b. Because the covered person has a lower benefit because the covered person did not use a preferred provider.

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

C. Claim means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:
   1. Services (including supplies);
   2. Payment for all or a portion of the expenses incurred;
   3. A combination of Paragraphs (1) and (2); or
   4. An indemnification.

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

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

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

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

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

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

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

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

1. Group and non-group insurance contracts and subscriber contracts;

2. Uninsured arrangements of group or group-type coverage;

3. Group and non-group coverage through closed panel plans;

4. Group-type contracts;

5. The medical care components of long-term care contracts, such as skilled nursing care;

6. The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts; and

7. Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (8)(h) or (i). That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

8. Plan does not include:
   a. Hospital indemnity benefits or other fixed indemnity coverage;
   b. Accident only coverage;
   c. Specified disease or specified accident coverage;
   d. Limited benefit health coverage, as defined under state law;
   e. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a “to and from school” basis;
   f. Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
g. Medicare supplement policies;
h. A state plan under Medicaid; or
i. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

N. **Primary plan** means a plan whose benefits for a person’s health care coverage must under this Plan be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

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

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

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

**Rules for Coordination of Benefits**

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

1. The primary plan will pay or provide its benefits as if the secondary plan or plans did not exist.

2. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

3. When multiple contracts providing coordinated coverage are treated as a single plan under this provision, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan will be responsible for the plan’s compliance with this provision.

B. If a person is covered by more than one secondary plan, the order of benefit determination rules of this provision decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan will take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this provision, has its benefits determined before those of that secondary plan. A plan that does not contain order of benefit determination provisions that are consistent with this provision is always the primary plan.
C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this provision, it is secondary to that other plan. If another plan is the primary under this Plan’s rules, and the other plan contains a provision that has the effect of capping its benefits for an individual covered under this Plan and of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of this Plan’s coordination of benefits rules, this Plan shall not be liable to provide benefits until the other plan provides as primary plan its customary benefits determined without regard to such cap or the existence of this Plan.

D. Order of Benefit Determination

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

1. Non-Dependent or Dependent
   a. Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.
   b. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
      i. Secondary to the plan covering the person as a dependent; and
      ii. Primary to the plan covering the person as other than a dependent (e.g. a retired employee),
      Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

2. Dependent Child Covered Under More Than One Plan: Unless there is a court decree stating otherwise, plans covering a dependent child will determine the order of benefits as follows:
   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
   b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s plan is the primary plan;
      ii. If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph will determine the order of benefits;
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph will determine the order of benefits; or
d. If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
   i. The plan covering the custodial parent;
   ii. The plan covering the custodial parent’s spouse;
   iii. The plan covering the non-custodial parent; and then
   iv. The plan covering the non-custodial parent’s spouse.

e. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits will be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-Off Employee
   a. The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
   b. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
   c. This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

4. COBRA or State Continuation Coverage
   a. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
   b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
   c. This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage
   a. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
   b. To determine the length of time a person has been covered under a plan, two successive plans will be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
   c. The start of a new plan does not include:
      i. A change in the amount or scope of a plan’s benefits;
      ii. A change in the entity that pays, provides or administers the plan’s benefits; or
      iii. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
d. The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

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

Calculating Benefits as the Secondary Plan and Paying a Claim

If this Plan is the secondary plan on a claim, it will calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under this Plan that is unpaid by the primary plan. This Plan may, as the secondary plan, reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim. In addition, this Plan, as the secondary plan, will credit any amounts paid by the primary plan on the claim toward this Plan’s deductible, if any. When the primary plan is a plan containing a sub-plan/no loss or similar provision, this Plan will not pay as the secondary plan until the primary plan has exhausted its benefits under any such provision.

Miscellaneous Coordination of Benefits Provisions

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

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

1. If the complying plan would be the primary plan under the rules set out here, it will pay or provide its benefits first;

2. If the complying plan would be the secondary plan under the rules set out here, it will pay or provide its benefits first, but the amount of the benefits payable will be determined as if the complying plan were the secondary plan. In such a situation, the payment will be the limit of the complying plan’s liability; and

3. If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan will assume that the benefits of the non-complying plan are identical to its own, and will pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it will adjust payments accordingly.
4. If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan will advance to the covered person or on behalf of the covered person an amount equal to the difference.

