and
Employers Health and Welfare Fund
Summary Plan Description and Plan Document
for
Bronze Part-time Employees
Medical and Prescription Drug Coverage Only

Effective January 2022

*** * * I M P O R T A N T * * ***

Please read this Summary Plan Description (SPD) in its entirety.

This SPD, which also serves as the Plan document, contains a summary in English of your rights and benefits under the UFCW Local 1262 and Employers Health and Welfare Plan of benefits (Plan) relating to your medical and prescription drug benefits.

This SPD describes the medical and prescription drug benefits available to you and your Dependent Children (if any) under the Plan and summarizes situations in which those benefits may be reduced, delayed, forfeited, or denied, as well as your rights and responsibilities, and the procedures and deadlines for filing a claim or appeal and taking legal action against the Plan and its fiduciaries.

Other documents affecting your Plan benefits may include a trust agreement, documents from insurers or third-party administrators, or notices that provide more detail with respect to certain benefits (collectively, the Plan Documents). In the event of a conflict between any provision in this SPD and any other Plan Document, except where explicitly stated otherwise in this SPD, the provisions of this SPD shall control.

If you have questions regarding this SPD or want more information about the Plan, please contact the Fund Office at (800) 522-4161 (TTY: 711).

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

INTRODUCTION

This SPD describes the Plan benefits provided by the UFCW Local 1262 and Employers Health and Welfare Fund (Fund) to Part-time Employees hired after 2009 who work sufficient hours in Qualifying Service to be eligible for medical and prescription drug benefits ("Bronze Part-time Employees"). Benefits provided to other groups of employees, and other benefits such as vision, dental, legal services, life and accidental death and dismemberment benefits, are contained in separate SPDs.

The SPD is made up of two sections.

- The first section of this SPD (pages 1 through 41) includes information about eligibility, enrollment, when coverage starts, when coverage ends, and the administrative provisions for the Plan. It also includes information required by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

- The second section of this SPD (pages 42 through 81) provides a description of Plan medical and prescription drug benefits and any exclusions and limitations that may apply. It describes the coverage that is in place for you and your enrolled Dependent Children.

The information in this SPD makes up the Plan Document and SPD for your Plan benefits in effect as of January 1, 2022. This SPD replaces any previous SPD, Plan Document, or summaries of material modifications (SMMs) describing these benefits.

Read all sections of this SPD and keep it in a safe place for future reference.

If these benefits are modified, you will receive an SMM that will explain the changes.

You and your enrolled Dependent Children should rely on this SPD for a description of Plan benefits. If you need additional assistance or have questions, contact the Fund Office.

Have a Question?

If you have a question about Plan benefits, you should call the Fund Office at (800) 522-4161 (TTY: 711).

WHO IS ELIGIBLE

Employee Eligibility Requirements

You are eligible for medical and prescription drug benefits under the Plan if you were hired on or after September 11, 2009 for New Jersey Stop & Shop or Tops Markets, or October 6, 2009, for New York Stop & Shop or Tops Markets, or January 1, 2010 for Morton Williams Tier B employees AND you work an average of at least 30 paid hours per week in Qualifying Service AND you pay the required Employee contribution established by the Trustees from time to time.

Dependent Child(ren) Eligibility Requirements

Bronze Part-time Employees are eligible for Dependent Child coverage for medical, prescription drug, dental and vision benefits. Service Clerks are not eligible for Dependent Child coverage unless they qualify for Bronze medical and prescription drug coverage.

You must enroll yourself and your eligible Dependent Children and pay the required contribution for Dependent Child coverage in the amount established by the Trustees for your Dependent Children to be covered under the Plan.

Eligible Dependent Children include:

- Children (married or unmarried) from birth to the last day of the month each child reaches age 26; and

- Children after age 26 if they were covered dependents and became disabled before age 26, live with you on a full-time basis, are dependent on you for support and are unable to sustain gainful employment. To apply for coverage for a disabled child, you must provide the Fund Office with proof of the child's disability before the child's 26th birthday. Horizon Blue Cross Blue Shield of New Jersey (referred to in this booklet as Horizon) will determine whether to approve your application. Horizon may ask you to submit additional proof of the child's disability before coverage will be extended.

Children include your biological children, stepchildren, and adopted children, as well as children placed with you for adoption.

If you are eligible for Dependent Child coverage, and you are required by a Qualified Medical Child Support Order (QMCSO) to cover your Dependent Children, you will be allowed to enroll your Dependent Children in the Plan. Please review the "Qualified Medical Child Support Orders" section on page 39 for more information.

Once enrolled, the benefits to which your Dependent Children are entitled are outlined in the "What the Plan Covers" section of this booklet.

WHEN COVERAGE BEGINS

Medical and Prescription Drug Coverage for Bronze Part-time Employees and their Dependent Children

Initial Eligibility for Medical and Prescription Drug Coverage

Medical and prescription drug coverage for Bronze Part-time Employees and their eligible Dependent Children initially begins on the first day of the month following the satisfaction of an Initial Measurement Period, provided that you enroll yourself and your Dependent Children prior to your enrollment deadline (you will be notified of this deadline in your enrollment materials), and will continue through the Initial Stability Period as long as you continue to work in Qualifying Service and pay the required contributions.

The "Initial Measurement Period" is the 12-month period that begins on or immediately after your date of hire.

The "Initial Stability Period" is the period that begins on the effective date of your medical and prescription drug coverage and continues for 12 consecutive months.

For example, if your date of hire is July 10, 2021 and you average 30 paid hours per week during the 12-month period that begins on or immediately after your date of hire, medical and prescription drug coverage for you and your Dependent Children can begin August 1, 2022 and will continue until July 31, 2023, provided you timely enroll in coverage, continue to work in Qualifying Service and pay the required employee contribution.

Ongoing Eligibility for Medical and Prescription Drug Coverage

Plan coverage is offered on a Calendar-Year basis. Once the Initial Measurement Period has ended (where applicable), eligibility for coverage for the next Calendar Year will be determined by your average paid hours during each Ongoing Measurement Period. The "Ongoing Measurement Period" runs from each October to the following October.

If you work the required number of hours in each Ongoing Measurement Period, medical and prescription drug coverage for Bronze Part-time Employees and their enrolled Dependent Children will continue throughout the Calendar Year that begins immediately following the completion of that Ongoing Measurement Period, provided that you enroll yourself and your Dependent Children prior to your enrollment deadline (you will be notified of this deadline in your enrollment materials). Unless terminated early for any of the reasons described in the "When Coverage Ends" section later in this SPD, you and your enrolled Dependent Children will remain covered for medical and prescription drug coverage throughout the Calendar Year (which is also called the Ongoing Stability Period) regardless of the number of hours you work in the Ongoing Stability Period.

Here is an example of how it works:

Date of hire: July 10, 2021
Initial Measurement Period: 12-month period that begins on or immediately after date of hire (August 1, 2021-July 31, 2022)
Initial Coverage Period: August 1, 2022 to July 31, 2023 (assuming you worked qualifying hours in Initial Measurement Period)

First Ongoing Measurement Period: October 2021 to October 2022
First Ongoing Stability Period: January 1, 2023 to December 31, 2023

If you average at least 30 paid hours per week during the first Ongoing Measurement Period, you will be eligible to continue medical and prescription drug coverage during the next Ongoing Stability Period, which is January 1, 2023 to December 31, 2023. If you average less than 30 paid hours per week during the first Ongoing Measurement Period, your medical and prescription drug coverage will end July 31, 2023.

Eligibility for Bronze Part-time Employees for medical and prescription drug coverage and Dependent Child coverage during each subsequent Ongoing Stability Period (or Calendar Year) is determined by your average paid hours in the immediately preceding Ongoing Measurement Period. This means that you must continue to average at least 30 paid hours per week during each Ongoing Measurement Period to maintain eligibility for medical, prescription drug and Dependent Child coverage for the next Ongoing Stability Period (or Calendar Year).

Imputed Hours

If you are on an unpaid but legally-protected leave of absence during an Initial or Ongoing Measurement Period, such as qualifying military leave, Family and Medical Leave Act (FMLA) leave or jury duty**,** for each week of such leave you will be credited with a number of hours that reflects the average weekly paid hours you worked in the month immediately preceding the protected leave. These imputed hours will be counted to determine whether you meet the eligibility requirements for coverage.

Effective March 1, 2020, if agreed to by your employer and the Union, your average weekly paid hours during an Initial or Ongoing Measurement Period will be determined without regard to other unpaid time during which you were not actively working (or a portion of such unpaid time)**.**

Enrollment and Employee Contribution Requirements

If the eligibility requirements listed above are met, Bronze Part-time Employees **must** enroll themselves, and their Dependent Children for coverage in the Plan each year during "open enrollment." During open enrollment, you will have to elect or waive coverage for your Dependent Children for the upcoming Calendar Year. Bronze Part-time Employees will also be given the opportunity to elect the level of medical and prescription drug coverage as follows: 1) Employee-only coverage or 2) coverage for you and your eligible Dependent Children. Your enrollment materials will provide more information on all your enrollment options, including the deadlines for completing enrollment. If enrollment is not completed prior to the deadline, your coverage for medical and prescription benefits and Dependent Child coverage will be waived for the remainder of the Calendar Year.

This type of event is called a "positive enrollment." It requires that Bronze Part-time Employees, whether actively at work or not, positively state that they want the medical and prescription drug and Dependent Child coverage provided by the Plan. If an Employee does not complete the enrollment process or chooses to waive medical and prescription drug coverage for himself or herself and/or coverage for all benefits for his or her Dependent Children during an open enrollment period or when first eligible for coverage, the Employee and the Dependent Children cannot enter the Plan until the next open enrollment period (unless the Employee is eligible for a special enrollment period as described in the "Special Enrollment Rights" section below), provided that the Employee satisfies the eligibility requirements listed above during the applicable Ongoing Measurement Period.

Moving Between UFCW Local 1262–Represented Employers

If you are a Bronze Part-time Employee (including Service Clerks) and your employment ends with one contributing employer and you begin working within 30 days for an employer who contributes to another health fund that is affiliated with UFCW Local 1262, your coverage from that second health fund for dental, vision, legal and life coverage will become effective on the later of the first day of the month following your new date of hire or when your combined service with the two employers meets the service requirements described in the booklet for those benefits. You must satisfy the Initial Measurement Period of 12 months of Service with your new employer to be eligible for medical and prescription drug coverage. Refer to your specific collective bargaining agreement to determine if this applies to you.

To maintain continuous coverage during periods when moving between contributing employers or different health plans that will cause you to lose coverage, you should consider purchasing COBRA continuation coverage. See page 30 for more information on purchasing continuation coverage through COBRA.

HOW TO ENROLL

Bronze Part-time Employees must enroll themselves for medical and prescription benefits and will be provided with the necessary enrollment materials if requested from the Fund Office.

Bronze Part-time Employees must enroll their Dependent Children during the annual enrollment period described above and will be provided with the necessary enrollment materials upon request to the Fund Office.

Employees and Dependent Children who are properly enrolled in the Plan are "Covered Persons." Once enrolled, identification cards from the benefit carriers will be sent to Covered Persons.

If you do not enroll yourself (where applicable) or your Dependent Children, you may enroll later in accordance with the special enrollment rights described below.

Special Enrollment Rights for Life Events

You may request a special enrollment outside of open enrollment if you experience one of the following life events:

If:	**Then:**
• You acquire a new dependent through marriage, birth, or adoption or	You must request enrollment within 60 days of the event. If enrollment is requested within 30 days of the event, the Fund's coverage will be retroactive to the date of the event. If enrollment is requested within 31-60 days of the event, the Fund's coverage will begin on the first day of the month following the request to enroll.
• You or your spouse loses other group health plan coverage	
You or a dependent: • Loses eligibility for coverage under the state Children's Health Insurance Program (CHIP) or Medicaid, or • Becomes eligible for premium assistance under CHIP or Medicaid	

NOTE: Effective March 1, 2020, the above deadlines are extended to the earlier of one (1) year from the deadline or the date that is 60 days from the date that the National Emergency for COVID-19 is declared over.

Dependent Child Verification

For Dependent Child coverage to be effective, you must provide sufficient proof as requested by the Fund Office that the individual is your dependent and is eligible for coverage (such as marriage certificates, birth certificates and proof of residency). All required documentation related to proof **must** include date and/or year, the Employee's name and the Dependent Child's name.

You should send all enrollment documents:

By fax to: (973) 778-1725

By regular mail to: UFCW Local 1262 and Employers Health and Welfare Fund Office
1389 Broad Street
Clifton, NJ 07013-4292

If Two or More Family Members Are Eligible for Coverage

No person will be eligible to be covered by this Plan for part-time employees as both a member and an eligible dependent, except under the Coordination of Benefits rules explained later in this SPD. If your eligible Dependent Child works part-time and qualifies for coverage, he or she may be enrolled as your Dependent Child instead of as an Employee. However, there is no maternity coverage for Dependent Children. A Part-time Employee who is eligible to be enrolled as a Dependent Child must be enrolled as a Part-time Employee (and not as a Dependent Child) to have services connected to maternity care covered by the Plan.

If Family Members Are Eligible Under Different UFCW Local 1262 Funds

If both you and your spouse qualify for coverage with different health funds affiliated with UFCW Local 1262, your eligible children will be eligible Dependent Children of the parent whose birthday occurs earlier in the year.

COST FOR COVERAGE

Your employer must contribute to the Fund on your behalf for you to receive Plan benefits.

Bronze Part-time Employees must also make employee contributions for their own coverage, as well as for Dependent coverage, through payroll deductions in an amount established by the Trustees to receive medical and prescription benefits.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for Plan medical benefits. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal that decision.

Overpayment of Benefits

If the Plan pays you or someone on your behalf an amount more than you or the recipient is entitled to under the Plan, the Plan reserves the right to recover any overpayment by legal action or offset payments to you or any of your family members on benefits otherwise payable. The Fund will apply the terms of the "Subrogation and Third-Party Reimbursement" section described in this booklet to any overpaid benefits that are not recovered through offset or your voluntary repayment. **You may appeal any offset under the appeals procedures described below**.

No Assignment of Benefits

The Plan will not recognize any assignment of any rights under the Plan or ERISA, and any attempt to assign such rights shall be void. The payment of benefits directly to a health care or other Provider, if any, shall be done as a convenience to you and shall not make the Provider an assignee. In no event shall any Provider be a "participant" or "beneficiary" under the Plan, and no Provider shall have standing under ERISA or the claims procedures of the Plan. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Claims for Benefits

A claim for benefits is a request for Plan benefits that is made in accordance with the Plan's claims procedures. All claims must be submitted in the format prescribed by the Fund's Board of Trustees within 12 months following receipt of the health care service, treatment or product to which the claim relates. In no event (except if you are legally incapacitated) will a claim be accepted more than 12 months after the date of receipt of the service, treatment or product to which the claim relates. **Any claims that are not submitted within this time frame will be denied as untimely**. A claim will be considered to be filed on the date it is received by the proper recipient, as indicated below.

