UFCW UNIONS
AND EMPLOYERS
HEALTH AND WELFARE PLAN
OF CENTRAL OHIO

Summary Plan Description
2018 Edition

UFCW UNIONS AND EMPLOYERS
HEALTH AND WELFARE PLAN
OF CENTRAL OHIO

TO ALL PLAN PARTICIPANTS:

The Board of Trustees is pleased to present you with this Booklet describing the UFCW Unions and Employers Health and Welfare Plan of Central Ohio (the "Plan"). This is your Summary Plan Description (or "SPD") for the Plan. Please read your SPD carefully so that you understand the coverage the Plan provides to you and your eligible Dependents. Please remember that this SPD is not complete unless it includes a Summary of Benefits insert. You must use this Booklet with your Summary of Benefits insert for an explanation of your coverage under the Plan. Also, if you are eligible for the Plan's Vision Expense and Dental Expense Benefits, your SPD should contain inserts describing these benefits.

The Plan offers a variety of benefits. Comprehensive Medical Expense Benefits under the Plan are paid from Plan assets and generally administered by the Plan Office. The Plan self-funds other benefits as well, such as the Plan's Accident and Sickness Weekly Benefit, Vision Expense Benefit and Dental Expense Benefit. In an effort to provide cost-effective benefits, the Plan may contract with other organizations to obtain access to certain network providers. The choice to use a network provider is entirely voluntary and the Plan makes no representation regarding the quality of services provided by any provider. The Plan is not responsible for care rendered by the provider. You should always review this SPD, including the Summary of Benefits insert, and, if applicable, the Vision Benefits Summary and Dental Expense Benefits inserts to determine whether and to what extent the Plan may cover a particular provider or service.

In addition, the Plan provides some benefits through insurance policies. Specifically, the Plan provides the Life Insurance Benefit and Accidental Death and Dismemberment Benefit to certain members under insured arrangements with insurance companies retained by the Board of Trustees.

The Plan coverage available to you is based on the class of benefits for which you are eligible. You should review your Summary of Benefits insert (and, if applicable, your Dental Expense Benefits and Vision Benefits Summary inserts) carefully to determine your eligibility for Plan benefits. Also, the Plan's general eligibility rules are described under the "Eligibility Rules" section of this SPD. This SPD describes the benefits for active employees and how active employees can qualify for benefits. A separate booklet describes the benefits and qualification rules for Retirees under the Plan.

Certain words in this SPD have specific definitions which can be found either in the "Definitions" section or in the same section in which the word is used.

If you have any questions concerning your eligibility to receive Plan benefits or anything else related to the Plan, feel free to call or visit the Plan Office.

Sincerely,

BOARD OF TRUSTEES

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ELIGIBILITY RULES – WHEN PLAN COVERAGE BEGINS

The Plan provides different benefits for Plan participants depending on employment status and benefit classification. Please review your Summary of Benefits insert (and, if applicable, your Vision Benefits Summary and Dental Expense Benefits inserts) carefully to determine your eligibility for Plan coverage, **including whether you are eligible for Dependent coverage under the Plan.**

IMPORTANT Please keep in mind that the Plan has enrollment and employee contribution requirements that currently apply to all Employees eligible to participate in the Plan.

A. Initial Eligibility for You

Subject to the Plan's enrollment and employee contribution requirements described below, you become eligible for the Plan's Comprehensive Medical Expense Benefits on the first day of the month in which your Employer is required to contribute to the Plan on your behalf in accordance with the terms of the collective bargaining agreement under which you are covered.

If you are eligible for the Plan's Accident and Sickness Weekly Benefits, Life Insurance, Accidental Death and Dismemberment Benefits and/or Vision Expense and Dental Expense Benefits, coverage for these Plan benefits will become effective in accordance with the terms of the collective bargaining agreement under which you are covered.

B. Initial Eligibility For Your Dependents

Subject to the Plan's enrollment and employee contribution requirements described below, if you are eligible for Dependent coverage under the Plan, your Dependents will generally become eligible for benefits on the same date your Plan coverage begins.

If you acquire a Dependent after you become eligible for Dependent coverage under the Plan, and you properly and timely enroll your Dependent and make the required employee contributions (if applicable), your Dependent will become eligible either: (1) on the date of your marriage; or (2) on the date of birth, adoption or placement for adoption in the case of Dependent children.

"Dependent" means only your:

1. Legally married spouse, including a spouse arising out of a common law marriage recognized in your state of residence, if eligible to be covered under the Plan in accordance with the terms of your collective bargaining agreement;

2. Natural or adopted child or "a child placed for adoption" who is under age 26. A "child placed for adoption" means your assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child; and

3. Unmarried child residing in your household or an unmarried child who resides with you and for whom you are legally responsible for payment of medical expenses pursuant to a court order, and who is: (a) under age 19; or (b) under age 23 if he or she is a full-time student at a high school or accredited college/university and depends on you for financial support.

IMPORTANT If your step-child is between the ages of 19 and 23, you must provide the Plan Office with satisfactory proof of such child's full-time student status each quarter/semester.

In addition, if you have an unmarried Dependent child who is incapable of self-support because of a developmental disability or physical handicap, that child may be eligible to continue Plan coverage for Comprehensive Medical Expense Benefits regardless of age. To be eligible for this coverage, your Dependent child must have become incapable of self-support prior to attaining the Plan's age limitations described above and such child must have been covered under the Plan immediately prior to attaining the age limit. In addition, you must furnish satisfactory proof to the Plan Office of your child's handicap within 31 days of the date your child's Plan coverage would normally have ended. The Trustees have the right to have your child periodically examined by a Doctor of their choice to determine incapacity.

"Dependent" does not include any person who is in full-time military, naval or air service.

The Plan also covers children named in a valid Qualified Medical Child Support Order ("QMCSO"). A QMCSO is a judgment, decree or order issued by a court or state agency that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute.

A QMCSO requires the Plan to cover an alternate recipient who might not otherwise be eligible for coverage. This Plan provides benefits according to, and to the extent required by the QMCSO and by Federal law. The Plan Office will notify affected participants and alternate recipients if a QMCSO is received. If you require more information regarding the procedure to follow to obtain coverage for an alternate recipient, please contact the Plan Office.

Please remember to refer to your Summary of Benefits insert (and, if applicable, your Vision Benefits Summary and Dental Expense Benefits inserts) to determine if you are eligible for Dependent coverage under the Plan. Some benefit programs under the Plan provide coverage for you only and other benefit programs provide coverage for you and your Dependents.

Special Eligibility Rule for Spouse

If your Dependent spouse is eligible for medical care or treatment provided by a health maintenance type of organization ("HMO") and does not utilize the services, facilities or providers covered by such an organization, your spouse will only be eligible for benefits from this Plan on a secondary basis. In the event the Plan cannot determine the benefits that would have been payable under the HMO if your spouse had utilized the services, facility or provider covered by such an organization, the Plan will assume the HMO pays benefits on the same basis as this Plan.

C. Enrollment and Employee Contribution Requirements

IMPORTANT This section describes the Plan's enrollment and employee contribution requirements. Currently, the Plan's enrollment and employee contribution requirements apply to all Employees eligible to participate in the Plan.

If you are eligible for Plan coverage, you must properly and timely enroll for Plan coverage and make the required employee contributions in order for Plan coverage to become effective for you and your eligible Dependents.

However, a special rule exists for the Plan's Accident and Sickness Weekly Benefits and Life Insurance and Accidental Death and Dismemberment Benefits. **If** you are eligible for the Plan's Accident and Sickness Weekly Benefits and Life Insurance and Accidental Death and Dismemberment Benefits, but decide not to enroll for Plan coverage, you will remain eligible for these Plan benefits. Please check your Summary of Benefits insert for eligibility information.

The Plan's employee contribution and enrollment requirements are described in greater detail on the next page.

Special Payment Rule for Spouses

A special payment rule for spouses applies to some Employees participating in the Plan. **To determine if the Plan's special payment rule for spouses applies to you and, if applicable, the amount of the additional monthly employee contribution, please refer to your collective bargaining agreement.**

If the Plan's special payment rule for spouses applies to you, and your spouse is enrolled in and covered under the Plan and your spouse is also eligible for health coverage through his or her employer (other than the same employer as you), an additional monthly employee contribution to the Plan will be required if your spouse does not enroll in his or her employer's plan. This additional employee contribution will remain in effect until your spouse enrolls in the available employer plan. To minimize any additional employee contributions, your spouse should enroll in his or her employer's plan as soon as possible.

1. Newly Eligible Employees. When you first become eligible for Plan benefits, you will have a 45-day period to submit an approved enrollment form to the Plan Office. Once your enrollment form has been received and approved, you will be required to make employee contributions for your Plan coverage back to your initial date of eligibility. The amount of the required employee contribution will depend on the Plan coverage you elect on your enrollment form.

If you do not submit the required enrollment form within this 45-day period, you and your eligible Dependents will not be able to enroll for Plan coverage again until the next annual open enrollment period or if earlier, after experiencing a special enrollment event as described below.

2. Non-Newly Eligible Employees. If you are currently enrolled for coverage under the Plan and making the required employee contributions, you will next have the opportunity to modify your Plan coverage during the Plan's annual open enrollment period or, if earlier, after

experiencing a special enrollment event. **To maintain Plan coverage, you must re-enroll yourself and your eligible Dependents during each annual open enrollment period.**

If you are eligible for Plan coverage but you decided not to enroll in the Plan, you and your eligible Dependents will not be able to enroll for Plan coverage until the next annual open enrollment period or, if earlier, after experiencing a special enrollment event. You will be required to make employee contributions for your Plan coverage, and the amount of the employee contributions will depend on the type of coverage you elect on your enrollment form.

3. Annual Open Enrollment Period. The Plan's "annual open enrollment period" is during the fall of every year, and coverage is effective on the first day of the following year. For example, if Plan coverage is properly elected during the Plan's Fall 2017 open enrollment period, such coverage will be effective as of January 1, 2018. The Plan Office will notify you in advance of the Plan's annual open enrollment period.

4. Special Enrollment Events. Under the Plan's enrollment and employee contribution rules, you are generally only allowed to elect Plan coverage when you are first eligible or during an annual open enrollment period. Once you are enrolled for Plan coverage, you are generally only allowed to change your enrollment status during the Plan's annual open enrollment period. However, you may enroll for Plan coverage or change your enrollment status outside of your initial enrollment period or the Plan's annual open enrollment period if you experience a situation described below.

(a) Persons Who Lose Other Coverage. If you are eligible for benefits but did not enroll yourself and/or your eligible Dependent spouse and/or child(ren) for coverage when you were first eligible to do so or at the following Open Enrollment, you will be allowed to enroll yourself and/or your Dependent spouse and/or child(ren) for coverage **if *all* of the following four conditions are met:**

- You were and/or the eligible Dependent spouse and/or child(ren) were covered under a different group health plan or health insurance coverage at the time coverage previously was offered;

- Your and/or the Dependent spouse's and/or child(ren)'s coverage ended because of (a) loss of eligibility (including legal separation, divorce, death, termination of employment, reduction in the number of hours of employment), (b) termination of the employer's contribution toward such other coverage, (c) exhaustion of coverage under COBRA, (d) denial of a claim due to operation of a lifetime or annual limit, or (e) if coverage was provided by an HMO, you are no longer residing, living or working in the service area of the HMO and the HMO does not provide coverage for that reason;

- You request enrollment in this Health and Welfare Plan for yourself and/or your Dependents **no later than 60 days** after the

date other coverage was lost for one of the reasons listed above; and

- You authorize the necessary weekly self-payment deduction to provide coverage for yourself and/or your Dependents at the time enrollment is requested.

(b) Acquisition of Eligible Dependent You and/or your eligible Dependent spouse and/or child(ren) may enroll under the Plan following the acquisition of a new Dependent **if *all* of the following four conditions are met:**

- You and/or your Dependent spouse and/or child(ren) are eligible for coverage under this Plan;

- A spouse and/or child(ren) becomes your Dependent through marriage, birth, adoption, or placement for adoption;

- You request enrollment for yourself and/or your Dependent spouse and/or child(ren) newly acquired through the marriage, birth, adoption or placement for adoption or other court order **within 60 days** of the event; and

- You authorize the necessary self-payment deduction to provide coverage for yourself and/or your Dependent(s) at the time enrollment is requested.

(c) Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program (SCHIP) (*e.g.*, Ohio Health Start) If you did not enroll yourself, and/or your Dependent spouse and/or child(ren) for coverage under this Plan when you were first eligible to do so, you will be allowed to enroll yourself and/or your Dependent spouse and/or child(ren) for coverage **if *all* of the following four conditions are met:**

- You and/or your Dependent spouse and/or child(ren) are currently eligible for coverage under the Plan;

- You and/or your Dependent spouse and/or child(ren) were covered under Medicaid or SCHIP;

- You and/or your Dependent spouse and/or child(ren) loses eligibility under Medicaid or SCHIP; and

- You request enrollment for yourself and/or your Dependent spouse and/or child(ren) within 60 days of the date Medicaid or SCHIP coverage terminates.

(d) Eligibility for Financial Assistance Under Medicaid or SCHIP (*e.g.*, Ohio Health Start) If you did not enroll yourself or your eligible Dependent children for

coverage under this Plan when you were first eligible to do so, you will be allowed to enroll yourself and/or your Dependent spouse and/or children for coverage **if *all* of the following three conditions are met:**

- You and/or your Dependent spouse and/or child(ren) are eligible for coverage under the Plan;
- You and/or your Dependent spouse and/or child(ren) become eligible for financial assistance through Medicaid or SCHIP, for example through a premium assistance subsidy, for coverage under the Plan; and
- You request enrollment for yourself and/or your Dependent(s) within 60 days of the date you or your dependent becomes eligible for the financial assistance.

(e) Effective Date of Coverage Provided the necessary self-payment is authorized, the effective date of coverage will be:

- For you and your Dependent spouse and/or child(ren) acquired through marriage – the date of marriage;
- For birth – date of birth;
- For adoption or placement for adoption – date of adoption or placement for adoption;
- For loss of coverage – date of loss of coverage; or
- For loss of coverage or financial assistance under Medicaid or SCHIP-no later than the first day of the first calendar month beginning after receipt of completed request for enrollment.

Please contact the Plan Office if you have questions about the special enrollment events or if you experience a special enrollment period.

D. Disenrollment

You may disenroll yourself or your Dependent during a calendar year only if either you or your Dependent becomes eligible for coverage under another plan, including Medicare, or your Dependent loses dependent status under the Plan. To disenroll yourself and/or your Dependent, you must submit a written request for disenrollment within 60 days of the event and timely complete any necessary forms required by the Plan. Coverage for a Dependent who loses Dependent status under the Plan will terminate in accordance with the Plan and the corresponding employee payment, if applicable, will be reduced on the first of the month following the Dependent's loss of Dependent status. Disenrollment due to becoming eligible under another plan will be effective on the first of the month following receipt of the written request.

E. Dual Coverage

You may be covered under the Plan as both an Employee and Dependent. Also, if you and your spouse are both covered under the Plan as Employees and both have Dependent coverage, your Dependents may be covered under both your coverage and your spouse's coverage. If you (or your Dependent) have dual coverage, you should review the Plan's Coordination of Benefit rules described in this booklet. Plan benefits will be payable in accordance with these rules. Please keep in mind that in no event will the total amount of Plan benefits paid exceed the amount of the expense actually incurred for which Plan benefits are payable.

F. Continued Eligibility

You and your Dependents will remain eligible for Plan benefits as long as the Plan receives the required contributions made in accordance with a collective bargaining agreement and you make the required employee contributions and properly complete all the forms required by the Plan to be eligible for benefits in a timely manner.

Please keep in mind that no Plan benefits will be paid for expenses incurred by you and/or your Dependents in any month for which your Employer does not make a required contribution to the Plan on your behalf or for which you do not make a required employee contribution.

ELIGIBILITY RULES – WHEN PLAN COVERAGE ENDS

The Plan has rules that will determine when coverage for you and/or your Dependents ends. The following paragraphs describe when Plan coverage ends for you and/or your Dependents. Please contact the Plan Office if you have any questions regarding eligibility.

A. Termination of Employee Eligibility

Your eligibility for Plan benefits will terminate if any of the following events occur:

1. On the last day of the month in which your employment with an Employer terminates;

2. If you are still employed by an Employer but fail to qualify for Plan contributions in accordance with the provisions of the collective bargaining agreement, the last day of the month in which your Employer is required to contribute to the Plan on your behalf;

3. If you are employed by an Employer that becomes delinquent in its contributions to the Plan, the last day of the month in which contributions are made to the Plan on your behalf, unless you make the necessary self-payments to continue your Plan eligibility;

4. If you are employed by an Employer whose participation under this Plan terminates, the last day of the month in which your Employer is required to contribute to the Plan on your behalf;

5. The date the Plan terminates;

6. The date your enrollment for Plan coverage expires (if applicable); or

7. The last day of the month for which the Plan receives your required employee contribution (if applicable).

Also, you may be eligible to continue Plan coverage in certain circumstances, as described below under the "Continued Plan Coverage" section.

B. Termination of Dependent Eligibility

Your Dependent's eligibility for Plan benefits will terminate if any of the following events occur:

1. The date your eligibility for Plan benefits ends;

2. The last day of the month your Dependent ceases to satisfy the Plan's definition of "Dependent," for example, your natural child attains age 26 or your 22 year old step-child is no longer a full-time student;

3. The last day of the month in which you are eligible for Dependent coverage under the Plan;

4. The date your enrollment for Dependent coverage under the Plan terminates (if applicable); or

5. The last day of the month for which the Plan receives the required employee contribution (if applicable).

Your Dependents may be eligible to continue Plan coverage in certain circumstances as described below under the "Continued Plan Coverage" section provided you notify the Plan Office within 60 days of termination of the Dependent's coverage.

It is important that you notify the Plan Office as soon as possible but not more than 60 days after you become divorced or your Dependent child no longer satisfies the Plan's definition of "Dependent."

C. Special Termination Rule for Military Service

If you enter uniformed service as defined by the Uniformed Services Employment and Reemployment Rights Act, as amended ("USERRA"), benefits under the Plan will continue as usual if the service is for a period of less than 31 days. If the uniformed service is for a period of greater than 30 days, all Plan benefits will terminate as of the date you commenced uniformed service, unless your Plan eligibility terminates sooner in accordance with the termination rules described above.