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

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

Rules for Coordination of Benefits with Medicare

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

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

If you are covered by Medicare and you cancel your coverage under this Plan, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of your Dependents are covered by Medicare and you cancel that Dependent’s coverage under this Plan, that Dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is yours, and yours alone. Neither this Plan nor your employer will provide any consideration, incentive or benefits to encourage you to cancel coverage under this Plan.
C. Coverage Under Medicare and This Plan When You Are Totally Disabled: If you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.

D. Coverage Under Medicare and This Plan When You Have End-Stage Renal Disease: If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

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

F. How Much This Plan Pays When It Is Secondary to Medicare

1. When the Plan Participant (as defined on page i) Is Covered by Medicare Parts A, B, and D: When the Plan participant is covered by Medicare Parts A, B, and D and this Plan is secondary to Medicare, this Plan pays the same benefits provided for active employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Usual and Customary Charges of the Health Care Provider.

2. When the Plan Participant Is Covered by Medicare + Choice (Part C) or Medicare Advantage: This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If a Plan Participant is covered by a Medicare + Choice (Part C of Medicare) or Medicare Advantage and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Part C or Medicare Advantage program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Part C or Medicare Advantage program.

However, if the Plan Participant doesn’t comply with the rules of the Medicare Part C or Medicare Advantage program, including without limitation, approved referral, preauthorization, case management or utilization of in-network provider requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the Plan Participant receives.
3. When the Plan Participant Is Not Covered by Medicare: If the Plan Participant is eligible for, but is not enrolled in Medicare, this Plan pays the same benefits provided for active employees less the amounts that would have been paid by Medicare had the Plan Participant been covered by Medicare Parts A and B and not on the Usual and Customary Charges of the Health Care Provider.

4. When the Plan Participant Enters Into a Medicare Private Contract: Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

Effect on the Benefits of this Plan

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

SPECIAL NOTES

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

A dependent spouse who declines subsidized coverage (as explained on page 9) will not be covered by this Plan at all, so there will be no coordination of benefits.
APPENDIX C: SUBROGATION, REIMBURSEMENT, AND LIENS

Generally

If this Plan pays out benefits to or on behalf of a covered person in connection with an illness or an injury for which a third party may be responsible, the Plan has the right to recover those benefits either directly from the third party or from the covered person. While these subrogation and reimbursement provisions are most often relevant in connection with automobile accidents, they also apply in any situation in which a covered person's injury or illness is caused by a third party. For example, these provisions apply if a covered person is injured by a faulty product, by medical malpractice, or by some defective condition of a third party's property.

Definitions

1. For purposes of these reimbursement and subrogation provisions, a “covered person” is a person to or on whose behalf this Plan pays out benefits by reason of an injury or illness. The term “covered person” also includes such individual’s guardian, estate, heirs, or other representatives, and anyone else who recovers or may have the right to recover from the third party because of the injury to the covered person.

2. For purposes of these reimbursement and subrogation provisions, a “third party” is a person who caused the covered person’s injury or illness and any other person or entity that has an obligation to pay compensation of any sort to the covered person as a result of that injury or illness. Both the insurer of the responsible third party and the insurer of the covered person are included in the meaning of “third party,” to the extent such insurers are obliged to compensate the covered person as a result of the injury or illness. For example, if you are injured in an auto accident and your insurer makes payments to you under your underinsured or uninsured motorist coverages, your own insurer is a “third party.” Any person or entity that makes payments to or on behalf of the covered person by reason of the injury or illness is a “third party.” (This does not include the payor under a health, hospitalization or disability policy that covers the covered person. Such payments are subject to the Plan’s coordination of benefit rules).

Plan’s Right to Reimbursement

If this Plan pays out any benefits to or on behalf of a covered person in connection with an illness or injury for which a third-party may be responsible, such benefits are paid on the express condition that the covered person must reimburse the Plan for the benefits it paid out if the covered person recovers any amounts from any third party or parties.

The description or characterization of any recovery from any third party does not affect the Plan’s right to reimbursement. By accepting benefits from the Plan, the covered person acknowledges the Plan’s right to reimbursement and agrees to make such reimbursement and agrees to hold any recovery received from a third party in trust for the Plan, to the extent of the amount of benefits the Plan paid out in connection with that injury or illness. The covered person must reimburse the Plan in full for benefits it paid in connection with the injury or illness before
any other amounts are deducted from the recovery paid by the third party or parties. Such reimbursement must be made within 30 days after the covered person receives any monies from any third party.

