UFCW

a VOICE for working America

Local 1262

# and

# Employers Health and Welfare Fund

# Summary Plan Description and Plan Document for

# Full-time Employees

**Effective January 2022**

***  *  *  IMPORTANT  *  *  ***

## 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 Fund Plan of Benefits (Plan).

This SPD describes the benefits available to you and your dependents 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**


INTRODUCTION ..... 6

WHO IS ELIGIBLE ..... 7

WHEN COVERAGE BEGINS ..... 8

- Moving Between UFCW Local 1262–Represented Employers ..... 8

HOW TO ENROLL ..... 9

- Special Enrollment Rights For Life Events ..... 9
- Dependent Verification ..... 10
- If Two or More Family Members Are Eligible for Coverage ..... 10
- If Family Members Work for Different Funds ..... 10

COST FOR COVERAGE ..... 11

CLAIMS AND APPEALS PROCEDURES ..... 12

- Overpayment of Benefits ..... 12
- No Assignment of Benefits ..... 12
- Claims for Benefits ..... 12
- How to File Claims ..... 12
- Claim Forms ..... 14
- Authorized Representatives ..... 14
- Reviewing Claims ..... 14
- Types of Claims ..... 15
- Claims Denial Notification ..... 16
- Appealing a Denied Claim ..... 17
- Notification of Decision on Appeal ..... 19
- External Review of Denied Medical, Mental Health, Substance Use Disorder or Prescription Drug Claims ..... 20
- Expedited IRO Review of Denied Claims ..... 22
- Special Affordable Care Act (ACA) Requirements ..... 22
- Exhaustion and Statute of Limitations ..... 23

OTHER BENEFIT SOURCES AND COORDINATION OF BENEFITS ..... 24

- Medicare ..... 24
- Your Coverage Options If You Continue Working After Age 65 ..... 24
- Subrogation and Third-Party Reimbursement ..... 24

## TABLE OF CONTENTS
(continued)

**Page**


Coordination of Benefits ..... 26

LENGTH OF COVERAGE ..... 29

When Coverage Ends ..... 29

Suspension of Benefits ..... 30

Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA) ..... 30

Family and Medical Leave Act (FMLA) ..... 31

General Notice of Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage Rights ..... 31

Paying for Coverage ..... 33

Duration of Coverage ..... 34

Extension of 18-Month COBRA Coverage Period for Disability ..... 35

Second Qualifying Event ..... 36

New Spouse or Acquiring New Dependents While Covered by COBRA ..... 36

Address Changes ..... 36

Financial Responsibility for Failure to Give Notice ..... 36

PLAN ADMINISTRATION AND LEGAL INFORMATION ..... 37

Plan Amendment or Termination ..... 38

Health Insurance Portability and Accountability Act of 1996 (HIPAA) ..... 38

Genetic Information Nondiscrimination Act of 2008 (GINA) ..... 40

Qualified Medical Child Support Orders (QMCSOs) ..... 40

YOUR RIGHTS UNDER ERISA ..... 41

Review Information About the Plan and Your Benefits ..... 41

Continue Group Health Plan Coverage ..... 41

Prudent Actions by Plan Fiduciaries ..... 41

Enforce Your Rights ..... 41

Assistance with Your Questions ..... 42

ABOUT YOUR BENEFITS ..... 43

YOUR UFCW LOCAL 1262 EMPLOYERS HEALTH & WELFARE FUND BENEFITS AT A GLANCE ..... 44

MEDICAL AND HOSPITAL BENEFITS ..... 51

Opportunity to Select a Primary Care Physician ..... 52

The Deductible ..... 52

## TABLE OF CONTENTS
(continued)

**Page**


The Annual Out-of-Pocket Maximum ..... 52
Utilization Management ..... 53
Pre-Authorization ..... 53
Case Management ..... 54
Alternate Treatment ..... 54
WHAT THE MEDICAL PLAN COVERS ..... 55
Wellness Benefits ..... 55
Well Child Care ..... 55
Well Adult Care ..... 56
Services Rendered by Providers ..... 57
Hospital Facility Benefits ..... 59
Emergency Room Benefits ..... 60
Outpatient (Ambulatory) Surgery (Pre-Authorization Required) ..... 61
Outpatient Pre-Admission Testing ..... 62
Infertility Services ..... 62
Transplant Benefits ..... 63
Skilled Nursing Facility Benefits (Pre-Authorization Required) ..... 64
Home Health Care Benefits (Pre-Authorization Required) ..... 64
Hospice Care Benefits (Pre-Authorization Required) ..... 65
Mental Health and Substance Use Disorder Treatment ..... 67
Other Covered Services ..... 68
Hearing Aid Benefit (Employee Only) ..... 71
Clinical Trial Benefit ..... 71
COVID-19 Benefit ..... 72
EXPENSES THE MEDICAL PLAN DOES NOT COVER ..... 73
PRESCRIPTION DRUG BENEFITS ..... 79
Statin Preventive Medication ..... 80
Specialty Drugs (Pre-Authorization Required) ..... 80
Step Therapy Program ..... 81
Mail at Retail Program ..... 81
Mail Order Drug Program ..... 81

**TABLE OF CONTENTS**
(continued)

**Page**


Prescription Drugs Not Covered ..... 81
COVID AT-HOME TESTS ..... 82
VISION BENEFIT ..... 84
Is a Claim Form Needed? ..... 87
How Can I Contact Davis Vision's Member Services? ..... 87
For Options Not Covered by the Plan ..... 87
Emergency Care ..... 88
Are There Other Exclusions under the Vision Plan? ..... 88
Vision Plan Insurance Policy Controls ..... 88
DENTAL BENEFITS ..... 89
Using a Participating Dentist ..... 89
Using a Non-Participating Dentist ..... 89
Pre-Treatment Review ..... 89
Alternative Treatment Benefits ..... 90
Covered Dental Services ..... 90
Orthodontic Treatment ..... 90
Maximum Benefits ..... 90
Extended Benefits ..... 90
Dental Expenses the Plan Does Not Cover ..... 91
Claiming Benefits ..... 92
LEGAL SERVICES PLAN ..... 93
How the LSP Works ..... 93
Covered Services ..... 93
What the LSP Does Not Cover ..... 104
Pre-Existing Matters ..... 104
Termination of Coverage ..... 105
Converting Coverage ..... 105
LSP Insurance Policy Controls ..... 105
LSP Administrator ..... 105
LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS (EMPLOYEE ONLY) ..... 106

**TABLE OF CONTENTS**
(continued)

**Page**


Life Insurance Plan ..... 106
Termination of Coverage ..... 106
Converting Coverage ..... 106
AD&D Plan ..... 106
Exclusions ..... 107
Claiming Death and Dismemberment Insurance Benefits ..... 108
RETIRED MEMBERS' BENEFITS ..... 109
Eligibility ..... 109
Eligibility Exclusions ..... 109
For Retirees Under Age 65 ..... 110
For Retirees Age 65 and Over ..... 110
Spouses of Retirees ..... 111
Retiree Legal Services ..... 111
How the Retired Members' Benefits Plan Works ..... 111
Medical Coverage ..... 111
Prescription Drug Coverage ..... 111
Dental Care Coverage ..... 111
Vision Care Coverage ..... 112
Life Insurance/Dismemberment Insurance ..... 112
Claiming Benefits ..... 112
When You Can Elect Coverage ..... 112
What You Pay for Coverage ..... 113
Coordination of Benefits ..... 113
If You Need Information ..... 113
GLOSSARY OF KEY TERMS ..... 114

## INTRODUCTION

This SPD describes the Plan benefits provided by the UFCW Local 1262 and Employers Health and Welfare Fund (Fund) to all full-time Employees (other than Service Clerks). Benefits provided to part-time Employees and all Service Clerks are contained in a separate SPD.

- The first section of this booklet (pages 1–42) 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 booklet (pages 43–121) provides a description of Plan benefits and any exclusions and limitations that may apply. It describes the coverage that is in place for you and your eligible dependents.

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

Read all sections of this SPD. Then, share this information with your dependents 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 eligible dependents 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

You are eligible for benefits under the Plan if:

- You are a member (Member)
    - covered under a collective bargaining agreement by and between your employer and the UFCW Local 1262 Union (Union); or
    - of the Union; or
    - of the Fund Office; and
- Your employer is obligated to make a contribution to the Fund on your behalf.

You may be required to satisfy a Service requirement before you are eligible for benefits under the Plan. Please see "When Coverage Begins" below.

**Your eligible dependents include:**

- Your lawful spouse (husband or wife), unless you are legally separated. Your lawful spouse does not include someone from whom you are divorced from bed and board. Lawful spouses include same-sex spouses so long as the marriage was legally entered into under the laws of the state or country in which the marriage took place. If your spouse is employed, he or she must be covered under any medical, prescription, dental or vision plan offered by his or her employer to be covered under this Plan. This rule does not apply to spouses covered prior to January 1, 1994;
- 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.

Children of a Member who are required to be covered under a Qualified Medical Child Support Order (QMCSO) (as described in the "Qualified Medical Child Support Orders" section on page 40) will be covered by the Plan.

The benefits to which you and your dependents are entitled are outlined in the second half of this SPD in the "What the Medical Plan Covers" section on page 55.

## WHEN COVERAGE BEGINS

If you are a full-time Member of UFCW Local 1262 or the Pension Fund, coverage for yourself and your eligible dependents will generally begin the first day of the month that follows 90 days of employment. However, if you are hired as a full-time Member of UFCW Local 1262 within 30 days of leaving employment with an employer that has a collective bargaining agreement with UFCW Local 1262, you and your eligible dependents are eligible for coverage effective the first of the month following your new date of hire, so long as your eligibility criteria has been met.

If you are a full-time Employee of a contributing employer that has a collective bargaining agreement with UFCW Local 1262, coverage for yourself and your eligible dependents will begin on the first of the month following one of the below events:

1. If you were hired between January 1, 2014 and December 31, 2014, following a 60-day waiting period that begins immediately following completion of 1,200 hours of Service for the contributing employer.

2. If you were hired on or after December 31, 2014 or if you are a Tier A Employee of Morton Williams, following a 60-day waiting period that begins immediately following completion of a 30-day probationary period with the contributing employer.

3. If you are reclassified as a full-time Member, following the later of the date that you were reclassified or the date you meet the eligibility requirements under No. 2 above.

Once you and your eligible dependents become eligible for benefits, eligibility for such benefits will continue as long as the required monthly contributions to maintain such level of benefits are paid on your behalf by an employer.

**Moving Between UFCW Local 1262–Represented Employers**

If your employment ends with one contributing employer and within 30 days you begin working for an employer that contributes to another Local health fund that is affiliated with UFCW Local 1262, your coverage will become effective on the first day of the month following your new date of hire. Refer to your specific collective bargaining agreement to determine if this applies to you.

To maintain continuous coverage during the 30-day period in which you move between contributing employers or different health plans that will cause you to lose coverage, you should consider purchasing COBRA continuation coverage. See page 31 for more information on purchasing continued coverage through COBRA.

## HOW TO ENROLL

You are automatically enrolled in coverage for yourself after you meet the eligibility requirements above. You **must** enroll your eligible dependents for them to receive benefits under the Plan. The Fund Office can provide you with an enrollment form. Be sure to fill in all of the required information and return it to the Fund Office. Otherwise, the date benefits start for your dependents may be delayed. If you do not enroll your dependents, you may enroll them later in accordance with the special enrollment rights for life events (Special Enrollment Rights) described below. Once you are properly enrolled in the Plan, you are a "Covered Person." When you enroll, you will receive identification cards from the benefits carrier.