The following are not considered claims for benefits:

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

Such inquiries should be directed to and will be handled by the appropriate "claims-processing entity" (described below).

How to File Claims

All claims must be submitted to the appropriate claims-processing entity listed below:

Hospital/Medical Claims

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1219
Newark, NJ 07101-1219

Mental Health/Substance Use Disorder Claims

Beacon Health Options (formerly known as Value Options)
P.O. Box 1850
Hicksville, NY 11802-1850

Prescription Drug Claims

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Claim Forms

All claims for benefits must be submitted on a claim form, which may be a form submitted electronically. You can obtain a claim form from the claims administrator or claims-processing entity (contact information above), or you may contact the Fund Office if the claims administrator cannot assist you. All claim forms must be properly completed and include the following information to be considered a valid claim:

- Member name
- Patient name
- Patient date of birth
- Social Security number of Employee
- Date of Service
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology as maintained and distributed by the American Medical Association)
- ICD-9 (the diagnosis code found in the International Classification of Diseases, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge(s)

- Number of units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the Provider
- Billing name and address of the Provider

Authorized Representatives

You may appoint an authorized representative to take action on your behalf, such as completing claim forms. To do so, you must notify the appropriate claims-processing entity and the Fund Office in writing of the representative's name, address, and telephone number and authorize the release of information (which may include medical information) to your representative. You may be required to provide additional information to verify that your representative is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (as described below) without you having to complete an authorized representative form.

Please contact the Fund Office for an authorized representative form.

Reviewing Claims

In making decisions on claims and appeals, the appropriate claims-processing entity will apply the terms of the Plan and any applicable guidelines, rules and schedules. The Plan's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the appropriate claims-processing entity may also request that you voluntarily allow for an extended period for the claims-processing entity to make a decision on your claim or your appeal.

Types of Claims

<u>Pre-Service Claims</u>

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

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

If you do not provide the information requested or do not properly refile your claim, your claim will be decided based on the information available. During this 45-day period, the deadline for making a decision on your claim will be suspended from the date of the extension notice for either 45 days or until the date

on which your response is received, whichever is earlier. The appropriate claims-processing entity will then have 15 days to make a decision on your Pre-Service Claim and notify you of its determination.

Urgent Care Claims

An Urgent Care Claim is a Pre-Service Claim that requires a shortened time frame for making a determination because a longer time frame could:

- Seriously jeopardize your or your Dependent Child's life or health or your or your Dependent Child's ability to regain maximum function; or

- In the opinion of a Provider with knowledge of your or your Dependent Child's medical condition, subject you or your Dependent Child to severe pain that cannot be adequately managed without the treatment that is the subject of the claim.

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

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

- The Fund's receipt of the specified information, or, if earlier,

- The end of the period you were given to provide the specified information.

Concurrent Care Claims

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

If your Concurrent Care Claim is an Urgent Care Claim, it will be decided as soon as possible. The decision will take into account medical circumstances and will be subject to the rules for Urgent Care Claims (see above), except that you will be notified of the decision (whether approved or denied) within 24 hours after receipt of the claim, so long as the claim is properly filed at least 24 hours before the end of the previously approved period or number of treatments.

Post-Service Claims

A Post-Service Claim is any claim submitted for payment after health services and treatment have already been obtained. If your Post-Service Claim is denied, in whole or in part, you will be notified of the claim denial within 30 days after the claim is received. The period for a decision may be extended for up to 15

additional days due to matters beyond the control of the appropriate claims-processing entity, provided that you will receive advance written notice of such extension before the end of the initial 30-day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which a decision is expected to be made.

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

NOTE: Effective March 1, 2020, the deadlines to submit claims are extended to the earlier of one (1) year from the deadline or the date that is 60 days from the date that the National Emergency for COVID-19 is declared over.

Claims Denial Notification

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

- information sufficient to identify the claim, including the date of service, the health care Provider, the claim amount (if applicable), and a statement describing the availability, upon written request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- the specific reason(s) for the denial, including any denial code and its corresponding meaning;

- a reference to the specific Plan provision(s) on which the denial is based, including a description of the Plan's standard, if any, that was used in denying the claim;

- an explanation of whether an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, and a statement that you may obtain free of charge a copy of such rule, guideline, protocol or similar practice or procedure upon request;

- if the denial of the claim was based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the clinical or scientific reasoning for denial of the claim or a statement that it will be provided to you free of charge upon request;

- a description of any additional material or information necessary to process the claim, and an explanation of why the material or information is necessary;

- a description of the appeal procedures (including voluntary appeals, if any) and external review process and applicable time limits, including a statement that the decision will be final unless it is appealed;

- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review and the time limits for doing so, and that any such action must be brought in the federal district court for the State of New Jersey; and

- for Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims (you may first be provided this information over the phone or in person, with written notification to follow).

Appealing a Denied Claim

First-Level Appeal

If your claim was denied because you were not eligible for benefits, you may appeal that decision by filing a written appeal with the Trustees. You must file such an appeal within 180 days after the date of the decision made on the claim.

If your claim is denied for any other reason, such as because the service or treatment was not covered, and you disagree with the decision on the claim, including how much the Plan paid on the claim, you must file an appeal with the following claims reviewers as explained below:

For medical/Hospital claims, you can file an appeal with Horizon. Your request for review must be made in writing to Horizon at P.O. Box 317, Newark, NJ 07101 within 180 days after you receive notice of denial. Appeals involving Urgent Care Claims may be made orally by calling Horizon at (800) 355-2583.

If your appeal involves an Urgent Care Claim, you may request an expedited external review with an Internal Review Organization (IRO) at the same time an appeal is submitted for an Urgent Care Claim.

If your claim for mental health/substance use disorder benefits is denied in whole or in part, you have 180 days to appeal that denial to Beacon Health Options, Administrative Level 1 Appeal, P.O. Box 1851, Hicksville, NY 11802-1851.

If your claim for prescription drug benefits is denied in whole or in part, you have 180 days to appeal that denial to the Trustees in care of the Fund Office, 1389 Broad Street, Clifton, NJ 07013.

NOTE: Effective March 1, 2020, the deadlines to submit appeals are extended to the earlier of one (1) year from the deadline or the date that is 60 days from the date that the National Emergency for COVID-19 is declared over.

Second-Level Appeal for Post-Service Medical, Mental Health and Prescription Drug Claims

If you disagree with the decision on the first-level appeal on your post-service medical, mental health or prescription drug claim, you may appeal to the Trustees. Note that either the Trustees or their designee will make a determination as to your second-level appeal. The second-level appeal is voluntary, but you must file such an appeal within 180 days after the date of the decision made on the claim. You are encouraged, but not required, to file a second-level appeal to the Trustees before you seek external review or file suit in federal court.

NOTE: Effective March 1, 2020, the above deadline is extended to the earlier of one (1) year from the deadline or the date that is 60 days from the date that the National Emergency for COVID-19 is declared over.

In support of your appeal at both the first and second levels, you have the right to:

- present evidence and written testimony relating to your claim, including written comments, documents, records, and other information relating to your claim for benefits;

- upon request, obtain reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits; and

- review your claim file.

In making a decision on review, the reviewer will review and consider all comments, documents, records, and other information submitted by you or your duly authorized representative without regard to whether such information was submitted or considered during the initial claim determination.

In reviewing your claim, the reviewer will not automatically presume that the initial decision was correct but will independently review your appeal.

If any new or additional evidence is considered in connection with your appeal, that evidence will be provided to you, free of charge, as soon as possible, and you will be given an opportunity to respond. Further, if the decision is based on a new or additional rationale, you will receive an explanation of the rationale, and you will be given an opportunity to respond before a final determination is made on your appeal.

In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary and Appropriate), the reviewer will consult with a health care professional in the appropriate medical field who was not the person consulted in the initial claim (or a subordinate of such person) and will identify the medical or vocational experts who provided advice on the initial claim.

Notification of Decision on Appeal

In the case of an appeal of an Urgent Care Claim, the reviewer will notify you of the decision on your appeal within 72 hours after receipt of your appeal. There is no second level appeal for Urgent Care Claims.

In the case of an appeal of a Pre-Service Claim or a Concurrent Care Claim for medical services, Horizon will notify you of the decision regarding your appeal within 15 days after receipt of your appeal.

In the case of an appeal of a Pre-Service Claim for prescription drugs, Express Scripts will notify you of the decision regarding your appeal within 15 days after receipt of your appeal.

In the case of an appeal of a prescription drug claim, a claim that was denied for eligibility or coverage reasons, or for a second-level appeal of a Pre-Service Claim or a Post-Service Claim, the Trustees will hear your appeal at the quarterly Appeals Committee meeting that is at least 30 days after your appeal is received by the Trustees. If the appeal is received less than 30 days from the quarterly Appeals Committee meeting, the appeal will be heard at the next following quarterly Appeals Committee meeting. If special circumstances require a further extension of the time for review by the Appeals Committee, you will be notified in writing of the circumstances requiring the extension and the date on which a decision is expected. In no event will a decision be made later than the third quarterly Appeals Committee meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether

approved or denied) within five days of the date on which the decision is made. The Appeals Committee consists of the entire Board of Trustees.

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

- information sufficient to identify the claim, including the date of service, the health care Provider, the claim amount (if applicable), and a statement describing the availability, upon written request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- the specific reason(s) for the denial, including any denial code and its corresponding meaning;

- a reference to the specific Plan provision(s) on which the denial is based, including a description of the Plan's standard, if any, that was used in denying the claim;

- an explanation of whether an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, and a statement that you may obtain free of charge a copy of such rule, guideline, protocol or similar practice or procedure upon request;

- if the denial of the claim was based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the clinical or scientific reasoning for denial of the claim or a statement that such explanation will be provided to you free of charge upon request;

- a description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;

- a description of the appeal procedures (including voluntary appeals, if any) and external review process and applicable time limits, including a statement that the decision will be final unless it is appealed; and

- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review and the time limits for doing so, and that any such action must be brought in the federal district court for the State of New Jersey.

The Trustees have the power and sole discretion to interpret, apply, construe, and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation, and application of the Plan. The Trustees have authority to delegate that power and discretion to the claims reviewers on first-level appeals, and to the Fund Office on second-level appeals challenging the amount paid to out-of-network providers. Except as explained below regarding external reviews, the decision of the claims reviewers (or with respect to a second-level appeal, the Trustees or their designee) is final and binding.

External Review of Denied Medical, Mental Health or Prescription Drug Claims

If your claim for medical, mental health or prescription drug benefits has been denied and if you have followed the Fund's internal claims and appeal procedures as described above, you may be entitled to appeal the decision to an Independent Review Organization (IRO). External review is limited to claims involving medical judgment (e.g., lack of medical necessity, or a determination that a claim is Experimental or cosmetic) or a rescission of coverage. No other denials will be reviewed by an IRO unless otherwise required by law.

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

NOTE: Effective March 1, 2020, the above deadline is extended to the earlier of one (1) year from the deadline or the date that is 60 days from the date that the National Emergency for COVID-19 is declared over.

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

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

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

You are permitted to submit in writing to the assigned IRO, within 10 business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days. If you choose to submit such information, within one business day the assigned IRO will forward the information to the Fund Office. Upon receipt of any such information, your claim that is subject to external review may be reconsidered by the Trustees. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Trustees decide upon completion of their reconsideration to reverse their denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

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

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

- a general description of the claim and the reason for the external review request;

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

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

Reversal of the Plan's Decision. If the IRO issues a final decision that reverses the Plan's decision, the Plan will pay the claim.

Expedited IRO Review of Denied Claims

You may request an expedited IRO review of an Urgent Care Claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if you have not yet been discharged from the facility. You may request an expedited IRO review at the same time an appeal is submitted.

Immediately upon receiving your request for an expedited IRO review, a determination will be made as to whether your request is eligible for external review as described above. The Fund Office will immediately send you a notice of the claim's eligibility determination.

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

Special Affordable Care Act (ACA) Requirements

Notwithstanding the foregoing, the Plan will comply with the applicable requirements of the ACA in connection with medical claims, including, but not limited to, the following:

- *Adverse Benefit Determination*. The definition of "adverse benefit determination" shall include having a rescission of coverage, regardless of whether the rescission had an adverse effect on any particular benefit;
- *Right to Review Claim File*. You shall be given the right to review your claim file, including access to and copies of documents, records, and other information relevant to your claim;
- *Opportunity to Present Evidence and Testimony*. You shall be given the opportunity to present evidence and testimony as part of the appeals process. The terms "evidence" and "testimony" shall be interpreted in accordance with DOL guidance;

- *Disclosure of New Rationale and Opportunity to Respond*. In the event the Trustees (or the subcommittee hearing an internal appeal of an adverse benefits determination on behalf of the Plan) consider, rely upon, or generate new or additional evidence in connection with the claim, or are considering a new or additional rationale for the denial of the claim at the internal claims appeal stage, the Trustees (or a subcommittee) will advise you in advance of the determination of the new evidence or rationale being considered, and shall allow you no less than 45 days to respond to such new evidence or rationale, except with respect to appeals of Urgent Care Claims, in which event you will be provided no less than two days to respond to the new evidence or rationale; and

- *No Conflict of Interest*. To the extent personnel of the Fund Office are involved in the claims process, the Trustees will not consider, in connection with any decision regarding the hiring, compensation, promotion, termination or other similar matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of your claims or appeals, whether or not such individual is likely to support the denial of benefits to you.

Exhaustion and Statute of Limitations

You must use and exhaust the Plan's administrative claims and appeals procedure before bringing a suit in New Jersey federal court. Similarly, if you do not follow the Plan's claims procedures in a timely manner, you will lose your right to bring a lawsuit regarding an adverse benefit determination. You do not have the right to assign your claim to any other party; however, as a convenience to you, a Provider, as your authorized representative, may submit for benefits on your behalf. If the Provider, as your authorized representative, seeks benefits on your behalf, he or she is only entitled to what you would be entitled to under the Plan and shall not have any rights greater than yours.

The decision under the Plan will be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the final decision, a review by a court of law will be limited to the facts, evidence, and issues presented during the claims procedure. Facts and evidence that become known to you after having exhausted the appeals procedure under the Plan may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Any claim or lawsuit related to benefits under the Plan must be brought in the correct court no later than 24 months after the earliest of:

- the date your first benefit payment was made or due;

- the date your request for a Plan benefit was first denied; or

- the earliest date you knew or should have known the material facts on which your lawsuit is based (collectively, the "24-month Claims Period").

The deadline for you to file your lawsuit will not expire until the later of (a) the last day of the 24-month Claims Period or (b) three months after the final notice of denial of your appealed claim is sent to you by the claims administrator. Any claim or action filed under these administrative claims and appeals procedures or any lawsuit that is filed in a court after the end of this 24-month Claims Period (or, if

applicable, after the end of the three-month period following exhaustion under the administrative claims and appeals procedures of the Plan) will be time-barred.