You may continue coverage for yourself and your eligible Dependents in accordance with the Plan's COBRA provisions and the provisions of USERRA for a maximum coverage period of 24 months if you enter uniformed service. You and your eligible Dependents will receive the more beneficial protections between the Plan's COBRA rules and the USERRA provisions. When you are discharged from uniformed service, you will become eligible for Plan benefits on the first day you return to active employment with an Employer, provided you return to work within the time as prescribed by law for reemployment rights.

The Plan’s COBRA provisions are located on pages 52 through 56 of this booklet.

Please contact the Plan Office when you return from uniformed service, and the Plan Office will advise you of any applicable enrollment and employee contribution requirements.

D. Continued Plan Coverage

If you and/or your Dependent would lose coverage under the Plan (for example because your employment with your Employer ends), you and/or your Dependent may be able to continue coverage under certain circumstances. The following paragraphs describe these circumstances. Please contact the Plan Office for more information.

1. Retiree Health Coverage. The Plan provides coverage for retirees under certain circumstances. The Plan's eligibility rules and benefits for retirees are described in another

booklet. If you are approaching retirement, please contact the Plan Office for additional information on the Plan's program for retirees.

2. Employer's Failure to Contribute. If you lose Plan coverage because of your Employer's failure to make required contributions to the Plan on your behalf and you do not terminate employment, you will be eligible to continue Plan coverage by making self-payments for a period not to exceed three consecutive months from the last month for which your Employer contributed to the Plan on your behalf. The continued Plan coverage is the same coverage you previously had, except it does **not** include Accident and Sickness Weekly Benefits and Life Insurance and Accidental Death and Dismemberment Benefits.

If you are laid-off during this three month period, you may make self-payments under the Plan's COBRA Continuation Coverage rules described in this booklet.

3. Disability Extension of Benefits. If you or your Dependent are Disabled on the date eligibility under the Plan ends, you (or your Dependent) may remain eligible for Comprehensive Medical Expense Benefits under the Plan for Covered Expenses incurred on account of the sickness or injury causing the Disability even if the Disabled individual is eligible for coverage under Medicare, another group insurance policy or any medical benefit for service plans written on a group basis plan at the time the individual becomes Disabled. If you believe you may be eligible for this extension, please contact the Plan Office for the necessary documentation as soon as you become Disabled.

This Plan coverage will remain in effect until the earliest of the following:

- You (or your Dependent) cease to be Disabled;
- You (or your Dependent) become eligible for coverage under Medicare or another group insurance policy or any medical benefit or service plan written on a group basis;
- The end of the period of twelve consecutive months following the date your (or your Dependent's) coverage under the Plan would have ended but for this extension;
- In the event the Comprehensive Medical Expense Benefits provision under the Plan is terminated, the end of the period of 90 days following the date of such termination; or
- The date the Plan is terminated.

This extension of Comprehensive Medical Expense Benefits provision is only applicable if you (or your Dependent) reject your right to continue coverage under the COBRA Continuation Coverage provisions of this booklet.

4. COBRA Continuation Coverage. The Plan's rules for COBRA Continuation Coverage are explained in detail under the "Continuation of Coverage (COBRA)" section of this SPD.

E. Family And Medical Leave Act ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") enables you, if you qualify, to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child or to care for your seriously ill spouse, parent or child. The Family and Medical Leave Act requires certain Employers to maintain health care coverage during the leave period. If you qualify and take an FMLA leave, your Plan benefits are protected. If you think this law may apply to you, please contact your Employer and/or your Union Representative.

DEFINITIONS

Certain words or phrases used in this booklet have specific meanings. Definitions for these words or phrases are set forth below, or are in the section of this booklet where the word or phrase is used.

ACA means the Patient Protection and Affordable Care Act, as amended from time to time and available guidance.

Disability or **Disabled** means the inability of an Employee because of injury or sickness to engage in **any** occupation for wages or profit for which the Employee is reasonably qualified by education, training or experience and the inability of a Dependent because of injury or sickness to perform all normal activities of a person in good health of the same age and sex.

Doctor means a person who is licensed to practice medicine and surgery as a Doctor of Medicine or as a Doctor of Osteopathy. While acting within the scope of his or her practice and to the extent that benefits are provided, Doctor also includes a person licensed to practice as a dentist, a podiatrist, a chiropractor, an optometrist or a psychologist. Doctor does not include the Employee, his or her Dependents or any person who is the spouse, parent, child, brother or sister of the Employee or the Employee's Dependents, unless the services provided by such Doctor are determined to be medically necessary by the Trustees or their designee. To the extent required under ACA, Doctor also means any person who performs services covered by the Plan if such provider is licensed to perform such services and such services are performed within the scope of such license under applicable state law.

Employee means (a) a person for whom payments are required to be made to the Plan by an Employer in accordance with a collective bargaining agreement or other written agreement with the Union or the Trustees, or (b) a person who is making self-payments to the Plan on his or her own behalf to maintain Plan coverage.

Employer means an employer who qualifies as an "Employer" under the Plan's Trust Agreement.

Expense Incurred or **UCR** means the maximum limits or allowances as established by the Board of Trustees. Any agreement as to fees or charges made between an Employee and/or a Dependent and the Doctor, Hospital or Provider does not bind the Plan in determining its liability with respect to Expense Incurred. Expense Incurred is deemed to be incurred on the date on which the service or supply which gives rise to the expense or charge is rendered or obtained. The Expense Incurred is determined as follows:

- **PPO Provider:** The Expense Incurred for services provided by a PPO Provider is the allowance established in the agreement between the preferred provider organization and the Plan, as amended from time to time.

- **Non-PPO Provider:** The Expense Incurred for services provided by a Non-PPO Provider is determined in accordance with the PPO organization's usual, customary and reasonable calculation when available and 130% of the Medicare allowable expense in all other cases, provided, however, the UCR for charges for services rendered by a Certified Registered Nurse First Assistant ("CRNFA") are limited to 16% of the UCR for the surgeon's fees for the same procedure.

No payment will be made for any benefits in excess of the Expense Incurred for any service or supply.

The Expense Incurred does not include, and no payment will be made for, charges which you are not legally obligated and required to pay to a PPO Provider or a non-PPO Provider.

An Expense Incurred also includes expenses for an approved clinical trial to the extent such coverage is required under the ACA.

Experimental or Investigative means services, treatments, procedures, technology, supplies or drugs which:

- Have not been approved by the Federal Food and Drug Administration;
- Are not widely recognized and generally accepted as standards of care of the medical profession for the diagnosis, cure, mitigation, treatment or prevention of sickness or injury in the United States;
- Are in the research or investigative stage, or conducted for research or similar purposes; or
- The patient has been asked to sign or has signed a release or other document indicating that the treatment is Experimental or Investigative or other term of similar meaning.

In determining any of the above, the Plan relies on recognized medical sources such as, but not limited to, the American Medical Association, including the Council of Technology Assistance Program and the Council on Medical Special Services; the National Institute of Health; Medicare; the Food and Drug Administration; and other accepted medical authorities and sources.

Home Health Care Agency means a public or private agency that specializes in giving nursing or therapeutic services in the home, is licensed as a Home Health Care Agency and operates within the scope of its license.

Hospice Agency means a hospice which is state-licensed and satisfies the hospice certification requirements of Medicare.

Hospital means only an institution which meets all of the following requirements:

- Maintains permanent and full-time facilities for bed care for five or more resident patients;

- Has a Doctor in regular attendance;
- Continuously provides 24-hour-a-day nursing service by registered nurses;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics or a place for substance abusers; and
- Is operating lawfully in the jurisdiction where it is located.

The term "Hospital" also includes a community mental health facility or alcohol or substance abuse treatment facility certified by the appropriate regulatory agency of the State of Ohio or approved by the Joint Committee on Accreditation of Healthcare Organizations.

Medically Necessary means those services, treatments or supplies provided by a Hospital, Doctor or Provider that are required to identify or treat an individual's sickness or injury and which are:

- Consistent with the symptoms or diagnosis and treatment of an individual's condition, disease, ailment or injury;
- Appropriate according to standards of good medical practice;
- Not solely for the convenience of you or your Dependent, Doctor, Hospital or Provider; and
- The most appropriate which can be safely provided.

Pregnancy includes (a) all pregnancies except extra-uterine types which are considered to be genito-urinary conditions, (b) childbirth, (c) miscarriage or (d) any complications arising wholly from pregnancy or childbirth, and (e) any pregnancy complications arising from any trauma.

PPO Provider means the following providers who have a contractual relationship with the PPO selected by the Plan:

- Comprehensive Medical Expense Benefits - a Doctor, Hospital or Provider;
- Dental Expense Benefits - Dentist or a dental hygienist under the supervision and direction of a Dentist; and
- Vision Expense Benefits - Optometrist or ophthalmologist licensed or otherwise qualified to practice vision care and/or provide vision care materials.

Provider includes the following individuals:

- A physical therapist who is licensed by the state in which the services are performed, if that state requires licensing;

- An individual who has a Master Degree of Social Work or is an Accredited Social Worker and who is under the supervision of a Doctor;

- A speech therapist who has a Master's Degree in speech pathology, has completed a supervised internship and who is licensed by the state in which the services are performed, if that states requires licensing;

- An occupational therapist who is licensed by the state in which the services are performed, if that state requires licensing, and who is under the supervision of a Doctor;

- A Professional Clinical Counselor ("LPCC" or "PCC") who is licensed by the State of Ohio or an individual who:

    (a) Provides services to an individual outside of the State of Ohio which are substantially similar to services provided by an LPCC or PCC; and

    (b) Is licensed in the state in which such services are provided, if that state requires licensing in order to provide such services;

- A Licensed Independent Social Worker ("LISW") who is licensed by the State of Ohio or an individual who:

    (a) Provides services to an individual outside the state of Ohio which are substantially similar to services provided by a LISW; and

    (b) Is licensed in the state in which such services are provided, if that state requires licensing in order to provide such services;

- A professional counselor ("LPC" or "PC") who is licensed by the State of Ohio and who is under the supervision of an M.D., Ph.D., LPCC or PCC or an individual who:

    (a) Provides services to an individual outside the State of Ohio which are substantially similar to services provided by an LPC or PC;

    (b) Is licensed in the state in which such services are provided, if that state requires licensing in order to provide such services; and

    (c) Who is under the supervision of an M.D., Ph.D., or under the supervision of a LPCC or PCC or their equivalent as described above;

- A physician's assistant who is licensed by the state in which the services are performed, if that state requires licensing;

- A certified nurse practitioner who is licensed or certified by the state in which services are provided; or

- To the extent required by ACA, "Provider" also includes any person who is licensed to provide a service covered by the Plan, who performs such service in the state in which the services are performed and who acts within the scope of that license.

Skilled Nursing Facility means a facility that satisfies all of the following requirements:

- It is primarily engaged in providing skilled nursing care to sick and injured persons as registered inpatients under 24-hour-a-day supervision by a Doctor or a registered nurse;

- It has available at all times the services of a Doctor who is a staff member of a Hospital;

- It has on duty 24 hours a day a registered nurse, a licensed vocational nurse or skilled practical nurse and it has a graduate nurse on duty at least eight hours a day;

- It maintains a daily medical record for each patient;

- For a facility which is not an integral part of a Hospital, it has a written agreement with one or more Hospitals providing for the transfer of patient and medical information between the Hospital and the facility;

- It complies with all licensing and other legal requirements; and

- It is not other than incidentally a place of rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a place for treating the physically or mentally handicapped or hotel or similar institution.

Union means a union which qualifies as a "Union" under the Plan's Trust Agreement.

LIFE INSURANCE BENEFIT
(Eligible Employees Only)

A. Eligibility

The Plan provides a Life Insurance Benefit for eligible Employees only. **To determine if you have coverage for the Plan's Life Insurance Benefit, you should review your Summary of Benefits insert.**

The Plan's Life Insurance Benefit is an insured benefit provided under a policy issued by the life insurance company listed on your Summary of Benefits insert. The terms and conditions of this Life Insurance Benefit are governed by the policy.

B. Payment of Benefits

If you are eligible for the Plan's Life Insurance Benefit, the death benefit listed on your Summary of Benefits insert will be payable upon your death to your designated beneficiary, provided the Plan Office has received written proof of your death before any benefits are payable. The death benefit listed on your Summary of Benefits insert will be reduced by the amount of any Accelerated Death Benefit paid to you.

If you do not have a properly completed beneficiary designation on file with the Plan Office, the Life Insurance Benefit will be paid to the following individuals as determined by the life insurance company: the executors or administrators of your estate; all to your surviving spouse; if your spouse does not survive you, your surviving children in equal shares; or, if no child survives you, your surviving parents in equal shares. If a beneficiary dies before you, the beneficiary's interest will end.

You may designate or change your beneficiary by giving written notice to the Plan Office on an acceptable form. Please contact the Plan Office to obtain an acceptable form.

Your Life Insurance Benefit is normally paid to your designated beneficiary in one lump sum. A different type of payment schedule may be arranged for all or part of your Life Insurance Benefit, if allowed by the life insurance company. Please contact the Plan Office for more information.

C. Conversion Privilege

If your eligibility for the Plan's Life Insurance Benefit ends for any reason, you may convert all or part of your Life Insurance Benefit to an individual life insurance contract. Conversion is not available for an amount of life insurance for which you were not previously eligible and covered under the Plan. In addition, if your coverage under the Plan's Life Insurance Benefit ends because the life insurance company's policy is terminated by the Plan, or coverage of the class of benefits under which you are eligible for the Plan's Life Insurance Benefit is terminated, then you must have been insured under the life insurance company's policy for five years or more in order to be eligible to convert coverage.

Evidence of good health is not required for this conversion privilege but you must apply to convert as soon as possible but no later than 31 days (or if later, within 15 days of the Plan signing the request for conversion, but not later than 91 days after the termination of life insurance).

If you would like to convert your Life Insurance Benefit or if you would like more information on conversion, please contact the Plan Office.

D. Accelerated Death Benefit

An Accelerated Death Benefit is available if you become terminally ill while eligible for the Plan's Life Insurance Benefit in an amount of at least $10,000 and you are under age 65. The Accelerated Death Benefit provides you with a portion of your Life Insurance Benefit while you are living. This option may be exercised only once and in no event will the Accelerated Death Benefit amount exceed 80% of your amount of life insurance. To be eligible for this benefit, you must apply in writing and provide proof to the Plan Office that you are terminally ill. This proof must include a certification by your Doctor.

An individual is "terminally ill" if a Doctor certifies that he or she has a life expectancy of 12 months or less. Please contact the Plan Office for additional information.

E. Disability Extension

If you become disabled prior to age 65 while insured, the full life insurance protection may be continued for as long as you remain continuously disabled but not after you attain age 65.

You are considered totally disabled for purposes of this life insurance benefit when you are completely unable to work because of sickness or injury for any work for which you are, or could become, qualified by education, training or experience. In addition, you will be considered Disabled if you have been diagnosed with a life expectancy of 12 months or less. You should contact the Plan Office for information regarding this disability extension.

You must furnish proof of Total Disability to the Plan as soon as possible after you become Disabled. The Trustees reserve both the right to have you examined by a Doctor of the Trustees' choice to determine if you have a Total Disability and to terminate coverage under this Continuation provision if such proof is requested but not received on a timely basis.

This Disability will terminate on the earliest of the following:

1. The date you are no longer Totally Disabled;

2. The date you attain age 65; or

3. The date the Plan terminates.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
(Eligible Employees Only)

A. Eligibility

The Plan provides an Accidental Death and Dismemberment Benefit for eligible Employees only. **To determine if you have coverage for the Plan's Accidental Death and Dismemberment Benefit, you should review your Summary of Benefits insert.**

The Plan's Accidental Death and Dismemberment Benefit is an insured benefit provided under a policy issued by the life insurance company listed on your Summary of Benefits insert. The terms and conditions of this Accidental Death and Dismemberment Benefit are governed by the policy.

B. Payment of Benefits

If you are eligible for the Plan's Accidental Death and Dismemberment Benefit, the benefit for a Covered Loss of Life will be payable upon your death to your designated beneficiary, provided the Plan Office is provided with written proof of loss before any benefits are payable. All other benefits for Covered Losses are payable directly to you.

To designate or change your beneficiary, you should review the beneficiary rules described in this booklet under the Plan's Life Insurance Benefit. These beneficiary rules also apply to the Plan's Accidental Death and Dismemberment Benefit.

C. Benefit Rules-Covered Losses

The Plan's Accidental Death and Dismemberment Benefit pays benefits for a Covered Loss. The amount payable depends on the type of Covered Loss and the amount of your Accidental Death and Dismemberment Benefit, as shown in your Summary of Benefits insert. All benefits are subject to the Limitation Per Accident rule as explained below.

For Loss of:	**Benefit:**
Life	Full amount of your insurance
Both Hands or Both Feet or Sight of Both Eyes	Full amount of your insurance
One Hand and One Foot	Full amount of your insurance
Speech and Hearing in Both Ears	Full amount of your insurance
Either Hand or Foot and Sight of One Eye	Full amount of your insurance
Movement of Both Upper and Lower Limbs (Quadriplegia)	Full amount of your insurance
Movement of Both Lower Limbs (Paraplegia)	Three-quarters of the amount of your insurance
Movement of Three Limbs (Triplegia)	Three-quarters of the amount of your insurance
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-half of the amount of your insurance

Either Hand or Foot ..... One-half of the amount of your insurance
Sight of One Eye ..... One-half of the amount of your insurance
Speech or Hearing in Both Ears ..... One-half of the amount of your insurance
Movement of One Limb (Uniplegia) ..... One-quarter of the amount of your insurance
Thumb and Index Finger of Either Hand ..... One-quarter of the amount of your insurance

Loss means with regard to:
1. Hands and feet, actual severance through or above wrist or ankle joints;
2. Sight, speech and hearing, entire and irrecoverable loss thereof;
3. Thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
4. Movement, complete and irreversible paralysis of such limbs.

Plan benefits for a Covered Loss are only payable if all of the following conditions are met:

- You suffer an accidental bodily injury while eligible for the Plan's Accidental Death and Dismemberment Benefit;

- The Covered Loss results directly from that injury and from no other cause; and

- You suffer the Covered Loss within 365 days after the accident.

Please remember that not all losses are covered. This is described in more detail below under "Exclusions."