**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:** | **You must request special enrollment within:** |
|---|---|
| • You acquire a new dependent through marriage, birth, or adoption or | 30 days of the event – coverage commences retroactive to the date of the event<br><br>If more than 30 days after the event – coverage commences as of the first day of the month following the date notice is provided |
| • You or your spouse loses other group health plan coverage | 30 days of the event – coverage commences retroactive to the date of the event<br><br>If more than 30 days after the event – coverage commences as of the first day of the month following the date notice is provided |
| You or a dependent:<br><br>• Loses eligibility for coverage under the state Children's Health Insurance Program (CHIP) or Medicaid, or<br><br>• Becomes eligible for premium assistance under CHIP or Medicaid | If within 30 days of the event – coverage will commence retroactive to the date of the event<br><br>If more than 30 days after the event – coverage will commence as of the first day of the month following the date notice is provided |

**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 Verification**

For dependent coverage to be effective, you must provide sufficient proof as requested by the Fund Office that the individual is your spouse or 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 Member's name and the dependent'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 as both a member and an eligible dependent, except under the Coordination of Benefits rules explained later in this SPD. If more than one family member is eligible for coverage in the Fund as a full-time member in active employment, each will be covered as such and neither will be covered as a dependent of the other. The full-time family member whose birthday occurs earlier in the Calendar Year will cover any Dependent Children he or she chooses to enroll.

If your eligible dependent works part-time and qualifies for coverage under the Fund's part-time medical plan, the part-time participant may be covered as your Dependent Child. The only exception is for services in connection with maternity benefits, where part-time members who are Dependent Children are only eligible for maternity benefits through the part-time medical plan if they meet the eligibility requirements of that part-time medical plan.

**If Family Members Work for Different Funds**

If both you and your spouse qualify for coverage with different health funds affiliated with UFCW Local 1262, your eligible children will be dependents 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.

## 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 this 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 the 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 this 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 this 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 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:

**Dental Claims**

Horizon Blue Cross Blue Shield of New Jersey Dental Programs
P.O. Box 1311
Minneapolis, MN 55440-1311

**Hospital/Medical Claims**

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

**Legal Service Claims**

ARAG
Attn: Claims Dept.
500 Grand Avenue
Suite 100
Des Moines, IA 50309

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

USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650

**Mental Health/Substance Use 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

**Vision Claims**

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

**Claim Forms**

All claims for benefits must be submitted on a claim form, which may be made electronically. You can obtain a claim form from the claims administrator or claims-processing entity (contact information below), 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 Member
- 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**

Pre-Service Claims

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 the 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 life or health or your ability to regain maximum function, or the ability of your eligible dependent to do so; or

- In the opinion of a doctor with knowledge of your or your dependent's medical condition, subject you or your dependent 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 the service or treatment was not covered, and you disagree with the decision on a 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 1-800-355-2583.

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

If your claim for mental health/substance abuse 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 Fund Office, 1389 Broad Street, Clifton, NJ 07013.

If your claim for dental benefits is denied in whole or in part, you have 180 days to appeal that denial to Horizon's Appeals Coordinator, P.O. Box 1311, Minneapolis, MN 55440-1311.

If your claim for vision benefits is denied in whole or in part, you have 180 days to appeal that denial to Davis Vision, Inc., Attn: Complaints and Appeals Dept., P.O. Box 791, Latham, NY 12110.

If your claim for life insurance and accidental death and dismemberment benefits is denied in whole or in part, you have 180 days to appeal that denial to USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650.

If your claim for legal services benefits is denied in whole or in part, you have 60 days to appeal that denial to ARAG, Attn: Appeals, 500 Grand Avenue, Suite 100, Des Moines, IA 50309.

**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 appeals for Post-Service medical, mental health/substance abuse disorder, prescription and dental claims only

If you disagree with the decision on the first-level appeal of your post-service medical, mental health/substance abuse disorder, prescription, or dental claim, you may appeal to the Trustees, or their designee. 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 or 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, 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 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 provided 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 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; 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 delegated 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 on a second-level appeal, the Trustees or their designee, is final and binding.

**External Review of Denied Medical, Mental Health, Substance Use Disorder or Prescription Drug Claims**

If your claim for medical, mental health/substance use disorder, 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) 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, the assigned IRO will forward the information to the Fund Office within one business day. 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 this 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 any Covered Person.

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 this Plan as your primary coverage, with Medicare as your secondary coverage. In this case, all claims should be submitted to this 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 this Plan stops for you, your spouse, and any children; you will have the option of either continuing or dropping dental and/or vision coverage for yourself and your enrolled spouse and enrolled children as well. If you elect to waive medical, prescription, dental and/or vision coverage, you will not be able to get back into this Plan in the future unless you have an event that would qualify you for the Special Enrollment Rights described on page 9. Your claims must then be submitted to Medicare only.

**Subrogation and Third-Party Reimbursement**

General Principle

The Plan will not cover claims (including medical, prescription drug, and dental care claims) for injuries where you or your enrolled dependents could have a claim against a third party. In these cases, claims that would otherwise be covered by the Plan will only be covered on the following terms and conditions.

If you or your dependents receive benefits under the Plan that are related to medical expenses that also may be payable under (i) workers' compensation, (ii) a statute or uninsured or underinsured motorist plan, (iii) a no-fault or school insurance plan, (iv) another insurance policy or (v) any other plan of benefits, or if another person may have to pay for the medical expenses (e.g., because they harmed you), whether through legal action, settlement or for any other reason, **you or your dependents must reimburse the Plan** for all related benefits you or your dependents recover or receive from any third party.

Specific Requirements and Plan Rights

The Plan is entitled to reimbursement from you or your dependents and is fully subrogated to any and all rights, recovery or causes of action or claims that you or your dependents may have against any third party (whether a person, insurance company, or other plan). The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party, up to the amount paid by the Plan. This right to reimbursement exists regardless of how the recovery is structured or worded, and even if you or your dependents have not been paid or fully reimbursed for all of the damages or expenses.

The Plan's share of this recovery will not be reduced because the full amount of damages or expenses claimed have not been paid, unless the Plan agrees in writing to such reduction, in its sole and absolute discretion. This will depend on the facts and circumstances of a particular case. Further, the Plan'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.

To enforce its rights of subrogation and reimbursement, the Plan reserves the right, in its sole and absolute discretion, to deny payment of any claim until you or your dependents take affirmative steps, as required by the Plan, 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 your dependents do not cooperate in attempting to obtain recovery from a responsible third party, or if the Plan becomes aware that you or your dependents have received a third-party payment or recovery and not reported this amount to the Plan, the Plan, in its sole discretion, may suspend all further benefit payments related to you or any of your dependents until the amount at issue (plus interest calculated on the Plan's Policy for the Collection of Overpayments), is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your dependents. The Plan also has the right to commence a lawsuit against you and/or your dependents to recover any amounts owed under its right of subrogation and reimbursement.

Covered Person Duties and Actions

By participating in the Plan, you and your dependents consent and agree that a constructive trust, a lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. This means that any amount received by you or your dependents, or your representatives (including your or your dependents' attorneys) that is due to the Plan under this provision shall be deemed to be held in trust by you or your dependents for the benefit of the Plan until paid to the Plan. You and your dependents agree to fully cooperate with the Plan in exercising its rights of subrogation and reimbursement.

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

If you or your dependents fail or refuse to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your dependents until the agreement is signed. Alternatively, if you or your dependents fail or refuse to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your dependents, your or your dependents' acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

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

**Coordination of Benefits**

The coordination of benefits provisions apply when you or your dependent 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 incurs.

Other plans include:

- Group blanket or franchise insurance coverage
- Hospital service pre-payment plan, medical service pre-payment plan or group practice plan
- Any coverage under a labor-management trusteed plan, union welfare plan, 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
- Automobile insurance, including but not limited to "no-fault" or personal Injury protection insurance
- 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 a covered dependent incurs a covered expense that is covered by this Plan and another plan, the primary plan will pay benefits first, then the secondary plan will pay its benefits, if any are to be paid – up to 100% of the Covered Charges.

Determining which plan is primary and which is secondary is based on the following rules for coordination with another group health plan or individual plan.

- If the other plan does not have a coordination-of-benefits provision, it pays benefits first.

- When both plans have a coordination-of-benefits provision:

    - The plan covering the claimant as an Employee is primary and will pay benefits first. The plan covering the claimant as an inactive participant (such as a retired or laid-off individual or as a spouse) will pay benefits second.

      **Note #1:** If a part-time participant is also an eligible Dependent Child of a full-time participant under this Plan, the part-time participant receives benefits as a Dependent Child of the full-time participant, except for benefits in connection with maternity care, which are paid by the part-time medical plan.

      **Note #2:** If more than one family member is eligible for coverage as a Member, the Fund's coordination-of-benefits provisions do not apply. The family will be treated as a single unit.

    - If a Dependent Child is covered by both parents' plans, the plan of the parent whose birthday occurs earlier in the Calendar Year is primary (regardless of the year of birth) – provided that both plans have this birthday rule.

    - If the parents are divorced or separated:

        - The plan of the parent with custody pays first; the plan of the parent without custody pays second, or
        - If the parent with custody has remarried, the plan of the parent with custody pays first; the plan of the stepparent pays second; and the plan of the parent without custody pays third, or
        - If parents have joint custody and neither parent is designated as responsible for health care expenses, the birthday rule described above applies.
        - If there is a court decree that specifies which parent is responsible for a child's health care expenses, that parent's plan will pay first. This does not apply to any claim for benefits paid or provided before the other insurer has actual knowledge of the court decree.

    - If payment responsibility is still unresolved, the first plan to make payment is the one covering the individual the longest.

- If you or your dependent is covered by Medicare or Medicaid, special rules apply. Contact the Fund Office for additional information.

- If the other plan is a reimbursement type of program or through an automobile insurance, homeowner's insurance or other similar policy, this Plan will automatically pay benefits second.

If this Plan is the primary payer, it will pay benefits as if there were no other coverage. If this Plan is the secondary payer, it will pay the difference between the covered expense and the amount paid by the other plan, but in no case more than this Plan would have paid had it been the only coverage.

**There is a special rule for automobile insurance. The Plan will be secondary to any "no fault" or other automobile insurance coverage even if you or your dependent elects that the automobile insurance coverage be the secondary payor. Even if you or your dependents decline to select health care coverage that is available under your automobile insurance, this Plan will only pay benefits secondary, 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 motor vehicle or "no-fault" 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 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.

However, your collective bargaining agreement may provide that if you are absent from work due to Illness or Injury, whether compensable or not, your coverage will continue for up to 90 days. 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. Your collective bargaining agreement may provide that if you are a full-time Covered Person and have more than five years of Service and are laid off, you may have coverage extended for yourself and your eligible dependents for up to three consecutive months following your layoff or until you obtain other employment that makes you eligible for health coverage. (Refer to your specific collective bargaining agreement to see if the extension for a layoff applies to you.) Legal Services Plan benefits will terminate at the end of the month in which you leave employment due to lay-off or Illness or Injury.

If the reason for your termination from active employment is due to retirement, you will have an opportunity to continue coverage. See the “Retired Members’ Benefits” section, beginning on page 109, for more information.

For Your Dependents

Your dependents’ coverage normally ends when your coverage ends. Coverage for dependents would also end on the earliest of:

- The date your dependent 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 dependents, i.e., you move from full-time to part-time employment;
- The date they no longer meet the definition of a Covered Person; or
- The date that the Plan discontinues dependent coverage for all Covered Persons.

When coverage ends for either you or your covered dependents, you or they may be eligible to extend coverage at your or their own expense through COBRA, as described beginning on page 31.

**Suspension of Benefits**

*Discontinuance of Coverage for Non-Payment 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 dependents 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, your and your dependents' 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*

Your and your dependents' 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 eligible dependents 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 dependents until the Fund has recovered in full the amount of claims paid for you and your dependents 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 dependents' 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 dependents while on 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 at the same time as continuation of coverage provided under any other leave of absence except COBRA, which is explained on page 31.

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 dependents 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 (FMLA)**

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 local Human Resources Department of your employer for additional information on your FMLA benefits. Please contact the Fund Office regarding benefits under this 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, spouses and Dependent Children, including alternate recipients under QMCSOs (as defined on page 119), 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; however, life insurance and legal plan coverage are not continued under COBRA, but please see the conversion options available to you on pages 105 and 106.