OTHER BENEFIT SOURCES AND COORDINATION OF BENEFITS

Medicare

Medicare is a government-provided health insurance plan for individuals:

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

Medicare has the following parts:

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

Your Coverage Options If You Continue Working After Age 65

If you continue in employment as a Covered Person after age 65, you can choose to:

- Keep the Plan as your only coverage.
- Keep the Plan as your primary coverage, with Medicare as your secondary coverage. In this case, all claims should be submitted to the Plan first. Medicare would then consider any remaining expenses.
- Elect Medicare as your only coverage. In this case, you must notify the Fund Office and sign a waiver of coverage for Plan benefits. Once you sign the waiver, medical and prescription drug coverage under the Plan stops for you and your enrolled Dependent Children; you will have the option of either continuing or dropping dental and/or vision coverage for yourself and your enrolled Dependent Children as well. If you elect to waive medical, prescription, dental and/or vision coverage, you will not be able get back into the Plan in the future unless you have an event that would qualify you for a HIPAA Special Enrollment Right described on page 9. Your claims must then be submitted to Medicare only.

Subrogation and Third-Party Reimbursement

General Principle

There is no coverage for claims incurred, including medical, prescription drug, and dental care claims, due to injuries that give rise to a claim by you or your enrolled Dependent Children against a third-party tortfeasor, or against any person or entity as the result of the actions of a third party. In such cases,

benefits otherwise payable under the Plan will be provided to or on behalf of you or your Dependent Children only on the following terms and conditions.

When you or your enrolled Dependent Children receive benefits under the Fund that are related to medical expenses that also may be payable under workers' compensation, any statute, any uninsured or underinsured motorist plan, any no-fault or school insurance plan, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person may be paid by a third party, whether through legal action, settlement or for any other reason, you or your Dependent Child must reimburse the Fund for all related benefits received out of any funds or monies you or your Dependent Child recovers or receives from any third party.

Specific Requirements and Plan Rights

Because the Fund is entitled to reimbursement, the Fund shall be fully subrogated to any and all rights, recovery or causes of action or claims that you or your Dependent Child may have against any third party. The Fund is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement exists regardless of the manner in which the recovery is structured or worded, and even if you or your Dependent Child has not been paid or fully reimbursed for all of the damages or expenses.

The Fund's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Fund agrees in writing to such reduction, in its sole and absolute discretion, given the facts and circumstances of a particular case. Further, the Fund's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, the "collateral source" rule, the "attorney's fund" doctrine, the anti-subrogation statute, regulatory diligence or any other equitable defenses that may affect the Fund's right to subrogation or reimbursement.

In order to enforce its rights of subrogation and reimbursement, the Fund reserves the right, in its sole and absolute discretion, to deny payment of any claim until you or your Dependent Child takes affirmative steps, as required by the Fund, to obtain recoveries from responsible third parties, including, but not limited to commencing legal action, filing and pursuing a claim for workers' compensation, or submitting an insurance claim to any insurer that may have liability.

If you or any of your Dependent Children do not cooperate in attempting to obtain recovery from the responsible third party, or if the Fund should become aware that you or your Dependent Child has received a third-party payment or recovery and not reported such amount, the Fund, in its sole discretion, may suspend all further benefits payments related to you or any of your Dependent Children until the reimbursable portion, plus interest (calculated pursuant to the Fund's policy for the collection of overpayments), is returned to the Fund or offset against amounts that would otherwise be paid to or on behalf of you or your Dependent Children. The Plan also has the right to commence a lawsuit against you and/or your Dependent Children to recover any amounts owed under its right of subrogation and reimbursement.

Covered Person Duties and Actions

By participating in the Fund, you and your Dependent Children consent and agree that a constructive trust, a lien or an equitable lien by agreement in favor of the Fund exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by

agreement, you and your Dependent Children agree to cooperate with the Fund in exercising its rights of subrogation and reimbursement. Any amount received by you or your Dependent Child, or your representatives (including your or your Dependent Child's attorneys) that is due to the Fund under this provision shall be deemed to be held in trust by you or them for the benefit of the Fund until paid to the Fund. The Fund shall have a lien on any amount received by you or your Dependent Child, or your representatives (including your or your Dependent Child's attorneys), that is due to the Fund under this provision, and any such amount shall be deemed to be held in trust by them for the benefit of the Fund until paid to the Fund.

Once you have any reason to believe that you or your Dependent Child may be entitled to recovery from any third party, you or your Dependent Child must notify the Fund as soon as reasonably possible. And, at that time, you and your Dependent Child (and your or your Dependent Child's attorneys, if applicable) may be required to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Fund's subrogation rights and the Fund's right to be reimbursed for expenses arising from circumstances that entitle you or your Dependent Child to any payment, amount or recovery from a third party.

If you or your Dependent Child fails or refuses to execute the required subrogation/reimbursement agreement, the Fund may deny payment of any benefits to you and any of your Dependent Children until the agreement is signed. Alternatively, if you or your Dependent Child fails or refuses to execute the required subrogation/reimbursement agreement and the Fund nevertheless pays benefits to or on behalf of you or your Dependent Child, your or your Dependent Child's acceptance of such benefits shall constitute agreement to the Fund's right to subrogation or reimbursement.

You and your Dependent Child consent and agree that you or your Dependent Child shall not assign your or your Dependent Child's rights to settlement or recovery against a third person or party to any other party, including your or your Dependent Child's attorneys, without the Fund's advance written consent. As such, the Fund's reimbursement will not be reduced by attorneys' fees and expenses.

Coordination of Benefits

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

Other plans include:

- Group blanket or franchise insurance coverage
- Hospital service prepayment plan, medical service prepayment plan or group practice plan
- Any coverage under a labor-management trusteed plan, union welfare plan, or employer organization or employee benefit organization plan
- Any coverage under governmental programs, to the extent permitted by law, and any coverage required or provided by any statute
- Any coverage sponsored by or provided through a school or other educational institution

- Any personal insurance
- Any plan considered an “excess” plan
- Any other group health plan or individual plan, including those purchased through the Health Insurance Marketplace
- Medical payments available through a homeowner’s insurance policy

If you or an enrolled Dependent Child incurs a covered expense that is covered by the Plan and another plan that is self-funded, the following rules apply:

- The plan covering the claimant as an employee will be primary and have its benefits determined before the plan covering the claimant as a dependent
- The primary plan will pay benefits first, then the secondary plan will pay the difference between the covered expense and the amount paid by the other plan

If you or an enrolled Dependent Child incurs a covered expense that is covered by the Plan and any other plan that is not self-funded, the following rules apply:

- The other plan will be primary, and the Plan will be secondary
- The Plan will pay the difference between the covered expense and the amount paid by the other plan

In no event will the Plan pay more than it would have paid if it had been the only source of coverage.

There is a special rule for automobile insurance. The Plan will be secondary to any “no-fault” or other automobile insurance coverage for medical care, even if you or your Dependent Child elects that the automobile insurance coverage be the secondary payor. Even if you or your Dependent Child decline to select health care coverage that is available under your “no fault” or automobile insurance, this Plan will only pay benefits secondarily, if at all. This provision is expressly intended to avoid the possibility that this Plan will be determined to be primary to coverage that is available under "no fault” or automobile insurance. Any payments made by the Fund are subject to the Fund’s right of subrogation and reimbursement.

LENGTH OF COVERAGE

When Coverage Ends

For You

You are covered under the Plan until 12:01 a.m. Eastern Time on the earliest of the following dates:

- The date you stop actively working in Qualifying Service;
- The last day of the period for which you paid required employee contributions;
- The date you no longer qualify for coverage under the Plan;
- The date you cease to qualify for COBRA because you fail to elect coverage or fail to make the required self-payment as specified in your COBRA entitlement notice; or
- The date the Plan terminates.

If you are on an approved disability leave of absence, all benefits you were receiving at the time you left Qualifying Service because of the disability (except Legal Services Plan benefits) will continue for 90 days after you leave Qualifying Service for the approved leave of absence. Legal Services Plan benefits will terminate at the end of the month in which you leave Qualifying Service because of a disability. If you return to work after your coverage has ended, coverage will start again on the first day of the month after you have returned to work with a contributing employer in a position covered by this Plan.

For Your Dependent Children

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

- The date you fail to pay the monthly premiums for Dependent Child coverage;
- The date your Dependent Child ceases to qualify for COBRA because he or she fails to elect coverage or fails to make the required self-payment as specified in his or her COBRA entitlement notice;
- The date you are no longer eligible to cover your Dependent Children, i.e., you fail to work the required hours of Qualifying Service during an Ongoing Measurement Period;
- The date they no longer meet the definition of a covered Dependent Child (see page 5 for the definition of Dependent Child); or
- The date that the Plan discontinues Dependent Child coverage for all Part-time Employees.

When coverage ends for either you or your covered Dependent Children, you or they may be eligible to extend coverage at your or their own expense through COBRA as described on page 30.

Suspension of Benefits

Discontinuance of Coverage for Nonpayment of Employer Contributions

If your employer is late in making or fails to make the required contributions on your behalf, your benefits may be suspended. If your employer timely pays to the Fund the contributions and any supplementary charge imposed by the Trustees, the coverage and benefits to you and your Dependent Children will be continued without interruption. However, if your employer fails or refuses to timely pay to the Fund the contributions and any supplementary charge imposed, you and your Dependent Children's coverage and benefits may be suspended upon 30 days' advance written notice to you.

Discontinuance of Coverage and Benefits for Failure to Cooperate in Subrogation Process

You and your Dependent Children's coverage and benefits may be suspended if you fail to cooperate with the Plan's subrogation process.

Prior to the suspension or offset of benefits under the Plan, you will receive 30 days' advance written notice from the Fund. The notice shall inform you that absent timely cooperation in the subrogation process and procedures: (a) your coverage and coverage for all of your Dependent Children for any benefits provided by the Fund shall be suspended for a specified period; and/or (b) the Fund will not pay any future claims for you and your Dependent Children until the Fund has recovered in full the amount of claims paid for you and your Dependent Children that were subject to subrogation.

If you timely cooperate in the subrogation process and procedures, coverage and benefits will be continued without interruption. However, if you fail to cooperate, you and your Dependent Children's coverage and benefits will be suspended upon 30 days' written notice to you.

Where the Trustees decide to suspend your coverage for a period due to your failure to comply with the Plan's subrogation process, benefits for you and your dependents will be suspended for the following periods:

- Amount of subrogation claim equal to $25,000-$50,000: 12 months
- Amount of subrogation claim over $50,000: 18 months

For more information on the Plan's subrogation processes, please see the "Subrogation and Third-Party Reimbursement" section on page 24.

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

Under USERRA, you may continue coverage for both you and your enrolled Dependent Children while on a military leave of absence for up to 24 months.

During the first 30 days of such continuation of coverage, you will be required to pay your portion of the contribution for coverage. Thereafter, you will be required to pay 102% of the total cost of the coverage. Payment must be made to the employer.

Any benefit changes that are implemented while you are continuing coverage on military leave will apply to you as of the effective date of each such change.

Continuation of this coverage while on military leave will run concurrently with continuation of coverage provided under any other leave of absence except COBRA, which is explained below.

You may continue this coverage up to the earlier of:

- 24 months, beginning on the date on which your absence begins; or
- The last day as specified under USERRA in which you have to return to work in employment covered by the Plan.

If you decide not to continue coverage while on military leave, coverage for you and your eligible Dependent Children will be reinstated immediately upon your return to work in employment covered by the Plan.

Any time spent on military leave will not count toward satisfying the waiting period required under the Plan. However, when you return to work you will be credited for any portion of the waiting period satisfied prior to going on military leave.

Family and Medical Leave Act

If you apply for and are approved for leave under the federal and/or state FMLA, you may be eligible to continue your medical coverage during the leave. Contact the Human Resources Department of your employer for additional information on your FMLA benefits. Please contact the Fund Office regarding benefits under the Plan and the right to continue coverage.

General Notice of Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage Rights

To qualify for COBRA continuation coverage, you must have a "qualifying event" that would otherwise end your coverage. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Only qualified beneficiaries may elect to continue their group health plan coverage. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, enrolled Employees and Dependent Children, including alternate recipients under QMCSOs, may be qualified beneficiaries. (Certain newborns and newly adopted children during the period of continuation coverage may also be qualified beneficiaries.)

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for coverage. Continuation coverage is the same health benefit coverage that the Plan gives to all other Covered Persons. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other Covered Persons covered under the Plan.

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

Who is a qualified beneficiary:	What is a qualifying event:	Who must notify the Fund Office of the event:
You, if you are an Employee and lose Plan coverage because	■ Your hours of employment are reduced ■ Your employment terminates (for reasons other than gross misconduct) ■ You retire	The employer within 30 days of the event
A Dependent Child* of an enrolled Employee who loses Plan coverage because	■ The parent-Employee dies ■ The parent-Employee's hours of employment are reduced ■ The parent-Employee's employment in service that is covered by the Plan terminates (for reasons other than gross misconduct)	The employer within 30 days of the event
	■ The parent-Employee becomes entitled to Medicare and elects to have Medicare be the primary coverage ■ The parents are divorced or legally separated ■ The child no longer meets the eligibility requirements	The Employee within 60 days of the event
*Children who are born to or placed for adoption with an Employee during the period of the Employee's continuation coverage under COBRA are qualified beneficiaries entitled to COBRA continuation coverage. Once a newborn or adopted child is enrolled in continuation coverage, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).		

NOTE: Effective March 1, 2020, the above deadlines are extended to the earlier of one (1) year from the deadline or the date that is 60 days from the date that the National Emergency for COVID-19 is declared over.

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

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

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Employees may elect COBRA continuation coverage on behalf of their Dependent Children.

To elect continuation coverage, you or your Dependent Children must complete and return the COBRA election form to the Fund Office within 60 days after you receive the COBRA election form. You must pay the first premium retroactive to the date coverage terminated, within 45 days after you return the COBRA election form. Coverage will not commence until payment is received in full.

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

Paying for Coverage

As provided by law, you and/or your Dependent Child(ren) must pay the full premium cost of benefits coverage from the Plan plus 2% for administrative expenses (a total of 102% of the cost) for the full 18- or 36-month period. In cases of extended continuation coverage due to disability, the cost for months 19 to 29 is 150% of the full premium for the benefits coverage. Coverage will not commence until payment is received in full.

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

The Fund will notify you and/or your Dependent Child(ren) that a premium payment is due or late. If payment is not made by the due date, the Fund will notify you or your Dependent Child(ren) that continuation coverage is about to be, or has been, terminated.

NOTE: Effective March 1, 2020, the above deadlines are extended to the earlier of one (1) year from the deadline or the date that is 60 days from the date that the National Emergency for COVID-19 is declared over. Claims will be suspended for any period of coverage for which a premium payment is not received. If the premium is received within the extended deadline, claims will be paid retroactively.