D. Seat Belt and Air Bag Benefit

If you sustain an injury that results in a Loss payable under the Accidental Death and Dismemberment Benefit, the life insurance company will pay an additional Seat Belt and Air Bag Benefit if the injury occurred while you were: (1) a passenger riding in; or (2) the licensed operator of, a properly registered Motor Vehicle and were wearing a Seat Belt at the time of the Accident as verified on the police accident report. If a Seat Belt Benefit is payable, the life insurance company will also pay an Air Bag Benefit if you were: (1) positioned in a seat equipped with a factory-installed Air Bag; and (2) properly strapped in the Seat Belt when the Air Bag inflated. Please contact the Plan Office if you would like more information.

E. Repatriation Benefit

If you sustain an injury that results in a Covered Loss of Life payable under the Accidental Death and Dismemberment Benefit, the life insurance company will pay an additional Repatriation Benefit, if the death occurs outside the territorial limits of the state or country of your place of permanent residence. The benefit will only be paid if your body is transported across state lines or country borders. Please contact the Plan Office if you would like additional information regarding this benefit.

F. Child Education Benefit

If you sustain an injury that results in a Covered Loss of Life payable under the Accidental Death and Dismemberment Benefit, the life insurance company will pay an additional Child Education Benefit to your children, provided written proof of your child(ren)'s status as a Student, as defined in the policy, is provided. Please contact the Plan Office for additional information regarding this benefit.

G. Day Care Benefit

If you sustain an injury that results in the Covered Loss of Life payable under the Accidental Death and Dismemberment Benefit, the life insurance company will pay an additional Day Care Benefit for each of your children if such child is under age 7 at the time of your death, provided written proof of enrollment in a Day Care Program as defined in the policy, is provided. Please contact the Plan Office for additional information regarding this benefit.

H. Rehabilitation Benefit

If you sustain an injury that results in a Covered Loss, other than Loss of Life, payable under the Accidental Death and Dismemberment Benefit, the life insurance company will pay an additional Rehabilitation Benefit for Rehabilitative Program Expenses Incurred within one year of the date of accident when certain criteria as defined under the policy are met. Please contact the Plan Office for additional information regarding this benefit.

I. Spouse Education Benefit

If you sustain an injury that results in a Covered Loss of Life payable under the Accidental Death and Dismemberment Benefit, the life insurance company will pay an additional Spouse Education Benefit to your surviving spouse when certain criteria as defined under the policy are met. Please contact the Plan Office for additional information regarding this benefit.

J. Adaptive Home and Vehicle Benefit

If you sustain an injury that results in a Covered Loss, other than Loss of Life, payable under the Accidental Death and Dismemberment Benefit, the life insurance company will pay an additional Adaptive Home and Vehicle Benefit when certain criteria as defined under the policy are met. The Adaptive Home and Vehicle Benefit pays a benefit for the one-time cost of alterations to your principal residence and/or private automobile to make the residence accessible and/or the private automobile drivable or rideable for you. The costs must be incurred within two years from the date of the accident. Please contact the Plan Office for additional information regarding this benefit.

K. Exclusions

No benefits are payable under the Plan's Accidental Death and Dismemberment Benefit for losses caused or contributed to by:

1. Intentionally self-inflicted injury;

2. Suicide or attempted suicide, whether sane or insane;

3. War or act of war, whether declared or not;

4. Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;

5. Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless prescribed by or administered by a Doctor;

6. Injury sustained while committing or attempting to commit a felony; or

7. Injury sustained while Intoxicated.

Intoxicated means: (1) the blood alcohol content; (2) the results of other means of testing blood alcohol level; or (3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

L. Claims Procedure and Proof of Loss

In order for benefits for a Covered Loss to be payable under the Plan's Accidental Death and Dismemberment Benefit, a properly completed claim form must be timely submitted to the Plan Office. Please contact the Plan Office for an approved claim form. The claim form will contain instructions.

In addition, with respect to accident coverage, written proof must be given within **90 days** after a Covered Loss occurs. A claim will not be considered valid unless written proof is provided within this 90-day period. However, if the life insurance company determines it was not reasonably possible to provide written proof within this time period, the claim will still be considered valid if the proof is furnished as soon as reasonably possible, but not later than one year after it is due unless you (or the person who has the right to claim benefits) are not legally competent.

M. Limitation Per Accident

If you sustain more than one Covered Loss as a result of the same accident, no more than the Accidental Death and Dismemberment Benefit listed in your Summary of Benefits insert will be paid.

ACCIDENT AND SICKNESS WEEKLY BENEFITS
(Eligible Employees Only)

The Plan provides an Accident and Sickness Weekly Benefit for eligible Employees. **To determine if you have coverage for the Plan's Accident and Sickness Weekly Benefit, you should refer to your Summary of Benefits insert.** Subject to the rules and limitations described below, you will be eligible for the Plan's Accident and Sickness Weekly Benefit if you have Plan coverage for this benefit, you become Disabled because of a nonoccupational injury or sickness and you satisfy certain other conditions.

A. Benefit Payments

If you are eligible to receive the Plan's Accident and Sickness Weekly Benefit, the Plan will pay you a weekly benefit for the time period that you are Disabled, starting with the next day after the end of the waiting period. The Plan will pay the weekly benefit for no longer than the maximum term. The weekly benefit, waiting period and maximum term are shown in your Summary of Benefits insert.

If any period for which Accident and Sickness Weekly Benefits are payable is less than a full week, the Plan will pay at the rate of one-seventh of the weekly benefit for each day in such period.

You are considered Disabled when you cannot, because of an injury or sickness, engage in **any** occupation for wages or profit for which you are reasonably qualified by education, training or experience. You must also be under the regular care of a Doctor to qualify for the Plan's Accident and Sickness Weekly Benefit.

B. Successive Periods of Disability

Payment for any one period of disability, whether due to one or more causes, will not exceed the maximum term shown in your Summary of Benefits insert.

Successive periods of disability separated by less than two weeks of regular active employment will be considered one period of disability, unless the subsequent disability results from causes entirely unrelated to the previous Disability and you have returned to regular active work between the periods of Disability.

C. Treatment of Vacation Periods

If you are receiving vacation pay from an Employer during a period that you are also receiving the Plan's Accident and Sickness Weekly Benefit, payment of benefits will continue and will not be suspended or offset by such vacation pay received by you, regardless of when the vacation was scheduled or approved.

D. Coordination with Wage Replacement Benefits Payable Under an Automobile Insurance Policy

If you are Disabled and eligible to receive Accident and Sickness Weekly Benefits under the Plan and wage replacement benefits under your automobile insurance policy, you will be eligible to receive Accident and Sickness Weekly Benefits from the Plan only to the extent the Plan's benefits exceed the wage replacement benefits you are eligible to receive under your automobile insurance policy.

In the event your claim for wage replacement benefits under your automobile insurance policy is denied, the Plan will only pay Accident and Sickness Weekly Benefits if you take all actions necessary to appeal the denial and you execute a repayment agreement in a form approved by the Trustees agreeing to repay any amounts you are not entitled to receive from the Plan.

E. Disputed Worker's Compensation Claims

In the event you become Disabled as a result of an injury or illness for which you may be eligible for benefits under worker's compensation or occupational disease law and you apply for and are denied such compensation, the Plan will pay the Accident and Sickness Weekly Benefit only if: (1) you take all actions necessary to appeal the denial; (2) you execute a repayment agreement in a form approved by the Trustees agreeing to repay any amounts paid by the Plan for a period of Disability for which you also received compensation under any worker's compensation or occupational disease law; and (3) you agree to furnish a copy of the ruling of the applicable person or entity deciding such appeal to the Plan regardless of the outcome.

F. Limitations

No Accident and Sickness Weekly Benefits will be paid for or on account of any period of Disability:

1. Starting after employment ends;

2. For which you are not under the regular care of a Doctor;

3. Which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain. Note: Special rules apply if you are:

    - Self-employed; or

    - You become Disabled due to a non-occupational Disability while Disabled due to an occupational Disability.

    Please contact the Plan Office for additional information;

4. Which is after your return to work;

5. Which is after you have exhausted the maximum term for payment of Accident and Sickness Weekly Benefits;

6. After your Doctor determines you are no longer Disabled; or

7. After your Employer ceases participation in this Plan.

IMPORTANT

You must see your Doctor **before** you will be considered for this benefit, and you will not be paid such benefit unless you are continuously under the regular care of your Doctor while disabled.

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

The Plan's Comprehensive Medical Expense Benefits are self-funded. The Trustees have entered into an arrangement with a preferred provider organization ("PPO"), currently Anthem JAA, to help decrease the costs of health care by accessing the network of preferred providers, called "PPO Providers." If you choose to utilize a PPO Provider, you may pay a smaller dollar amount or percentage of the costs of the services you receive than if you went to a Non-PPO Provider. The Plan Office will determine if you qualify for Out-of-Area benefits under the Plan and if you do, you will qualify for Plan benefits at the higher Out-of-Area rate shown in your Summary of Benefits insert.

IMPORTANT

The choice to use a PPO Provider is entirely voluntary. The Plan makes no representation regarding quality of services provided by any provider, and the Plan is not responsible for care rendered by the provider.

If you have questions about whether a particular provider is a PPO Provider or if you need help locating a PPO Provider, please contact the PPO at the phone number listed on the back of your Plan identification card.

IMPORTANT

Please remember that the Plan's Wellness Benefit is only payable if you use a PPO Provider (or if you qualify for Out-of-Area coverage). The Plan's Wellness Benefit is described later in this booklet.

A. Identification Card

You should have received a Plan identification ("ID") card when your coverage under the Plan became effective. You should present your ID card to healthcare providers at the time you obtain services. Please read the information contained on your ID card, especially the information regarding the Plan's precertification requirements.

B. Calendar Year Deductible Amount – General Rules

The Plan has a calendar year Deductible for each person (the "Individual Deductible") and, if you are eligible and enrolled for Dependent coverage, for your entire family (the "Family Deductible"). A "Deductible" is the amount of Covered Expenses that must be incurred by you (or your eligible Dependent) in a calendar year before benefits for Covered Expenses are payable under the Plan. There is a separate Deductible for PPO Covered Expenses and Non-PPO Covered Expenses with respect to both the Individual Deductible and the Family Deductible. However, Covered Expenses applied to satisfy the PPO Deductible are also applied to satisfy the Non-PPO Deductible and vice versa.

Not all Covered Expenses are subject to the Plan's Deductible. For example, the Deductible does **not** apply to the Plan's Wellness Benefit. Please review your Summary of Benefits insert and this SPD's benefit descriptions carefully to understand when the Plan's Deductible applies. Please keep in mind that the Plan's Deductible will apply to all Comprehensive Medical Benefits unless specifically noted otherwise.

1. Individual Deductible. You will satisfy the Individual PPO Deductible when the amount of PPO and Non-PPO Covered Expenses you incur in a calendar year equals the Individual PPO Deductible shown in your Summary of Benefits insert. Similarly, you will satisfy the Individual Non-PPO Deductible when the amount of PPO and Non-PPO Covered Expenses you incur in a calendar year equals the Individual Non-PPO Deductible Amount shown in your Summary of Benefits insert.

2. Family Deductible. To satisfy the Family PPO Deductible amount, members of the same family must incur PPO and Non-PPO Covered Expenses in a calendar year that total the Family PPO Deductible shown in your Summary of Benefits insert. No one family member is required to satisfy the Individual Deductible. The same is true for the Non-PPO Family Deductible, which is satisfied when members of the same family incur PPO and Non-PPO Covered Expenses in a calendar year that total the Non-PPO Family Deductible shown in your Summary of Benefits insert.

C. Emergency Room Fee

If you or your Dependent obtain care in an emergency room, you or your Dependent must satisfy the Plan's Deductible and incur Covered Expenses equal to the Emergency Room Fee, as described in your Summary of Benefits insert, before the Plan will pay Comprehensive Medical Expense Benefits. The Emergency Room Fee is separate from and in addition to the calendar year Deductible and applies to each emergency room visit, regardless of whether it is a PPO or Non-PPO emergency room. However, if you (or your Dependent) are admitted on either an inpatient or outpatient basis, the Plan will waive the Emergency Room Fee for that visit.

The Emergency Room Fee will be applied toward satisfaction of the Out-of-Pocket Maximum described in section D. below and you (or your Dependent) will not be subject to the Emergency Room Fee as described in this section after satisfaction of the Out-of-Pocket Maximum.

In addition, after you satisfy the Plan's Deductible and Emergency Room Fee (if applicable), Plan benefits for Covered Expenses for an emergency room visit are payable at the applicable percentage payable for PPO Covered Expenses described in your Summary of Benefits insert, regardless of whether you receive treatment at a PPO or Non-PPO Hospital emergency room.

D. Calendar Year Out-of-Pocket Maximum – General Rules

The Plan's Out-of-Pocket Maximum is shown in your Summary of Benefits insert and is applied each calendar year. Unless specifically provided in your Summary of Benefits insert, the "Out-of-Pocket Maximum" is the amount of Covered Expenses you (or your eligible Dependents) must incur in a calendar year before the Plan's Comprehensive Medical Expense Benefits are payable at 100% of Covered Expenses. The Plan has a calendar year Out-of-Pocket Maximum for each person (the "Individual Out-of-Pocket Maximum"), and if you are eligible

and enrolled for Dependent coverage, for your entire family (the "Family Out-of-Pocket Maximum"). There is a separate Out-of-Pocket Maximum for PPO Covered Expenses and Non-PPO Covered Expenses with respect to both the Individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum. However, Covered Expenses applied to satisfy the PPO Out-of-Pocket Maximum may be applied to satisfy the Non-PPO Out-of-Pocket Maximum and vice versa.

In addition, Covered Expenses applied to satisfy the Plan's calendar year Deductible, the Emergency Room Fee, the Live Health Online Office Visit Copay and, if applicable, the Primary Care Physician's Office Visit Benefit co-payment will also be applied to satisfy the Plan's annual Out-of-Pocket Maximum.

1. Individual Out-of-Pocket Maximum. You will satisfy the Individual Out-of-Pocket Maximum when the amount of PPO and Non-PPO Covered Expenses you incur in a calendar year equals the Individual PPO Out-of-Pocket Maximum shown in your Summary of Benefits insert. After satisfaction of the Individual PPO Out-of-Pocket Maximum, the Plan will pay all subsequent PPO Covered Expenses you incur in the same calendar year. You will satisfy the Individual Non-PPO Out of Pocket Maximum when the amount of PPO and Non-PPO Covered Expenses you incur in a calendar year equals the Individual Non-PPO Out-of-Pocket Maximum shown in your Summary of Benefits insert. After satisfaction of the Individual Non-PPO Out-of-Pocket Maximum, the Plan will pay all subsequent Non-PPO Covered Expenses you incur in the same calendar year.

2. Family Out-of-Pocket Maximum. To satisfy the Family PPO Out-of-Pocket Maximum, members of the same family must incur PPO and Non-PPO Covered Expenses in a calendar year that total the Family PPO Out-of-Pocket Maximum shown in your Summary of Benefits insert. After satisfaction of the Family PPO Out-of-Pocket Maximum, the Plan will pay all subsequent PPO Covered Expenses incurred by you or your Dependents in the same calendar year. No one family member is required to satisfy the Individual Out-of-Pocket Maximum. The same is true for the Family Non-PPO Out-of-Pocket Maximum, which is satisfied when members of the same family incur PPO and Non-PPO Covered Expenses in a calendar year that total the Family Non-PPO Out-of-Pocket Maximum shown in your Summary of Benefits insert. After satisfaction of the Plan's Family Non-PPO Out-of-Pocket Maximum, the Plan will pay all subsequent Non-PPO Covered Expenses incurred by you or your Dependents in the same calendar year.

E. Benefit Payment Percentages

After your Deductible has been satisfied and before you satisfy the Out-of-Pocket Maximum, benefits for Covered Expenses will generally be payable at the Benefit Payment Percentage (or Coinsurance Level) shown in your Summary of Benefits insert. If you choose a PPO Provider, Plan benefits for Covered Expenses are generally payable at a higher percentage after you satisfy the Deductible. This is also true if you live outside of the PPO service area and you choose a Non-PPO Provider. The Plan Office will determine whether you qualify for Out-of-Area benefits under the Plan. If you live within the PPO service area and choose a Non-PPO Provider, the higher Non-PPO Deductible will apply and Plan benefits for Covered Expenses will generally be payable at a lower percentage.

IMPORTANT

Later in this SPD, you will learn about certain benefits that are not subject to the Plan's Deductible. These benefits may also be subject to different Benefit Payment Percentages.

F. Mandatory Hospital Precertification

The Plan has a precertification requirement for inpatient hospitalizations. When you are going to be admitted to a Hospital, including an admission for treatment of mental health disorders or substance abuse, you must contact the Plan's utilization review provider to request a review before you are admitted to the Hospital. This requirement also applies to emergency hospitalizations. In the event of an emergency, you must contact the Plan's utilization review provider within 72 hours of the Hospital admission.

The utilization review provider's contact information is listed on the back of your Plan identification card.

You should tell the Plan's utilization review provider that you receive benefits under the UFCW Unions and Employers Health and Welfare Plan of Central Ohio, and you should also be prepared to provide the following information: Employee's name, address and telephone number; Employee's identification number; patient's name; Hospital name and telephone number; Doctor's name and telephone number and diagnosis.

Precertification is not a guarantee of coverage. Even if your admission is precertified, payment of benefits is subject to all Plan provisions and benefits for Covered Expenses are payable as shown on your Summary of Benefits insert. You are responsible for determining your eligibility for benefits before seeking precertification. If you have questions regarding your eligibility, you should contact the Plan Office.

If you do not comply with the Plan's precertification requirements for Hospital admissions, you will be subject to a $200 reduction in Expense Incurred for such admission.

Charges applied to satisfy this $200 penalty for failure to satisfy the Plan's precertification requirements will not be applied toward satisfaction of the Out-of-Pocket Maximum and you (or your Dependent) will be subject to this penalty after satisfaction of the Out-of-Pocket Maximum.

This precertification requirement is your responsibility, not your health care provider's responsibility. If the Hospital or provider tells you they will call the Plan's utilization review provider and they do not, the $200 penalty will still apply.

Also, although not required, it is recommended that you contact the Plan's utilization review provider in connection with childbirth so that in the event a Hospital stay lasts longer than 48 hours for a vaginal birth or 96 hours for a cesarean birth, the utilization review provider may assist in maximizing your Plan coverage.