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<br>▪ Your employment terminates (for reasons other than gross misconduct)<br>▪ 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<br>▪ The parent-Employee's hours of employment are reduced<br>▪ The parent-Employee's employment in service that is covered by this 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 primary coverage<br>▪ The parents are divorced or legally separated<br>▪ The child no longer meets the eligibility requirements | The Employee, within 60 days of the event |
| A spouse of an Employee who loses Plan coverage because | ▪ The spouse-Employee dies<br>▪ The spouse-Employee's hours of employment are reduced<br>▪ The spouse-Employee's employment in a position that is covered by this Plan terminates (for reasons other than gross misconduct) | The employer within 30 days of the event |
| | ▪ The Employee becomes entitled to Medicare and elects to have Medicare be primary coverage<br>▪ The Employee and spouse are legally separated or divorced | The Employee within 60 days of the event |

*New spouses and 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. A new spouse will not be considered a qualified beneficiary and will only have continuation coverage under COBRA for the same length of time as the former Employee maintains 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, spouse's or Dependent Child's Social Security number, and the type and date of the qualifying event and proof of the qualifying event. For example, if the qualifying event is a 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 would 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 spouses and/or Dependent Children.

To elect continuation coverage, you, your spouse, or your Dependent Child(ren) must complete and return the COBRA Notice and Election Form to the Fund Office within 60 days after you receive the COBRA Notice and Election Form. You must pay the first premium retroactive to the date when coverage terminated, within 45 days after you return the COBRA Notice and Election Form. Coverage will not commence until payment is received in full.

If you, your spouse or a Dependent Child qualifies for COBRA continuation coverage and you waive your right to coverage during the election period, you, your spouse 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, your spouse 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, your spouse 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, your spouse 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 dependents | 18 months |
| Your working hours are reduced | You and your eligible dependents | 18 months |
| You are determined to be disabled by the Social Security Administration | You and your eligible dependents | 29 months |
| You die | Your dependents | 36 months |
| You divorce or legally separate | Your dependents | 36 months |
| Your Dependent Children no longer qualify as dependents | Your Dependent Children | 36 months |
| You become entitled to Medicare benefits | Your dependents | 36 months |

COBRA coverage will end before the period shown above if any of the following events occur, as of the date 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 dependents become, after electing COBRA coverage, 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 covering a significant number of the Employees formerly covered under this 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 spouse and 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 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 your 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 Covered Person, the Covered Person's Social Security number, and 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, the spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent Children getting COBRA continuation coverage if the Employee, or former Employee, dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); 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 spouse or 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 Covered Person or qualified beneficiary, the Covered Person'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.

**New Spouse or Acquiring New Dependents While Covered by COBRA**

If you have a new spouse or acquire a new dependent (either a child born or placed for adoption during a period of COBRA coverage), you may enroll such spouse or dependent for continuation coverage for the balance of your COBRA continuation coverage period. You must follow all of the Plan's rules for enrolling a new spouse or newly born or adopted child. Your spouse will not be considered a qualified beneficiary and therefore his or her coverage will end when your COBRA coverage ends no matter the circumstance. However, the Dependent Child will be considered a qualified beneficiary, and will have independent COBRA rights from yours.

**Address Changes**

To protect your family's rights, you should keep the Fund Office informed of any changes in address for you and any of your eligible family members. 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 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 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 benefits in effect as of January 1, 2022. Benefits for part-time Employees are described in a separate SPD. | |
| Plan Name | UFCW Local 1262 and Employers Health and Welfare Fund | |
| Plan Sponsor | Board of Trustees<br>UFCW Local 1262 and Employers Health and Welfare Fund<br>1389 Broad Street<br>Clifton, NJ 07013-4292 | |
| Employer Identification Number (Plan Sponsor) | 23-7042767 | |
| Plan Number | 501 | |
| Type of Plan | Group health plan providing health, life, accidental death and dismemberment, and prepaid legal service benefits | |
| Plan Year | December 1 through November 30 | |
| Plan Administrator | Board of Trustees<br>UFCW Local 1262 and Employers Health and Welfare Fund<br>1389 Broad Street<br>Clifton, NJ 07013-4292<br>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<br>Generoso Del Rosario<br>Michelle Castellana<br>Ann Nichols<br>c/o Stop & Shop<br>1129 Rte. 34 North<br>Aberdeen, NJ 07747 | Union Trustees<br>Harvey Whille<br>James Feimster<br>Donald Merritt<br>c/o UFCW Local 1262<br>1389 Broad Street<br>Clifton, NJ 07013-4292 |
| Agent for Service of Legal Process | Plan Administrator<br>1389 Broad Street<br>Clifton, NJ 07013-4292<br>Phone: (800) 522-4161 (TTY: 711)<br>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 the Union that require contributions to the Plan, and investments thereon. With the exception of life insurance, AD&D, and legal service benefits, all benefits under the Plan are self-insured and provided by the Fund. Vision benefits became insured effective April 1, 2017. | |
| Collective Bargaining Agreements | This 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 the Union Office. | |

| | |
|---|---|
| Participating Employers | Stop & Shop<br>Tops Markets<br>Morton Williams<br>UFCW Local 1262 Union<br>Office of the UFCW Local 1262 and Employers Pension Fund<br>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, 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 which 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 service, 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

Complaints may also be made in writing to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights (OCR), 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 http://www.hhs.gov/ocr/hipaa or by calling 1-866-627-7748. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications, ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for Protecting Your Health Insurance Coverage). These publications and other useful information are also available on the Internet at http://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 (QMCSOs)**

Any child of an enrolled Employee 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 Children. 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, that assigns to a child the right to receive health benefits for which a dependent 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 the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons are entitled to:

**Review 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, your spouse, or eligible Dependent Children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the "General Notice of Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage Rights" section beginning on page 31 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 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, 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 http://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 http://www.healthcare.gov.

## ABOUT YOUR BENEFITS

The Plan provides benefits to:

- Help you pay:
  - Hospital and medical expenses;
  - prescription drug expenses;
  - dental expenses;
  - vision expenses; and
  - legal services expenses;
- Provide financial assistance to your Beneficiary in case of your death; and
- Provide financial assistance to you if you are accidentally dismembered.

This section describes these benefits. In combination with the information included in the first part of this booklet, it is the Plan document and the SPD.

## YOUR UFCW LOCAL 1262 EMPLOYERS HEALTH & WELFARE FUND BENEFITS AT A GLANCE

Here are the highlights of your Fund 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:** |
|---|---|---|
| **For Health Benefits** | | |
| 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.<br><br>If you use out-of-network Providers, the Plan does not pay benefits unless you experience a life-threatening emergency. **When 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 covered services 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.** | 52 |
| What preventive care does the Plan cover? | The Plan helps you pay the cost of:<br>■ Well-child care, including immunizations, and<br>■ Wellness screenings and preventive care for adults. | 55-57 |
| What if I get sick or hurt?<br><br>■ Doctors' office or home visits | The Plan pays 100% of the Allowed Amount after you pay a copay. | 58 |

| | | **For more information, go to page:** |
|---|---|---|
| ■ Doctors' charges for surgery<br><br>■ Doctors' charges for a second surgical opinion | The Plan pays 90% of the Allowed Amount after you pay a deductible.<br><br>The Plan pays 100% of the Allowed Amount. | |
| Does the Plan cover maternity visits? | Coverage is provided for the Member or the Member's spouse, but not for covered Dependent Children. | 57 & 60 |
| What if I need to go into the Hospital? | You must have a Hospital stay preauthorized. Plan benefits include semi-private room, board and other Hospital charges for:<br><br>■ Hospitalization outside of the United States<br>■ Newborn infant care<br>■ Treatment of an Illness or Injury | 59-60 |
| What if I have an emergency?<br><br>■ Ambulance | 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.<br><br>The Plan pays the Allowed Amount for ambulance transportation to the nearest facility that can treat the condition. | 60-61<br><br>68 |

| | | **For more information, go to page:** |
|---|---|---|
| What hearing expenses are covered? | The Plan pays the Allowed Amount for hearing tests and a hearing aid (but not the cost of battery replacements) for enrolled Employees only | 71 |
| Does the Plan pay for any other services? | The Plan also provides benefits for: | |
| | ■ Abortion | 68 |
| | ■ Acupuncture (Medically Necessary) | 68 |
| | ■ Ambulance | 68 |
| | ■ Anesthesiologist's charges | 68 |
| | ■ Applied Behavioral Analysis (ABA) Therapy | 67-68 |
| | ■ Blood | 69 |
| | ■ Chemotherapy, radiation and hemodialysis | 69 |
| | ■ Chiropractic care | 69 |
| | ■ Cognitive rehabilitative therapy | 69 |
| | ■ Diagnostic tests and X-rays, MRI, CAT and PET scans | 69 & 71 |
| | ■ Dialysis | 69 |
| | ■ Durable medical equipment, including Prosthetics (Pre-Authorization required for all rentals and purchases) | 69 |

| | | |
|---|---|---|
| | | **For more information, go to page:** |
| | ■ Home Health Care (Pre-Authorization required) | 64-65 |
| | ■ Hospice care (Pre-Authorization required) | 65-66 |
| | ■ Infertility services (Pre-Authorization required) | 62 |
| | ■ Infusion therapy | 69 |
| | ■ Mental health and substance use disorder treatment | 67 |
| | ■ Nutritional counseling | 70 |
| | ■ Occupational therapy | 70 |
| | ■ Outpatient (ambulatory) surgical facility (Pre-Authorization required) | 61 |
| | ■ Orthotic shoe inserts | 70 |
| | ■ Oxygen | 70 |
| | ■ Physical therapy | 70 |
| | ■ Pre-admission testing | 62 |
| | ■ Private duty nursing (Pre-Authorization required) | 70 |
| | ■ Radiation therapy | 70 |
| | ■ Respiration therapy | 70 |

| | | **For more information, go to page:** |
|---|---|---|
| | ■ Skilled nursing facility (Pre-Authorization required)<br>■ Speech therapy<br>■ Transplant benefits<br>■ Vision care<br>■ Walk-In Clinic<br>■ Wigs | 64<br>70<br>63-64<br>71<br>61 & 121<br>71 |
| 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. | 12 |
| Does the Plan provide benefits for prescription drugs? | The Plan covers prescription drugs that you obtain at a participating retail or mail-order pharmacy. | 79-83 |
| Does the Plan provide vision benefits? | The Plan helps pay the cost of covered vision care expenses, which include an eye exam and one pair of eyeglasses or contact lenses. You can use any vision care Provider. However, your out-of-pocket costs will generally be less if you use a participating Provider. | 84 |
| What dental expenses are covered? | You can obtain dental care from any dentist. However, your out-of-pocket costs will generally be less if you use a participating dental office. In addition, if you use a non-participating dentist, you must meet an annual deductible before the Plan pays benefits for covered services, except preventive care. Covered services include:<br>■ Crowns and bridges | 89 |

| | | |
|---|---|---|
| | | **For more information, go to page:** |
| | ■ Examinations and X-rays<br>■ Extractions<br>■ Fillings<br>■ Oral surgery<br>■ Prosthetics (dentures)<br>■ Repairs<br>■ Root canal therapy | |
| **For Legal Services Plan Benefits** | | |
| Does the Plan provide benefits if I need the services of an attorney? | You and your eligible dependents have access to a network of participating attorneys for many covered services including: | |
| | ■ Bankruptcy | 98 |
| | ■ Child Support Enforcement | 99 |
| | ■ Consumer Protection Defense | 97 |
| | ■ Court Adoption | 97 |
| | ■ Criminal Misdemeanor Defense | 102 |
| | ■ Debt Collection Defense | 97 |
| | ■ Divorce | 98 |
| | ■ Document Preparation and Review | 99 |
| | ■ Domestic Violence Protection | 98 |
| | ■ Driving Privilege Protection | 103 |

| | | |
|---|---|---|
| | | **For more information, go to page:** |
| | ■ Financial Education and Counseling Services | 96 |
| | ■ Foreclosure | 99 |
| | ■ Immigration | 95 |
| | ■ IRS Audit Protection and IRS Collection Defense | 101 |
| | ■ Juvenile Court Proceedings/Parental Responsibilities | 102 |
| | ■ Real Estate – Purchase, Sale and Refinancing (primary residence) | 100 |
| | ■ Social Security/Veterans/Medicare | 101 |
| | ■ Telephone Legal Services | 94 |
| | ■ Tenant Matters | 100 |
| | ■ Wills/Powers of Attorney/Codicils | 101 |
| **Life and Dismemberment Benefits (Members Only)** | | |
| What benefits are paid in case of my death? | Your Beneficiary (or your estate, if you have not named a Beneficiary) will receive $30,000 in a lump sum if you are under age 70 at the time of your death or $15,000 if you are over age 70. | 106 |
| What benefits are paid if I am dismembered? | You will receive a benefit of $30,000 or $15,000 or $7,500 if you have attained age 70), depending on the extent of your loss. | 107 |

## MEDICAL AND HOSPITAL BENEFITS

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 exception is 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 the 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 dependents. If you choose to select a PCP, you and your dependents 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 individual once each Calendar Year. To meet the family maximum deductible, two family members must each meet his/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, vision or in-network dental benefits.

| For each: | EPO Plan Deductible |
|---|---|
| Individual in a Calendar Year | $250 |
| Family in a Calendar Year | $500 |

**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 copays, deductible and coinsurance. The annual out-of-pocket maximums effective January 1, 2022 are:

- $1,500 for an individual (made of up $1,350 in eligible medical expenses and $150 in eligible prescription drug expenses), and
- $3,000 for a family (made up of $2,700 in eligible medical expenses and $300 in eligible prescription drug expenses).