Duration of Coverage

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

Qualifying COBRA Events		
If You Lose Coverage Because:	**These People Would Be Eligible:**	**For COBRA Coverage For Up To:**
Your employment terminates for a reason other than gross misconduct	You and your eligible Dependent Children	18 months
Your working hours are reduced	You and your eligible Dependent Children	18 months

Qualifying COBRA Events		
If You Lose Coverage Because:	**These People Would Be Eligible:**	**For COBRA Coverage For Up To:**
You are determined to be disabled by the Social Security Administration	You and your eligible Dependent Children	29 months
You die	Your eligible Dependent Children	36 months
You divorce or legally separate	Your eligible Dependent Children	36 months
Your Dependent Children no longer qualify as dependents	Your eligible Dependent Children	36 months
You become entitled to Medicare benefits	Your eligible Dependent Children	36 months

COBRA coverage will end before the period shown above if any of the following events occur as of the dates indicated below:

- The date that the Plan terminates;
- The date that a required premium is due and unpaid after the 30-day grace period;
- The date that you and/or your Dependent Children, after electing COBRA coverage, become covered under another group health plan;
- If coverage has been extended for up to 29 months due to disability and there has been a final Social Security Administration determination that the individual is no longer disabled. In this case, coverage will end as of the month that begins more than 30 days after the date of the Social Security Administration final determination; or
- The date that your former employer stops contributing to the Fund and provides coverage through a different group health plan for a significant number of employees formerly covered under the Plan.

Note: A few words about Medicare:

- If you or your eligible dependents become eligible for Medicare while continuing coverage, COBRA coverage will continue, but such coverage will be secondary to, and pay benefits after, Medicare.
- If you are age 65 or older, you have a special enrollment period during which you can enroll in Medicare following your loss of coverage as an active employee. If you enroll during this period (typically eight months), you will not have to pay a late enrollment penalty under Medicare Part B. Your election of COBRA coverage does not extend your Medicare special enrollment period. Your loss of active coverage is what starts the enrollment period for you and your spouse (if over age 65).

If the qualifying event is the end of your employment or a reduction in your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA

continuation coverage for your qualified Beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA continuation coverage for your Dependent Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Certain qualifying events, or a second qualifying event during the initial period of coverage, may also permit a qualified Beneficiary to receive a maximum of 36 months of coverage.

Extension of 18-Month COBRA Coverage Period for Disability

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

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

The notice must be in writing and must include the name and address of the Employee or Dependent Child, the Employee's or Dependent Child's Social Security number, a copy of the Social Security Administration's disability determination letter and proof of when you were determined to be disabled. In addition, you must notify the Fund Office in writing before the end of the 18-month continuation period. If you do not notify the Fund Office within this time frame, you will not qualify for this extension.

Second Qualifying Event

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

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

Acquiring New Dependents While Covered by COBRA

You may enroll a Dependent Child born or placed for adoption during a period of COBRA continuation coverage for the balance of your COBRA continuation coverage period. You must follow all of the Plan's rules for enrolling a newly born or adopted child. The Dependent Child will be considered a qualified Beneficiary.

Address Changes

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

Financial Responsibility for Failure to Give Notice

If the Plan pays a claim for you or your Dependent Child(ren) and your coverage terminated as a result of a qualifying event, but you did not elect continuation coverage and the Fund Office was not notified within the 30- or 60-day time frames noted above, you or your employer will be required to repay the Plan for any claims that should not have been paid. If you do not repay the Plan, the amount due will be deducted from other benefits payable to you or, to the extent that the Fund can recover overpaid benefits directly from you, the Fund will recover those amounts through legal action.

If your employer fails to notify the Fund Office of a qualifying event within 30 days and you or your Dependent Child(ren) elect continuation coverage more than 90 days after the qualifying event, the employer must reimburse the Plan for all claims paid on your behalf. The Trustees, in their sole discretion, may limit the application of this provision if the circumstances indicate that you would have elected continuation coverage within the 90-day election period if you had been notified of your right to do so.

PLAN ADMINISTRATION AND LEGAL INFORMATION

SPD Edition Date	This SPD describes the medical and prescription drug benefits for Bronze Part-time Employees in effect as of January 1, 2022. Benefits for other groups of Employees, and other benefits, are described in a separate SPD.	
Plan Name	UFCW Local 1262 and Employers Health and Welfare Fund	
Plan Sponsor	Board of Trustees UFCW Local 1262 and Employers Health and Welfare Fund 1389 Broad Street Clifton, NJ 07013-4292	
Employer Identification Number (Plan Sponsor)	23-7042767	
Plan Number	501	
Type of Plan	Group health plan providing health, life insurance, accidental death and dismemberment, and prepaid legal service benefits	
Plan Year	December 1 through November 30	
Plan Administrator	Board of Trustees UFCW Local 1262 and Employers Health and Welfare Fund 1389 Broad Street Clifton, NJ 07013-4292 Phone: (800) 522-4161 (TTY: 711)	
Type of Administration	The Board of Trustees administers the Plan; it contracts with various entities to provide administrative services to the Plan.	
Trustees	Employer Trustees Generoso Del Rosario Michelle Castellana Ann Nichols c/o Stop & Shop 1129 Rte. 34 North Aberdeen, NJ 07747	Union Trustees Harvey Whille James Feimster Donald Merritt c/o UFCW Local 1262 1389 Broad Street Clifton, NJ 07013-4292
Agent for Service of Legal Process	Plan Administrator 1389 Broad Street Clifton, NJ 07013-4292 Phone: (800) 522-4161 (TTY: 711) In addition, service of legal process may also be made on any Plan Trustee.	
Source of Contributions and Financing of the Plan	Benefits are funded through contributions from employers that have participation agreements with the Plan or collective bargaining agreements with UFCW Local 1262 that require contributions to the Plan, and investments thereon. With the exception of life insurance, AD&D and legal services benefits, and, effective April 1, 2017, vision benefits, all benefits under the Plan are self-insured and provided by the Fund.	
Collective Bargaining Agreements	The Fund is maintained in accordance with collective bargaining agreements. You may obtain a copy of the agreement that applies to you by making a written request to UFCW Local 1262's Office.	
Participating Employers	Stop & Shop Tops Markets Morton Williams	

	UFCW Local 1262 Union UFCW Local 1262 and Employers Pension Fund This list may change from time to time. Upon written request to the Fund Office, you may ask whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.

Plan Amendment or Termination

The Trustees of the Fund are authorized at any time and on such basis as they, in their sole discretion, deem appropriate to amend, modify, add to or eliminate any provision or benefit from the Plan. Benefit changes may be made by formal Plan amendment, Trustee resolution, action by the Trustees when not in session by telephone or written action and/or other methods as may be permissible for action by the Trustees.

The Trustees also reserve the right to terminate the Plan at any time for any reason under the conditions set forth in the Plan Documents. Should the Plan be terminated, the Trustees shall apply the monies of the Plan to provide benefits or otherwise carry out the purposes of the Plan in an equitable manner until the entire remainder of its assets have been distributed by the Trustees.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Federal privacy laws set limits on how health plans, pharmacies, Hospitals, clinics, nursing homes and other direct-care Providers (called covered Providers) use individually identifiable health information.

This overview describes your rights and protection of personal information related to your health. Please review it carefully.

Key provisions of these privacy standards include:

- **Access to Medical Records** – HIPAA gives you the ability to review and obtain copies of your medical records. If your medical records are maintained electronically, you may request access to your electronic medical records if that format is readily producible. Otherwise, the covered Provider must provide the requested information in an electronic format that you can read on your computer (e.g., Word, Excel). You may also request corrections if you have identified any errors. Covered Providers generally should provide access to your records within 30 days of your request and may charge for the cost of copying and sending the records to you.

- **Notice of Privacy Practices** – Covered Providers will provide you with a HIPAA notice advising you of your rights. You may be asked to sign, initial or otherwise acknowledge that you have received this notice. You may also ask to restrict the use or disclosure of your information beyond the practices included in the notice, but the covered Providers would not have to agree to the changes.

- **Limits on Use of Personal Medical Information** – The privacy rule sets limits on how covered Providers may use your identifiable health information. These limits do not restrict the ability of health care professionals to share any medical information needed for treatment. They do restrict its use for purposes not related to health care. Covered Providers may use or share only the minimum amount of protected information needed for a particular purpose. In no case will a

covered Provider use or disclose your personal medical information that is Genetic Information for underwriting purposes. You must provide written authorization for the following medical information to be disclosed:

- Psychotherapy notes if maintained by the Plan.

- Personal medical information for marketing purposes. For example, your written authorization will be required for the covered Provider to share your medical information to promote health care products or services or alternative treatments, or provide appointment or treatment reminders. Your written authorization will not be required for prescription refill reminders, general health and wellness communications or communications about government or government-sponsored programs, such as eligibility for Medicare or Medicaid.

- Disclosures that constitute a sale of your personal medical information. A sale means that the covered entity receives direct or indirect remuneration in exchange for personal medical information. Your authorization is not required if remuneration for personal medical information is required to perform activities or provide services, such as for research or for the services provided by the health information exchange.

- Personal health information released to a life insurer, a bank, a marketing firm or another outside business for purposes not related to your health care.

■ **Stronger State Laws** – The federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; any state law providing additional protections would continue to apply. When a state law requires a certain disclosure, the federal privacy regulations may not preempt the state law.

■ **Confidential Communications** – Under the privacy rule, you can request that your doctors, health plans and other covered Providers take reasonable steps to ensure that their communications with you are confidential. For example, you could ask your doctor to call you at work rather than at home, and the doctor's office should comply with that request if it can be reasonably accommodated.

■ **Complaints** – You may file a formal complaint regarding the Fund's privacy practices to:

Privacy Officer
UFCW Local 1262 and Employers Health and Welfare Fund Office
1389 Broad Street
Clifton, NJ 07013-4292
(800) 522-4161 (TTY: 711)

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

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

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

Genetic Information Nondiscrimination Act of 2008 (GINA)

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

Qualified Medical Child Support Orders

Any child of an enrolled Part-time Employee eligible for Dependent Child coverage who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the Plan. A QMCSO is an order that meets certain legal requirements and requires the Plan to provide health coverage to your eligible Dependent Child(ren). You may obtain a copy of the Fund's procedures governing QMCSO determinations, free of charge, by contacting the Fund Office.

A QMCSO is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law, that has the force and effect of law in that state, and that assigns to a child the right to receive health benefits for which a Part-time Employee is eligible under the Plan, and that the Trustees (or their delegates) determine is qualified under the terms of ERISA and applicable state law. Please contact the Fund Office if you have any questions about QMCSOs.

YOUR RIGHTS UNDER ERISA

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

Receive Information About the Plan and Your Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the DOL and available at the Public Disclosure Room of the EBSA. These documents are available upon written request to the Plan Administrator.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of the summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself or your Dependent Children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent Children may have to pay for such coverage. Review the "General Notice of Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage Rights" section for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

control of the Plan Administrator. After exhausting your appeal rights, you may file suit in a state or federal court if you have a claim for benefits that is denied or ignored, in whole or in part. After exhausting your appeal rights, you may file suit in a federal court if you disagree with the Plan's decision. 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 a 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 DOL, 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 that your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the EBSA, DOL, listed in your telephone directory or:

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

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

YOUR MEDICAL AND PRESCRIPTION DRUG BENEFITS AT A GLANCE

Here are the highlights of your medical and prescription drug benefits. Benefits may be subject to certain limits and restrictions. Be sure to read the rest of this SPD for a more complete description of Fund benefits.

		For more information, go to page:
What are my out-of-pocket costs?	If you use Advantage EPO in-network Providers, you generally pay part of the Allowed Amount through a deductible, copay and/or coinsurance. You also pay for costs that exceed the Plan's maximum limits. If you use out-of-network Providers, the Plan does not pay benefits unless you experience a life-threatening emergency or if you have an in-network hospitalization**. Where there is an in-network hospitalization, the Plan will pay the Allowed Amount for out-of-network charges for anesthesiology, radiology, surgical and pathology services received at an in-network facility through no fault of your own that are related to that in-network admission, and for out-of-network emergency treatment, up to the Allowed Amount, but you will be responsible for any amounts billed in excess of what the Plan pays.**	47
What preventive care does the Plan cover?	The Plan helps you pay the cost of: ■ Well-child care, including immunizations; and ■ Wellness screenings and preventive care for adults.	50-51
What if I get sick or hurt? ■ Doctors' office or home visits ■ Doctors' charges for surgery ■ Doctors' charges for a second surgical opinion	 The Plan pays 100% of the Allowed Amount after you meet a copay and the deductible The Plan pays 70% of the Allowed Amount after you meet the deductible The Plan pays 70% of the Allowed Amount after you meet the deductible and copays for office visits	52
Does the Plan cover maternity visits?	The Plan pays 70% of the Allowed Amount after you meet the deductible and a copay for office visits Coverage is for Employees only, not Dependent Children	52 & 54

		For more information, go to page:
What if I need to go into the Hospital?	You must have a Hospital stay Pre-Authorized. Plan benefits include semi-private room, board and other Hospital charges for: ■ Hospitalization outside of the United States ■ Newborn infant care ■ Treatment of an Illness or Injury	52-54
What if I have an emergency?	For a sudden and serious Illness or Injury, call 911 or go straight to the nearest emergency room. For a nonemergency, go to your doctor's office, an in-network Walk-in Clinic or an in-network urgent care facility (no benefits are paid if you have a nonemergency and go to the emergency room or if you go to out-of-network Walk-in Clinics or urgent care facilities). If you are admitted to the Hospital from the emergency room, you must have your Hospital stay Pre-Authorized.	54-55
■ Ambulance	The Plan pays the Allowed Amount for ambulance transportation to the nearest facility that can treat the condition.	61
Does the Plan pay for any other services?	The Plan also provides benefits for:	
	■ Abortion	60
	■ Acupuncture	60
	■ Ambulance	61
	■ Ambulatory surgical facility (Pre-Authorization required)	55
	■ Anesthesiologist's charges	52
	■ Applied Behavioral Analysis (ABA) therapy	59-60
	■ Blood	61
	■ Chiropractic care	61
	■ Chemotherapy, radiation and hemodialysis	61

		For more information, go to page:
	■ Cognitive rehabilitation therapy	61
	■ Diagnostic tests and X-rays and MRI, CAT and PET scans	61-62
	■ Dialysis	61
	■ Durable medical equipment, including Prosthetics (Pre-Authorization required for rentals and purchases)	61
	■ Home Health Care (Pre-Authorization required)	57
	■ Hospice care (Pre-Authorization required)	57-59
	■ Infusion therapy	61
	■ Mental health and substance use disorder treatment	59-60
	■ Nutritional counseling	61
	■ Orthotic shoe inserts	61
	■ Oxygen	61
	■ Pre-admission testing	55
	■ Radiation therapy	62
	■ Respiration therapy	62
	■ Skilled nursing facility (Pre-Authorization required)	56
	■ Speech therapy	62
	■ Transplant benefits	55-56
	■ Vision care	62

		For more information, go to page:
	■ Walk-in Clinic ■ Wigs	54 & 81 62
How do I submit a claim?	Most claims will be filed for you electronically. If you have out-of-pocket costs that require you to file a claim, request a claim form from the Fund Office.	13-14
Does the Plan provide benefits for prescription drugs?	The Plan covers prescription drugs that you obtain at a participating retail or mail-order pharmacy.	69-73

MEDICAL AND HOSPITAL BENEFITS FOR BRONZE PART-TIME EMPLOYEES AND THEIR ENROLLED DEPENDENT CHILDREN

All medical benefits described in this SPD are subject to Allowed Amount fee limitations. For any service or treatment, the Plan will only pay the Allowed Amount as defined in the Glossary of Key Terms section of this SPD.