G. Covered Expenses

Subject to the Exclusions listed below, the term "Covered Expense" means only the Expense Incurred for the following services and supplies:

- Hospital charges for room and board, including intensive care;
- Hospital charges for supplies and services received on a day for which hospital room and board are payable;
- Hospital and Doctor charges for outpatient treatment of any illness;
- Surgical services provided by a Doctor;
- Professional medical services by a Doctor, a Provider, registered graduate nurse or a certified registered nurse first assistant ("CRNFA");
- Professional services by a radiologist or laboratory for diagnosis or treatment;
- Professional ambulance service;
- Anesthetics and oxygen and their administration;
- Rental or, if more economical, purchase of durable medical equipment with prior approval of the Trustees or their designee, required exclusively for the treatment of an injury or illness or to prevent a reoccurrence of an injury or illness and the replacement of such durable medical equipment if such equipment is no longer operational. In addition, certain expenses relating to a manual or electric breast pump are covered to the extent required by ACA and such charges will be paid at 100% if obtained from a PPO Provider;
- Initial artificial limbs and eyes required to replace natural limbs or eyes, provided such replacement occurs within two years of the loss of the natural limb or eye;
- Replacement of artificial limbs and eyes, including replacement if the replacement is required because of a change in the physical condition of you or your Dependent;
- X-ray and radium, radioactive isotope therapy or chemotherapy;
- Services by a Home Health Care Agency, Hospice Care Agency or a Skilled Nursing Facility, subject to the applicable descriptions set forth below under "Home Health Care Benefit," "Hospice Care Benefit" and "Skilled Nursing Facility Care";
- Surgical assistance by a Doctor (limited to 20% of the Expense Incurred for the surgeon's fee for the same procedure) or by a certified registered nurse first assistant ("CRNFA") (limited to 16% of the Expense Incurred for the surgeon's fees for the same procedure);
- Outpatient kidney dialysis;

- Custom made orthotics and non-custom made orthotics when determined to be Medically Necessary by a Doctor;

- BRCA testing in accordance with current United States Preventive Services Task Force guidelines;

- Obstetrical services are covered the same as any illness, except that obstetrical services required by a Dependent child are covered only to the extent required by ACA;

- Organ transplants subject to the following:

    - If the transplant recipient is an individual covered by the Plan, the donor will also be considered an individual covered by the Plan and the Expenses Incurred by both the donor and recipient will be Covered Expenses;

    - If only the donor is an individual covered by the Plan, then the Expenses Incurred by the donor only will be Covered Expenses; and

    - The benefit limitations under this Plan will apply in the aggregate to Expenses Incurred by the donor and recipient;

- Charges for physical therapy or occupational therapy performed by an applicable Provider and authorized by a Doctor;

- Speech and hearing therapy when Medically Necessary for diagnosis and treatment of speech and hearing disorders resulting from prior surgery, brain disorders, strokes, congenital deformities, motor or nervous system problems and speech impediments;

- Expenses for the following will be considered Covered Expenses for an individual for whom the Plan is providing benefits in connection with a mastectomy:

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

    - Surgery and reconstruction of the other breast to provide a symmetrical appearance, or, as an alternative to reconstruction, a prophylactic mastectomy of the other breast; and

    - Prosthesis and physical complications of all stages of mastectomy, including lymphodemas.

Home Health Care Benefit

Subject to the Exclusions listed below, the Plan provides benefits for Covered Expenses incurred for services and supplies provided by a Home Health Care Agency, subject to the following rules:

1. Your Doctor must submit a written treatment plan to the Plan Office and your Doctor must certify in writing that, in lieu of such services being provided by the Home Health Care Agency, you (or your Dependent) would have to be confined in a Hospital;

2. Covered Expenses under the Plan's Home Health Care Benefit are limited to the following:

    - Expenses incurred for medical services and supplies which would have been payable under the Plan if you (or your Dependent) had been confined in a Hospital; and

    - Expenses incurred for services provided to you (or your Dependent) in your home by a registered nurse, a licensed practical nurse, a licensed vocational nurse, a licensed physical or occupational or speech therapist or a home health care aide;

3. The Plan will not pay for services rendered or supplies furnished primarily for custodial care, which includes, but is not limited to, non-medical day-to-day care (for example, assistance with dressing or use of bathroom facilities); and

4. The Plan will not pay more than the cost that would have been incurred if you (or your Dependent) were confined in a Hospital.

Hospice Care Benefit

Subject to the Exclusions listed below, the Plan provides benefits for Covered Expenses incurred for services or supplies provided during a Hospice Benefit Period by a Hospice Care Agency, subject to the following rules:

1. Your Doctor must submit a written treatment plan to the Plan Office and your Doctor must certify in writing that, in lieu of such services being provided by the Hospice Care Agency, you (or your Dependent) would have to be confined in a Hospital;

2. A "Hospice Benefit Period" means a period that begins on the date a Doctor certifies that you (or your Dependent) are Terminally Ill and ends six months after or, if earlier, on your (or your Dependent's) death. If the Hospice Benefit Period ends before death, a new Hospice Benefit Period may begin if the Doctor again certifies that you (or your Dependent) are Terminally Ill;

3. "Terminally Ill" means that you (or your Dependent), according to a Doctor's written certification, have less than six months to live;

4. Please contact the Plan Office for more information on the specific services covered under the Plan's Hospice Care Benefit; and

5. No expenses will be payable under the Plan for services provided by volunteers or individuals who do not normally charge for their services or for services which could have been provided by a member of your household without endangering your (or your Dependent's) life or seriously impairing your (or your Dependent's) condition.

Skilled Nursing Facility Care

The Plan will pay the Expense Incurred for services provided by a Skilled Nursing Facility to the extent such would have been payable under the Plan if you (or your Dependent) would have been confined in a Hospital; if a Doctor certifies in writing that in lieu of such services being provided in a Skilled Nursing Facility, you (or your Dependent) would have been confined in a Hospital; and if the Doctor submits a written treatment plan.

Primary Care Physician Office Visit Benefit

IMPORTANT You should check your Summary of Benefits insert to determine if you are eligible for the Plan's Primary Care Physician Office Visit Benefit. If your insert does not reference the Primary Care Physician Office Visit Benefit, such charges will be subject to the Plan's general rules for Comprehensive Medical Expense Benefits.

The Plan provides a Primary Care Physician Office Visit Benefit to **eligible** Employees and Dependents, subject to the rules and limitations described below. Under this benefit, office visits provided to you by a Primary Care Physician who is a PPO Provider are subject to special rules. These special rules will also apply to a Non-PPO Primary Care Physician if you live outside the PPO service area, as determined by the Plan Office. The services billed by that PPO Primary Care Physician for the office visit will be paid at 100% after you pay the applicable co-payment shown in your Summary of Benefits insert, and the Plan's Deductible will **not** apply. Any amounts you pay for this benefit will apply towards your Out-of-Pocket Maximum. Eligible Employees and Dependents will **not** continue to be subject to the office visit co-payment applicable to this benefit after satisfaction of the Out-of-Pocket Maximum.

A "Primary Care Physician" includes only the following types of Doctors:

- Pediatrician;
- OB/GYN;
- Internist;
- Family Practitioner;
- General Practitioner;
- Physician's Assistant; and
- Nurse Practitioner.

IMPORTANT

If the PPO Doctor specializes in a sub-category of one of the categories listed above, the Doctor will not qualify as a "Primary Care Physician" and the special rules described above will **not** apply. In this case, payment of claims will be subject to the Plan's general rules for Comprehensive Medical Expense Benefits. For example, a pediatric cardiologist does not qualify as a "Primary Care Physician."

In addition, any Doctor or Provider providing medical services to you or your Dependent at a Little Clinic or Minute Clinic shall also be considered a Primary Care Physician regardless of the Doctor or Provider's specialty.

If you use a Non-PPO Primary Care Physician, the special rules described above will **not** apply, and payment will be subject to the Plan's general rules for Comprehensive Medical Expense Benefits, such as the Plan's Deductible requirement and Benefit Payment Percentage shown in your Summary of Benefits insert.

Mental Health and Substance Abuse Benefits

The Plan provides benefits for inpatient and outpatient treatment of mental health disorders and substance abuse to **eligible** Employees and Dependents, subject to the rules and limitations set forth below.

IMPORTANT Please keep in mind that inpatient treatment requires precertification, as described on page 29.

- **Inpatient Treatment**. Expenses Incurred for the inpatient treatment of mental health disorders and substance abuse will be payable at the Benefit Payment Percentage (or Coinsurance Level) shown in your Summary of Benefits insert after your calendar year Deductible is satisfied. Inpatient treatment of mental health disorders and substance abuse is subject to the same precertification requirements as a hospitalization for a medical condition. See important information on page 29 for Precertification Requirements for inpatient treatment.

- **Outpatient Treatment**. Expenses Incurred for the outpatient treatment of mental health disorders and substance abuse will be payable at the Benefit Payment Percentage (or Coinsurance Level) shown in your Summary of Benefits insert after your calendar year Deductible is satisfied.

The Plan's Mental Health and Substance Abuse Benefits are subject to the Plan's Deductible, and apply towards the Plan's Out-of-Pocket Maximum.

Wellness Benefits

The Plan provides a Wellness Benefit for **eligible** Employees and Dependents, subject to the rules and limitations described below. Some special rules apply to colonoscopies.

Wellness Benefits under the Plan are only payable if you use a PPO Provider (or if you live outside of the PPO service area as determined by the Plan Office and you use a Non-PPO Provider).

The Plan's Wellness Benefit covers charges for the preventive care services listed on the Grade A and B Recommendations of the United States Preventive Service Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration, as required by federal regulations (the "ACA Preventive Services"), and any related office visit provided by a PPO Provider without application of the Deductible Amount or office visit co-payment. The Plan will not pay for these services provided by a Non-PPO Provider. More information on the specific services covered can be found at the following website: www.healthcare.gov or by calling the Plan Office.

For example, the following items are Covered Charges under this Wellness Benefit:

- Colonoscopies - One colonoscopy after you (or your Dependent spouse) reaches age 50, and then one colonoscopy every ten years thereafter, or more frequently or at a younger age if you or your Dependent is determined to be high risk based on family history;
- Well child examinations;
- Childhood immunizations that are appropriate under the American Academy of Pediatrics ("AAP") guidelines. If submitted charge is not appropriate based on AAP guidelines, the charge will not be covered;
- Flu shots and pneumonia shots for adults;
- Generally, adult immunizations, including the tetanus-diphtheria (Td) booster, and immunizations not completed in childhood;
- Other prescribed screenings associated with Preventive Care, including mammograms and pap smears;
- Diagnostic Screening, including the following:
    - Blood pressure screening;
    - Periodic cholesterol screening;
    - Glucose testing;
    - Hemoglobin or hematocrits; and
    - Lipid panel.

Important Precertification Requirements

If you have a diagnosis of family history of colorectal cancer, you must contact the Plan's utilization review provider to precertify your colonoscopy. **If you do not comply with this precertification requirement, your colonoscopy may not be covered by the Plan.** The utilization review provider's contact information is listed on the back of your Plan identification card. Please refer to the "Utilization Management and Precertification" section of this Booklet for more information on the Plan's precertification requirements.

Manipulative Therapy Benefit

The Plan provides a Manipulative Therapy Benefit for **eligible** Employees and Dependents, subject to the rules and limitations described below. If you or your Dependent receives Manipulative Therapy, the Plan will pay 50% of the Expense Incurred for such treatment up to a maximum of $1,000 per calendar year subject to the following provisions:

- "Manipulative Therapy" is the manipulation and/or mobilization to any joint in the body performed by a Doctor;
- Services performed by a licensed physical therapist will **not** be considered Manipulative Therapy; and
- The Plan will not cover expenses incurred for "maintenance" treatment.

Eligible manipulative therapy charges are **not** subject to the Plan's Deductible and do **not** apply towards satisfaction of the Plan's Out-of-Pocket Maximum.

Hearing Aid Benefit

IMPORTANT You should check your Summary of Benefits insert to determine if you are eligible for the Hearing Aid Benefit. If your insert does not reference the Hearing Aid Benefit, such charges are not covered under the Plan.

The Plan provides a Hearing Aid Benefit for **eligible** Employees and Dependents. If you (or your eligible Dependent) incurs expenses for the purchase and fitting of hearing aids, the Plan will pay 100% of the Expense Incurred for such expenses up to $1,000 per ear every five years.

Eligible Hearing Aid Benefit charges are **not** subject to the Plan's Deductible, are not subject to a Benefit Payment Percentage (or Coinsurance Level) and do **not** apply towards satisfaction of the Plan's Out-of-Pocket Maximum.

H. Exclusions

If a procedure, service or supply is not specifically mentioned in this SPD, you should not assume the Plan provides benefits for such procedure, service or supply. In addition, Comprehensive Medical Expense Benefits under the Plan are not payable for or on account of the following:

- Any fees exceeding the Expense Incurred;
- Any charges not due to an injury or illness, unless specifically provided in this SPD or shown as payable in your Summary of Benefits insert;
- Any bodily injury or sickness if you (or your eligible Dependent) are not under the regular care of a Doctor;
- Any injury or illness which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain;
- Dental services and supplies for the treatment of teeth, treatment of gums (other than for tumors) and treatment of other associated structures primarily in connection with the treatment or replacement of teeth, unless the Expense Incurred is required within 12 months of an accident for the necessary repair or alleviation of damage to natural teeth resulting from such accident;
- Services or supplies furnished by or payable under any plan or law of any federal or state, dominion or provincial government, or furnished by a county, parish or municipal Hospital when there is no legal requirement to pay for such services or supplies;
- Services or supplies for which no charge is made or for which you are not legally required to pay;
- Charges incurred as a result of a Dependent child's Pregnancy, childbirth, miscarriage or abortion, including, but not limited to, Hospital confinement services or supplies provided on account of a Dependent child's Pregnancy, except charges required to be covered by the ACA;
- Cosmetic surgery unless required under the Women's Health and Cancer Rights Act or required within 12 months of an accident for the necessary repair or alleviation of damage resulting from such accident;
- Eye refractions;
- Hearing aids or eyeglasses, except where specifically shown as payable in your Summary of Benefits insert;
- Routine examinations or checkups or other preventive care not required to be covered under ACA;
- Housekeeping or custodial care;
- Charges for treatment which is Experimental or Investigative, including, but not limited to, acupuncture or hypnotism;

- Administrative costs of processing a claim, including, but not limited to, charges for completion of a claim form or charges for failure to keep a scheduled appointment, for preparation of medical reports or for mileage charges;

- Treatment of obesity, unless such charges are for surgery to enhance or result in weight loss, including but not limited to gastric bypass or lap-band surgery, and such charges are approved in advance by the Plan's utilization review provider based upon the applicable National Institute of Health Treatment Guidelines;

- Charges incurred after you (or your eligible Dependent) have been declared neurologically dead;

- Treatment or procedures not Medically Necessary, except if specifically shown as payable in this SPD;

- All forms of artificial insemination, including but not limited to in-vitro fertilization;

- Bedwetting correction devices;

- Food, food substitutes or supplements or vitamins when you (or your eligible Dependent) are not confined as an inpatient in a Hospital;

- Treatment of sexual dysfunction with prosthetic devices, except in a case in which medical evidence is submitted which establishes to the satisfaction of the Trustees or their designee that such dysfunction is caused by illness or injury;

- Treatments or operations for the restoration of fertility, to increase fertility or promote conception;

- Reversal of sterilization;

- Personal comfort services such as telephones, radio, television, barber and beauty services, or in connection with air conditioners, air purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, vibratory equipment, elevator or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs and devices for simulating natural body contours, unless prescribed in connection with a mastectomy;

- Routine foot care;

- Radial keratotomy or other surgery to correct or improve vision;

- Transsexual surgery and for any treatment leading to or in connection with transsexual surgery;

- Drugs and medicine not administered during a Hospital confinement;

- Manipulative therapy in excess of the Annual Maximum set forth in the Summary of Benefits insert;

- Services or supplies for which you (or your eligible Dependent) are eligible for reimbursement under "no-fault" automobile insurance or when not eligible, if ineligibility for reimbursement is a result of such person's failure to purchase such "no-fault" insurance, to the extent state law mandates the purchase of such insurance;

- Routine care of a newborn well child, unless specifically shown as payable as a Wellness Benefit in your Summary of Benefits insert or coverage is required by ACA;

- Charges for any Expense Incurred on a date you (or your Dependent) are not eligible for Plan benefits;

- Charges for Manipulative Therapy for "maintenance" treatment;

- With respect to Wellness Benefits, charges for preventive screenings unless coverage is specifically required by ACA; and

- Charges made by any provider that is not a Doctor, Hospital, or a Provider, unless specifically shown as payable in your Summary of Benefits insert.

DENTAL EXPENSE BENEFIT

A. General

The Plan provides a Dental Expense Benefit for certain eligible Employees and Dependents. **If you and/or your Dependents are eligible for the Plan's Dental Expense Benefit, you will receive a Dental Expense Benefit insert. If you do not receive a Dental Expense Benefit insert, you are not eligible for Dental Expense Benefits.**

The Trustees have entered into an arrangement with Delta Dental as a preferred provider organization, which means a provider that has a contractual relationship with Delta Dental is a PPO Provider with respect to Dental Expense Benefits.

The Plan will pay, subject to the Exclusions and Limitations below, the charges for Covered Dental Expenses actually made to you or your Dependent that are included for payment in the applicable list of Covered Services set forth in your **Dental Expense Benefit insert**.

B. Dental Deductible

The Dental Deductible is the amount of expense each person must incur for Covered Dental Expenses in a calendar year before Dental Expense Benefits are payable. Please review your Dental Expense Benefit insert to determine if the Dental Deductible applies to you. If the Dental Deductible applies to you, the Dental Expense Benefit insert will list the Dental Deductible which applies to you and your eligible Dependents. Please note that the Plan's Dental Deductible is a per person amount. In other words, each person must separately satisfy the Dental Deductible (if applicable) for a calendar year before benefits for Covered Dental Expenses are payable, regardless of whether other family members have already satisfied the Dental Deductible for the calendar year.

If the Dental Deductible applies to you, please keep in mind that it applies to all Covered Dental Expenses, **except** Diagnostic Services, Preventive Services and Orthodontics.

C. Dental Annual Maximum

The Dental Annual Maximum is the maximum amount the Plan will pay each calendar year for Covered Dental Expenses. Please review your Dental Expense Benefit insert to determine the Dental Annual Maximum that applies to you and your eligible Dependents. Please keep in mind that the Plan's Dental Annual Maximum is a per person limit. In other words, each person eligible for the Plan's Dental Expense Benefit has a separate Dental Annual Maximum for each calendar year, regardless of whether other family members have already reached their Dental Annual Maximum for the calendar year. The Dental Annual Maximum does **not** apply to Orthodontics.