The combined expenses of all covered family members are used to meet the family maximum amount. Once the annual out-of-pocket maximum is reached, the Plan pays 100% of remaining eligible expenses for that individual (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, vision and dental charges, penalties for failure to precertify a claim, or other services excluded from coverage under the Plan.

**Utilization Management**

Utilization management services–including Pre-Authorization, second surgical opinions 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 physician recommends surgery or Hospitalization, you may notify Horizon at 1-800-355-2583 to confirm which services require pre-authorization (as 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 physician 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.**

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

It is your responsibility to obtain any required Pre-Authorization for you and/or your covered dependents from Horizon.

Horizon will notify you or your physician of the outcome of the request for Pre-Authorization. If the review results in a denial, Horizon will confirm the denial in writing. If Pre-Authorization determines that the stay or services and supplies are not covered expenses, the notification will explain why and how the decision can be appealed. You or your Provider may request a review of the Pre-Authorization decision.

If approved for an inpatient admission to a facility, Horizon will notify your physician and the facility about your pre-authorized length of stay. If your physician recommends that your stay be extended, additional days will need to be authorized by Horizon. You, your physician, 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 physician 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 is your health care advocate and will 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 a Covered Person 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 the Covered Person, Horizon and 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 dependents 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 non-network provider without cost-sharing.

**Well Child Care**

The Plan covers:

- An initial Hospital check-up, 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 examination, developmental assessment, 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<br>■ Office visits | 100% of the Allowed Amount |

**Well Adult Care**

For any Covered Person 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
  - Measles, mumps, rubella (MMR)
  - 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<br>■ Pap test<br>■ Prostate exam (age limits may apply)<br>■ Wellness visits | 100% of the Allowed Amount |

**Services Rendered by Providers**

| | |
|---|---|
| Allergy testing and treatment | 100% (copay applies when an office visit is billed) |
| Anesthesia | 90% 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 incurred within 12 months of an accident | 90% of the Allowed Amount after the deductible |
| Hearing screenings<br>Office visit | 100% after you pay a $30 copay |
| In-Hospital visits not related to surgery | 90% of the Allowed Amount after the deductible |
| Maternity care,[1] including pregnancy and routine pregnancy-related conditions before and after delivery | Office Visits: 100% of the Allowed Amount after you pay a $30 copay for the first office visit<br>Delivery: 90% of the Allowed Amount after the deductible |

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

| | |
|---|---|
| Office or home visits by a primary care Provider or specialist for treatment of an Illness or Injury<br>Note: You do not need a referral from a PCP to see a specialist. | 100% of the Allowed Amount after you pay a:<br>• $20 copay for each visit to a PCP<br>$30 copay for each visit to a specialist (the deductible does not apply unless a surgical procedure is performed) |
| Outpatient other than office visit | 90% of the Allowed Amount after the deductible |
| Second surgical opinion[2] | 100% of the Allowed Amount |
| 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) | 90% of the Allowed Amount after the deductible |

The ***Women's Health and Cancer Rights Act*** requires plans that cover mastectomies (as this Plan does) to also cover:

- A Hospital stay of at least 72 hours following a modified radical mastectomy and 48 hours following a simple mastectomy
- Prostheses
- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas

[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, 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 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.

**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.

***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 eligible dependents 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 | 90% of the Allowed Amount after the deductible |

| **Hospital Facility Benefits for Maternity (Pre-Authorization Required)** | |
|---|---|
| Newborn Infant Care*<br><br>■ Premature infant (weighing less than five pounds)<br><br>■ Sick baby<br><br>■ Well baby (for up to 48 hours following a vaginal delivery; up to 96 hours following a Cesarean section) | 90% 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, an 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 non-emergent services will not be covered.** Some examples of non-emergent 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<br><br>**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 $75 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 free-standing 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)** |
|---|
| 90% 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 |
|---|
| 90% of the Allowed Amount after the deductible |

**Infertility Services**

The Plan pays benefits for services related to the treatment of infertility including but not limited to:

- Artificial insemination
- A total of four attempted or completed egg retrievals per lifetime
- Diagnosis and diagnostic tests
- Embryo transfer
- Gamete intrafallopian transfer*
- Intracytoplasmic sperm injection
- In vitro fertilization*
- Surgery
- Zygote intrafallopian transfer*

*These Covered Services are limited to a Covered Person who has used all reasonable, less expensive and Medically Necessary treatments and is still unable to become pregnant or carry a pregnancy and is 45 years of age or younger.

Infertility services must be provided at a facility that conforms to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

| | Infertility Services (Pre-Authorization Required) |
|---|---|
| Professional office care | 100% after you pay a $30 copay |
| Professional outpatient care | 90% of the Allowed Amount after the deductible |
| $5,000 lifetime maximum benefit per family; $500 maximum for sperm or egg storage for up to five years. | |

**Transplant Benefits**

The Plan pays benefits for transplants of the following:

- Allogeneic bone marrow
- Allogeneic stem cell
- Chondrocycte (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-myeloblative 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** |
| --- |
| 90% 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 the covered patient and an immediate family member, where the covered patient's age, medical condition or incapacity necessitate a traveling companion ("traveling companion") for one round trip to and from the network facility. 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 preapproved by Horizon in order for the expenses to be covered.

Covered expenses are limited to the aggregate of $300 per day for lodging and meal, 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)** |
|---|
| 90% of the Allowed Amount after the deductible |
| Maximum of 100 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 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 (RN)

- 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)

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)** |
|---|
| 90% of the Allowed Amount after the deductible |
| Maximum of 100 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 an 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)** |
|---|
| 90% of the Allowed Amount after the deductible |
| Maximum of 10 days for respite care |

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 Prior 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 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, 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** | **What The Plan Covers** |
|---|---|
| Abortion (outpatient and elective); for Covered Person and spouse only | 90% of the Allowed Amount after the deductible |
| Acupuncture (but not for pain management) | 90% of the Allowed Amount after the deductible |
| 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; 90% after the deductible if not an emergency |
| Anesthesiologist services provided by a doctor other than the operating surgeon and as part of a covered surgical procedure | 90% of the Allowed Amount after the deductible |

| Service, Supply, Treatment | What The Plan Covers |
|---|---|
| Blood (blood, blood products, blood transfusions and the cost of testing and processing blood, but not for blood that has been donated or replaced) | 90% of the Allowed Amount after the deductible |
| Chelation therapy | 90% of the Allowed Amount after the deductible |
| Chemotherapy, radiation and hemodialysis (inpatient or outpatient) | 90% of the Allowed Amount after the deductible |
| Chiropractic care | 100% of the Allowed Amount after you pay a $30 copay for each visit |
| Cognitive rehabilitative therapy | 90% of the Allowed Amount after the deductible ($30 copay outpatient/out-of-Hospital professional, only for an initial evaluation or a reevaluation visit) |
| Diabetic supplies/syringes | 90% of the Allowed Amount after the deductible |
| Dialysis | 90% of the Allowed Amount after the deductible |
| Durable medical equipment, including Prosthetics (for the rental, fitting and adjusting of durable medical equipment)<br>**Note:** The Plan reserves the right to purchase rather than rent any item. | 90% of the Allowed Amount after the deductible<br>Pre-Authorization is required for rentals and purchases. If you fail to obtain Pre-Authorization, your claim will be denied. |
| Infusion therapy | 90% of the Allowed Amount after the deductible |
| MRI, CAT, PET scans<br>Routine and Outpatient Diagnostic<br>Inpatient Diagnostic | <br>100% of the Allowed Amount<br>100% of the Allowed Amount |

| Service, Supply, Treatment | What The Plan Covers |
|---|---|
| Nutritional counseling if prescribed by a Practitioner | 90% of the Allowed Amount after the deductible; 100% of the Allowed Amount for preventive care |
| Occupational therapy (maximum of 90 visits for occupational therapy and/or physical therapy in a Calendar Year) | 90% of the Allowed Amount after the deductible ($30 copay outpatient/out-of-Hospital professional, only for an initial evaluation or a reevaluation visit) |
| Orthotic shoe inserts (for Members only) | Up to $250 once every three Calendar Years |
| Oxygen and its administration | 90% of the Allowed Amount after the deductible |
| Physical therapy (maximum of 90 visits for occupational therapy and/or physical therapy in a Calendar Year) | 90% of the Allowed Amount after the deductible ($30 copay outpatient/out-of-Hospital professional, only for an initial evaluation or a reevaluation visit) |
| Private duty nursing on an outpatient basis only if ordered by a physician and furnished while intensive skilled nursing care is required to treat an acute Illness or Injury and the patient is not in a facility that provides nursing care (Pre-Authorization required)<br><br>**Note:** $7,000 maximum per Calendar Year | 90% of the Allowed Amount after the deductible |
| Radiation therapy | 90% of the Allowed Amount after the deductible |
| Respiration therapy | 90% of the Allowed Amount after the deductible ($30 copay outpatient/out-of-Hospital professional, only for an initial evaluation or a reevaluation visit) |
| Speech therapy (maximum of 90 visits in a Calendar Year) | 90% of the Allowed Amount after the deductible ($30 copay outpatient/out-of-Hospital professional, only for an initial evaluation or a reevaluation visit) |

| Service, Supply, Treatment | What The Plan Covers |
|---|---|
| Vision care (non-routine) | 100% of the Allowed Amount after you pay a $30 copay |
| Wigs (if Medically Necessary) | 100% of the Allowed Amount up to $500 annual maximum |
| X-rays and laboratory tests<br><br>**Note:** In-network labs are based on the location of the Provider ordering the tests. Please refer to the Horizonblue.com Provider Directory or contact Horizon at 1-800-355-2583 to find an in-network lab. | |
| Routine and Outpatient Diagnostic | 100% of the Allowed Amount |
| Inpatient Diagnostic | 100% of the Allowed Amount |

**Hearing Aid Benefit (Employee Only)**

The Plan only pays a hearing aid benefit for enrolled Members (dependents are not eligible for this benefit). Covered Services must be performed by an audiologist or licensed physician. Covered Services include:

- A hearing test, including an audiogram for air and bone conduction, a discrimination test score and a speech reception score
- Hearing aid(s) (but not the cost of battery replacements)

The hearing aid benefit is up to a maximum benefit of $350 once every five years.

**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) non-health services that the Covered Person needs 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 medical 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, the Plan will pay the first $2,000 in covered medical expenses, once you have met any deductible under this Plan, 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 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 re-implantation of teeth (and related services); any orthodontic treatment; 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 pre-marital 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, this 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 Persons'

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 this Plan ends, except as stated in this SPD
- Which are not Medically Necessary and Appropriate
- Which 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 or the United States Pharmacopoeia Drug Information, or by a clinical study or review article in a major peer-reviewed professional journal
- Temporomandibular joint (TMJ) dysfunction 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

The Plan provides prescription drug benefits for you and your enrolled dependents 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 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 up to a: | The Prescription Drug Plan pays 100% after you pay a copay of: |
|---|---|
| ■ For Non-Preferred Brand Name Drugs | $30 |
| 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 Plan's PBM. These drugs require Prior 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 Plan's 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 Shop Rite, 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.