The Plan has arranged for access to providers through the Horizon Advantage Exclusive Provider Organization (Advantage EPO) network. Horizon administers and maintains this exclusive network of Providers, who have agreed to provide Hospital, medical and ancillary services at discounted, in-network rates.

Each time you need health care, you have the freedom to choose the Provider or facility you prefer, but the amount you and the Plan will pay depends on whether the Provider or facility is in the Advantage EPO network. If you choose a Provider or facility that participates in the Advantage EPO network, the Plan will reimburse or pay part or all of the Allowed Amount for Covered Services.

If you use an out-of-network Provider, the Plan does not pay benefits—you must pay the full cost of the care you receive. The only exceptions are if you experience a life-threatening emergency, or you have an in-network hospitalization and are treated by certain out-of-network providers through no fault of your own (such as radiologists, anesthesiologists, pathologists and surgeons). The Plan will pay Covered Services related to such treatment rendered by out-of-network Providers up to the Allowed Amount, but you will be responsible for any amounts billed in excess of what the Plan pays.

The Trustees have discretion on appeal to approve payment of claims for services performed or to be performed by out-of-network Providers on the same terms as for comparable in-network providers only if the following conditions are met: (a) the claimant was being treated by the out-of-network Provider prior to January 15, 2015; (b) no comparable in-network provider is available within 50 miles or, if less, within 25 minutes of average travel time, of the claimant's primary home address; (c) it is in the best interest of the claimant's health to continue the treatment by the out-of-network Provider; and (d) it is in the economic interest of the Plan to approve the claim. This extremely limited exception will apply only to the specific claimant and out-of-network Provider that was treating the claimant prior to January 15, 2015. Similar treatment by other out-of-network Providers or to other claimants does not fall within this extremely limited exception.

The Plan makes no representation regarding the quality of services provided, and the Plan is not responsible for care rendered by a Provider.

To find a list of Providers and facilities in the Advantage EPO network, call the toll-free number or go to the website shown on your identification card (which you will receive when you enroll).

Please note that the network changes, meaning that new physicians and facilities are added from time to time, while others leave the network. It is your responsibility to confirm whether a physician or facility is in the Advantage EPO network when you call to make an appointment and at the time of each visit, including Hospital treatments, procedures and stays.

Opportunity to Select a Primary Care Physician

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

The Deductible

The deductible is the amount you must pay for covered medical expenses—not including coinsurance or copays—before the Plan pays benefits for certain covered medical expenses. The deductible applies to each covered family member once each Calendar Year. To meet the family maximum deductible, two family members must each meet his or her individual deductible amount. Once the family maximum deductible is reached, no further deductibles are required for any remaining family members for the rest of the Calendar Year. The deductible does not apply to expenses for covered prescription drug benefits.

For each:	**Bronze Part-time Employees Deductible**
Individual in a Calendar Year	$2,000
Family in a Calendar Year	$4,000

The Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the maximum dollar amount that you have to pay for eligible expenses in a Calendar Year. The annual out-of-pocket maximum includes copayments, deductibles and coinsurance.

The combined expenses of all covered family members are used to meet the family out-of-pocket maximum amount. Once the annual out-of-pocket maximum is reached, the Plan pays 100% of remaining eligible expenses for those individuals (or family) for the rest of that Calendar Year.

Not all expenses are included in the out-of-pocket maximum. For example, any amounts you pay for services with an out-of-network Provider beyond what the Plan pays are not included. Nor are any expenses you pay for non-Covered Services, penalties for failure to Pre-Authorize a claim, or other services excluded from coverage under the Plan.

The out-of-pocket maximum for Bronze Part-time Employees will always be the maximum allowed by law and may increase each year. For the current Calendar Year's out-of-pocket maximum, please contact the Fund Office. Effective January 1, 2022, the out-of-pocket maximums are:

- $8,700 for an individual (made of up $7,830 in eligible medical expenses and $870 in eligible prescription drug expenses)
- $17,400 for a family (made up of $15,660 in eligible medical expenses and $1,740 in eligible prescription drug expenses)

Utilization Management

Utilization management services—including Pre-Authorization and case management—are important features of your health care coverage. These services are provided through Horizon and can help you avoid extended periods of Hospitalization and unnecessary surgery.

If a Provider recommends surgery or Hospitalization, you can call Horizon at 1-800-355-2583, to confirm services are pre-authorized as required and explained more fully below.

Pre-Authorization

Certain services, such as a nonemergency inpatient Hospital stay, all in-patient surgery, and certain outpatient surgery, require Pre-Authorization. It is recommended that you call Utilization Management Department to confirm if Pre-Authorization is required prior to any surgery. Pre-Authorization is a process that helps you and your Provider determine whether the services being recommended are covered expenses under the Plan. You are responsible for making sure your Provider obtains Pre-Authorization from Horizon, which is the Fund's medical/hospital claims processor, for the following Covered Services. **Claims for these services will be denied if not pre-authorized**.

- Nonemergency admissions to a facility, including a Hospital, skilled nursing facility, Hospice facility, or ambulatory surgical facility (excluding maternity)
- Cardiac catheterization
- Cochlear implants
- Durable medical equipment (including Prosthetics) rentals and purchases (including diabetic supplies)
- Elective inpatient admissions
- Gastric bypass/bariatric procedures
- Home Health Care
- Home IV infusion
- Hospice care
- Implantable cardioverter/defibrillator (ICD)
- In-vitro fertilization (IVF)
- Pacemakers
- Reconstructive surgery
- Sinus (nasal) surgery
- Specialty Drugs
- Ultrasound echo stress and echocardiography, including nuclear and gated studies
- Varicose vein surgery
- Vestibular rehabilitations

It is your responsibility to obtain any required Pre-Authorization for you and/or your enrolled Dependent Children from Horizon.

Horizon will notify you or your Provider of the outcome of the request for Pre-Authorization. If the review results in a denial, Horizon will notify you in writing, explaining why and how the decision can be appealed. You or your Provider may request a review of the Pre-Authorization decision.

If you or your enrolled Dependent Child is approved for an inpatient admission to a facility, Horizon will notify your Provider and the facility about your Pre-Authorized length of stay. If your Provider recommends that your or your Dependent Child's stay be extended, additional days will need to be authorized by Horizon. You, your Provider, or the facility will need to call Horizon at the number on your ID card as soon as reasonably possible, but no later than the final authorized day, for the extended authorization. Horizon will review and process the request for an extended stay. You and your Provider will receive a notification of an approval or denial.

Case Management

Horizon provides case management services for catastrophic Illnesses and Injuries or any problem that can result in significant medical expenses. In such a situation, a professional from Horizon will act as your dedicated case manager. He or she will be your health care advocate and work with you, your physician and your Hospital to develop an appropriate plan for your care. Case management services are provided to you at no cost and participation is voluntary.

Alternate Treatment

If you or your Dependent Child has a catastrophic Illness or Injury, Horizon will evaluate the appropriateness of the level of care and the setting in which that care is received. To maintain or enhance the quality of patient care, Horizon will develop an alternate treatment/individual case management plan consistent with the Plan's covered benefits. The plan includes treatment plan objectives, a course of treatment and each party's responsibilities, and the estimated cost and savings. If you or your Dependent Child, Horizon and your physician agree in writing to the alternate treatment plan, the services and supplies needed for it will be deemed to be covered expenses under the Plan.

WHAT THE MEDICAL PLAN COVERS

This section describes the expenses that are eligible for reimbursement under the Plan.

Wellness Benefits

To encourage you and your enrolled Dependent Children to stay healthy, the Plan pays benefits for well-child care, well-adult care and annual preventive screenings provided by in-network Providers, as described below.

If you satisfy the guidelines discussed below, the services will be covered with no copayments or deductibles when rendered by an in-network Provider.

For any preventive care services that the Plan is required to provide, if no in-network provider within a 50-mile radius of the claimant's primary home residence can provide a covered preventive care service, the Plan will cover the services performed by a nonnetwork provider without cost-sharing.

Well-Child Care

The Plan covers:

- An initial Hospital checkup, following birth; and
- Office visits based on the guidelines supported by the Health Resources and Services Administration from birth to age 19 (at age 20, coverage is provided under well-adult care). See **https://www.healthcare.gov/preventive-care-children/**.

Covered office visit services include:

- Physical examinations, developmental assessments, anticipatory guidance and lab tests ordered during a visit and performed in the office or at a laboratory
- The following immunizations:
    - DPT (diphtheria, pertussis, tetanus)
    - Polio
    - MMR (measles, mumps, rubella)
    - Hepatitis A and B
    - Hemophilus

Well-Child Care Benefits	
■ Initial Hospital visit, following birth ■ Office visits	100% of the Allowed Amount

Well-Adult Care

For any Employee or Dependent Child age 20 or older, the Plan covers well-adult care based on the guidelines supported by the Health Resources and Services Administration. See **https://www.healthcare.gov/preventive-care-adults/** and **https://www.healthcare.gov/preventive-care-women/**. These guidelines may change periodically so be sure to check these websites before a visit.

Covered Services include:

- Annual wellness visits and the following immunizations:
  - Annual influenza
  - Hepatitis A
  - Hepatitis B
  - Herpes zoster (shingles) (beginning at age 50)
  - Human papillomavirus
  - MMR (measles, mumps, rubella)
  - Meningococcal conjugate (MCV4)
  - Revaccination with pneumococcal polysaccharide 23 (PPSV23) for adults age 65 and older
  - Shingrix
  - Tetanus and diphtheria, pertussis (Td/Tdap) booster
  - Varicella (chickenpox)
- One routine mammography every year beginning at age 40
- Routine Pap test beginning at age 21
- Prostate cancer screening beginning at age 50 (earlier if the Covered Person is at greater risk)

Well-Adult Care Benefits	
■ Mammography ■ Pap test ■ Prostate exam (age limits may apply) ■ Wellness visits	100% of the Allowed Amount

Services Rendered by Providers

Bronze Part-time Employees	
Allergy testing and treatment	100% (copay applies when an office visit is billed)
Anesthesia	70% of the Allowed Amount after the deductible
Dental care, treatment of oral tumors and cysts, and treatment of injury to sound natural teeth or jaw	70% of the Allowed Amount after the deductible (claim must be filed within 12 months of the accident causing the injury)
In-Hospital visits not related to surgery	70% of the Allowed Amount after the deductible and $250 copay
Hearing screenings	100% after the deductible and $40 copay
Maternity care,[1] including pregnancy and routine pregnancy-related conditions before and after delivery (for Employee only)	Office visits: 100% of the Allowed Amount after the deductible and a $20 copay for the first office visit Delivery: 70% of the Allowed Amount after the deductible and $250 copay for inpatient delivery
Office or home visits by a PCP or specialist for treatment of an Illness or Injury Note: You do not need a referral from a PCP to see a specialist	100% of the Allowed Amount after the deductible and: • $20 copay for each PCP visit • $40 copay for each specialist visit • $50 copay for Walk-In Clinic office visit
Outpatient other than office visit	70% of the Allowed Amount after the deductible
Second surgical opinion[2]	70% after the deductible (copay also applies if office visit is billed)
Surgery[3] by a specialist for treatment of an Illness or Injury as an inpatient or at an outpatient facility if the claim is coded as a surgical procedure (Pre-Authorization required for procedures shown below)	70% of the Allowed Amount after the deductible (copay also applies if office visit is billed)

[1] Maternity care benefits are not provided for Dependent Children except for complications of pregnancy including, but not limited to, toxemia, spontaneous abortion and ectopic pregnancy.

[2] You can obtain a second surgical opinion if you are scheduled for an elective surgical procedure. If the second opinion does not confirm the need for surgery, you may request a third opinion. The Plan will cover charges if the Practitioner(s) who provides the opinion is board certified, is not a business associate of the Practitioner who recommended the surgery, and does not perform or assist with the surgery.

[3] If more than one surgical procedure is performed on the same patient by the same physician and on the same day, the Plan will cover the primary procedure plus 50% of what the Plan would have paid for each additional

Hospital Facility Benefits (Pre-Authorization Required; See Services Rendered by Providers for Related Coverage)

The Plan covers confinement in a Hospital for treatment of an Illness or Injury. To be eligible for reimbursement, the charges must be consistent with the diagnosis and treatment.

Covered Services include:

- Anesthesia supplies and use of anesthesia equipment
- Any additional Medically Necessary services and supplies customarily provided by the Hospital
- Basal metabolic examinations
- Blood transfusions and use of transfusion equipment
- Dressings and plaster casts
- Drugs and medicines provided by the Hospital
- Laboratory and pathological examinations
- Oxygen and its administration
- Pregnancy-related conditions and maternity care for Employees
- Semi-private room and board (if you use a private room, you must pay the difference in cost between the semi-private and private room rates)
- Use of cardiographic equipment and supplies
- Use of intensive care or special care units and equipment
- Use of operating, cryptoscopic and recovery rooms and equipment
- Use of physiotherapeutic and hydrotherapeutic equipment and supplies
- X-ray examinations

The Newborns and Mothers Health Protection Act of 1996 requires that the Plan pay benefits for a Hospital stay in connection with childbirth for the mother and newborn child for 48 hours following a normal vaginal delivery and for 96 hours following a Cesarean section. However, the Plan may cover a shorter stay if the attending Provider, in consultation with the mother, decides on an earlier discharge from the Hospital.

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procedure (up to five). If more than five procedures are performed, the amount the Plan pays beyond the fifth will be based on the circumstances of each case.

Admissions Outside the United States – The Plan provides benefits outside of the United States for emergency and other unexpected medical situations. Call BlueCard Worldwide Access at (800) 810-2583 for additional information, including the names and addresses of doctors and hospitals in the area where you or your Dependent Children need care. The Trustees in their sole discretion may limit the number of covered Hospital days and/or Covered Services based on the diagnosis and course of treatment abroad. If you make payment in the local currency, you must provide a statement from a bank showing the exchange rate of that currency on the dates of hospitalization along with a paid receipt.

Hospital Facility Benefits (Pre-Authorization Required)	
Hospital room and board and other miscellaneous charges for treatment of an Illness, Injury or maternity	70% of the Allowed Amount after the deductible and $250 copay

Hospital Facility Benefits for Maternity (Pre-Authorization Required; Employee only—no Dependent Child Coverage	
Newborn Infant Care* ■ Premature infant (weighing less than five pounds) ■ Sick baby ■ Well baby (for up to 48 hours following a vaginal delivery; up to 96 hours following a Cesarean section)	70% of the Allowed Amount after the deductible
*Birthing center benefits will be covered at the same level as those for regular Hospital facility benefits for maternity or newborn infant care, provided that the pregnancy goes full term.	