The Trustees of the Plan, in their sole and absolute discretion, based on all of the circumstances, including the total amount of the recovery and the costs and attorney’s fees incurred by the covered person, may determine it is in the best interests of the Plan to reduce their claim for reimbursement.

Plan’s Right to Subrogation

“Subrogation” means the substitution of one person in the place of another with respect to a claim, demand or right.

To the extent of benefits it pays out, the Plan will be subrogated to all claims, demands, actions and rights of the action the covered person may have against any third party or parties. This means that to the extent the covered person has a claim against anyone as a result of an injury or illness for which the Plan pays out benefits, the Plan has a right to pursue the covered person’s claim. In effect, the Plan “stands in the place” of the covered person with respect to such claim or claims. For example, if you are injured in an auto accident caused by another person and the Plan pays out benefits for the treatment of your injury, the Plan could, on its own, sue the person who caused the accident or, if you sued that person, the Plan could join in your lawsuit.

If the Plan pursues, the amount of the Plan’s subrogation interest is equal to the amount it paid out in connection with the injury or illness, plus the attorney’s fees and costs it incurs in pursuing the claim against the third party or parties.

The Plan may assert its claim against any third party even if the covered person does not, or the Plan may join in any action the covered person brings against any third party or parties. The Plan does not waive any of its rights to reimbursement by not independently asserting its claim against any third party or by not joining in any action brought by the covered person against any third party.

By accepting benefits from this Plan in connection with any injury or illness for which a third party may be responsible, the covered person expressly acknowledges the Plan’s rights to subrogation and agrees to do nothing to prejudice those rights and to cooperate fully with the Plan in asserting those rights.

The Plan’s Rights Constitute a Lien

This Plan’s rights to reimbursement and subrogation constitute both a legal and an equitable lien on any amounts due from or paid by a third party to the covered person by reason of the injury or illness for which the Plan provides benefits. The Plan may inform any such third parties of the existence of this lien.
Covered Person’s Responsibilities

In order to receive benefits from this Plan in connection with an injury or illness for which a third party may be responsible to compensate the covered person, that covered person must do all of the following:

1. Notify the Plan when he or she suffers an injury or illness for which a third party may be required to compensate the covered person;

2. Provide the Plan with any and all documents and information regarding the injury or illness the Plan may request;

3. Execute an agreement setting forth the Plan’s rights and the covered person’s obligations under these subrogation and reimbursement provisions;

4. Provide the Plan with notice if the covered person asserts a claim or claims against any third party and keep the Plan informed as to the status of such claim or claims;

5. Obtain the written consent of the Plan or its designee prior to settling any claim with respect to the injury or illness;

6. Notify the Plan of any compensation the covered person receives from any third party in connection with the injury or illness and immediately reimburse the Plan upon the receipt of such compensation;

7. Cooperate fully with the Plan in its efforts to protect and exercise its rights to subrogation and reimbursement; and

8. Take no actions to compromise or impair the Plan’s rights to reimbursement or subrogation.

If the covered person fails to comply with these obligations, the Plan will not pay out benefits in connection with that injury or illness. If the covered person fails to reimburse the Plan as required, the Plan may withhold future benefits due the covered person and his or her covered family members or may take any other such action necessary to enforce the Plan’s right to reimbursement.

Because the definition of “covered person” includes anyone who represents the injured person and anyone who may have the right to recover from a third party because of the injury to injured person, these responsibilities set out here apply equally to the spouse, children, parents, and representatives of the injured person to the extent they assert or may have the right to recover from the third party because of the injury to the injured person.

Rejection of “Make-Whole” Doctrine

This Plan specifically rejects the “make-whole” doctrine. The Plan’s rights to reimbursement and subrogation do not depend on whether the covered person recovers from third parties monies sufficient to fully compensate the covered person for his or her losses.
Plan’s Enforcement of These Provisions

In the event the covered person fails to fulfill his or her obligations under these reimbursement and subrogation provisions, the Plan may take any action the Trustees deem necessary to enforce the Plan’s rights under these provisions. The Plan may refuse to pay benefits in connection with the injury or illness if the covered person fails to fulfill his or her obligation to provide information and documents or fails to execute the required reimbursement and subrogation agreement. If the Plan does pay benefits and the covered person later fails to fulfill his or her duties, the Plan may withhold future benefits from the covered person and his or her family members, may bring an action against the covered person, or may recoup amounts it paid out from the providers to whom such amounts were paid or from any other available sources. Should the Trustees bring legal action to enforce the Plan’s rights under these reimbursement and subrogation provisions, and succeed in whole or in part in such action, the covered person or his or her spouse shall pay the legal fees and costs the Trustees incur in that action.