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## VISION BENEFIT

Vision benefits are provided under an insurance policy with Horizon. Horizon has partnered with Davis Vision program to make available an extensive network of optometrists and ophthalmologists, conveniently located in medical offices and shopping centers close to your home or work. When you use a participating Provider, your benefits are generally higher than if you receive vision care services from a non-participating Provider (see below). The frequency with which these benefits can be received is determined on a Calendar Year basis. Any questions regarding vision benefits should be directed to Davis Vision at (800) 278-7753.

| **For:** | **If you use a participating Provider, the Plan pays the following:** | **If you use a non-participating Provider, you will be reimbursed the following amounts:** |
|---|---|---|
| Annual eye examination (one every Calendar Year) | 100%<br>Includes dilation when professionally indicated<br><br>Does not include fees for contact lens evaluation and fitting; you will be responsible for these but will receive a 15% discount from participating Providers | Up to $40 |
| Eyeglass lenses<br>(one pair every Calendar Year)<br><br>Clear plastic lenses in any prescription below (see chart below for more information related to eyeglass lenses) | | |
| ■ Single vision | 100% | Up to $40 |
| ■ Bifocal lenses | 100% | Up to $60 |
| ■ Trifocal lenses | 100% | Up to $80 |
| ■ Lenticular lenses | 100% | Up to $100 |

| For: | If you use a participating Provider, the Plan pays the following: | If you use a non-participating Provider, you will be reimbursed the following amounts: |
|---|---|---|
| Frames<br>(one pair every Calendar Year) | $100 or $150 allowance; 20% savings on amounts over allowance<br><br>**Covered-in-Full Frames**: Any Fashion level frame from Davis Vision's Collection[4] (retail value, up to $100).<br><br>**OR, Frame Allowance**: $100 toward any frame from Provider plus 20% off any balance.[5] No copayment required.<br><br>**OR, Visionworks Frame Allowance**: $150 allowance plus 20% off any balance toward any frame from a Visionworks retail store.[6] No copayment required. | Up to $50 |
| Contact lenses if Medically Necessary (e.g., following cataract surgery) (one pair every Calendar Year) | Covered in full with prior approval. | Up to $225 |
| Contact lenses that are not Medically Necessary and in lieu of eyeglasses (one pair every Calendar Year) | **Contact Lens Allowance**: $100 allowance toward any contacts from participating Provider's supply plus 15% off any balance.[5] No copayment required. | Up to $80 |
| | **Contact Lens Exam Fitting and Evaluation**: 15% discount | Not covered |

[4] The Davis Vision Collection is available at most participating Provider locations. Collection is subject to change.
[5] Additional discounts not applicable at Walmart, Sam's Club or Costco locations. .
[6] Enhanced Allowance is available at Visionworks store locations nationwide.

| Additional Frames and Lenses Costs Not Covered by the Plan | Price You Will Pay at Participating Provider |
|---|---|
| Davis Vision Collection Frames: Fashion \| Designer \| Premier | $0 \| $15 \| $40 |
| Tinting of Plastic Lenses | $15 |
| Oversize Lenses | $0 |
| Scratch-Resistant Coating | $0 |
| Ultraviolet Coating | $15 |
| Anti-Reflective Coating: Standard \| Premium \| Ultra | $40 \| $55 \| $69 |
| Polycarbonate Lenses | $0[7]-$35 |
| High-Index Lenses | $60 |
| Progressive Lenses: Standard \| Premium \| Ultra | $65 \| $105 \| $140 |
| Polarized Lenses | $75 |
| Photochromic Lenses (i.e., Transitions®, etc.)[8] | $70 |
| Intermediate-Vision Lenses | $30 |
| Scratch Protection Plan: Single Vision \| Multifocal Lenses | $20 \| $40 |

The prices above are subject to change. For current prices, contact Davis Vision toll-free at (800) 278-7753.

If you obtain the above special frames, lenses or coatings from a non-participating Provider, you are responsible for 100% of the charges. If you choose to be reimbursed for contact lenses, you will not get reimbursed for new frames until 12 months have passed since you were reimbursed for your first pair of contact lenses.

**Please note:** Your Davis Vision Provider reserves the right to not dispense materials until the Covered Person has paid all applicable costs, fees and copayments. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees related to the evaluation and fitting allowance for contact lenses are the responsibility of the Covered Person. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. Your allowance may not be combined with other discounts or offers offered by your Provider.

**Finding a Participating Provider**
To find a Davis Vision Provider, you can go to http://www.davisvision.com and click on Find a Provider or call Davis Vision toll-free at (800) 278-7753. Once you've selected a Davis Vision Provider, call to make an appointment and identify yourself as a Davis Vision Covered Person. The benefits in the charts above apply if you use participating Providers.

[7] For Dependent Children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.

[8] Transitions® is a registered trademark of Transitions Optical Inc.

**Using a Non-Participating Provider**
If your provider is not part of the Davis Vision network, you pay the full cost for vision care services at the time you receive them. You must submit a claim for reimbursement within 12 months of the date of service.

**Is a Claim Form Needed?**

Claim forms are only required if you visit a non-participating Provider. Claim forms are available at davisvision.com. The following information will be needed to file your claim:

- An itemized receipt with the following information
  - the name, address and phone number of the non-participating Provider
  - date of service
  - a complete description of each service provided
  - amount paid for each service
- The group name
- Your name, address, phone number and Social Security number
- The patient's name and birth date (and phone number and address if they are different from yours)
- The patient's relationship to you

Keep a copy of your claim and receipts and mail the originals to:

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

**How Can I Contact Davis Vision's Member Services?**

Call 1.800.278.7753 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847).

**For Options Not Covered by the Plan**

If you use services or products not covered by the Plan – such as eyeglass frames that exceed the Plan allowance, sunglasses, oversized lenses or blended lenses – you must pay the additional cost. Generally, however, the difference you'll pay is based on Davis Vision's low, discounted member pricing. Your doctor can help you choose the best frame for you based on your coverage.

**Emergency Care**

Vision care to treat a medical condition due to Illness or Injury is not covered under the Plan. These services may be covered under the Medical and Hospital Benefit. For assistance with nonmedical emergencies – such as lost, stolen or broken glasses – contact the Vision Care Processing Unit directly at (800) 278-7753.

**Are There Other Exclusions under the Vision Plan?**

The Vision Plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; nonprescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; or two pairs of eyeglasses in lieu of bifocals.

**Vision Plan Insurance Policy Controls**

Information on the Vision benefit provided in this SPD is intended to provide a general overview of the Vision benefit and is not a contract. Only the insurance policy between the Fund and Horizon, which is incorporated into this SPD, can give actual terms, coverages, amounts, conditions and exclusions. The insurance policy is available for review at the Fund Office.

## DENTAL BENEFITS

Each Calendar Year you can receive a dental benefit of up to a maximum of $2,500 for each Covered Person.

If dental charges total more than $2,500, you will be advised of those charges before any treatment begins. In that case, you will be required to make that payment out of your own pocket.

You can use any dental Provider you choose. Keep in mind, however, that if you use a participating dental Provider, you will spend less out of your own pocket. By using participating dentists, you can minimize your out-of-pocket expenses since all participating dentists agree to limit their fees to the Plan's allowances for Covered Services.

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

**Using a Participating Dentist**

When you or your eligible dependents need dental treatment, call the Fund Office at 1-800-522-4161 (TTY: 711) to find a participating dental office close to your home or work, or check the Fund's website at http://www.1262funds.org to see which dental Providers participate in the Fund's network. Then, call the participating dentist and be sure to identify yourself as a Covered Person of the UFCW Local 1262 and Employers Health and Welfare Fund when you make your appointment. The dentist will verify your eligibility with the dental administrator.

If you use a participating dentist, there is nothing you need to do at the time of your visit. Your dentist will handle all of the claims processing for you and will file claims directly with Horizon Dental Services. Horizon will handle all the claims processing and administrative services, including paying your dental Provider directly for your covered dental benefits.

**Using a Non-Participating Dentist**

If you or a covered dependent chooses to use a dentist who does not participate in network established by the Fund, you will be responsible for paying the dentist at the time you receive service and submitting a claim under the Plan. You will be reimbursed based on the Plan's fee schedule. Keep in mind that this reimbursement may not cover the full cost of the dental services you receive. You must also pay an annual deductible of $15 for an individual or $30 for an entire family when using a non-participating dentist. The deductible applies to all covered services except preventive care as defined by applicable federal law.

**Pre-Treatment Review**

The Plan has a pre-treatment review provision that helps to improve the quality of your dental care. If your dentist estimates that the cost of your treatment will be $250 or more, your dentist must submit a claim for predetermination of benefits along with X-rays before treatment begins. Horizon Dental Services will review the proposed treatment and answer any questions about coverage and the proposed procedure before the work is completed. If your dentist recommends a course of treatment that is more extensive than usual in similar cases, Horizon may suggest alternative treatments. This review also lets you and the dentist know what is covered under the Plan and what your benefits will be. The Plan

encourages you to ask your dentist to use the pre-treatment review process to protect you against large out-of-pocket dental bills for treatment that is not covered.

**Alternative Treatment Benefits**

This feature governs the benefits available under the Plan. If as part of the pre-treatment review process Horizon determines that your dentist's recommended treatment is more expensive than deemed appropriate, the Plan will pay benefits based on the cost of the less-expensive, alternative treatment.

**Covered Dental Services**

Appendix A attached to this SPD provides the fee schedule for covered dental services, effective as of August 1, 2019. As the fee schedule may change from time to time, for an updated list of covered dental services, call the Fund Office at (800) 522-4161 (TTY: 711). Note that the Trustees reserve the right to change the fees in this schedule at any time.

**Orthodontic Treatment**

Covered Persons under age 23 are eligible for orthodontic treatment under the Plan. The maximum lifetime orthodontic benefit is $1,925 for each Covered Person. The maximum out-of-pocket amount a Covered Person will be responsible for is $800 for orthodontic services performed by participating Providers; this limit will not apply to orthodontic services performed by non-participating Providers.

Benefits for orthodontic treatment are paid in installments. The initial benefit payment is 25% of lifetime maximum (25% x $1,925) – or $481.25. The Plan then divides the balance of the lifetime maximum ($1,925 minus $481.25) – or $1,443.75 – by the number of months of treatment and pays this amount to you quarterly. For example, if treatment is to continue over 24 months, you would receive $180.48 each quarter over the 24-month period ($1,443.75/24 = $60.16 x 3 months per quarter).

**Maximum Benefits**

The Plan pays up to a maximum of $2,500 in dental benefits for each Covered Person each Calendar Year for all Covered Services except orthodontia. There is a separate individual lifetime maximum of $1,925 for orthodontic treatment. The Plan also has an individual maximum of $2,262 in any continuous three-year period for periodontal care.

**Extended Benefits**

If you begin treatment while coverage is in effect, but coverage ends before your dentist has completed treatment, your benefits will be extended for up to 90 days for:

- Bridges
- Crowns
- Dentures
- Orthodontics

- Root canal

The Plan considers treatment to have begun when:

- An impression is taken for dentures
- Orthodontic bands and wires are placed on the teeth
- Preparation of the tooth begins for crowns or bridgework
- Root canal therapy begins on the tooth

**Dental Expenses the Plan Does Not Cover**

In addition to the exclusions described under "Expenses The Medical Plan Does Not Cover," the Plan does not cover the following dental expenses:

- Anesthesia other than general anesthesia for one hour in the dentist's office
- Any claim submitted more than 12 months after the treatment date
- Any dental or orthodontic treatment that began prior to your coverage under the Plan
- Any services that are Experimental or not generally accepted by the dental profession
- Costs that exceed the Plan's fee schedule
- Duplication of dentures
- Examinations, diagnostic procedures or treatment by any method of jaw joint problems, including TMJ, TMJ pain syndromes, craniomandibular disorders and myofascial pain dysfunction or other conditions of the joint linking the jaw bone (mandible) and skull and the complex muscles, nerves and other tissues related to the joint
- Hospital visits or expenses
- Implants
- Instruction on dental hygiene and plaque control
- Orthodontic care for covered individuals older than age 23 (unless the Claims Administrator determines that the person has handicapping malocclusions)
- Replacement of a crown, inlay, onlay, bridge or full or partial denture that was installed less than five years earlier
- Restorations are limited to the replacement of lost teeth when due to decay, fracture, abrasion, attrition or erosion.