Emergency Room Benefits

The Plan will pay for outpatient care of a true, life-threatening medical emergency. Coverage includes treatment that is Medically Necessary and Appropriate at any designated level I or II trauma center. A medical emergency is a condition that manifests itself in acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use disorders such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

If you have a true, life-threatening emergency, do not hesitate to call 911 or go to the emergency room. Otherwise, it's best to get care at an in-network Walk-in Clinic, urgent care facility or your doctor's office. Care obtained at out-of-network urgent care facilities is not covered. If you use an out-of-network Walk-in Clinic or urgent care facility, you will be responsible for the entire amount billed. **Care at an emergency room for nonemergent services will not be covered**. Some examples of nonemergent medical conditions

that should be treated at an in-network Walk-in Clinic or urgent care facility include earache, moderate fever, sore throat, and sprains. Some examples of emergent medical conditions that should be treated at an emergency room include heart attack, stroke, loss of consciousness, poisoning, severe burns, difficulty breathing, high fever, and wounds that need stitches.

Emergency Room Benefits	
For a sudden and serious Illness in which serious Injury may result if treatment is not received within 24 hours or other true emergency **Note:** If you receive out-of-network benefits for a true emergency, expenses will be covered as in-network up to the Allowed Amount, but you will be responsible for any amounts billed in excess of what the Plan pays	100% of the Allowed Amount after you pay a $500 copay (copay waived if admitted)
For a nonemergency	Not covered

Outpatient (Ambulatory) Surgery (Pre-Authorization Required)

If you or a dependent has surgery in a Hospital's outpatient facility or in a freestanding surgical facility, the Plan covers the facility's charge. You must contact Horizon to obtain Pre-Authorization before you have surgery.

Outpatient (Ambulatory) Surgery Benefits (Pre-Authorization Required)
70% of the Allowed Amount after the deductible

Outpatient Pre-admission Testing

The Plan covers outpatient pre-admission testing performed within seven days of a scheduled covered surgical procedure performed in the same facility as the surgery.

Outpatient Pre-admission Testing Benefits
70% of the Allowed Amount after the deductible

Transplant Benefits

The Plan pays benefits for transplants of the following:

- Allogeneic bone marrow
- Allogeneic stem cell
- Chondrocyte (for knee)
- Cornea
- Double lung
- Heart
- Heart/kidney
- Heart/lung
- Heart valve
- Kidney
- Kidney/pancreas
- Liver
- Liver/small bowel
- Lung
- Multivisceral transplant (small bowel and liver with one or more of the following: stomach, duodenum, jejunum, ileum, pancreas, colon)
- Non-myeloablative stem cell
- Pancreas
- Small bowel
- Tandem stem cell

If organs/tissues are harvested from a cadaver, the Plan will also cover those charges for surgical, storage and transportation services that are directly related to the tissue/organ donation and are billed by the Hospital when the transplant is performed.

The Plan also covers the following services required for a live donor, provided that the recipient is covered by the Plan and the donor's own coverage does not pay benefits for these services:

- Harvesting of the organ tissue and related services
- Immunologic typing
- Processing of tissue
- Search for a donor (not to exceed $10,000 per transplant), subject to review by the case management consultant

Transplant Benefits
70% of the Allowed Amount after the deductible

The Plan also covers certain transportation and lodging expenses in connection with covered transplant services performed at network facilities that are more than 50 miles from the covered patient's home, including:

- Transportation costs for one round trip to and from the network facility for the covered patient and an immediate family member ("traveling companion") where the case management consultant approves the medical necessity for the traveling companion due to the covered patient's age, medical condition or incapacity. Coach airline fare will be reimbursed. Automobile mileage will be reimbursed at the then-current mileage reimbursement rate as set by the Internal Revenue Service.
- Reasonable lodging and meal expenses for the traveling companion. Lodging must be pre-approved by Horizon in order for expenses to be covered.

Covered expenses are limited to the aggregate of $300 per day for lodging and meals, and $10,000 per admission for lodging, meals and transportation of both the covered patient and the traveling companion.

For more information or to arrange for reimbursement of covered travel expenses, please contact the Fund Office.

Skilled Nursing Facility Benefits (Pre-Authorization Required)

The Plan pays benefits for room and board, including diets, drugs, medicines, dressings and general nursing care in a skilled nursing facility. The patient must be admitted to the skilled nursing facility within 14 days of discharge from a Hospital for continuing medical care and treatment prescribed by a physician.

Skilled Nursing Facility Benefits (Pre-Authorization Required)
70% of the Allowed Amount after the deductible
Maximum of 90 days in a Calendar Year

Home Health Care Benefits (Pre-Authorization Required)

The Plan will pay benefits for home treatment provided by a Home Health Care agency in accordance with a Home Health Care Plan. Prior hospitalization is not required. Any expenses incurred that are not included in the Home Health Care Plan will not be eligible for reimbursement under the Plan.

In addition, the patient must be:

- Under the continuous care of a doctor;
- Homebound; and
- In need of skilled nursing care, or physical, speech or occupational therapy under a plan prescribed by an attending physician and approved by Horizon.

The following services are covered:

- Durable medical equipment, including Prosthetics;
- Part-time skilled nursing services provided by or under the supervision of a registered nurse;
- Physical, speech or occupational therapy (rehabilitative only);
- Related treatment and/or services that would otherwise be covered by Hospital outpatient benefits, except drugs and the administration of dialysis. and

Each visit by a Home Health Care Provider for up to four hours of care will count as one Home Health Care visit.

Home Health Care Benefits (Pre-Authorization Required)
70% of the Allowed Amount after the deductible and $40 copay
Maximum of 60 visits in a Calendar Year

Home Health Care benefits do not cover:

- Any services provided during a period when you are not under the continuing care of a physician
- Custodial care, which means any care, services or supplies that help with the activities of daily living
- Home health care services provided by an individual who normally lives with you or is a member of your or your spouse's immediate family
- Transportation services

Hospice Care Benefits (Pre-Authorization Required)

Hospice differs from traditional care because it provides services for the family as well as the patient. Hospice teams help the patient and the family cope with the physical, psychological, spiritual, economic

and social stress of serious Illness, end of life and bereavement. When possible, Hospice care is administered at home. The team of professionals can include physicians, nurses, psychiatrists, psychologists and social workers.

The Hospice care benefit covers:

- Diagnostic services
- Dietician services
- Family counseling related to the patient's terminal condition
- Home health aide services provided under the supervision of a registered nurse (RN)
- Inpatient room, board and general nursing services
- Medical and surgical supplies and durable medical equipment, including Prosthetics, if given Pre-Authorization by Horizon
- Medical care rendered by a Hospice Care Program Practitioner
- Medical social services
- Oxygen and its administration
- Part-time professional nursing services of an RN, licensed practical nurse or licensed vocational nurse
- Prescription drugs
- Psychological support services to the Terminally Ill or Injured patient
- Respite care (maximum of 10 days per Calendar Year)
- Therapy Services

Hospice Care Benefits (Pre-Authorization Required)
70% of the Allowed Amount after the deductible

Hospice care benefits do not cover charges for:

- Bereavement counseling
- Dialysis treatment
- Food or home-delivered meals
- Funeral services and arrangements

- Homemaker services
- Hospice care services that are not given Pre-Authorization by Horizon
- Legal or financial counseling or services
- Medical care provided by the patient's private Practitioner
- Pastoral services
- Private duty nursing services
- Treatment not included in the Hospice Care Program
- Volunteer services or services and supplies provided by others without charge

Mental Health and Substance Use Disorder Treatment

The Plan covers the treatment of mental health and substance use disorders the same way it covers treatment for any other Illness, if treatment is provided by a licensed or certified mental health or substance use disorder treatment Provider. Inpatient or outpatient care may be provided in a:

- Provider's office
- Licensed health care facility
- Licensed detoxification facility (for alcoholism and substance use disorder treatment)
- Licensed, certified or state-approved residential treatment facility under a program that meets minimum standards of those prescribed by the Joint Commission.

All mental health and substance use disorder services must be coordinated through Beacon Health Options by calling (800) 843-5503. **If you use a Provider that is not in the Beacon Health Options network, coverage (except for emergency treatment) will be denied and you will be responsible for all amounts billed. For emergency treatment, the Plan will pay up to the Allowed Amount and you may be responsible for balance bills**.

Effective August 1, 2017, the Plan covers Applied Behavior Analysis (ABA) treatment for covered diagnoses. Covered diagnoses include autism, which is a general term used to describe a group of complex developmental brain disorders known as Pervasive Developmental Disorders (PDDs) within the American Psychiatric Association Diagnostic and Statistical Manual 5 (DSM 5). Autism Spectrum Disorder (ASD) is a type of PDD. Your benefit covers Medically Necessary ABA treatment for ASD.

The other covered pervasive developmental disorders are PDD-NOS (Pervasive Developmental Disorder – Not Otherwise Specified), Asperger Syndrome, Rett Syndrome and Childhood Disintegrative Disorder. All of these diagnoses, along with a diagnosis of being "at risk" of autism or PDD, will be covered.

When necessary, ABA coverage also includes an initial evaluation with a qualified provider (with a psychiatrist and/or via two hours of psychological testing to evaluate/diagnose ASD), coverage of

medication management and outpatient therapies for ASD diagnoses, and standard family and member support services available under the Medical Plan.

Benefit coverage of ABA services will require prior authorization or pre-certification and includes coverage for the following services by a Beacon Health Options in-network provider:

- ABA treatment
- Individual, family, and group therapy
- Intensive case management for complex cases (individuals with extraordinary care needs)
- Medication management
- Psychiatric evaluation to confirm the ASD diagnosis
- Psychological testing, as necessary to confirm the ASD diagnosis

You will be responsible for any outpatient cost sharing related to ABA treatment, including any applicable deductible, copays or coinsurance.

You can obtain prior authorization or pre-certification from Beacon Health Options by calling (800) 843-5503. During this call, a care manager will request basic information including, but not limited to, the diagnosis, the medical doctor or licensed psychologist who made the diagnosis and what the presenting symptoms are (i.e., developmentally delayed skills or problem behaviors). If the diagnosis has not been confirmed by an MD or PhD, Beacon Health Options will help coordinate a screening for this purpose. With this confirmation, you will be provided with a list of providers and you will select one from the list who will then conduct an assessment to document the problem behaviors and determine treatment needs.

If your treatment is approved, ABA therapy will be covered according to the Plan's benefits when provided or supervised by a Beacon Health Options' ABA-licensed or -certified provider of services. Prior authorization or pre-certification will be required in order for benefits to be paid.

Other Covered Services

The Plan covers the following services, supplies and treatment. Provider services must be within the scope of the Provider's license.

Service, Supply, Treatment	**The Plan Pays**
Abortion (outpatient and elective); for Employee only	70% of the Allowed Amount after the deductible; additional $250 copay for inpatient care
Acupuncture (but not for pain management)	70% of the Allowed Amount after the deductible

Service, Supply, Treatment	The Plan Pays
Ambulance (for air or ground transportation to the nearest Hospital able to treat the condition when Medically Necessary)	100% of the Allowed Amount if an emergency; not covered if not an emergency
Anesthesiologist services provided by a doctor other than the operating surgeon and as part of a covered surgical procedure	70% of the Allowed Amount after the deductible
Blood (blood, blood products, blood transfusions and the cost of testing and processing blood, but not for blood that has been donated or replaced)	70% of the Allowed Amount after the deductible
Chelation therapy	70% of the Allowed Amount after the deductible
Chemotherapy, radiation and hemodialysis (inpatient or outpatient)	70% of the Allowed Amount after the deductible
Chiropractic care	100% of the Allowed Amount after the deductible and $40 copay for each visit; maximum 20 visits per Calendar Year
Cognitive rehabilitative therapy*	70% of the Allowed Amount after the deductible ($40 copay outpatient/out-of-Hospital professional only for an initial evaluation or a reevaluation visit)
Diabetic supplies/syringes	70% of the Allowed Amount after deductible
Dialysis	70% of the Allowed Amount after the deductible
Durable medical equipment, including Prosthetics (for the rental, fitting and adjusting of durable medical equipment) **Note:** The Plan reserves the right to purchase rather than rent any item	70% of the Allowed Amount after the deductible
Infusion therapy	70% of the Allowed Amount after the deductible
MRI, CAT, PET scans Diagnostic Routine	 100% of the Allowed Amount 100% of the Allowed Amount
Nutritional counseling if prescribed by a Practitioner	100% of the Allowed Amount
Occupational therapy*	70% of the Allowed Amount after the deductible ($40 copay outpatient/out-of-Hospital professional only for an initial evaluation or a reevaluation visit)
Orthotic shoe inserts (for Employees only)	70% after deductible; post-surgery only
Oxygen and its administration	70% of the Allowed Amount after the deductible
Physical therapy*	70% of the Allowed Amount after the deductible ($40 copay outpatient/out-of-Hospital professional only for an initial evaluation or a reevaluation visit)

Service, Supply, Treatment	The Plan Pays
Radiation therapy	70% of the Allowed Amount after the deductible
Respiration therapy*	70% of the Allowed Amount after the deductible ($40 copay outpatient/out-of-Hospital professional only for an initial evaluation or a reevaluation visit)
Speech therapy*	70% of the Allowed Amount after the deductible ($40 copay outpatient/out-of-Hospital professional only for an initial evaluation or a reevaluation visit)
Vision care (nonroutine)	70% of the Allowed Amount after deductible and $40 copay
Wigs (if Medically Necessary)	70% of the Allowed Amount
X-rays and laboratory tests Diagnostic Routine **Note:** In-network labs are based on the location of the Provider ordering the tests. Please refer to Horizonblue.com or the Provider Directory or contact Horizon to locate an in-network lab.	 100% of Allowed Amount 100% of the Allowed Amount

* There is a 90-visit combined limit on cognitive rehabilitation therapy, occupational therapy, physical therapy, respiration therapy and speech therapy services obtained in a calendar year.

Clinical Trial Benefit

The Plan covers participation in an approved clinical trial for which a Covered Person is a qualified individual with respect to the treatment of cancer or another life-threatening disease condition. This coverage will be provided if (a) the Covered Person's Practitioner is involved in the clinical trial, and (b) the Practitioner has concluded that the Covered Person's participation is appropriate or if the Covered Person gives medical or scientific information proving that such participation would be appropriate. This coverage includes, to the extent coverage would be provided other than for the clinical trial, (a) Practitioner's fees, (b) lab fees, (c) Hospital charges, (d) treating and evaluating the Covered Person during the course of treatment or regarding a complication of the underlying Illness, and (e) other routine costs related to the Covered Person's care and treatment, to the extent that these services are consistent with the usual and customary patterns and standards of care furnished whenever a Covered Person receives medical care associated with an approved clinical trial. This coverage does not include (a) the cost of Experimental or Investigational drugs or devices themselves, (b) nonhealth services that the Covered Person needs in order to receive the care and treatment, (c) the costs of managing the research, or (d) any other services, supplies or charges that the Plan would not cover for treatment that is not Experimental or Investigational. For purposes of this provision, the terms "qualified individual," "life-threatening disease or condition," "approved clinical trial," and "routine patient costs" shall have the same meanings as found in the Public Health Service Act section 2709.