Future Claims Relating to the Same Injury or Illness

Once the covered person’s claims against the third party or parties are resolved, the Plan will not pay out any additional benefits in connection with the injury or illness caused by the third party until the total claims that would otherwise be covered under the Plan exceed the total amount of compensation paid to or on behalf of the covered person and his or her dependents by the third party or parties. In such a situation only the excess portion of the otherwise covered claims will be treated as covered.

Waiver

The Trustees in their sole and absolute discretion may agree to waive their rights under this Appendix C. Such waiver shall not automatically occur in any matter. Waivers of these provisions may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. Waivers will generally not be granted if the past medical expenses are greater than $500 or if the total judgment or settlement exceeds $5,000.
## APPENDIX D: CONTRIBUTING EMPLOYERS

### Local 534

- Bills IGA
- Capri IGA Greenville
- Capri IGA Hillsboro
- Capri IGA Litchfield
- Carlyle IGA Market
- Dierbergs Market
- Edwardsville Frozen
- Harmons IGA
- Harmons / Big H Warehouse
- Hart Food and Drug
- Highland Tru Buy
- Kroger
- Local 534 Employees
- Mad Pricer Foods
- Main Street Market
- Meehans Inc
- Millstadt Supermarket
- Park N Shop E St L
- Park N Shop Bethalto
- Park N Shop Godfrey
- Red Bud IGA
- Schnuck Markets Inc
- Schuette Stores
- Sinclair Foods South
- Supervalue DbA Shop N Save
- Toms Foodland Freeburg
- Toms Supermarket Mascoutah
- Toms Supermarket Lebanon

### Local 881

- Anns Printing & Copying Co
- Capri IGA - Hillsboro
- Capri IGA - Litchfield
- Capri IGA - Greenville
- Dierbergs Market
- Dolly Madison
- Dons Hardware
- Hart Food and Drug
- Highland Tru Buy
- Kroger
- Millstadt Super Mart
- Park N Shop Bethalto
- Park N Shop Godfrey
- Red Bud IGA
- Schnuck Markets Inc
- Supervalue Inc. Dba Shop N Save
- Toms Foodland Freeburg
- Toms Supermarket Mascoutah
- Vision Care Assoc.

### Local 700

- Kroger Co. (Louisville)
### Local 655

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<th>Company Name</th>
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<td>Price Chopper</td>
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<td>Queens Barnhart</td>
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<td>Schnuck Markets Inc.</td>
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<td>St. Louis Labor Council</td>
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<td>Ste Genevieve Country Mart</td>
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<td>Straubs Markets</td>
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<td>Tallo (Little Debbie)</td>
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<td>Tom Boyer Auto Sales</td>
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<td>Value City Discount Florissant</td>
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<td>Wellsville Super Save</td>
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<td>Miller Ham Company</td>
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<td>Moore Funeral Home</td>
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APPENDIX E: THE PLAN’S USE AND DISCLOSURE AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION

How the Plan Uses and Discloses Your Protected Health Information

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

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

Definition of Payment

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

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

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

**Definition of Health Care Operations**

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

4. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

5. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;

7. Business management and general administrative activities of the entity, including, but not limited to:
   a. management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
   b. customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
   c. resolution of internal grievances; and
   d. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and

8. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, SARs and other documents.
The Plan’s Disclosure of Protected Health Information to the Board of Trustees

For purposes of this section the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor for the purpose of deciding health claim appeals. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the documents governing the Plan have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description and Plan Document or as required by law;

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual;

5. Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make the information available that is required to provide an accounting of disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the group health plan with HIPAA;

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
The Plan may disclose summary health information, as defined in 45 C.F.R., Sec. 164.501, to the Plan Sponsor if such information is requested by the Plan Sponsor for the purpose of obtaining bids for providing health care coverage under the Plan, or for the purpose of modifying, amending or terminating the Plan. The Plan may also disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled or has disenrolled from the Plan.

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees will be given access to PHI:

1. The Fund Administrator; and
2. Staff designated by the Fund Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description and Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a “Hybrid Entity” because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

Effective April 21, 2005, 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 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.