- Services furnished by or for the U.S. government or any government agency
- Services performed on teeth with a poor prognosis
- Services that are not necessary for treatment of a diagnosed condition, or are provided for purely cosmetic reasons
- Splinting of implants
- Surgical removal of bone tissue, tumors or cysts (which may be covered by your medical benefits)
- Tests and laboratory examinations
- Treatment of fractures

**Claiming Benefits**

Claim forms for dental care reimbursements with non-participating dentists are available by calling the Fund Office at (800) 522-4161 (TTY: 711). A claim for dental benefits must include your name, diagnosis, treatment and charge for each treatment. Dentists must indicate their federal tax identification or Social Security numbers on the invoice or claim form.

As the Claims Administrator, Horizon will not accept canceled checks, balance due statements or paid receipts in place of the actual bill or itemized statement as part of your claim for benefits. (See the Claims and Appeals Procedures section on page 12 for information on appealing a claim.) It is important that you complete the claim form as directed. Otherwise, the form will be returned to you, causing a delay in processing and reimbursement.

Horizon may require you to verify a claim for benefits under this Plan. The additional information that may be requested includes, but is not limited to, the following:

- A complete dental chart showing extractions, missing teeth, fillings, prostheses, periodontal mobility and pocket depths and the date of any previously performed work
- An itemized bill showing tooth numbers and quadrants
- X-rays taken before and after the work is performed, study models and laboratory reports
- An examination by a dentist chosen by the Claims Administrator

Send your claim form and bills to:

Horizon Blue Cross Blue Shield of New Jersey Dental Programs
P.O. Box 1311
Minneapolis, MN 55440-1311

## LEGAL SERVICES PLAN

The Legal Services Plan (LSP) provides Covered Persons and their enrolled eligible dependents with legal assistance in certain incidences. If you need legal assistance, you can call ARAG at (800) 247-4184 or visit its website at http://www.ARAGLegalCenter.com and type in access code 17997wf for detailed information on Plan benefits and how to use the LSP and FAQs. You can also:

- Talk to an ARAG Customer Care Counselor by calling the toll-free number (800) 247-4184 Monday through Friday from 7 a.m. to 7 p.m. Central Time

- Email an ARAG Customer Care Counselor at service@ARAGgroup.com

**How the LSP Works**

Under the LSP, you may choose to receive services from any attorney. However, in-office legal services benefits are paid differently depending on whether you see a network attorney (an attorney who is a member of the LSP) or a non-network attorney.

If you see a network attorney, the LSP pays attorney hourly fees in full for most covered legal matters. In addition, you do not need to file a claim for reimbursement – the network attorney does it for you. You can obtain a complete list of network attorneys for your state, the areas of law they practice, their phone numbers and the languages they speak by calling (800) 247-4184 or by visiting ARAG's website at http://www.ARAGLegalCenter.com (access code 17997wf).

If there is not a network attorney located within 30 miles of your home, ARAG guarantees that you will receive in-network benefits. ARAG will work with you to arrange for you to receive covered legal services through an attorney in your area.

If you receive services from a non-network attorney, you pay the cost of legal services and then file a claim form along with your attorney's billing statement to ARAG. You will be reimbursed for covered expenses up to the lesser of actual costs or a scheduled amount outlined in the corresponding tables. If you see a non-network attorney, you must notify ARAG within 60 days of the date you first consult with that attorney. In addition, your claim for reimbursement must be received by ARAG within 120 days after you incur a legal expense.

**Covered Services**

The LSP covers a range of personal legal services for you – and most of the same services for your enrolled spouse and any of your enrolled Dependent Children. Covered services include the following:

| Legal Services That Are Not Performed in an Attorney's Office | Plan Pays |
|---|---|
| **Learning Center**<br><br>An extensive online library of easy-to-understand legal articles, guidebooks and videos created to help you:<br><br>• Learn more about dealing with common legal and financial matters, such as estate planning, identity theft and consumer protection.<br><br>• Understand how the legal insurance plan works and the coverages, services and resources it provides. | Paid in full |
| **Do-It-Yourself Legal Documents**<br><br>You have online access to more than 350 state-specific documents authored and reviewed by attorneys for accuracy and state-specific compliance in all 50 states. | Paid in full |
| **Identity Theft Services**<br><br>Identity theft services help you protect your privacy, identity, reputation and your property. Services include:<br><br>• Legal advice and representation: you can work with an attorney in-person or via telephone for legal advice and representation. Most covered legal matters – including IRS audit protection, IRS collection defense and debt collection – are 100% paid in full when you work with a network attorney.<br><br>• Prevention and recovery tools: you have access to several online tools to help you prevent and recover from identity theft. These tools include an identity theft tracking sheet, personal information organizer, identity theft prevention and victim action guidebooks and more.<br><br>• Assisted identity restoration: identity theft case specialists are available to help you assess your situation and identify your objectives. They will assist you with tracking activities and progress until the conclusion of each case. | Paid in full |
| **Telephone Legal Services**<br><br>• Toll-free telephone advice on how the law relates to a Covered Person's personal legal matter and which actions may be taken<br><br>• Follow-up correspondence and telephone calls to third parties regarding a Covered Person's personal legal matter<br><br>• Specific document preparation and review<br><br>• A Covered Person will receive legal assistance from the Telephone Legal Access Law Firm for the preparation or review of a standard will or codicils. A "standard will" | Paid in full |

| Legal Services That Are Not Performed in an Attorney's Office | Plan Pays |
|---|---|
| means a will document without trust provisions other than a support trust for Dependent Children limited to appointing a guardian and placing assets for Dependent Children until they reach their age of majority. | |
| **Immigration Services**<br><br>You have access to network attorneys over the phone for:<br>• Legal advice and consultation on:<br>  ○ Immigration processes and guidelines<br>  ○ Filing and processing of applications or petitions<br>  ○ Laws and regulations governing various types of immigration benefits, including asylum, adjustment of status, business visas and employment authorizations<br>  ○ Deportation and removal proceedings<br>• Document review of any immigration forms<br>• Document preparation of affidavits and powers of attorney<br>• Preparation for immigration hearings | Paid in full |
| For additional immigration services, network attorneys provide a reduced rate of at least 25% off their normal rates for any representation-based immigration services. Network attorneys will bill the Covered Person directly. | At least a 25% reduced rate |
| **Reduced-Fee Network Attorneys**<br><br>• If your legal matter is not fully covered under the LSP terms and is not listed under "Exclusions" later in this LSP section, you may be eligible to work with a network attorney and pay a reduced fee that will be at least 25% off the attorney's normal hourly rate. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a network attorney prior to the effective date of your LSP coverage, the reduced fee benefit is not available. Payment of attorneys' fees is handled directly between you and the network attorney. Access to a reduced-fee network attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to a network attorney within legal practice areas.<br><br>• For matters that include a cap on the number of hours the LSP will pay a network attorney, and where your legal matter will exceed the cap set, the network attorney will bill you directly at reduced rates of at least 25% off the attorney's normal hourly rate. Payment of attorneys' fees is handled directly between you and the network attorney. | At least a 25% reduced rate |

| Legal Services That Are Not Performed in an Attorney's Office | Plan Pays |
|---|---|
| • For telephone advice, if your matter cannot be resolved over the phone and is not fully covered under the LSP terms and not excluded under "Exclusions" later in this LSP section, you may be eligible to receive at least 25% off the attorney's normal hourly rate. Payment of the attorneys' fees is handled directly between you and the network attorney. | |
| **Reduced Contingency Fees**<br><br>This service provides you access to a network attorney for a legal matter the network attorney deems to be appropriately handled through the use of a contingency fee. The network attorney will represent you under a contingency fee arrangement where the contingent fee will not exceed 25% of the net recovery if successfully resolved before or after trial or will not exceed 30% of the net recovery if successfully resolved on or after an appeal. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a network attorney prior to the effective date of your LSP coverage, the reduced contingency fee benefit is not available. | Reduced Rate |
| **Financial Education and Counseling Services**<br><br>• This service provides you toll-free telephonic access to financial counselors. Financial counselors are available to assist you with questions and guidance on a variety of financial planning matters or provide instructions on how to use the financial tools that ARAG offers, such as cash and debt management, budgeting, general financial planning information and guidance, federal tax information and education, retirement planning, Individual Retirement Accounts (IRAs) and investment planning.<br><br>• You can also access a financial planning website where you can manage a secure, easily updateable record of your progress toward goals (such as a down payment on a house, reduction of debt or college funding for a child). This website includes a comprehensive suite of financial modeling tools as well as an online reference library that can be used to create a personalized financial plan. You can always call or chat with a financial counselor for personalized guidance on implementation action items.<br><br>• Financial counselors will help you consolidate bill payments and negotiate with creditors to lower payments – in some cases reducing or eliminating interest and fees. Consolidating bills can help you repay your unsecured debt in three to five years. | Paid in full |

| In-Office Legal Services | Plan Pays When Using a Network Attorney | Plan Pays When Using a Non-Network Attorney |
|---|---|---|
| **Name Change**<br>For legal services for a Covered Person to legally change his or her name. | Paid in full | $240* |
| **Court Adoption**<br>Legal services in an uncontested or contested adoption for you to become an adoptive parent and/or for international adoptions, where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement in addition to the benefits available in the United States. | | |
| Uncontested | Paid in full | $400* |
| Contested | | |
| Advice, negotiations and office work prior to trial | Paid in full | $800* |
| Trial for three days or less | Paid in full | $1,800** |
| Trial starting on day four until completion | Paid in full | $100,000*** |
| **Consumer Protection**<br>Legal services for you as a defendant regarding written contracts or warranties relating to consumer goods or services (excluding residential contractor and insurance disputes). | | |
| Advice, negotiations and office work prior to trial | Paid in full | $800* |
| Trial for three days or less | Paid in full | $1,800** |
| Trial starting on day four until completion | Paid in full | $100,000*** |
| **Defense of Debt Collection**<br>Legal services for you as the defendant in a legal action related to consumer goods or services (excluding foreclosure, garnishment, mechanic's lien and student loan debt collection). | | |
| Advice, negotiations and office work prior to trial | Paid in full | $480* |
| Trial for three days or less | Paid in full | $1,800** |
| Trial starting on day four until completion | Paid in full | $100,000*** |

| In-Office Legal Services | Plan Pays When Using a Network Attorney | Plan Pays When Using a Non-Network Attorney |
|---|---|---|
| **Small Claims Court** | | |
| Legal services for a Covered Person to obtain advice and counseling to bring a claim in Small Claims Court (or similar court of limited civil jurisdiction). This does not include representation in court. | Paid in full | $320* (to bring claim) |
| Legal services to defend an action in Small Claims Court (or similar court of limited civil jurisdiction), including representation in court where allowed by law. | Paid in full | $400* (to defend claim) |
| **Bankruptcy** | | |
| Legal services for a Covered Person up to and including filing of a Chapter 7 bankruptcy final report or confirmation of a Chapter 13 bankruptcy. This does not include ongoing maintenance of a Chapter 13 repayment plan. | | |
| Chapter 7 | Paid in full | $880* |
| Chapter 7 post-discharge amendment/modification | Paid in full | $240* |
| Chapter 13 | Paid in full | $1,200* |
| Chapter 13 post-confirmation amendment/modification | Paid in full | $240* |
| **Protection from Domestic Violence** | | |
| • Legal services for a Covered Person to obtain a protective order related to domestic violence. | Paid in full | $320* |
| • Legal services for a Covered Person to obtain a protective order related to domestic violence when the opposing party is not an insured under the same certificate. | Paid in full | $320* |
| **Divorce** | | |
| Legal services for a Covered Person in an uncontested or contested divorce, legal separation and/or annulment of marriage. | | |
| Uncontested | Paid in full | $640* |
| Contested | Paid-in-full up to 20 hours per covered event | $1,600* |