D. Orthodontic Lifetime Maximum

The Plan has an Orthodontic Lifetime Maximum applicable to the Plan's Orthodontic Benefits. To determine if you are eligible for Orthodontic Benefits and, if eligible, the applicable Orthodontic Lifetime Maximum please refer to your Dental Expense Benefit insert. The Plan's Orthodontic Lifetime Maximum is also a per person amount and is applied separately to each person covered for Orthodontic Benefits under the Plan's Dental Expense Benefit.

E. Payment of Benefits

After your Dental Deductible (if applicable) has been satisfied, and before you reach the Dental Annual Maximum, Covered Dental Expenses charged by a PPO Provider are payable at the percentage of the PPO Provider's negotiated rate identified on your Dental Expense Benefit insert, subject to the Exclusions and Limitations described below. Covered Dental Expenses charged by a non-PPO Provider are payable at the billed rate up to the Plan's Dental Fee Scheduled amount and are also subject to the Exclusions and Limitations described below.

The Plan's Orthodontic Benefits are not subject to the Plan's Dental Fee Scheduled amount maximum, but are payable at the Benefit Payment Percentage shown in your Dental Expense Benefits insert (if you are eligible for Orthodontic Benefits), up to the Orthodontic Lifetime Maximum and subject to the Exclusions and Limitations described below. The Fee Schedule Amount for each dental procedure is determined by the Trustees.

F. Covered Dental Expense

"Covered Dental Expense" means the Expense Incurred by you or your eligible Dependent for necessary dental treatment for a procedure identified in your Dental Expense Benefit insert.

To qualify as a Covered Dental Expense, the treatment must be rendered by a Dentist, or in the case of dental prophylaxis, by a licensed dental hygienist under the supervision and direction of a Dentist.

The term "Dentist" means only a person who is licensed to practice as a dentist and, to the extent required by the ACA, "Dentist" also includes any person who performs dental services covered by the Plan if such person is licensed to perform such dental services and such services are performed within the scope of such license under applicable state law.

G. Exclusions

Covered Dental Expenses do not include the following:

1. Any dental procedure performed for cosmetic reasons (including repairs to facings posterior to the second bicuspid position);

2. Services started or appliances started before a person became eligible for Dental Expense Benefits, however this exclusion does not apply to Orthodontic Benefits;

3. Services or supplies for correction of congenital deformity or development;

4. Replacement of a lost, missing or stolen appliance and replacement or repair of orthodontic appliances or space maintainers;

5. Any treatment for an illness or injury which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain (Note: Special rules apply if an individual is self-employed);

6. Any services or supplies for which no charge is made or would be made in the absence of the Plan;

7. Any services or supplies for which you or your Dependent is not required to pay;

8. Any services or supplies furnished by or payable under any plan or law of any government, federal or state, dominion or provincial or any political subdivision of such government;

9. Prescription drugs (except intramuscular injectable antibiotics), medicaments/solutions, premedications and relative analgesia;

10. General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless Medically Necessary, except non-intravenous conscious sedation and nitrous oxide are Covered Dental Expenses;

11. Hospitalization, laboratory tests and histopathological examinations;

12. Failure to keep a scheduled appointment;

13. Services or supplies for which no valid need can be demonstrated, that are specialized techniques or that are investigational in nature, as determined by the standards of generally accepted dental practice, including services or supplies required to treat complications from investigational procedures;

14. Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;

15. Services or supplies covered under the Plan's Comprehensive Medical Expense Benefits or Prescription Drug Benefit;

16. Fluoride rinses, self-applied fluorides or desensitizing medicaments;

17. Preventive control programs, including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling and home care medicaments;

18. Veneers;

19. Temporary, interim or provisional crowns;

20. Prefabricated crowns used as final restorations on permanent teeth;

21. Appliances, surgical procedures and restorations for: increasing vertical dimension; altering, restoring or maintaining occlusion; replacing tooth structure loss resulting from attrition, abrasion or erosion; or periodontal splinting;

22. Paste-type root canal fillings in permanent teeth;

23. Replacement, repair, relines or adjustments of occlusal guards;

24. Chemical curettage;

25. Metal bases on removable prosthesis;

26. Tooth replacement beyond the normal complement of teeth;

27. Personalization/characterization of any service or appliance;

28. Temporary appliances or crowns used for temporization during crown or bridge fabrication;

29. Posterior bridges in connection with partial dentures in the same arch;

30. Precision attachments and stress breakers;

31. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index;

32. Diagnostic photographs and cephalometric films, unless done for covered orthodontic services;

33. Myofunctional therapy;

34. Mounted case analyses;

35. Completion of claim forms;

36. Consultations performed in conjunction with examinations, evaluations or diagnostic procedures;

37. Local anesthesia;

38. Acid etching, cement bases, cavity liners and bases or temporary fillings;

39. Infection control;

40. Gingivectomy as an aid to the placement of a restoration;

41. Correction of occlusion performed with prosthetics and restorations involving occlusal surfaces;

42. Diagnostic casts performed in conjunction with restorative or prosthodontic procedures;

43. Palliative treatment when any other service is provided on the same date except x-rays and tests necessary to diagnose the emergency condition;

44. Post-operative x-rays following any completed service or procedure;

45. Periodontal charting;

46. Pins and/or preformed posts when done with core buildups for crowns, onlays or inlays;

47. A pulp cap done with a sedative filling or other restoration;

48. A sedative or temporary filling when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or other endodontic procedure;

49. The opening and drainage of a tooth or palliative treatment performed by the same Dentist or dental office on the same day as a completed root canal treatment;

50. A pulpotomy on a permanent tooth except on a tooth with an open apex;

51. A therapeutic apical closure on a permanent tooth except when the root is not fully formed on that tooth;

52. Retreatment of a root canal by the same Dentist or dental office within 24 months of the original root canal treatment;

53. Prophylaxis or full mouth debridement done on the same day as periodontal maintenance on scaling root planing. Full mouth debridement is payable only once in a lifetime;

54. Occlusal adjustment performed on the same day as the delivery of an occlusal guard;

55. Reline, rebase or any adjustment or repair within six months of the delivery of a particular denture; and

56. Tissue conditioning performed on the same day as the delivery, reline or rebase of a denture.

H. Limitations

The following limitations apply to Covered Dental Expenses:

1. Prophylaxes, including periodontal prophylaxes, and routine oral exams are payable twice per calendar year, and if you or your Dependent have a documented history of periodontal disease, up to four additional periodontal procedures are payable per calendar year for individuals with a documented history of periodontal disease;

2. Preventive fluoride treatments are payable twice per calendar year;

3. Bitewing x-rays are payable twice per calendar year;

4. Full mouth x-rays are payable once in any three year period. Full mouth x-rays include bitewing x-rays and panographic x-rays;

5. Patient screening is payable once per calendar year;

6. Sealants are payable only if on the occlusal surface of any tooth that is free from decay and restorations;

7. Space maintainers are a Covered Dental Expense;

8. Composite resin restorations are payable for posterior teeth only;

9. Crowns or onlays are payable only for extensive loss of tooth structure due to caries and/or fracture;

10. Inlays and onlays are Covered Dental Expenses;

11. Porcelain fused to metal and porcelain crowns are payable only for posterior teeth;

12. Porcelain/ceramic bridges are Covered Dental Services;

13. Surgical treatment or manipulation of the jaw for treatment of temporomandibular joint disorders ("TMD") are not payable under the Plan's Dental Expense Benefit. Benefits for TMD are limited to those services normally provided by a Dentist to relieve oral symptoms associated with malfunction of the temporomandibular joint unless payable under the Comprehensive Medical Expense Benefit;

14. Expenses for implants and related services are payable only once per tooth in any five year period;

15. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core build up and cast substructures) on the same tooth are payable once in any five-year period;

16. Individual crowns over implants are payable as prosthodontic benefits;

17. Occlusal guard benefits are payable once in a lifetime;

18. Interim partial dentures are payable only for the replacement of permanent anterior teeth during the healing period or for individuals up to age 17;

19. Benefits for prosthodontic services are limited as follows:

    (a) one complete upper and one complete lower denture are payable once in any five-year period;

(b) a removable partial denture, an implant or a fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance;

(c) fixed bridges and removable partial dentures are not payable for individuals under age 16;

(d) a reline or complete replacement of denture base material is payable once in any three-year period per appliance;

(e) implant removal is payable once per lifetime per tooth or area; and

(f) implant maintenance is payable once per year.

20. Orthodontic benefits are limited as follows:

(a) if the treatment plan is terminated before completion for any reason, payments will terminate at that time;

(b) payment will terminate for lack of patient interest and cooperation, as determined by the PPO; and

(c) observation and adjustment expenses are payable twice in a 12-month period.

21. Amalgam and composite resin restorations by the same Dentist or dental office are payable once in any two-year period, regardless of the number or combination of a restoration placed on a surface;

22. Core buildups and other substructures are payable only when necessary to retain a crown on a tooth with excessive breakdown due to caries and/or fractures;

23. Recementation of a crown, onlay, inlay, space maintainer or bridge by the same Dentist or dental office is payable within six months of the seating date;

24. Retention pins are payable once in any two-year period;

25. Only one substructure per tooth is payable;

26. Root planing is covered only once in any two-year period;

27. Periodontal surgery, including subgingival curettage, by the same Dentist or dental office is payable once in any three-year period;

28. Complete occlusal adjustment is payable once in a five-year period. The fee for a completed occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is payable up to three times in a five-year period. The fee for a limited occlusal adjustment includes adjustments that are necessary for a six-month period;

29. Tissue conditioning is payable up to twice per arch in any three-year period;

30. Substructures, porcelain, porcelain substrate and cast restorations are not payable for an individual under age 12;

31. Payment for denture repair, including reline and rebase, will not exceed half of the fee for a new denture; and

32. Payment for overdentures will not exceed the amount paid for a conventional denture.

VISION EXPENSE BENEFIT

A. General

The Plan provides a Vision Expense Benefit for eligible Employees and Dependents. The Plan's Vision Expense Benefit is administered by Vision Service Plan ("VSP"). **If you and/or your Dependents are eligible for the Plan's Vision Expense Benefit, you will receive a Vision Benefits Summary insert. If you do not receive a Vision Expense Benefit insert, you are not eligible for Vision Expense Benefits.** You may visit your VSP participating doctor without obtaining a benefit form. In order to access Vision Expense Benefits, simply contact your VSP participating doctor to make an appointment.

When calling the doctor's office for an appointment for you or your eligible Dependent, identify yourself as a VSP patient. Indicate that you are covered by the Plan under the VSP Signature Network. The VSP participating doctor will obtain the necessary authorization and information about your eligibility and coverage.

B. Locating a VSP Participating Doctor

To locate a VSP participating doctor, go on-line to the VSP website (*www vsp.com*), find the "Members" page and click on the "Find a Doctor" option. Then enter the zip code and select the "Signature" Network option to generate the appropriate Doctor Directory.

In addition, VSP has implemented an automated member service system accessible via a toll-free number. By calling 800-VSP-7195 (877-7195), you can request a list of participating doctors to be mailed to you and enter a doctor's telephone number to verify the office's participation in the VSP network.

Should you need additional assistance, a Customer Service Department representative is available. VSP's automated member service system is available from 9:00 a.m. to midnight Monday through Friday, 11 a.m. to midnight Saturday and 11 a.m. to 11 p.m. Sunday (Eastern Standard Time). If you need additional assistance, please contact the Plan Office.

C. Benefits

VSP is a prepaid program. If you elect to receive vision care services from one of VSP's participating doctors, services are generally provided at no out-of-pocket expense, **however you will be responsible for your co-payment, if any, and any additional cost resulting from cosmetic options, noncovered services and materials, or materials costing over the scheduled allowance.** Refer to the **Vision Benefits Summary insert** for more information and for the schedule of allowances.

Selecting a VSP doctor assures direct payment to the doctor and a guarantee of cost control.

When you choose to go to a nonparticipating Doctor, you may secure services from an optometrist, ophthalmologist and/or dispensing optician and you will be reimbursed according to

a schedule of allowances set forth in your **Vision Benefits Summary insert**. You should pay the doctor his full fee and VSP will then reimburse you in accordance with the schedule of allowances.

The Plan's Vision Expense Benefit provides benefits for Covered Vision Services, subject to the Exclusions and Limitations described in Sections F. and G. and the limits listed in your **Vision Benefits Summary insert**.

The choice to use a VSP Provider is entirely voluntary. The Plan makes no representation regarding quality of services provided by any provider, and the Plan is not responsible for care rendered by the provider.

D. Covered Vision Services

The Plan's Vision Expense Benefit provides benefits for Covered Vision Services. Covered Vision Services are services and materials medically or visually necessary to restore or maintain an individual's visual acuity and health and for which there is no less expensive professionally acceptable alternative, as determined by VSP, subject to the Exclusions described below and the limits listed in your Vision Benefits Summary insert.

Covered Vision Services include the following:

1. A complete vision analysis once every calendar year, including prescription of corrective eyewear as indicated on your Vision Benefits Summary insert;

2. Lenses, once every calendar year;

3. Frames, once every two calendar years;

4. Contact lenses, once every calendar year in lieu of all other frame and lens benefits. When contact lenses are obtained, lenses and frames will not be covered again for one calendar year; and

5. Low vision benefits for you (or your eligible Dependent) who has severe visual problems that are not correctable with regular lenses, subject to prior approval by VSP. Such benefits include a complete low vision analysis and diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or visions aids where indicated and subsequent low vision therapy as visually necessary or appropriate. Please contact the Plan Office for more information.

E. Diabetic Eyecare Plus Program

Additional vision care benefits are available to you or your Dependent if such individual is diagnosed with type 1 or type 2 diabetes and have diabetic eye disease, glaucoma or age-related macular degeneration. If the individual satisfies the above, they may be eligible for additional services, such as medical follow-up exams and diagnostic tests if not covered under the

Comprehensive Medical Expense Benefit. In addition, benefits are provided for retinal screenings.

F. Exclusions

The following expenses and procedures are **not** covered by the Plan's Vision Expense Benefit:

1. Orthoptics, vision training and any associated supplemental testing, except as specifically provided in this SPD;

2. Contact lenses (except as specifically provided in this SPD and the Vision Benefits Summary insert);

3. Two pairs of glasses in lieu of bifocals;

4. Replacement of lost or broken lenses or frames, except at the normal intervals when services are otherwise available;

5. Medical or surgical treatment of the eyes;

6. Services and/or materials in excess of the allowances shown on your Vision Benefits Summary insert;

7. Services and/or materials not shown on your Vision Benefits Summary insert as Covered Vision Expenses;

8. Professional services or materials connected with subnormal vision aids unless specifically provided, aniseikonic lenses or multifocal plastic lenses;

9. Eye examinations required by a governmental body or agency or by an employer as a condition of employment or by virtue of a labor agreement;

10. Services or materials for which you (or your Dependent) may be compensated under any worker's compensation law or other employer's liability law regardless of jurisdiction (Note: Special rules apply if an individual is self-employed);

11. Services for which you (or your Dependent) can obtain, without cost, the needed care from any federal, state, county, municipality or special service district organization or agency;

12. Service or supplies more often than the permitted time intervals;

13. Corrective vision treatment which is considered Experimental or Investigative; or

14. RK and PRK surgery or any other surgery to correct or improve vision.

G. Limitations.

If you or your Dependent select any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and you will pay the additional costs for the options:

1. No-line bifocals (blended tye);
2. Plano (nonprescription) lenses;
3. Oversize lenses;
4. Photochromic lenses, tinted or coated lenses except pink #1 and #2;
5. Progressive multifocal lenses;
6. The laminating of the lens or lenses;
7. Ultraviolet protected lenses;
8. The coating of lenses, including anti-reflective, mirror or scratch coating;
9. Cosmetic lenses;
10. Optional cosmetic processes;
11. Low vision care except as specifically provided in this SPD; or
12. Frames that cost more than the allowance listed in your Vision Benefits Summary insert.

CONTINUATION OF COVERAGE (COBRA)

A. General Rules

This section has important information about your right to COBRA Coverage, which is a temporary extension of coverage under the Plan. **This section explains COBRA Coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA Coverage, you may also become eligible for other coverage options that may cost less than COBRA Coverage.

The right to COBRA Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Coverage can become available to you and other members of your family when group health coverage would otherwise end.

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

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

Under COBRA Coverage, benefit coverage under the Plan is the same coverage you and/or your Dependent child or legal spouse previously had, except it does **not** include Accident and Sickness Weekly Benefits and Life Insurance and Accidental Death and Dismemberment Benefits.

The Plan's COBRA rules require you and/or your Dependent child or legal spouse (or a representative) to provide notice to the Plan Office of certain events, such as a divorce or a Dependent child's loss of eligibility. You should carefully review the "COBRA Notice Procedures" section below for more information.

COBRA Coverage may continue for up to 18 consecutive months under the following circumstances:

- Termination of employment with your Employer (unless due to gross misconduct), including retirement; or

- Lack of hours for eligibility caused by factors such as, but not limited to, change from full-time to part-time status, leave of absence, lay-off or strike.

You and your eligible Dependent child and/or legal spouse may make self-payments to continue Plan coverage even if you and/or your Dependents are eligible for coverage under another group health plan at the time that you and/or your Dependent child and/or legal spouse elect to make self-payments for COBRA Coverage.

Also, if you lose Plan coverage because your Employer does not make a required contribution on your behalf, you may be eligible to continue Plan coverage. The rules regarding this extension of coverage are located under paragraph D of the "Eligibility Rules - When Plan Coverage Ends" section of this SPD.

If you are Disabled and eligible for extended Plan coverage as described under paragraph D of the "Eligibility Rules – When Plan Coverage Ends" section of this SPD, you must reject your right to the extension of benefits due to Disability to elect COBRA Coverage.

If you are absent from employment due to military service and the right to make self-payments is required by the provisions of USERRA, the 18-month limit is extended to 24 months.