COVID-19 Benefits

Effective March 1, 2020, the Plan covers certain medical treatment and services related to COVID-19 through June 30. 2021, or such other date as required by law if later than June 30, 2021, as follows and only as required by law:

- The cost of testing for COVID–19 at an in-network provider (including serological tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus), including the cost of the doctor's visit (whether in an office, via telemedicine, or other settings) will be covered without deductibles, coinsurance or copayments and will not be subject to pre-authorization or other medical management requirements. If testing for COVID-19 is received from a non-network provider, the cost of such services will be covered up to the non-network provider's publicly published rate.

- The cost of preventive services and vaccines for COVID–19 at an in-network provider, including the cost of the doctor's visit (whether in an office, via telemedicine, or other settings) will be covered without deductibles, coinsurance or copayments and will not be subject to pre-authorization or other medical management requirements. For non-network providers, the same will be covered at the in-network reimbursement rates, with no deductibles, copayments or co-insurance.

EXPENSES THE MEDICAL PLAN DOES NOT COVER

The following expenses are not covered by the Plan. The Plan also excludes any expense not specifically listed as covered.

- Administration of oxygen, unless specifically listed as covered
- Anesthesia and consultation services when they are given in connection with non-Covered Charges
- Any part of a charge that exceeds the allowance
- Any therapy not included in the definition of Therapy Services
- Biofeedback services
- Blood or blood plasma or other blood derivatives that are replaced by a Covered Person
- Canceled appointments (and any associated cancellation fees)
- Charges and claims not submitted within 12 months of the date of service
- Charges incurred during a Covered Person's temporary absence from a Provider's grounds before discharge
- Charges for any services necessitated by a motor vehicle accident that can be collected under the terms of any federal or state law mandating indemnification regardless of fault, whether or not the Covered Person asserts rights to obtain coverage under the applicable law. As an example, if you are in a single-car automobile accident and incur covered medical expenses and your

automobile insurance has health care coverage up to $50,000 with a $2,000 deductible, once you have met any deductible under this Plan, the Plan will pay the first $2,000 in covered medical expenses, and then nothing until you have exhausted your $50,000 coverage limit.

- Completion of claim forms
- Consumable medical supplies that are purchased outside of a Hospital, Walk-In Clinic or office visit, which are nondurable medical supplies that cannot withstand repeated use, are usually disposable, and are generally not used in the absence of Illness or Injury; they include, but are not limited to, bandages, antiseptics, and skin preparations
- Cosmetic services, including procedures, treatments, drugs, biological products and complications of cosmetic surgery
- Court-ordered treatment that is not Medically Necessary and Appropriate
- Custodial or domiciliary care, including respite care except as otherwise provided under the Hospice Care Benefits section of this SPD
- Dental care or treatment, except as otherwise provided for in this SPD; this exclusion includes, but is not limited to, the restoration of tooth structure lost by decay, fracture, attrition or erosion; endodontic treatment of teeth; surgery and related services to treat periodontal disease; osseous surgery and any other surgery to the periodontium; the replacement of missing teeth; the removal and reimplantation of teeth (and related services); any orthodontic treatment; and dental implants and related services
- Diversional/recreational therapy or activity
- Drugs that are not dispensed by a pharmacist or a pharmacy; services rendered by a pharmacist that are beyond the scope of his or her practice
- Educational services or supplies, except as covered under the ABA benefit described below or otherwise specifically covered in this booklet. A service or supply is educational if either (a) the primary purpose of the service or supply is to provide the Covered Person with training in the activities of daily living (other than training directly related to treatment of an Illness or Injury that resulted in a loss of a previously demonstrated ability to perform those activities); instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or (b) the service or supply is provided to promote development beyond any level of function previously demonstrated. The length of a Hospital stay and Hospital services and supplies are not covered to the extent that they are allocable to the scholastic education or vocational training of the patient
- Employment/career counseling
- Expenses incurred after any payment, duration or visit maximum is or would be reached
- Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this SPD

- Eye exams, eyeglasses, contact lenses and all fittings, except as otherwise stated in this SPD; orthoptic therapy, surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy
- Facility charges when billed by a Provider that is not an eligible facility
- Food products (including enterally administered food products, except when used as the sole source of nutrition)
- Home health care visits connected with the administration of dialysis
- Hospice services, except as provided under the Hospice Care Benefits section of this SPD
- Housekeeping services, except as an incidental part of Covered Services and supplies furnished by a Home Health Agency
- Occupational Illness or Injury
- Immunizations, except as stated in this SPD
- Light-box therapy and the appliance that radiates light
- Maintenance therapy for physical therapy, manipulative therapy, occupational therapy and speech therapy
- Marriage or financial counseling, or sex therapy
- Membership costs for health clubs, weight loss clinics and similar plans/programs
- Methadone maintenance
- Milieu therapy; inpatient services and supplies that are primarily for milieu therapy even though covered treatment may also be provided
- Nonmedical equipment that may be used primarily for personal hygiene or for the comfort or convenience of the patient, including, but not limited, to air conditioners, dehumidifiers, purifiers, saunas, hot tubs, televisions, telephones, first aid kits, exercise equipment, and heating pads
- Pastoral counseling
- Personal comfort and convenience items
- Psychoanalysis to complete the requirements of an educational degree or residency program
- Psychological testing for educational purposes
- Removal of abnormal skin outgrowths and other growths, including, but not limited to, paring or chemical treatment to remove corns, calluses, warts, hornified nails and all other growths unless

it involves cutting through all layers of the skin (this does not apply to services needed for treatment of diabetes)

- Rest or convalescent cures
- Room and board charges for any time the patient was not physically present in the room
- Routine exams (including related diagnostic X-rays and lab tests) and other services connected with activities such as premarital or similar exams or tests, research studies, education or experimentation, and mandatory consultations required by Hospital regulations
- Routine foot care, except as may be Medically Necessary and Appropriate for the treatment of certain Illnesses or Injuries, including treatment for corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except as otherwise stated in this SPD
- Services involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations
- Services performed by anyone who does not qualify as a Practitioner, a Hospital resident, intern or other Practitioner who is paid by the facility and is not allowed to charge for Covered Services (Hospital-employed physician specialists may bill separately for their services)
- Services required by an employer as a condition of employment, and services rendered through a medical department, clinic or other similar service provided or maintained by the employer
- Services or supplies
    - Connected with any procedure or exam not needed for the diagnosis or treatment of an Injury or Illness for which a bona fide diagnosis has been made because of existing symptoms
    - Eligible for payment under federal or state programs (except Medicare and Medicaid when, by law, the Plan is primary)
    - For which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair
    - For which the Covered Person is not legally obligated to pay
    - For which the Covered Person would not have been charged if he or she did not have health care coverage
    - For which the Provider has not received a certificate of need or such other approvals as required by law
    - Furnished by a member of the Covered Person’s family (spouse, child, parent, in-law, brother or sister)

- Needed due to an Injury or Illness to which a contributing cause was the Covered Person's commission of or attempt to commit a felony, or to which a contributing cause was the Covered Person's engagement in an illegal occupation
- Provided by a government Hospital or provided by or in a facility run by the Department of Defense or Veterans Administration for a service-related Illness or Injury unless coverage for the services is required by law
- Provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister
- Provided by a social worker, except as otherwise stated in this SPD
- Provided during any part of a stay at a facility or during Home Health Care chiefly for bed rest, rest cure, convalescent care, custodial or sanatorium care, diet therapy or occupational therapy
- Provided to treat an Injury or Illness resulting from war or an act of war if the Injury or Illness occurs while, or as a result of the special hazards incident to, the Covered Person's serving in the military, naval or air forces of any country, combination of countries or international organization, or serving in any civilian noncombatant unit supporting or accompanying the military, naval or air forces
- Provided to treat an Injury or Illness resulting from war or an act of war if the Injury or Illness occurs while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Illness occurs outside the home area
- Rendered prior to the Covered Person's coverage date or after his or her coverage under the Plan ends, except as stated in this SPD
- That are not Medically Necessary and Appropriate
- That are specifically limited or excluded in this SPD

- Smoking cessation aids of all kinds and the services of stop-smoking providers, except when covered under the Prescription Drug Plan or as required by federal regulation
- Special medical reports not directly related to treatment of the Covered Person
- Stand-by services required by a Practitioner, or services performed by surgical assistants not employed by a facility
- Sterilization reversal
- Sunglasses, even if by prescription

- Surgery, sex hormones and related medical and psychiatric services to change sex, as well as services and supplies arising from complications of sex transformation and treatment for gender identity disorders

- Telephone consultations, except as Horizon may request

- The administration or injection of any drugs, except that this exclusion will not apply to a drug that: (a) has been prescribed for a treatment for which it has not been approved by the U.S. Food and Drug Administration (FDA) and (b) has been recognized as being medically appropriate for such treatment in the American Hospital Formulary Service Drug Information, the United States Pharmacopoeia Drug Information or a clinical study or review article in a major peer-reviewed professional journal

- Temporomandibular joint (TMJ) dysfunctions syndrome treatment

- Transplants, except as otherwise stated in this SPD

- Transportation and travel, except as otherwise stated in this SPD

- Vision therapy, vision or visual acuity training, orthoptics, pleoptics

- Vitamins and dietary supplements

- Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans, or any related products, except as otherwise stated in this SPD

- Hair transplants, hair weaving or any drug used to eliminate baldness, except as otherwise stated in this SPD

PRESCRIPTION DRUG BENEFITS FOR BRONZE PART-TIME EMPLOYEES AND THEIR ENROLLED DEPENDENT CHILDREN

The Plan provides prescription drug benefits for you and your enrolled Dependent Children through its Pharmacy Benefit Manager (PBM) (currently Express Scripts). When you are first enrolled, you will receive a prescription drug ID card, which you should present when you fill a prescription. Prescription benefits are only available when the drugs are prescribed by a Practitioner.

You must use an in-network retail pharmacy to receive benefits, unless you have a life-threatening emergency. If you use an out-of-network pharmacy, no benefits will be paid, and you will have to pay the full cost of your prescription out of your own pocket.

Use of Generic Drugs where available is mandatory, unless a Practitioner certifies that the Covered Person has a medical condition that precludes the ability to take the Generic Drug and the PBM provides Prior Authorization based on such certification. Absent such Prior Authorization, when a Covered Person, Practitioner or pharmacy chooses a Preferred Brand Name Drug or Non-Preferred Brand Name Drug (collectively, a Brand Name Drug) when a therapeutically equivalent Generic Drug is available, the Covered Person must pay the difference in cost between the Generic Drug and the Brand Name Drug, in addition to the copayment amount for the Brand Name Drug. For purposes of this rule, a Generic Drug is "therapeutically equivalent" to a Brand Name Drug if it has essentially the same effect in the treatment of a disease or condition as the Brand Name Drug.

If you are on a maintenance prescription drug (one that you take for an extended period such as blood pressure, cholesterol-reducing, or heart medication), you must obtain your prescription drugs through the Mail at Retail Program or Mail Order Drug Program explained below. You may have your initial prescription and two refills processed at a retail pharmacy, but any further prescriptions must be processed through the Mail at Retail Program or Mail Order Drug Program. **Attempts to fill maintenance drug prescriptions at retail pharmacies outside of these limits will be rejected and your claims for those prescription drugs will be denied**.

The Plan also offers an over-the-counter assistance program. If you obtain a prescription for certain over-the-counter allergy medications or proton-pump inhibitors, you may fill your prescription and receive an over-the-counter allergy medication or proton pump inhibitor for a copay ($5 copay for a monthly supply and $10 copay for a 90-day supply). Please contact the Fund Office for additional details on the over-the-counter assistance program.

For up to a:	**The Prescription Drug Plan pays 100% after you pay a copay of:**
34-day supply of medication at an in-network retail pharmacy or Specialty Drugs (see below)	
■ For Generic Drugs and certain prescribed over-the-counter allergy medications and proton-pump inhibitors	$5
■ For Preferred Brand Name Drugs	$15
■ For Non-Preferred Brand Name Drugs	$30

For up to a:	The Prescription Drug Plan pays 100% after you pay a copay of:
90-day supply of medication through the PBM mail order pharmacy or Mail at Retail Program	
■ For Generic Drugs and certain prescribed over-the-counter allergy medications and proton-pump inhibitors	$10
■ For Preferred Brand Name Drugs	$30
■ For Non-Preferred Brand Name Drugs	$60

Statin Preventive Medication

The Plan covers low- to moderate-dose statin preventive medication for you and your dependents at no cost to the extent required by the Affordable Care Act. This preventive statin medication coverage is available if the following requirements are satisfied:

- Person is between 40 and 75 years old,
- A cardiovascular disease risk factor drug is included in the person's claims history, and
- No implantable cardioverter defibrillator or drug marker for cardiovascular disease is included in the person's claims history.

If you do not meet the criteria listed above, standard copays will apply for your statin prescription.

Specialty Drugs (Pre-Authorization Required)

Note that certain drugs are characterized as Specialty Drugs,* as defined by the PBM. These drugs require Pre-Authorization review by the PBM. If the drug you are trying to obtain is classified as a Specialty Drug, you or your physician should contact the PBM and provide certain information in advance of attempting to fill the prescription at the pharmacy.

Before starting therapy, you or your physician should contact the PBM. Information regarding the diagnosis code, duration of the therapy, directions for administration of the medication, and any therapies previously tried to treat the condition must be provided to the specialty pharmacy. Once this information is received, it is then forwarded to a specific clinical review department, where it will be either denied or approved.

*The list of Specialty Drugs is maintained by the PBM and is subject to change on an ongoing basis. You can call the Fund Office and request a copy of the Specialty Drug list if you so choose.

Step Therapy Program

If your doctor prescribes a new maintenance medication, this program requires you to try a Generic Drug (if available, otherwise a Preferred Brand Name Drug) before a higher-cost Non-Preferred Brand Name Drug is used. If your doctor prescribes a Non-Preferred Brand Name Drug, the PBM will work with your doctor to see if a Generic Drug alternative or Preferred Brand Name Drug would be equally effective, in which case the Fund will cover only the cost of the Generic Drug or the Preferred Brand Name Drug, as applicable (In some cases, special circumstances may require you to use a Non-Preferred Brand Name Drug.)

Mail at Retail Program

The Mail at Retail Program allows you to obtain a 90-day supply of maintenance prescription drugs directly from certain retail stores in the pharmacy network at the mail order cost. The Mail at Retail Program network includes ShopRite, Stop & Shop and certain Foodtown stores.

Mail Order Drug Program

You can obtain a 90-day supply of maintenance medications through the Mail Order Drug Program. You can have each prescription refilled up to three times within a 12-month period.