| In-Office Legal Services | Plan Pays When Using a Network Attorney | Plan Pays When Using a Non-Network Attorney |
|---|---|---|
| **Child Custody, Child Support and Child Visitation Agreement**<br><br>Legal services for the creation of initial child custody, child support or child visitation agreements. This benefit does not include the modification of current agreements. | | |
| Uncontested | Paid in full | $320* |
| Contested | Paid in full up to 8 hours per covered event. | $640* |
| **Alimony, Child Support, Child Custody and Child Visitation Enforcement**<br><br>Legal services for a motion brought by you or against you to enforce a final decree for child support, child custody, child visitation or alimony. | | |
| Uncontested | Paid in full | $320* |
| Contested | Paid in full up to 8 hours per covered event. | $640* |
| **Alimony, Child Support, Child Custody and Child Visitation Modification**<br>Legal services for you for a motion brought by you or for you to modify a final decree for child support, child custody, child visitation or alimony. | | |
| Uncontested | Paid in full | $320* |
| Contested | Paid in full up to 8 hours per covered event. | $640* |
| **Foreclosure**<br>Legal services for you regarding written notice of foreclosure related to your primary residence. | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $480*<br>$1,800**<br>$100,000*** |
| **Document Preparation and Review**<br>Legal services for a Covered Person for the preparation and review of deeds, mortgages, promissory notes, affidavits, lease | Paid in full | $40 per document |

| In-Office Legal Services | Plan Pays When Using a Network Attorney | Plan Pays When Using a Non-Network Attorney |
|---|---|---|
| contracts, demand letters and installment contracts, bills of sale, HIPPA authorization forms and certifications of trust. | | |
| **Mechanic's Lien**<br>Legal services for you to remove a mechanic's lien | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $480*<br>$1,800**<br>$100,000*** |
| **Student Loan Debt Collection**<br>Legal services for you as the defendant in a legal dispute related to your student loan | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $480*<br>$1,800**<br>$100,000*** |
| **Purchase of Real Estate**<br>Legal services for a Covered Person for the purchase of your primary residence for the review and preparation of documents, including contract for purchase and attendance at closing. | Paid in full | $320* |
| **Sale of Real Estate**<br>Legal services for a Covered Person for the sale of your primary residence for the review and preparation of documents, including contract for purchase and attendance at closing. | Paid in full | $320* |
| **Refinancing – Primary Residence**<br>Advice and review of relevant documents for a Covered Person regarding refinancing of your primary residence. | Paid in full | $160* |
| **Tenant Matters**<br>Legal services for a Covered Person as a plaintiff or defendant with your landlord as a tenant of your primary residence, including but not limited to eviction and security deposit disputes. | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $320*<br>$1,800**<br>$100,000*** |

| In-Office Legal Services | Plan Pays When Using a Network Attorney | Plan Pays When Using a Non-Network Attorney |
|---|---|---|
| | | |
| **IRS Audit Protection**<br>Legal services for a Covered Person involving Internal Revenue Service (IRS) audit(s) related to your personal tax return where the initial written notice is received after the effective date of your LSP coverage and while your coverage is in effect. This does not include audits related to your failure to file a personal tax return or pay taxes owed as indicated on a personal tax return that was filed. | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $480*<br>$1,800**<br>$100,000*** |
| **IRS Collection Defense**<br>Legal services for a Covered Person in the defense against collection actions by the IRS related to errors on your personal tax return where the initial written notice is received after the effective date of your LSP coverage and while your coverage is in effect. This does not include collection actions related to your failure to file a personal tax return or pay taxes owed as indicated on a personal tax return that was filed. | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $480*<br>$1,800**<br>$100,000*** |
| **Social Security/Veterans/Medicare**<br>Legal services for a Covered Person in an administrative proceeding arising out of Social Security, Veterans, Medicare or Medicaid benefits. | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $400*<br>$1,800**<br>$100,000*** |
| **Wills and Durable Powers of Attorney**<br>Individual will or spousal will(s). Does not include any tax planning services done in connection with the will(s). | Paid in full | $320 single document; $400 spousal documents |

| In-Office Legal Services | Plan Pays When Using a Network Attorney | Plan Pays When Using a Non-Network Attorney |
|---|---|---|
| "Will" means a standard will that does not include trust provisions other than a support trust for dependent children that is limited to appointing a guardian and placing assets for dependent children until they reach the age of majority. | | |
| **Codicil – Amendment to a Will** | Paid in full | $40 single document; $80 spousal documents |
| **Living Will/Health Care Directive** | Paid in full | $40 single document; $80 spousal documents |
| **Power of Attorney/Financial Power of Attorney** | Paid in full | $40 single document; $80 spousal documents |
| **Juvenile Court Proceedings Involving an Enrolled Child**<br>Legal services for an enrolled child charged with a crime (except those involving traffic matters or felony charges) when the court proceedings are held in juvenile court. If the matter is removed from juvenile court, coverage under this benefit will cease as of the date of the removal. | | |
| Advice, negotiations and office work prior to trial | Paid in full | $480* |
| Trial for three days or less | Paid in full | $1,800** |
| Trial starting on day four until completion | Paid in full | $100,000*** |
| **Parental Responsibilities**<br>Legal services for a Covered Person in juvenile court proceedings (except those involving traffic matters) where a state has brought an action regarding your parental responsibilities for an enrolled child. | | |
| Advice, negotiations and office work prior to trial | Paid in full | $480* |
| Trial for three days or less | Paid in full | $1,800** |
| Trial starting on day four until completion | Paid in full | $100,000*** |
| **Criminal Misdemeanor Defense**<br>Legal services for a Covered Person in the defense against criminal misdemeanor charges, except those involving motorized vehicles and domestic violence charges. If a charge is | | |

| In-Office Legal Services | Plan Pays When Using a Network Attorney | Plan Pays When Using a Non-Network Attorney |
|---|---|---|
| escalated to a felony, coverage will cease as of the date of the escalation. If a felony charge is reduced or pled down to a misdemeanor, no coverage is available. | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $720*<br>$1,800**<br>$100,000*** |
| **Minor Traffic Offenses Excluding DWI-related**<br>Legal services for a Covered Person in the defense of a traffic offense where a conviction would not result in the suspension or revocation of your driving privileges. This does not include driving while impaired or under the influence of drugs or alcohol. | Paid in full | $240* |
| **Driving Privilege Protection**<br>Legal services for a Covered Person in the defense of a traffic offense where conviction of the offense will directly result in the suspension or revocation of the Covered Person's driving privileges. | | |
| Advice, negotiations and office work prior to trial<br>Trial for three days or less<br>Trial starting on day four until completion | Paid in full<br>Paid in full<br>Paid in full | $480*<br>$1,800**<br>$100,000*** |
| **Driving Privilege Restoration**<br>Legal services for you in an administrative proceeding for the restoration of your suspended or revoked driving privilege. This does not include driving while impaired or under the influence of drugs or alcohol or a related offense. | Paid in full | $240 |
| * Non-network attorney benefits are up to the stated amount<br>** Trial benefits are $300 per half day of trial time up to the stated amount<br>*** Trial benefits are $400 per half day of trial time up to the stated amount | | |

**What the LSP Does Not Cover**

The LSP does not cover the following:

- Matters against the Fund;
- Matters against the Trustees, the Administrator, or any Employee of the Fund Office;
- Matters against UFCW Local 1262 or any of its officers, directors, Employees or agents;
- Matters against a contributing employer;
- Matters against ARAG;
- Matters against any person covered by the Legal Services Plan except as expressly listed in this SPD;
- Legal services arising out of a business interest, investment interests, employment matters, your role as an officer or director of an organization, and patents or copyrights;
- Legal services in class actions, post-judgments, punitive damages, personal injury, malpractice, appeals, and small claims court or equivalent court in your state; or
- Legal services deemed by the Fund to be frivolous or lacking merit, or in actions in which you are the plaintiff and the amount we pay for your legal services exceeds the amount in dispute, or in our reasonable belief you are not actively and reasonably pursuing resolution of your case. However, this exclusion does not apply to the Small Claims Court benefit described above.

Also, benefits for telephone legal advice and consultation will not be provided for:

- Matters outside the jurisdiction of the United States of America.
- Matters that, in the opinion of the telephone legal access law firm, may not ethically or appropriately be handled over the telephone.
- Matters that require, in your and/or the telephone attorney's opinion, your personal presence in a firm's office or your direct and personal representation by another attorney.

**Pre-Existing Matters**

Any legal matter that occurs or is initiated prior to the date you are covered by the LSP will be considered excluded by the LSP and you will not be entitled to benefits for that matter. ARAG defines "initiated" as of the date on which written notice of a legal dispute is sent or filed by you or received by you, a ticket or citation is issued, or an attorney is hired.

As long as a matter is not specifically excluded, in-network assistance for a pre-existing legal matter is available via the telephone and 25 percent reduced fee benefit (so long as the network attorney was not retained prior to the effective date of your LSP coverage). Paid-in-full office visit or representation coverage is not available.

**Termination of Coverage**

If you stop working for a contributing employer, your LSP benefit ends on the last day of the month in which you leave employment. If a case or legal matter that was opened while you were employed has not been concluded when your benefit would otherwise end because your employment terminated, the LSP will continue benefits until the case or matter is concluded or the maximum benefit has been paid, whichever occurs first.

**Converting Coverage**

Once your LSP benefit ends, you may convert it to an individual legal services policy at your own cost. You must notify ARAG within 90 days of the date your coverage ends to make arrangements for the premium payment. If you have any questions regarding the ARAG conversion plan, please contact ARAG at (800)-247-4184.

**LSP Insurance Policy Controls**

Information on the LSP benefit provided in this SPD is intended to provide a general overview of the LSP benefit and is not a contract. Only the insurance policy between the Fund and ARAG, which is incorporated into this SPD, can give actual terms, coverages, amounts, conditions and exclusions. The insurance policy is available for review at the Fund Office.

**LSP Administrator**

If you have any questions or concerns, please contact the LSP administrator at ARAG, Attn: Appeals, 500 Grand Avenue, Suite 100, Des Moines, IA, 50309 or at 1-800-247-4184. You may also email ARAG at service@araglegal.com.

## LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS (EMPLOYEE ONLY)

**Life Insurance Plan**

Only Employees are entitled to life insurance benefits. As a full-time Employee, you have a life insurance benefit that depends on your age at the time of your death, as follows.

| If your death occurs: | Your death benefit is: |
|---|---|
| Before age 70 | $30,000 |
| After age 70 | $15,000 |

Benefits will be paid to your Beneficiary in a lump sum.

To name or change your Beneficiary, you must file a new application with the Fund Office. The change will become effective on the day you complete and submit the new application.

If you do not have a designated Beneficiary at the time of your death, or if your Beneficiary dies before you, your death benefit will be paid to your estate.

In case of your death, your authorized representative should contact the Fund Office by phone at (800) 522-4161 (TTY: 711). He or she will receive the necessary forms. The forms must be completed and returned to the Fund Office along with a certified death certificate within 90 days of your death.

**Termination of Coverage**

If you stop working for a contributing employer, your life insurance benefit ends on your last day of work. If you are absent from work due to a disability, your life insurance benefit will continue for up to 90 days.

**Converting Coverage**

Once your life insurance benefit ends, you can apply to convert it to an individual life insurance policy with terms based on the rules of the life insurance company. You must complete a conversion form within 31 days of the date your coverage ends or as specified by the life insurance company. You can obtain the conversion form by calling USAble Life at (800) 648-0271.

**AD&D Plan**

The full amount of your AD&D benefit is $30,000 ($15,000 if you have attained age 70). It will be paid to your named Beneficiary if you die as the result of and within 90 days of an accident. Payment will be made in a lump sum.

If you lose your sight or a limb, the following table shows the amount of your dismemberment plan benefit.

| If you have: | Your Dismemberment benefit is: | |
|---|---|---|
| | If you are under age 70 | If you are age 70 or over |
| Total, irrecoverable loss of sight in both eyes | $30,000 | $15,000 |
| Loss of both hands, severed at or above the wrist joints | $30,000 | $15,000 |
| Loss of both feet, severed at or above the ankle joints | $30,000 | $15,000 |
| Loss of one hand at or above the wrist joint and one foot at or above the ankle joint | $30,000 | $15,000 |
| Loss of one hand at or above the wrist joint, one foot at or above the ankle joint and sight in one eye | $30,000 | $15,000 |
| Total, irrecoverable loss of sight in one eye | $15,000 | $7,500 |
| Loss of one hand, severed at or above the wrist joint | $15,000 | $7,500 |
| Loss of one foot, severed at or above the ankle joint | $15,000 | $7,500 |
| Loss of thumb and index finger of the same hand | $7,500 | $3,750 |

If you suffer more than one loss in any one accident, payment will be made only for the loss providing the largest amount payable.