The following situations may extend the 18-month period for self-payments:

- If you die, get divorced or your eligible Dependent child loses Dependent status within the 18-month period, your eligible Dependent may have the 18-month maximum period extended an additional 18 months to a 36-month total period;

- If the Social Security Administration determines that you or your eligible Dependent child or legal spouse was disabled in accordance with Title II or XVI of the Social Security Act at the time of your reduction in hours or termination of employment, or during the first 60 days of your COBRA Coverage, the 18-month period may be extended to a maximum of 29 months. To be eligible for the extra 11 months of coverage, you or your eligible Dependent child or legal spouse must notify the Plan Office prior to the expiration of the 18-month period, and within 60 days after the determination or, if later, within 60 days of your reduction in hours or termination of employment. The self-payment amount for the extra 11 months of coverage will be increased to the maximum amount allowed by law. You must also advise the Plan Office if it is later determined that you are not disabled under Title II or XVI of the Social Security Act within 30 days of such determination. This 11-month extension is available to the disabled individual and his or her family members who were covered under COBRA Coverage; or

- If you are entitled to Medicare at the time of your loss of coverage, your eligible Dependent child or legal spouse will be eligible to continue coverage under this provision for up to 36 months measured from the date of your Medicare entitlement, or 18 months measured from the date of your loss of coverage, whichever period is longer.

Your eligible Dependent child or legal spouse may make self-payments for COBRA Coverage for a period of not more than 36 consecutive months in the following situations:

- Your death;
- Your divorce from the Dependent; or
- Loss of status as a Dependent.

An eligible Dependent may make self-payments to continue Plan coverage even if the Dependent is eligible for coverage under another group health plan at the time the Dependent elects to make self-payments for COBRA Coverage.

B. Administration of COBRA Self-Pay Coverage

The Plan Office will provide you and/or your eligible Dependent child or legal spouse with an election form advising you and/or your Dependent of the self-payment rights, if any, and the amount of the required self-payment within 30 days after the Plan Office is notified of your termination of employment or reduction in hours. However, if your eligible Dependent loses Plan coverage due to divorce or loss of status as a Dependent, you or your Dependent must notify the Plan Office within 60 days of the occurrence of the event in order to make self-payments to the Plan. If this notice is timely, the Plan Office will then provide you or your Dependent with an election form within 30 days describing the self-payment rights, if any, and the amount of the required self-payment.

COBRA Coverage must be elected no later than 60 days after the notification date or 60 days after the termination date shown on the election form, whichever is later.

The first payment, which must include payments for any months retroactive to the date coverage under the Plan terminated, is due no later than 45 days after the date you or your Dependent signs the election form and returns it to the Plan Office. Subsequent monthly payments will be due on the first day of the calendar month for which coverage is to be provided, with a grace period of 30 days.

Self-payments are to be in the form of a check or money order made payable to the **UFCW Unions and Employers Health and Welfare Plan of Central Ohio** and submitted to the Plan Office.

All benefits will end immediately if the required self-payment is not received on a timely basis. Once terminated, COBRA Coverage cannot be reinstated.

COBRA contribution rates will be set from time to time by the Trustees.

C. COBRA Notice Procedures

The Plan will offer COBRA Coverage to you and/or your eligible Dependents only after the Plan Office has been notified that an event has occurred entitling you and/or your eligible Dependents to COBRA Coverage.

1. Employer Notices. If the event is your termination of employment, reduction of hours of employment or death, your Employer must notify the Plan Office of the event. The notice must contain sufficient information to enable the Plan Office to determine the identity of the benefit classification, the covered Employee, the event and the date of the event.

2. Participant Notices. If the event is your divorce or a Dependent child's loss of eligibility for coverage as a Dependent, you or your Dependent (or a representative) must notify the Plan Office in writing within 60 days after the event occurs.

If you and/or your Dependent are receiving COBRA Coverage for 18 months, you and/or your Dependent (or a representative) must notify the Plan Office in writing of a second event that would entitle your Dependent to extended COBRA Coverage or a disability determination by the Social Security Administration within 60 days of the occurrence of the event or disability determination or, if later, within 60 days of your loss of coverage or reduction in hours and before the initial 18-month period of coverage expires. In addition, the Plan Office must be notified of a determination by the Social Security Administration that a disabled person is no longer disabled within 30 days of the determination.

The notices described in this section must be sent to the Plan Office.

3. Notice Requirements. All notices must be **in writing** and must include the following information:

- The names of persons entitled to COBRA Coverage;
- Your name (if different);
- The address and telephone number of the persons entitled to COBRA Coverage;
- The nature of the event (for example, divorce, disability determination or second event); and
- The date of the event.

A notice that does not contain all of the required information will not be considered adequate notice. Failure to supplement the notice with the additional information necessary to meet the content requirements will result in the loss of the right to elect COBRA Coverage.

4. Other Coverage Options. Instead of enrolling in COBRA Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Coverage. You can learn more about many of these options at www.healthcare.gov.

D. Termination of COBRA Coverage

A person who is eligible for COBRA Coverage under the Plan will lose eligibility for this coverage upon the first to occur of the following events:

1. The date you or an eligible Dependent become covered under another group health plan after the person has elected COBRA Coverage, and that group health plan does not contain any exclusion or limitation with respect to any preexisting condition applicable to you or your Dependent;

2. The correct self-payment is not made on a timely basis;

3. The date the Plan is terminated or, as to any benefit, the date such benefit is terminated;

4. The date you or an eligible Dependent become entitled to Medicare;

5. Where coverage has been extended for up to 29 months due to disability, the date of a final determination that the disabled individual is no longer disabled; or

6. The end of your COBRA Coverage period.

E. Current Addresses

To protect your family's rights, you should keep the Plan Office and your Employer informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Plan Office or your Employer.

F. More Information

These provisions do not fully describe COBRA Coverage or other rights under the Plan. More complete information is available from the Plan Office. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

UTILIZATION MANAGEMENT AND PRECERTIFICATION

A. General Information

Utilization management, case management and precertification are designed to assist you in making informed medical care decisions to utilize appropriate levels of Plan benefits for each proposed course of treatment. These decisions are based on the medical information provided by you and your Doctor. You and your Doctor will determine the course of treatment. The assistance provided through these services does not constitute the practice of medicine. Payment of Plan benefits is not determined through these processes, although failure to comply with certain requirements may result in penalties.

Utilization management may include precertification, concurrent review and retrospective review.

B. Precertification of Comprehensive Medical Expense Benefits

Precertification is not a guarantee of coverage. Even if your admission or treatment is precertified, payment of benefits is subject to all Plan provisions and benefits are payable as shown on your Summary of Benefits insert. You are responsible for determining your eligibility for benefits before seeking precertification. If you have any questions regarding eligibility, please contact the Plan Office.

If you or your Dependent are to receive a service which requires precertification, you must contact the Plan's utilization review provider. The utilization review provider's contact information is listed on the back of your Plan identification card.

You should tell the Plan's utilization review provider that you receive benefits under the UFCW Unions and Employers Health and Welfare Plan of Central Ohio, and you should also be prepared to provide the following information: Employee's name, address and telephone number; Employee's identification number; patient's name; hospital name and telephone number; Doctor's name and telephone number; and diagnosis.

If you fail to comply with the Plan's precertification requirements, the Expense Incurred for such admission or treatment will be reduced by $200. Also, if your failure to comply with the Plan's precertification requirements results in a penalty, the reduction in Expense Incurred will **not** be applied to satisfy the Plan's Out-Of-Pocket Maximum.

This precertification requirement is your responsibility, not your health care provider's responsibility. If the Hospital or provider tells you they will call the Plan's utilization review provider and they do not, the benefit reduction described above will still apply.

C. Right to Review of Advice Under Precertification Requirements.

If, in connection with the Plan's precertification requirements, you or your Dependent are advised by the Plan's utilization review provider that a contemplated medical service, therapy,

treatment or purchase of medical equipment (a "Medical Service" for purposes of this section) does not satisfy criteria, does not meet clinical guidelines or clinical review criteria, or is not covered, in whole or part, under the Plan's program of benefits, then you or your Dependent may request to have the Plan's utilization review provider's advice reviewed by a second review firm. If the second review firm determines that the Medical Service does not satisfy criteria, does not meet clinical guidelines or clinical review criteria, or is not covered in whole or part, under the Plan's program of benefits, then you or your Dependent will be entitled to request a review of such determination by the Claims Appeal Committee. The review shall take place at the next quarterly meeting of the Claims Appeals Committee, except that any request made less than 30 days before such meeting will be reviewed at the next following quarterly meeting. The Plan will notify you or your Dependent of the decision.

1. Content of Denial Notice on Review. Written notice of denial will explain the specific reason(s) for the denial and include information sufficient to identify the claim involved, specific reference to the pertinent provision of the Plan documents on which the denial is based and a discussion of the decision. The notice will notify you or your Dependent of the right to receive a copy of any records relevant to the determination, free of charge. The notice will inform you or your Dependent if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion, provide the scientific or clinical judgment for the determination or offer a copy free of charge upon request and inform you or your Dependent of the right to request the diagnosis and treatment codes for the claim and their corresponding meanings. The notice will also inform you or your Dependent of the right to bring a civil action under ERISA or to request an external review from an independent review organization following denial on appeal and inform you or your Dependent if an internal rule, guideline, protocol or other similar criterion was relied upon and offer a copy free of charge upon request.

2. External Review of a Denied Health Claim.

(a) Right to Request External Review. You or your Dependent may request an external review of their denied health claim consistent with external review rights under available guidance issued by the Departments of Health and Human Services and Labor and the Internal Revenue Service.

(b) Claims Eligible for External Review. Only health claims involving questions of medical judgment are eligible for external review. Other health claims are not eligible for external review.

(c) Procedure. To request external review of a denied health claim, you or your Dependent must send a written request for an external review of the claim denial to the Plan no later than four months after the date you or your Dependent receives the notice of denial. Any individual filing a timely request for review may submit additional materials for consideration on review, including a written explanation of and comments on the issues.

Your right hereunder to request review is independent of, and shall not substitute for or impair, your rights under the Plan's Rules and Regulations to appeal from or have reviewed a denied claim.

COORDINATION OF BENEFITS

The Plan has rules for coordinating your benefits with Other Coverage. If you and/or any of your Dependents are eligible for Other Coverage, the Comprehensive Medical Expense Benefits, Vision Expense Benefits and Dental Expense Benefits described in this SPD and the Prescription Drug Benefits as described in the insert included with this SPD and paid to you will be coordinated with any benefits received under the Other Coverage. This system of paying claims eliminates double payment for the same illness or injury and at the same time provides benefits for the covered expenses you incur.

A. How It Works

The amount payable under any Other Coverage will be taken into account in determining the amount payable under this Plan. You will receive benefits otherwise payable under this Plan in the full amount allowed by this Plan or, because of the Other Coverage, you will receive a reduced benefit through this Plan. Please review the Example below to better understand how the Plan coordinates benefits with Other Coverage. Please contact the Plan Office if you have questions about how the Plan coordinates benefits. In addition, special rules apply if the Plan is secondary and the services are provided by a PPO Provider.

"Other Coverage" means any plan (excluding individual policies or contracts other than franchise coverage) providing benefits or services for or by reason of medical care or treatment under an insurance policy, any governmental programs or coverage required or provided by any statute or any coverage:

1. Provided under hospital or medical service plans or other prepayment coverage, labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans; or

2. Sponsored or provided through a school or other educational institution.

The term "Other Coverage" will be construed to mean each separate benefit provision if the plan contains two or more separate benefit provisions (a) some of which by the terms of the policy, contract or other arrangement reserve the right to consider the benefits payable under other plans in determining its benefits, and (b) some of which do not reserve such right.

Benefits under this Plan will be coordinated in the same fashion with benefits which would have been payable under the Other Coverage if claim had been properly made.

Important

If your spouse is eligible for medical care or treatment provided by a health maintenance type of organization ("HMO") and does not utilize the services, facilities or providers covered by such an organization, your spouse will only be eligible for benefits from this Plan on a secondary basis. In the event the Plan cannot determine the benefits that would have been payable under the HMO if your spouse had utilized the services, facilities or providers covered by such an organization, the Plan will assume the HMO pays benefits on the same basis as this Plan.

B. Example

The following example illustrates how the Plan's coordination of benefit rules apply when Other Coverage determines its benefits first. This is just one example. Different rules apply to different benefits under the Plan. Review this SPD carefully and contact the Plan Office if you have questions regarding how these rules will affect a particular Plan benefit.

John is an Employee with Dependent coverage under the Plan for his wife, Betsy. Betsy is also covered under her employer's group health plan ("Other Coverage"). Betsy incurs Covered Expenses during an inpatient PPO Hospital stay. The Other Coverage is "primary" and so its benefits are determined first. Any Covered Expenses unpaid after the Other Coverage has determined its benefits will be paid by the Plan, **subject to the Plan's Deductible and Benefit Payment Percentages and any other Plan rules applicable to the Covered Expenses**. In no event may payment exceed 100% of the amount the Plan would have paid if the individual was not eligible for Other Coverage.

C. Benefit Determination

If an Employee or Dependent is eligible for Other Coverage, benefits will be paid under the Plan in accordance with the first of the following provisions that apply and that determine the order of benefit payments:

1. General Rules. When you or your Dependent are covered under this Plan under COBRA Coverage, and such person is covered as an employee or a dependent under the Other Coverage, the Plan will determine its benefits after the Other Coverage.

When you are covered as a Dependent under this Plan and not covered as a Dependent under the Other Coverage, the Plan will determine its benefits after the Other Coverage.

When you are covered as a part-time Employee under this Plan and as a full-time employee under the Other Coverage, the Plan will determine its benefits after the Other Coverage.

2. Rules for Dependent Children of Married Parents or Whose Parents Live Together Without a Court Decree. If a Dependent is covered under this Plan and under Other Coverage and the Dependent's parents are married (not divorced or separated) or the parents live together but have never been married and a court decree does not exist, the following rules apply:

(a) Subject to (b) and (c) below, the benefits of a plan which covers the child as a dependent of the parent whose date of birth, excluding year, occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose date of birth, excluding year, occurs later in a calendar year. This order of benefit determination is called the "Birthday Rule";

(b) If both parents' birthdays are on the same day, the benefits of the plan covering the person for the longer period of time will be determined before the benefits of the plan covering such person for a shorter period of time; or

(c) If the Other Coverage does not include the "Birthday Rule" in its coordination of benefits rule, the rules set forth in the Other Coverage will determine the order of benefits. However, if the Other Coverage does not have a provision for coordinating benefits, the Plan will determine its benefits after the Other Coverage.

3. Rules for Dependent Children of Divorced or Separated Parents or Parents Who Were Never Married But a Court Decree Exists. If a Dependent is covered under this Plan and under Other Coverage and the Dependent's parents are divorced or separated or were never married but a court decree exists, the following rules apply:

(a) If a court decree awards joint custody of a child without assigning financial responsibility or requires each parent to maintain coverage for health care expenses, the "Birthday Rule" will apply;

(b) If a court decree states that one of the parents is responsible for the child's health care coverage, the order of payment is:

(i) The plan of the financially responsible parent;

(ii) The plan of the spouse of the parent with financial responsibility;

(iii) The plan of the parent who is not financially responsible; and

(iv) The plan of the spouse of the parent who is not financially responsible.

(c) If a court decree does not provide for joint custody and does not assign financial responsibility or require each parent to maintain coverage for the child's health coverage, the order of benefit payment is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the noncustodial parent; and

(iv) The plan of the spouse of the noncustodial parent.

If none of the above rules determines the order of coordination, the plan under which you or your Dependent has been covered longer will determine benefits before the benefits of the plan covering such person for the shorter period of time.

D. Non-Recognition

If Other Coverage, which is sponsored, maintained or contributed to by a person's employer or former employer, contains provisions that operate to do any of the following, the provision will be of no force or effect and this Plan will coordinate its benefits with the benefits of the Other Coverage as if the provision had not existed:

1. Modifies, limits or reduces its benefits for the person due to coverage under another plan;

2. Effectively shifts coverage liability to this Plan in a manner designed to avoid any liability under the Other Coverage;

3. Effectively avoids the customary operation of this Plan's coordination of benefit rules; or

4. Excludes the person from eligibility under the Other Coverage due to coverage under another plan.

Also, if Other Coverage sponsored or maintained by a person's employer or former employer provides: (a) that the person will not be considered to be covered by the Other Coverage if he or she is covered under another health plan (such as the Plan); or (b) that benefits will be payable under this Plan before the benefits of the Other Coverage are payable, then the Plan will consider the provision to be void and will coordinate its benefits with the benefits that would have been payable under the Other Coverage if the provision had not existed.

E. Right to Recover and Direct Payment

If payment has been made by this Plan in excess of what the Plan should have paid, the Trustees or their delegates have the right to recover such excess from any individual with respect to whom such payments were made or any insurance company or organization which acquires the payment.

In the event payments which should have been made under this Plan have been made under any Other Coverage, the Trustees have the right in their sole discretion to pay any organization making such payments any amounts determined to be warranted and amounts so paid will be deemed benefits under the Plan and will fully discharge the Plan's liability to the extent of the payments.

F. Right to Information

For the purposes of enforcing or determining the order of benefits under this Coordination of Benefits provision, the Trustees or their delegates may release to or obtain from any insurance company, organization or individual any information which the Trustees or their delegates deem to be necessary for such purposes without the consent of or notice to you or your Dependents. Any person claiming benefits under this Plan must provide the Trustees any necessary information for such purposes.

G. Dual Coverage

Benefits are also coordinated within the Plan if you are covered under the Plan as an Employee and a Dependent or if you are a Dependent of two employees subject to application of the Deductible and the applicable percentage payable. Please review the Example below to better understand how the Plan coordinates benefits if you have dual coverage. The Plan will first pay benefits for you as an Employee and then as a Dependent, provided the total amount paid by the Plan will not exceed 100% of the Expense Incurred. If you are a Dependent of two employees, the Plan will determine the order of benefit payment in accordance with section C above and the total amount paid by the Plan will not exceed 100% of the Expense Incurred. More information regarding Dual Coverage is contained under paragraph E of the "Eligibility Rules – When Plan Coverage Begins" section of this Booklet.

Example

John is an Employee who is also eligible for Dependent coverage under the Plan. Both classes have a $1,000 calendar year Deductible and a 75% in-network percentage payable. John incurs a $10,000 charge for in-network services and has not satisfied the calendar year Deductible.

The Plan would first process John's claim as an Employee as follows:

- Assess the $1,000 calendar year Deductible;
- Then pay 75% of the $9,000 balance;
- Resulting in a $6,750 payment on the claim by the Plan.

The Plan will then process the remaining balance of John's claim as a Dependent as follows:

- Remaining balance is $3,250;
- Assess the $1,000 calendar year Deductible;
- Then pay 75% of the $2,250 balance;
- Resulting in a payment of $1,687.50.