To fill a prescription through the Mail Order Drug Program, you must complete an application and enclose the appropriate copayment. You can pay for your prescription with a check or credit card. Do not send cash through the mail. Mail Order Drug Program prescription applications and self-addressed envelopes are available by calling the Fund Office at (800) 522-4161 (TTY: 711). Your prescription will be filled and mailed (along with another application form and self-addressed envelope) within 24 hours of receipt. After 12 months, you must mail a new written prescription to the mail order pharmacy.

To reach a Mail Order Drug Program customer service representative, write or call the PBM at:

Express Scripts
Home Delivery Services
P.O. Box 8545
Bensalem, PA 19020-8545
Tel. (866) 388-0450

Prescription Drugs Not Covered

In addition to the exclusions described under “Expenses The Medical Plan Does Not Cover,” prescription drug benefits do not include the following; provided, however, that some of the following may be covered under the “Medical and Hospital Benefits” section:

- Administration of drugs
- All drugs on the federal DESI listed as ineffective
- Any drug labeled “Caution—limited by Federal Law for investigational use” or Experimental drugs, except as otherwise required by applicable federal law

- Any medication taken or administered while a Covered Person is an inpatient in a licensed Hospital, rest home, sanitarium, extended-care facility, convalescent home, nursing home or similar institution
- Biological serum
- Blood and blood plasma
- Claims and charges not submitted within 12 months of the date of service
- Contraceptive devices that are not required to be covered by applicable law
- Drugs administered in the Practitioner's office
- FDA-approved non legend drugs
- Injectables
- Medications for the treatment of infertility or impotency
- Medications for which there is no charge under local, state and/or federal programs
- Over-the-counter drugs and diet supplements (except for aspirin, allergy medications and proton-pump inhibitors when prescribed by a physician)
- Over-the-counter vitamins unless required by the ACA or other applicable law
- Prescriptions for cosmetic purposes (such as Minoxidal, Retin-A, Rogaine)
- Therapeutic devices or appliances
- Unauthorized refills

Please also see the "Coordination of Benefits" section above if prescription drugs may be paid, in whole or in part, by any other plan.

COVID-19 At-Home Test Kits

Effective January 15, 2022, and for as long as required by federal law, the Plan shall cover federally-approved over-the-counter at-home COVID-19 diagnostic tests as required by federal law. Specifically, such test kits purchased through the Express Scripts network for members and their enrolled eligible dependents ("covered persons") will be covered without out-of-pocket expense to the individual, the need to meet a deductible, pre-authorization or other medical management requirements. The Plan shall reimburse covered persons for expenses incurred in purchasing federally-approved at-home COVID-19 diagnostic test kits outside of the Express Scripts network on and after January 15, 2022, whether over-the-counter or by prescription, as required by federal law and up to $12 per test kit, without the need to meet a deductible, pre-authorization or other medical management requirements. Direct coverage of such test kits shall be provided through Express Scripts. Reimbursement of such test kits through non-network sources shall be available through Express Scripts on forms supplied by Express Scripts and with

a receipt or other proof of purchase acceptable to Express Scripts. Claims for test kits shall be approved for medical purposes only and only when obtained by covered persons for use by covered persons. Submission of claims for test kits shall be deemed to be express or implied certification that the purchase of the test kit complies with these limitations. Claims for test kits obtained by or for use by non-covered persons or for non-permitted purposes such as employment, travel or public health surveillance, shall be denied; if such claims are paid, they will be subject to the plan terms for overpayment of benefits.

GLOSSARY OF KEY TERMS

For the reader's convenience, these key terms' definitions may be provided within the text of the document, as well as below.

24-month Claims Period—Any claim or lawsuit related to benefits under the Plan must be brought in the correct court no later than 24 months after the earliest of:

- the date when your first benefit payment was made or due;
- the date when the request for a Plan benefit was first denied; or
- the earliest date when the person knew or should have known the material facts on which the lawsuit is based.

Advantage Exclusive Provider Organization (Advantage EPO) Network—A network of Hospitals and medical service Providers administered and maintained by Horizon Blue Cross Blue Shield of New Jersey.

Allowed Amount—The amount the Plan will pay for medical Covered Services according to the schedule of rates established by Horizon Blue Cross Blue Shield of New Jersey for its Advantage EPO Network Providers. For out-of-network charges that are covered by the Plan, the Allowed Amount will be up to the maximum Advantage EPO Network reimbursement level within the same geographic area in which the service was performed, or as required by federal law.

Beneficiary—The person or persons you name to receive your death benefits. You may name anyone as your Beneficiary and can change your choice at any time and for any reason. Your primary Beneficiary is the individual who will receive your life insurance benefit if you die. Your contingent Beneficiary receives your life insurance benefit if your primary Beneficiary dies before receiving benefits. If you name more than one primary or contingent Beneficiary, they will share the benefit equally, unless you designate otherwise.

Calendar Year—The 12-month period that begins on January 1 of each year.

COBRA—The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Concurrent Care Claim—A claim that is reconsidered after an initial approval is made, and which results in a reduction, termination or extension of the approved benefit. An example of a Concurrent Care Claim is an inpatient Hospital stay that was initially certified for five days and is reviewed at three-day intervals to determine if additional days are appropriate.

Covered Charges—The Advantage EPO scheduled fee allowances for services and treatments eligible for reimbursement under the Plan. You may only receive reimbursement for covered charges incurred while you or a dependent is participating in the Plan.

Covered Person—A person properly enrolled in the Plan.

Covered Services—Services and treatments eligible for reimbursement or payment under the Plan. The Plan will only pay for or reimburse Covered Services received while you or your Dependent Child is enrolled in the Plan.

Dependent Child or Children—A biological child, adopted child, stepchild, or child placed with you for adoption who meets the eligibility requirements for coverage and is properly enrolled in the Plan.

Employee—A person whose employment is covered by a collective bargaining agreement by and between the employer and UFCW Local 1262 that requires the employer to make contributions to the Fund on the person's behalf. For purposes of COBRA coverage, Employee shall also include former Employees, as applicable. "Part-time Employee" means an Employee who is employed on a part-time basis as defined in a collective bargaining agreement between an employer and UFCW Local 1262 or a participation agreement with the Fund. "Service Clerk" means an Employee who is employed as a Service Clerk as defined in a collective bargaining agreement between an Employer and UFCW Local 1262 or participation agreement with the Fund.

ERISA—The Employee Retirement Income Security Act of 1974, as amended.

Exclusive Provider Organization (EPO) Plan—A plan providing in-network benefits only through a Blue Cross Blue Shield nationwide network of doctors and hospitals.

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

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

- There must be sufficient proof (i.e., well-designed and well-documented investigations), published in peer-reviewed scientific literature that confirms its effectiveness.

- It must result in measurable improvement in health outcomes and the therapeutic benefits must outweigh the risks, as shown in scientific studies.

- It must be as safe and effective as any established modality.

- It must demonstrate effectiveness when applied outside of the investigative research setting.

Fund—The United Food and Commercial Workers Local 1262 and Employers Health and Welfare Fund.

Fund Office—The office maintained by the Trustees of the UFCW Local 1262 and Employers Health and Welfare Fund. It is located at 1389 Broad Street, Clifton, NJ 07013-4292. The phone number is (800) 522-4161 (TTY: 711).

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

Genetic Information—Information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic

services by the individual or a family member of the individual. Genetic Information includes, with respect to a pregnant woman (or a family member of a pregnant woman), Genetic Information about the fetus, and, with respect to an individual using assisted reproductive technology, Genetic Information about the embryo. Genetic Information does not include information about the sex or age of any individual.

HIPAA—The Health Insurance Portability and Accountability Act of 1996.

Home Health Agency—A Provider that mainly provides care for an ill or injured person in the person's home under a Home Health Care Plan designed to eliminate Hospital stays. The Plan will recognize an agency if it is:

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

Home Health Care—Nursing and other home health care services rendered to a Covered Person in his or her home, provided that:

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

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

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

Home Health Care Services—Any of the following services to the extent that they would be covered if the Covered Person were a Hospital inpatient:

- Nursing care
- Physical, occupational or speech therapy
- Medical social work
- Nutritional services
- Services of a home health aide

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

Hospice—A Provider that mainly provides palliative and supportive care for Terminally Ill or Injured people under a Hospice Care Program. A Hospice must comply with all state and local laws governing Hospices and be either:

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

Hospice Care Program—A health care program coordinated through an interdisciplinary team directed by a physician for the Terminally Ill.

Hospital—An institution that:

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

Unless specifically provided, the term "Hospital" does not include any institution, or part of one, that is used primarily as a convalescent home, a rest or nursing facility, an infirmary, or a Hospice; a substance use disorder treatment center or facility (or part of one) that mainly provides domiciliary or custodial care, educational care, nonmedical or ineligible services or supplies, or rehabilitative care; or a facility for care of the aged.

The Plan will pay benefits for Covered Services and supplies incurred at Hospitals operated by the U.S. government only if:

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

Illness—A bodily sickness, disorder, disease or pregnancy. Coverage for pregnancy is for Members only. Pregnancy coverage is not provided for Dependent Children.

Initial Measurement Period—The 12-month period that begins on or immediately after your date of hire.

Initial Stability Period—The period that begins on the effective date of your medical and prescription drug coverage and continues for 12 consecutive months.

Injury—Any damage caused by an accident.

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

Any expense that is not Medically Necessary and Appropriate will not be considered an eligible expense under the Plan and will not be eligible for reimbursement. The Trustees reserve the right to review medical care and to determine whether or not the service, treatment, supply or confinement is Medically Necessary and Appropriate. The Trustees may rely on an independent reviewer to make that determination. The fact that a physician or any other health care Provider orders or recommends a service, treatment, supply or confinement does not, in and of itself, make it Medically Necessary and Appropriate.

Medicare—The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member—A person covered under a collective bargaining agreement by and between the person's employer and the Union; or of the Union; or of the Fund Office; **and** whose employer is obligated to make a contribution to the Fund on the person's behalf. The person may be required to satisfy a service requirement before being eligible for benefits under the Plan.

Non-Preferred Brand Name Drugs—Those medications not included on the PBM's list of Preferred Brand Name drugs.

Ongoing Measurement Period—The period that runs from October to October each year.

Ongoing Stability Period—The period that runs from January 1 to December 31 of each year. The Ongoing Stability Period coincides with the Calendar Year.

Plan—The plan of benefits described in this SPD.

Plan Year—The 12-month period that begins on December 1 of each year.

Practitioner (or Provider)—A person the Plan recognizes who:

- Is properly licensed or certified to provide medical care under the laws of the state in which he or she practices
- Provides medical services within the scope of his or her license that are Covered Services under the Plan

Practitioners include, but are not limited to, physicians, chiropractors (for Bronze Plan benefits only), dentists, optometrists, pharmacists, chiropodists, psychologists, physical therapists, audiologists, speech language pathologists, certified nurse midwives, registered professional nurses, nurse practitioners and clinical nurse specialists.

Pre- (or Prior) Authorization—An authorization required for certain benefits under the Plan, whereby the receipt of such benefits is conditioned, in whole or in part, on the approval of the benefits before the Covered Person receives the medical care or pharmacy benefit, as applicable. The receipt of Pre- (or Prior) Authorization should not be interpreted to be a promise that the Plan will cover the full cost of the benefit for the Covered Person. Even if a service, treatment or supply receives Pre-Authorization, coverage is still subject to the terms and conditions of the Plan, including the excluded services.

Preferred Brand Name Drugs—A list of medications approved by the U.S. Food and Drug Administration, compiled by the PBM in conjunction with physicians and pharmacists. The PBM reviews and updates the list periodically.

Pre-Service Claim—A claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the approval of the benefits before you receive the medical care.

Post-Service Claim—A claim for benefits under the Plan that is submitted for payment after health services and treatment have already been obtained.

Prosthetics—An artificial device that is not surgically implanted and that is used to replace a missing limb, appendage, or any other external human body part, including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs or other devices that could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body. Prosthetics will be covered if obtained from a licensed orthotist or prosthetist or certified pedorthist if determined Medically Necessary by a physician.

QMCSO (Qualified Medical Child Support Order)—A judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law, that has the force and effect of law in that state, and that assigns to a child the right to receive health benefits for which a part-time Employee is eligible under the Plan, and that the Trustees (or their delegates) determine is qualified under the terms of ERISA and applicable state law.

Qualifying Service—Employment that is covered by a collective bargaining agreement by and between your employer and UFCW Local 1262 (Union) that requires your employer to make contributions to the Fund on your behalf.

Specialty Drug—Those injectable and noninjectable drugs approved by the U.S. Food and Drug Administration and compiled by the PBM on its specialty product list.

Terminally Ill or Injured—A Covered Person who has a life expectancy of six months or less, as certified by the Covered Person's medical Practitioner.

Therapy Services—The following services and supplies ordered by a Practitioner or provided by a Provider that are Medically Necessary and Appropriate for the treatment of a Covered Person's Illness or Injury:

- chelation therapy, which is the administration of drugs or chemicals to remove toxic concentrations of metal from the body

- chemotherapy, which is treatment of malignant diseases by chemical or biological antineoplastic agents

- cognitive rehabilitation therapy, which is the retraining of the brain to perform intellectual skills that it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process

- dialysis treatment, which is treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body and which includes hemodialysis and peritoneal dialysis

- infusion therapy, which is the administration of antibiotic, nutrient or other therapeutic agents by direct infusion

- occupational therapy, which is treatment to develop or restore a physically disabled person's ability to perform the ordinary tasks of daily living

- physical therapy, which is treatment by physical means to relieve pain, develop or restore normal function, and prevent disability following Illness, Injury or loss of limb

- radiation therapy, which is treatment of disease by X-ray, radium, cobalt or high-energy particle sources and which includes the rental or cost of radioactive materials (diagnostic services requiring the use of radioactive materials are not radiation therapy)

- respiration therapy, which is the introduction of dry or moist gases into the lungs

- speech therapy, which is therapy provided by a qualified speech therapist and is either (a) to restore speech after a loss or impairment of a demonstrated, previous ability to speak (but therapy to correct pre-speech deficiencies or therapy to improve speech skills that have not fully developed is NOT covered), or (b) to develop or improve speech to correct a defect that both existed at birth and impaired or would have impaired the ability to speak

Trustee—A member of the Board of Trustees of the UFCW Local 1262 and Employers Health and Welfare Fund.

Urgent Care Claim—A Pre-Service Claim that requires a shortened time frame for making a determination because a longer time frame could (a) seriously jeopardize your or your Dependent Child's life or health or your or your Dependent Child's ability to regain maximum function; or (b) in the opinion of a Provider with knowledge of your or your Dependent Child's medical condition, subject you or your Dependent Child to severe pain that cannot be adequately managed without the treatment that is the subject of the claim.

Walk-in Clinic—A clinic outside of a Hospital where Practitioners provide medical care and services to people with Illnesses or Injuries that require prompt attention but are not life-threatening and do not require the services of an emergency room.

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