For additional benefits that may be available under the AD&D Plan, please see your Certificate of Insurance. For a copy of the Certificate of Insurance, please contact the Fund Office.

**Exclusions**

No AD&D benefits will be payable for any loss caused directly or indirectly by:

- Bodily or mental Illness or disease
- Hernia, regardless of how or when sustained
- Intentionally self-inflicted Injury, whether or not you are medically deemed insane
- Medical or surgical treatment of an Illness or disease
- Participation in the commission of a crime, whether or not you are convicted, or engaging in any illegal act, occupation or felonious act, aggravated assault or intentional tort
- Ptomaine or bacterial infections (except a septic wound caused by a violent, external and accidental occurrence)
- The process of diagnosing the Illness or disease
- Service in the U.S. military
- War or act of war, declared or undeclared

**Claiming Death and Dismemberment Insurance Benefits**

To file a claim for benefits, your Beneficiary (or you in case of dismemberment) must notify the Fund Office at (800) 522-4161 (TTY: 711). You should file a claim for benefits as soon as is reasonably possible. You or your Beneficiary will need to provide proof of the loss.

## RETIRED MEMBERS' BENEFITS

As a retired Member, you may still be eligible for benefits from the Fund. Your benefit eligibility as a retiree is different than eligibility for active Members. To be eligible for retiree benefits, a full-time Member must be at least 60 years old and have completed at least 10 years of credited Service as a full-time Member, with five years having occurred immediately prior to retirement.

Note: If you retired before January 1, 1994 and you were eligible for health benefits, you continue to have coverage under the prior plan. Complete information about the prior plan is distributed separately to those Members who retired before January 1, 1994. For a copy of that booklet, call the Fund Office at (800) 522-4161 (TTY: 711).

Note: If you retired after January 1, 1994 and you are eligible for retiree benefits, you are classified as a "Plan V" retiree and your medical benefits are described in the retiree supplement to this SPD. Complete information about retiree benefits is distributed separately to those Members who retired after January 1, 1994. For a copy of that booklet, call the Fund Office at (800) 522-4161 (TTY: 711).

**Eligibility**

A retired Member (retired on or after January 1, 1994) becomes eligible to participate in the Retired Members' Benefit Plan if the following eligibility criteria are satisfied:

- The retired Member has completed at least 10 years of credited Service as such term is defined under the Local 1262 and Employers Pension Plan;
- The retired Member has completed, at a minimum, 10 years of cumulative full-time service, of which five years occurred immediately prior to retirement;
- The retired Member has retired from active full-time employment on or after his or her 60th birthday and elected to either receive benefits (within 30 days following his or her retirement date) immediately as a covered retired Member or defer receipt of such benefits until attainment of his or her 65th birthday.

A retired Member's spouse becomes eligible to participate if the spouse was legally married to the retired Member throughout the one year prior ending on the date of the covered retired Member's date of retirement.

**Note: To continue to be eligible, the retired Member and/or his or her spouse shall be required to make contributions in accordance with the rules described in the "What You Pay for Coverage" section.**

**Eligibility Exclusions**

Retirees with less than 10 years of service are not eligible to participate in the Retired Members' Benefits Plan. Also, certain Members who are not covered by the "Major Food Industry" collective bargaining agreement and are employed by an independent contributing employer immediately prior to their retirement may not be covered by this Plan. If you work as a member for an independent contributing employer, review your specific collective bargaining agreement and contact the Fund office at (800) 522-4161 (TTY: 711) to determine your eligibility.

If you are under age 65 and meet the criteria to qualify for coverage but you do not elect retiree coverage on your retirement, you will not be eligible to enroll in retiree coverage until you attain age 65. If you are age 65 or older when you retire and you do not elect retiree coverage within 30 days of your retirement, you will not be eligible to enroll in retiree coverage at a later date.

**For Retirees Under Age 65**

Full-time Members under age 65 who are eligible for an early or normal pension from the UFCW Local 1262 and Employers Pension Plan (Pension Plan) and who retire on or after January 1, 1994, may elect to purchase either one of the following benefits:

- **Medical Plan A** – includes the EPO, Prescription Drug Plan, Dental Care Plan and Vision Care Plan

- **Medical Plan B** – includes the EPO and Prescription Drug Plan

If both you and your spouse are under age 65, you must elect the same option.

**For Retirees Age 65 and Over**

Full-time Members age 65 or older who are eligible for an early or normal pension from the Pension Plan and who retire on or after January 1, 1994 may elect to purchase one of the following benefits with Medicare providing primary coverage:

- Fund Medicare Supplement Plan for Post-65 Retirees and Spouses – group coverage provided through the Fund

- RightOpt Medicare Supplement Plan for Post-65 Retirees and Spouses – individual coverage provided through RightOpt. This option is available at any time, not just at retirement. You can elect coverage through RightOpt as of January 1 of any year following retirement by enrolling during the annual open enrollment period. **Note: If you elect to enroll in individual supplemental Medicare coverage through RightOpt, you will not have medical coverage under this Plan and will not be able to reenroll in group medical coverage with the Plan in the future.**

- COBRA coverage with respect to the following benefits: Medical Plan, Prescription Drug Plan, Dental Care Plan and Vision Care Plan, or

- May elect no coverage.

**Note:** If you do not qualify for Retired Members' Benefits, you may be eligible to elect COBRA continuation coverage (see page 31), depending on the date you became entitled to Medicare.

Retiree health coverage begins on the first day of the month coincident with or next following your retirement date.

If your active coverage ends before your retiree health coverage commences, you must continue your active coverage under COBRA to bridge any coverage gap.

Notwithstanding any election made prior to becoming a retired Member, you may make an irrevocable election for only the Prescription Drug Plan. To make this election, you must provide proof satisfactory to

the Plan Administrator that you have enrolled in a Medicare Supplemental Plan (whether or not the Medicare Supplemental Plan has prescription drug coverage).

**Spouses of Retirees**

Spouses of eligible retired Members are eligible for benefits based on the spouse's age. For example, if your spouse is under age 65 and you are over age 65, then your spouse receives under–age 65 benefits and you receive over–age 65 benefits.

Your spouse is eligible for coverage under the Retired Members' Benefits Plan only if you were legally married for at least one year prior to your retirement. In addition, your spouse may be eligible to continue coverage after your death only if he or she was covered by the Plan at the time of your death. If you die before your actual retirement, your spouse may be eligible to extend coverage only through COBRA continuation described on page 31.

**Retiree Legal Services**

If you retired and your former employer currently contributes to the LSP, you are eligible for the following services under the LSP, but only if these services are provided by a participating Provider:

- Consultation, advice and document preparation and review
- Administrative proceedings
- Preparation and probate of wills

**How the Retired Members' Benefits Plan Works**

You may choose to participate in the Retired Members' Benefits Plan with coverage for yourself and your eligible spouse. Premiums for benefits are determined each year by the Plan's Trustees.

**Medical Coverage**

Eligible retired Members and eligible spouses are entitled to coverage under the Medical Plan, provided that they elect to participate in the Retired Members' Benefits Plan and pay the appropriate premium.

The Medical Plan is described starting on page 55. At age 65, you become eligible for coverage under the Medicare Supplement Plan for Post-65 Retirees and Spouses. You will receive complete information on this benefit as you near age 65.

**Prescription Drug Coverage**

Eligible retired Members and eligible spouses are entitled to coverage under the Prescription Drug Plan, provided they elect to participate in the Retired Members' Benefits Plan and pay the appropriate premium. The Prescription Drug Plan is described starting on page 79.

**Dental Care Coverage**

Eligible retired Members under age 65 and their eligible spouses under age 65 are entitled to coverage under the Dental Care Plan if they elect to participate in the Retired Members' Benefits Plan and pay the

appropriate premium. The Dental Care Plan is described starting on page 89. At age 65, you are no longer eligible for dental care coverage.

**Vision Care Coverage**

Eligible retired Members under age 65 and eligible spouses under age 65 are entitled to coverage under the Vision Care Plan, provided they elect to participate in the Retired Members' Benefits Plan and pay the appropriate premiums for their ages. The Vision Care Plan is described starting on page 83. At age 65, you are no longer eligible for vision care coverage.

**Life Insurance/Dismemberment Insurance**

Retired Members are not eligible to participate in the Life Insurance Plan or the Dismemberment Insurance Plan. However, you are entitled to convert your life insurance policy when you retire. The conversion features of the Life Insurance Plan are described in that section. There is no conversion available for the Dismemberment Insurance Plan.

**Claiming Benefits**

Claiming benefits under the Medical, Prescription and Vision Care Plans for eligible retired Members and their eligible spouses is the same as for active Members. However, Dental Plan claims are processed by the Fund Office.

For the necessary claim forms, call the Fund Office at (800) 522-4161 (TTY: 711).

**When You Can Elect Coverage**

Continuing coverage in the Retired Members' Benefits Plan following retirement is neither mandatory nor automatic. However, there will only be two opportunities for you or your spouse to elect to participate in the Plan: at the time you retire or when you reach age 65.

Prior to becoming a retired Member, you may:

- Elect coverage for yourself and your spouse, if he or she meets the eligibility requirements
- Elect coverage for yourself and decline coverage for your spouse
- Both decline coverage

When you retire, you and your spouse may also be eligible to continue coverage under the provisions of COBRA (see page 31).

If you decline coverage for your spouse, the only other opportunity for your spouse to reenter the Plan is if your spouse has an event that qualifies for the "Special Enrollment Rights."

If you decline coverage at retirement and decide to reenter the Plan at age 65, you must contact the Fund Office in writing at least 30 days before and no later than 30 days following your 65th birthday or the special enrollment event. If you do not enroll within 30 days following your 65th birthday, you will not be eligible for coverage under the Plan.

**What You Pay for Coverage**

From retirement until you reach age 65, you pay a premium for your benefits, which is set each year by the Plan's Trustees. Your premium is equal to 110% of the projected COBRA rates for active Members. At age 65, you can continue to be covered by the Plan for supplemental medical and prescription drug benefits (dental and vision coverage stops at age 65) if you pay a premium rate (based on the projected per capita cost of retiree coverage, plus administrative costs) as determined each year by the Plan's Trustees. If your spouse is also eligible for benefits, you pay the premium applicable for your spouse's age.

The Plan's Trustees determine the premium each year based on the historical cost of the benefits, the anticipated cost for the new period and the administrative expense. The premium rates are usually adjusted annually on January 1.

Subject to approval of the collective bargaining parties, the Trustees may increase the retired Members' contribution beyond the specified rates and/or reduce benefits to deal with adverse economic conditions as they, in their sole discretion, may deem necessary.

If your medical benefits may be paid by any other plan, please see the Coordination of Benefits Section below.

**Coordination of Benefits**

For retired Members, the guidelines used to determine which plan pays your medical benefits first include:

- The plan that covers the person as an active participant will pay benefits before a plan that covers the person as a retired participant.

- The plan that covers the person as a dependent of an active participant will pay benefits before a plan that covers the person as a retired participant.

- The plan that covers the patient as a retired participant will pay benefits before the plan that covers the patient as a dependent of a retired participant.

**If You Need Information**

You should call the Fund Office at (800) 522-4161 (TTY: 711) for information on eligibility, filing claims for benefits, questions about Supplemental Medicare coverage and/or questions about the claims administrator.

## 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 or reimburse Covered Services received while you or your dependents are 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 his or her 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. "Full-Time Employee" means an Employee who is employed on a full-time basis as defined in a collective bargaining agreement between an employer and UFCW Local 1262 or a participation agreement with the Fund. "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.

**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.

- 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 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 full-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 which:

- 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; a Hospice, substance use 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 and covered spouses only. Pregnancy coverage is not provided for Dependent Children.

**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 the service, treatment, supply or confinement is Medically Necessary. 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.

**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.

**Plan** – The plan of benefits described in this SPD.

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

**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; and

- 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, 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-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.

**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.

**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 person's medical Practitioner.

**Therapy Services** – Except as expressly excluded in the Plan, 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 (1) seriously jeopardize a Covered Person's life or health or the Covered Person's ability to regain maximum function, or (2) in the opinion of a doctor with knowledge of the Covered Person's medical condition, subject the Covered Person 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.