This results in the Plan paying a total of $8,437.50 on behalf of John's claim and John will owe $1,562.50.

COORDINATION WITH MEDICARE

"Medicare" means Title XVIII of the Social Security Act of 1965, as amended from time to time.

A. When the Plan Is Primary For Person Over 65

If an Employee or the Employee's Dependent spouse is age 65 or older and is not entitled to Medicare as an End Stage Renal Disease (ESRD) beneficiary, and the Employee has "current employment status" (as defined in applicable federal laws or regulations governing coordination with Medicare as in effect from time to time), benefits will be payable under the Plan without regard to such person's entitlement or potential entitlement to Medicare.

B. When the Plan is Primary for Disabled Person Under Age 65

Benefits will be payable under the Plan without regard to an Employee's or Dependent's entitlement or potential entitlement to Medicare if the person is:

- Under age 65;
- An Employee (or Dependent of an Employee) who has "current employment status" as defined in applicable federal laws or regulations governing coordination with Medicare as in effect from time to time; and
- Entitled or potentially entitled to Medicare as a disabled beneficiary other than as an ESRD beneficiary.

C. When the Plan Is Primary for ESRD Beneficiaries

Benefits will be payable under the Plan without regard to an Employee's or Dependent's entitlement to Medicare if the person is entitled to Medicare as an ESRD beneficiary, and not more than 30 months have elapsed since the earliest of the following:

- The month in which the person began a regular course of renal dialysis if the person takes a course in self-dialysis or if the person does not take a course in self-dialysis, the fourth month of dialysis;
- The month in which the person received a kidney transplant;
- The month in which the person was admitted to the hospital in anticipation of a kidney transplant that was performed within the next two months; or
- The second month before the kidney transplant was performed if performed more than two months after admission.

D. When the Plan Is Secondary

The Plan is secondary to Medicare in all other cases. Benefits otherwise payable under the Plan for Allowable Expenses will be reduced so that the sum of benefits payable under the Plan and Medicare shall not exceed the total of such Allowable Expenses.

"Allowable Expenses" means reasonable charges as determined by the Plan, which are for medical care and treatment of the type and kind covered under both Medicare and the Plan.

E. All Eligible Individuals Considered Enrolled in Medicare

Benefits will be considered payable by Medicare Part A or B whether or not the person eligible for Medicare benefits has enrolled in or applied for benefits under Medicare Part A and B or has failed to take any other action required by Medicare to qualify for benefits. However, benefits will only be considered payable by Medicare Part D if the person has enrolled in or applied for benefits under Medicare Part D.

IMPORTANT

You (or your Dependent) should apply for coverage under Medicare as soon as eligible. The Plan will coordinate benefits with Medicare Parts A and B when you become eligible for Medicare coverage, regardless of whether you enroll.

SUBROGATION AND REIMBURSEMENT

A. Plan's Right to Subrogation and Reimbursement

The Plan is entitled to subrogation or reimbursement with regard to all rights of recovery of you, or your Dependent or representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts and any other agents, persons or entities that may receive a benefit on behalf of you or your Dependent (collectively, for purposes of this Subrogation and Reimbursement provision, "Person"), to the extent of any amounts which the Plan has paid or may become obligated to pay on account of any claim against any person, organization or other entity in connection with the injury, sickness, accident or condition to which the claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverages and any employer of a Person under the provisions of a Worker's Compensation or Occupational Disease Law or any individual policy of insurance which is maintained by a Person. The Plan is also entitled, to the extent of payments made or to be made on account of the claim, to reimbursement from the proceeds of any settlement, judgment or payments from any Source that may result from the exercise of any rights of recovery by a Person.

Such subrogation and reimbursement rights shall apply on a priority, first-dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether a Person is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses. Once the Plan makes or is obligated to make payments on behalf of a Person on account of the claim, the Plan is granted, and the Person consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Person from any Source.

B. Action Required of Person

If requested in writing by the Trustees, you and/or your Dependent must take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover payments made or to be made by the Plan from any Source and must hold that portion of the total recovery from any Source which is due for payments made or to be made in trust for the benefit of the Plan to be paid to the Plan immediately upon recovery thereof. You nor your Dependent must not do anything to impair, release, discharge or prejudice the rights referred to in this Subrogation and Reimbursement provision. You and/or your Dependent must assist and cooperate with representatives designated by the Plan to recover payments made by the Plan and do everything that may be necessary to enable the Plan to exercise its subrogation and reimbursement rights described in this section.

The Trustees may also require you and/or your Dependent to execute a Subrogation and Reimbursement Agreement ("Agreement") in a form provided by and acceptable to the Trustees

as a condition to receiving benefits for a claim. Further, the Plan has the right to suspend all benefit payments if the Agreement is not executed by you or your Dependent(s) or if the Agreement is modified in any way without the consent of the Plan. However, in its sole discretion, if the Plan advances claims payments in the absence of an Agreement, or if the Plan advances claims payments in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to reimbursement or subrogation. If you or your Dependent is a minor or incompetent to execute the Agreement, that person's parent, the Participant (in the case of a minor dependent child), the Participant's spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Plan. You and your Dependent must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Plan. In this regard, you and your Dependent agree that the amount the Plan has advanced or is obligated to advance in benefits received from any Source will be immediately deposited into a trust for the Plan's benefit and the Plan has an equitable lien by agreement which is enforceable under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Plan's subrogation and reimbursement rights apply regardless of whether the Person executes an Agreement.

C. Enforcement of Rights

The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests under this provision through any appropriate legal or equitable remedy, including but not limited to the initiation of a recognized cause of action under ERISA section 502(a)(3), including injunctive action to ensure the claim payment amounts that the Plan has advanced are preserved and not disbursed, or any other applicable federal or state law; the imposition of a constructive trust; or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment or otherwise. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Plan's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Person, as opposed to the general assets of the Person. Enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Person.

Further, in the event a Person receives monies as the result of an injury, illness, sickness, accident or condition and the Plan is entitled to such monies in accordance with this Subrogation and Reimbursement provision and is not reimbursed the amount it has paid for such injury, illness, sickness, accident or condition, the Plan shall have the right to reduce future payments due to you or your Dependent or the Employee of whom such person is a Dependent or any other Dependent of such Employee by the amount of benefits paid by the Plan. The right of offset shall not, however, limit the rights of the Plan to recover such monies in any other manner described in this Subrogation and Reimbursement provision.

D. Person's Attorney's Fees

The Plan's subrogation and reimbursement rights apply to any recovery by the Person without regard to legal fees and expenses of the Person. The Person shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, illness, sickness, accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses, unless the Trustees, in their sole discretion, have agreed in writing to discount the Plan's claim by an agreed upon amount of such fees or expenses.

E. Disavowal of Common Law Defenses

The Plan specifically disavows any claims that a Person may make under any federal or state common law defense, including, but not limited to, the common fund doctrine, the double-recovery rule, the make-whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. This means that the Plan's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the Person from any Source without regard to legal fees and expenses of the Person and the Person is solely responsible for paying all legal fees and expenses. It also means that the Person grants priority, first-dollar security, interest and a lien on any recovery received from any Source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such injury, sickness, accident or condition.

HOW TO FILE A CLAIM

All claims should be submitted to the Plan Office as soon as possible. Benefits will be paid by the Plan only if a claim is submitted within 365 days of being incurred, unless the Trustees determine, in their sole discretion, that failure to file the claim within 365 days should be excused for good cause.

A. Eligibility

All questions regarding eligibility should be directed to the Plan Office.

B. Life Insurance Benefit and Accidental Death and Dismemberment Benefit

All claims regarding this coverage should be directed to the Plan Office. You should contact the Plan Office for a claim form. All claims for Life Insurance and Accidental Death and Dismemberment Benefits should be submitted as soon as possible. The deadline for filing a claim for Life Insurance Benefits is 365 days, unless it was not reasonably possible to give proof within the required time or the person who has the right to claim benefits, is not legally competent.

The deadline for filing a claim for Accidental Death and Dismemberment Benefits is 90 days unless it was not reasonably possible to give proof within the required time or you or the person who has the right to claim benefits is not legally competent.

C. Accident and Sickness Weekly Benefits

All claims and questions regarding the Plan's Accident and Sickness Weekly Benefits should be directed to the Plan Office. You should contact the Plan Office for a claim form.

The claim form for the Plan's Accident and Sickness Weekly Benefits should be completed by you, your Employer and your Doctor and returned to the Plan Office as soon as possible. If your Disability extends over a period of weeks, you will be requested to supply evidence of regular care and continuing proof of Disability. More information is provided in the section of this SPD describing this benefit.

All claims should be submitted to the Plan Office as soon as possible. The deadline for filing a claim for Accident and Sickness Weekly Benefits is **365 days** after you become Disabled.

D. Vision Expense Benefit

If you receive Covered Vision Services from a VSP participating provider, your provider will submit your claim to the vision care company for processing and VSP will pay the provider directly for covered services and eyewear. However, if you receive Covered Vision Services from a Non-VSP participating provider, you are responsible for paying the provider in full and then submitting a claim for reimbursement to VSP. Your Vision Expense Benefit insert provides more information on submitting claims. **Please keep mind that claims for reimbursement for**

services or eyewear received from a Non-VSP participating provider must be submitted to the vision care company within 365 days from the date of service. All claims should be submitted to:

VSP
Member Claims
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

E. Dental Expense Benefit

All questions regarding the Plan's Dental Expense Benefit should be directed to the Plan Office. You should contact the Plan Office for a claim form.

All claims should be submitted to Delta Dental as soon as possible. The deadline for filing a claim for Dental Expense Benefits is **365 days** from the date the claim is incurred. Claims are to be submitted to:

Delta Dental
P.O. Box 9089
Farmington Hills, MI 48333-9089

F. Comprehensive Medical Expense Benefits

In most cases, if you receive Comprehensive Medical Expense Benefits from a PPO Provider, you will not need to submit a claim for payment. The PPO Provider will submit the claim on your behalf, and the Plan will make payment directly to the PPO Provider. However, if you receive Comprehensive Medical Expense Benefits from a Non-PPO Provider, or in some other circumstances, you may be required to submit a claim form to receive payment of benefits.

You should contact the Plan Office for a claim form. Also, all questions regarding this coverage should be directed to the Plan Office.

All claims should be submitted to the Plan Office as soon as possible. The deadline for filing a claim for Comprehensive Medical Expense Benefits is **365 days** from the date the claim was incurred, unless the Trustees, in their sole discretion, determine that the failure to file the claim timely should be excused for good cause.

G. Physical Examinations and Autopsies

The Plan, at its own expense, has the right and opportunity to examine any Employee or Dependent whose injury or sickness is the basis of a claim when and as often as it may reasonably require while a claim is pending or may require an autopsy in case of death if not forbidden by law.

H. Altered or Forged Claim Forms

Any claim form submitted on behalf of an Employee or Dependent which is altered or forged will be rejected by the Plan and the Board of Trustees reserves the right to forward the altered or forged document to a local law enforcement agency for whatever legal action the agency deems to be appropriate.

INITIAL DECISION ON CLAIMS AND APPEAL PROCEDURES

These provisions will govern all claims and appeals except for those claims made on the basis of an insurance contract governing insured benefits (Life Insurance Benefit and Accidental Death and Dismemberment Benefit) which will be determined solely by the insurance company and except for claims for the Plan's Vision Expense Benefit which will be determined solely by VSP and claims for the Plan's Dental Expense Benefits which will be determined solely by Delta Dental. The claims procedures for all benefits are described below.

You or your Dependent may authorize a representative to act on your behalf, provided any such authorization must be in writing.

Comprehensive Medical Expense Benefits and Accident and Sickness Weekly Benefits

A. Time Limits on Decisions of Claims

1. Health Claims.

(a) Urgent Care Claims. The Plan will inform the claimant of the decision on an Urgent Care claim as soon as possible, but not later than 72 hours after the claim was filed. If, during the review, additional information is required from the claimant, the claimant will be notified within 24 hours and will be provided at least 48 hours to provide the information. In such a case, the Plan will inform the claimant of the decision no later than 48 hours after the additional information is submitted.

An Urgent Care claim is a claim for medical care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of the claimant or subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an Urgent Care claim is determined by the Plan, deferring to the judgment of a Doctor with knowledge of the claimant's condition.

(b) Pre-Service Claims. The Plan will inform the claimant of the decision on a Pre-Service claim within 15 days of the date the claim is filed, regardless of whether all necessary information was included with the claim. Within that 15-day period, the claimant will receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 15-day benefit determination period, by which the claimant can expect to receive a decision.

If, during the review, additional information is required from the claimant, the claimant will be notified within the required time period for notice of a decision detailed above. The claimant will have 45 days to provide such information. Following the claimant's provision of the required information, the Plan will issue a written notice of the decision within 15 days of receipt of the information. If the required information is not received within 45 days,

the claim will be denied and the Plan will issue a denial notice containing specific information as noted in the "Content of Denial Notice on a Claim" section of this SPD.

A Pre-Service claim is a claim for medical care or treatment with respect to which the Plan requires approval of the benefit in advance of obtaining medical care.

(c) Post-Service Claims. The Plan will inform the claimant of the decision on a Post-Service claim within 30 days of the date the claim is filed, regardless of whether all necessary information was included with the claim. Within that 30-day period, the claimant will receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 30-day benefit determination period, by which the claimant can expect to receive a decision.

If, during the review, additional information is required from the claimant, the claimant will be notified within the required time period for notice of a decision detailed above. The claimant will have 90 days to provide such information. Following the claimant's provision of the required information, the Plan will issue a written notice of the decision within 15 days of receipt of the information. If the required information is not received within 90 days, the claim will be denied and the Plan will issue a denial notice containing specific information as noted in the "Content of Denial Notice on a Claim" section of this SPD.

(d) Concurrent Care Claims. Any request by a claimant to extend the duration or number of treatments previously approved through a Pre-Service claim is a Concurrent Care claim. The Plan will inform the claimant of the decision on a Concurrent Care claim involving Urgent Care within 24 hours after receiving the claim if the claim was received by the Plan at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. The claimant may provide any additional information required to reach a decision. If the Concurrent Care claim does not involve Urgent Care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (i.e., Urgent, other Pre-Service or Post-Service).

2. Accident and Sickness Weekly Benefit Claims. If a claim for Accident and Sickness Weekly Benefits is denied in whole or in part, the Plan will inform the claimant of the denial within 45 days of the date the initial claim was received regardless of whether all necessary information was included with the claim.

(a) Extension. Special circumstances may require more time to review a claim. If so, written notice will be provided within the 45-day period explaining the reason for the delay and setting a date upon which the notice will be issued and such date will not be later than 30 days after the end of the initial 45-day benefit determination period. If special circumstances again require more time to review a claim, a second 30-day extension may be taken subject to written notice within the initial 30-day extension, subject to the same rules as detailed above.

(b) Additional Information. If, during the review, additional information is required from the claimant, the claimant will be so notified within the required time periods for

notice of a decision or extension detailed above. The claimant will have 90 days to provide such information. If the required information is not received within 90 days from the claimant, the claim will be denied and the Plan will issue a denial notice containing specific information as noted in the "Content of Denial Notice on a Claim" section of this booklet. If the claimant provides the required information, the Plan will issue a written notice of any denial within 30 days, unless special circumstances require a second 30-day extension, subject to the rules detailed above.

B. Content of Denial Notice on a Claim

1. All Claim Denial Notices. If a claimant's claim is partially or wholly denied, the claimant will receive notice from the Plan:

- Stating the specific reason(s) for the denial including information sufficient to identify the claim involved;
- Stating the specific reference to the pertinent provision of the Plan document on which the denial is based;
- Describing and explaining any additional material or information required of the claimant in order to make the claimant's claim valid;
- Explaining what steps must be taken to have the initial claim denial reviewed;
- Explaining the initial decision will be a final decision unless the decision is appealed as described below; and
- Informing the claimant of the right to bring a civil action under ERISA section 502(a) following a denial on appeal.

2. Health Claim Denial. If the claim is a denied health claim, the notice will also provide and/or advise the claimant of the following:

- If the denial is based on a determination of medical necessity or experimental treatment or similar exclusion, provide an explanation of the scientific or clinical judgment for the determination or offer a copy free of charge upon request;
- The right to request the diagnosis and treatment codes for the claim and their corresponding meanings free of charge;
- Copies of any internal rule, guideline, protocol or other similar criterion that was relied upon or offer a copy of such rule, guideline, protocol or similar criteria free of charge upon request;
- If an Urgent Care claim is denied, a description of the expedited review process applicable to such claim; and

- The right to request an external review with an independent review organization, following denial on appeal of a claim involving a question of medical judgment.

3. Accident and Sickness Weekly Benefit Denial. If the denied claim is for Accident and Sickness Weekly Benefits, the notice will also provide and/or advise the claimant of the following:

- A discussion of the decision, including the basis for disagreement with or for not following:
  - The views of a health care professional treating the claimant or vocational professional who evaluated the claimant;
  - The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; and
  - A disability determination made by the Social Security Administration regarding the claimant;
- If the denial is based on a determination of medical necessity or experimental treatment or similar exclusion, provide an explanation of the scientific or clinical judgment for the determination or offer a copy free of charge upon request;
- Copies of any internal rule, guideline, protocol or similar criteria that was relied upon or a statement that such internal rule, guideline, protocol or similar criteria does not exist; and
- He may request, copies of all documents, records and other information relevant to his claim for benefits or reasonable access to such documents, records and other information free of charge.

C. Appeal of Denied Claim -- How to Request a Review of a Denied Claim

If a claimant wants to have the denied claim reviewed, the claimant must send a written request for a review of the claim denial to the Plan no later than 180 days after the date the notice of denial is mailed by the Plan. Any claimant filing a timely request for review may submit additional materials for consideration on review including a written explanation of the issues and comments on the issue.

D. Review of Denied Claim

1. Full and Fair Review. The Trustees or Claims Appeal Committee will review the denied claim according to the terms and conditions of the Plan. The review will consider all comments, documents, records and other information submitted by the claimant, regardless of whether the information was submitted or considered in the initial determination. The claimant will have the right to access and copy all documents, records and other information relevant to

the claim (information relied upon, submitted, considered or generated in the review or demonstrating compliance with the claims processing requirements). If the decision requires medical judgment, the Board of Trustees or Committee will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

The claimant will receive copies of all new or additional information considered, relied upon or generated during the appeal as well as any new or additional rationale for the denial, if any. Such new or additional evidence or rationale will be provided as soon as possible and sufficiently in advance of the Trustees' or the Claims Appeal Committee's final decision in order to give the claimant a reasonable opportunity to respond.

2. Time of Decision.

(a) Urgent Care Claims. The Plan will inform the claimant of the decision on the review of an Urgent Care claim within 72 hours of the Plan's receipt of the request for review.

(b) Pre-Service Claims. The Plan will inform the claimant of the decision on the review of a Pre-Service claim within 30 days of the Plan's receipt of the request for review.

(c) Post-Service Claims. The Trustees or Claims Appeal Committee will meet quarterly to make a determination on appeals of Post-Service Claims received since the prior meeting, provided any appeal filed within the 30-day period before a meeting will be decided at the next following quarterly meeting. The Trustees or Claims Appeal Committee may review and make determinations, without a meeting, more frequently than quarterly. If special circumstances require a delay in the decision, the decision will be made no later than the third quarterly meeting following receipt of the appeal, and the Plan will notify the claimant of the reasons for the delay prior to any extension. The Plan will notify the claimant of the decision within five days of the date the decision is made.

(d) Concurrent Care Claims. The Plan will inform the claimant of the decision on the review of a Concurrent Care claim within 72 hours of the Plan's receipt of the request for review if the claim involves an Urgent Care claim; 30 days if the claim involves a Pre-Service claim; and 60 days if the claim involves a Post-Service claim.

(e) Accident and Sickness Weekly Benefits. The Trustees or Claims Appeal Committee will meet quarterly to make a determination on appeals of Accident and Sickness Weekly Benefits received since the prior meeting, provided any appeal filed within the 30-day period before a meeting will be decided at the next following quarterly meeting. The Trustees or Claims Appeal Committee may review and make determinations, without a meeting, more frequently than quarterly. If special circumstances require a delay in the decision, the decision will be made no later than the third quarterly meeting following receipt of the appeal, and the Plan will notify the claimant of the reasons for the delay prior to any extension. The Plan will notify the claimant of the decision within five days of the date the decision is made.

3. Content of Denial Notice on Review.

(a) Notices of Denial on All Appeals. Written notice of denial on appeal will:

- Explain the specific reason(s) for the denial and include information sufficient to identify the claim involved;
- State the specific reference to the pertinent provision of the Plan document on which the denial is based and an explanation of the basis for the decision;
- Notify the claimant of the right to receive a copy of any records relevant to the determination, free of charge, or reasonable access to such documents, records and other information; and
- Include a statement of the claimant's right to bring a civil action under ERISA section 502(a) following a denial on appeal.

(b) Denial of Health Claim on Appeal. Written notice of denial of a health claim on appeal will also provide and/or advise the claimant:

- If the denial on appeal is based on a determination of medical necessity or experimental treatment or similar exclusion, provide an explanation of the scientific or clinical judgment for the determination or offer a copy free of charge upon request;
- Of the right to request the diagnosis and treatment codes for the claim and their corresponding meanings free of charge;
- Copies of any internal rule, guideline, protocol or other similar criteria that was relied upon or offer a copy free of charge upon request; and
- Of the right to request an external review from an independent review organization for a denial on appeal based on medical judgment.

(c) Denial of Accident and Sickness Weekly Benefit on Appeal. Written notice of denial of a claim for Accident and Sickness Weekly Benefits on appeal will also:

- Include a discussion of the decision, including the basis for disagreement with or for not following:
    - The views of a health care professional treating the claimant or a vocational professional who evaluated the claimant;

- The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; and

- A disability determination made by the Social Security Administration regarding the claimant;

- If the denial is based on a determination of medical necessity or experimental treatment or similar exclusion, provide an explanation of the scientific or clinical judgment for the determination or offer a copy free of charge upon request;

- Include copies of any internal rule, guideline, protocol, standard or similar criteria that was relied upon or a statement that such rule, guideline, protocol, standard or similar criteria does not exist; and

- Include the calendar date by which the claimant may bring a civil action under ERISA section 502(a).

4. External Review of a Denied Health Claim.

(a) Right to Request External Review. Claimants may request an external review of their denied health claim in accordance with and to the extent required by available guidance issued by the Departments of Health and Human Services and Labor and the Internal Revenue Service.

(b) Claims Eligible for External Review. Only health claims involving questions of medical judgment or rescission are eligible for external review. Other health claims and all claims for Accident and Sickness Weekly Benefits are not eligible for external review.

(c) Procedure. To request external review of a denied health claim, the claimant must send a written request for an external review of the claim denial to the Plan no later than four months after the date the claimant receives the notice of denial of the claim on appeal. Any claimant filing a timely request for review may submit additional materials for consideration on review, including a written explanation of and comments on the issues.

E. Further Action

In the event a claim for benefits has been denied, no lawsuit or other action against the Plan or its Trustees may be filed until the matter has been submitted for review in accordance with the claims appeal provisions set forth in this Initial Decision on Claims and Appeal Procedures section. Further, in the event a claim has been submitted for review in accordance with such procedures and the claim has again been denied, no lawsuit or other action against the Plan or its Trustees may be filed after 12 months from the date the claimant has been given written notice of the Trustees' decision on his appeal in accordance with section D.3, Content of Denial Notice on Review, above.

If the time limitation described above is less than that required by law, such limitation is extended to conform to the minimum period permitted by law.

F. Life Insurance and Accidental Death and Dismemberment Benefits

1. Claim Denial. If a claim for benefits is wholly or partly denied, you or your beneficiary will be furnished with written notification of the decision. This written notification will:

(a) Give the specific reason(s) for the denial;

(b) Make specific reference to the provisions upon which the denial is based;

(c) Provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and

(d) Provide an explanation of the review procedure.

2. Claim Appeal. On any claim, the claimant or his representative may appeal to the insurance carrier for a full and fair review. To do so, he or she:

(a) Must request a review upon written application within:

- 180 days of receipt of claim denial if the claim requires the insurance carrier to make a determination of disability; or
- 60 days of receipt of claim denial if the claim does not require the insurance carrier to make a determination of disability; and

(b) May request copies of all documents, records, and other information relevant to the claim; and

(c) May submit written comments, documents, records and other information relating to the claim.

The insurance carrier will respond in writing with their final decision on the claim.

3. Policy Interpretation. The insurance carrier has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the insurance policy. This provision applies where the interpretation of the insurance policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

4. Incontestability. Except for non-payment of premiums, your Life Insurance Benefit cannot be contested after two years from its effective date.

All statements made by the Plan or you under the insurance policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or your representative.

5. **Legal Actions.** Legal action cannot be taken against the insurance carrier:

(a) Sooner than 60 days after the date written proof of loss is furnished; or

(b) More than 6 years after the date proof of loss is required to be furnished according to the terms of the insurance policy.

G. Dental Expense Benefits

If you receive notice of a denial and you think that Delta Dental incorrectly denied all or part of your claim for Dental Expense Benefits, you or your Dentist should contact Delta Dental's Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (800) 524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to recheck its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

1. **Formal Claims Appeal Procedure.** If you receive notice of a denial of a claim for Dental Expense Benefits, you, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your claim, send your request in writing to: **Dental Director, Delta Dental, PO Box 30416, Lansing, Michigan 48909-7916**. Please include your name and address, your Member ID, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the contract between Delta Dental and your employer or organization and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided. If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the reviewer will

consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination. The reviewer will make a determination within 60 days of receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of denial during the Formal Claims Appeal Procedure will meet the requirements described below.

2. Manner and Content of Notice. Your notice of denial will inform you of the specific reason(s) for the denial, the pertinent Plan provision(s) on which the denial is based, the applicable review procedures for dental claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your claim free of charge. This notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary and a statement that you have a right to bring a civil action in court if you receive a denial after your claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the denial, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the denial is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

H. Vision Expense Benefits

1. Complaints and Grievances. You or your Dependent shall report any complaints and/or grievances to VSP at:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to VSP verbally or in writing. You or your Dependent may submit written comments or supporting documentation concerning his/her complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than 120 days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, VSP will notify you or your Dependent of the expected resolution date. Upon final resolution, VSP will notify you or your Dependent of the outcome in writing.

2. Claim Denial Appeals. If, under the terms of this Plan, a claim for vision benefits is denied in whole or in part, a request may be submitted to VSP by you or your authorized representative for a full review of the denial. You and your Dependent may designate

any person, including his/her provider, as his/her authorized representative. References in this section to "you or your Dependent" include your authorized representative, where applicable.

(a) Initial Appeal. The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the individual for whom the claim was denied, including your name, your Member Identification Number, your or your Dependent's name and date of birth, the provider of services and the claim number. You and your Dependent may review, during normal working hours, any documents held by VSP pertinent to the denial. You and your Dependent may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to you and your Dependent as follows:

Denied Claims for Services Rendered: within 30 calendar days after receipt of a request for an appeal from you or your Dependent.

(b) Second Level Appeal. If you or your Dependent disagrees with the response to the initial appeal of the claim, you or your Dependent have a right to a second level appeal. Within 60 calendar days after receipt of VSP's response to the initial appeal, you or your Dependent may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to you or your Dependent in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

(c) Other Remedies. When you or your Dependent have completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or you may contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (section 502(a)(1)(B)) [29 U.S.C. 1132(a)(l)(B)], you have the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and you or your Dependent disagree with the outcome.

3. Time of Action. No action in law or in equity shall be brought to recover on the claim prior to you or your Dependent exhausting his grievance rights as described in items 1 and 2 above and/or prior to the expiration of 60 days after the claim and any applicable invoices have been filed with VSP. No such action shall be brought after the expiration of six years from the last date that the claim and any applicable invoices may be submitted to VSP, in accordance with the terms of this Plan.

IMPORTANT PLAN INFORMATION

A. Name of the Plan

The Plan is known as the UFCW Unions and Employers Health and Welfare Plan of Central Ohio.

B. Type of Plan

The Plan is a multiemployer group health plan.

C. Board of Trustees

The Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and the Unions that have entered into collective bargaining agreements relating to the Plan. If you wish to contact the Board of Trustees, please use the following address:

Board of Trustees of the UFCW Unions and Employers
Health and Welfare Plan of Central Ohio
4150 East Main Street, First Floor
Columbus, OH 43213
614-237-7618
800-282-6483

The Board of Trustees is both the Plan Sponsor and the Plan Administrator. As of April 2018, the Trustees of the Plan are:

EMPLOYER TRUSTEES

Don Sattler, SPHR
Manager, Health Care Labor Strategy
The Kroger Co.
1014 Vine Street
Cincinnati, OH 45202

Mr. Steven Springer
Health Care Labor Strategy
The Kroger Co.
1014 Vine Street
Cincinnati, OH 45202

UNION TRUSTEES

Randy A. Quickel
President
UFCW Union, Local No. 1059
4150 East Main Street
Columbus, OH 43213

Mark Fluharty
Secretary-Treasurer
UFCW Union, Local No. 1059
4150 East Main Street
Columbus, OH 43213

EMPLOYER TRUSTEES	UNION TRUSTEES
Rob Francin Senior Director, Labor Relations and HR Compliance CVS Health 200 Campus Drive, Suite 310 Florham Park, NJ 07932	Paul Smithberger Collective Bargaining Director UFCW Union, Local No. 1059 4150 East Main Street Columbus, OH 43213

D. Plan Administrator

The Board of Trustees is the Plan Administrator. As Plan Administrator, the Board of Trustees is responsible for reporting Plan information to government agencies and disclosing information to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Board of Trustees has contractually delegated aspects of Plan administration to other entities.

E. Participating Employers and Unions

Plan participants and beneficiaries may examine a complete list of the Employers and Unions sponsoring the Plan and may obtain a copy of such list for a reasonable charge by writing to the Board of Trustees at the address listed for the Board of Trustees above.

F. Identification Numbers

The identification number assigned to the Board of Trustees by the Internal Revenue Service is 31-0656412. The number assigned to the Plan by the Board of Trustees is 501.

G. Agent For Service of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon any of the Plan's Trustees at the address listed for the Board of Trustees above. Service of legal process may be made upon any Trustee.

H. Collective Bargaining Agreements

This Plan is maintained pursuant to collective bargaining agreements and other written agreements. Plan participants and beneficiaries may examine these agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed above or may obtain copies free of charge from participating Local Unions.

I. Source of Contributions

The Plan's benefits for eligible Employees are provided through Employer and Employee contributions. The amount of Employer and Employee contributions is determined by the provisions of the collective bargaining agreements and other written agreements.

J. Trust Fund

All Plan assets are held in trust by the Board of Trustees. Plan assets are used to provide benefits to participants and pay reasonable administrative expenses.

K. Plan Year

The fiscal records of the Plan are kept separately for each 12-month period ending on December 31.

L. Types and Providers of Benefits.

All Plan benefits, except the Plan's Life Insurance and Accidental Death and Dismemberment Benefits, are provided on a self-funded basis from Plan assets. A staff of individuals hired by the Plan Administrator administer the Plan's self-funded benefits.

The Plan's Life Insurance Benefit and Accidental Death and Dismemberment Benefit are insured and administered by Hartford Life and Accident Insurance Company, the life insurance company listed in your Summary of Benefits insert.

M. Procedure for Obtaining Additional Plan Documents

If you wish to inspect or receive copies of additional documents relating to this Plan, contact the Plan Office in writing at the address shown for the Board of Trustees above. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.

OTHER PLAN INFORMATION

NO AGENT MAY INTERPRET THE PLAN

Only the full Board of Trustees or, with respect to the Plan's insured benefits or Vision Expense Benefits or Dental Expense Benefits, the appropriate insurance carrier, VSP or Delta Dental, respectively, can issue Plan interpretations. If you would like any provisions of this SPD or any of the Plan documents clarified, please contact the Plan Office.

NO GUARANTEE

None of the benefits provided under the Plan are guaranteed by the Board of Trustees, any participating Employer, Union or any other individual or entity. The Plan's benefits may be provided only from assets in the Plan that are collected and available for such purposes. The Board of Trustees reserves the right to interpret, amend, modify or terminate all or a part of this Plan and to take any action it deems desirable to preserve the financial stability of the Plan.

DOCUMENTS CONTROL

This SPD describes the Plan's benefits in general terms and does not provide all of the rules under which the Plan operates. If there is any inconsistency between this SPD and the documents governing the Plan, such as the Plan's Rules and Regulations, Trust Agreement and policies and procedures adopted by the Board of Trustees, or applicable insurance policies or contracts, the documents governing the Plan or applicable insurance policies or contracts will control.

DETERMINATION BY TRUSTEES BINDING

The Trustees or, where Trustee responsibility has been delegated to others, such delegates shall have complete authority to determine the standard of proof required in any case and to apply and interpret this SPD and the Plan's Rules and Regulations. The decisions of the Trustees or their delegates shall be final and binding.

All questions or controversies, of whatsoever character, arising in any manner or between any parties or persons in connection with this Plan or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of this SPD and the Rules and Regulations, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Trustees or, where Trustee responsibility has been delegated to others, to such delegates for decision. The decision of the Trustees or their delegates will be binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court having jurisdiction over such matter.

OVERPAYMENTS

In the event any payment is made by the Plan to, or on behalf of, a person who is not entitled to such payment, the Plan shall have the right to reduce future payments due to such person or the Employee of whom such person is a Dependent or any other Dependent of such Employee by the amount of any such erroneous payment. This right of offset shall not, however, limit the rights of the Plan to recover such overpayments in any other manner.

RETIREE BENEFITS

The Plan's eligibility rules and benefits for retirees are described in another booklet. If you are approaching retirement, please contact the Plan Office for additional information on the Plan's program for retirees.

If you are a retiree receiving benefits from the Plan, or will become one in the future, please understand that the program of benefits for retirees may be terminated at any time. Further, the benefits you receive as a retiree may be modified and the amount that you pay for retiree benefits may be increased at any time.

NOTICE TO THE PLAN

It is important that you notify the Plan Office whenever:

1. You want to change a beneficiary;

2. You are receiving worker's compensation benefits;

3. You return to work after a Disability ends;

4. You enter any branch of military service;

5. You acquire a new Dependent (either through marriage, birth, or adoption);

6. You have a change of marital status;

7. You or your Dependent become eligible for other coverage (such as coverage under your spouse's employer);

8. You terminate employment; or

9. Your Dependent child loses eligibility because he or she no longer qualifies as a Dependent under the Plan (for example, your Dependent child attains the age limit).

It is also important that you notify your Employer and the Plan Office of any change in your home address.

YOUR RIGHTS UNDER ERISA

As a participant in the UFCW Unions and Employers Health and Welfare Plan of Central Ohio, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

A. Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrative office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration);

Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies; and

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

B. Continue Coverage

You also have the right to:

- Continue coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description (or "SPD") and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights; and

- Request a Certificate of Creditable Coverage, free of charge, before losing coverage, when you lose coverage under the Plan, when you become entitled to elect COBRA Coverage, when your COBRA Coverage ceases or within 24 months after losing coverage. To request a Certificate from the Plan, you may call the Plan Office at 1-800-282-6483 or 1-614-237-7618 and request a Certificate or you may send a written request for a Certificate to the Plan Office at 4150 East Main Street, First Floor, Columbus, Ohio 43213.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) under a group health plan by which you are covered after your enrollment date in your coverage.

C. Prudent Actions By Fiduciaries

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

D. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. However, please remember that you must exhaust the Plan's claim and appeal procedures before filing suit, and that certain time limits apply.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

E. Assistance with Your Questions

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

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Federal law requires that if the Plan is providing medical and surgical benefits to an individual in connection with a mastectomy, the Plan must also provide benefits to such individual for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, prostheses and physical complications of all stages of mastectomy, including lymphedemas. Benefits for reconstructive breast surgery will be provided on the same basis as other surgical procedures covered by the Plan. If you have questions about the level of coverage the Plan provides for mastectomies or reconstructive surgery, please contact the Plan Office for additional information.

NOTICE OF PRIVACY RIGHTS

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

Effective Date of Notice
September 23, 2013

The UFCW Unions and Employers Health and Welfare Plan of Central Ohio (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);

2. your privacy rights with respect to your PHI;

3. the Plan's duties with respect to your PHI;

4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and

5. the person or office to contact for further information about the Plan's privacy practices.

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

Section 1
Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

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

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

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss

insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

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

For example, the Plan may disclose to a treating Doctor the name of your treating radiologist so that the Doctor may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

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

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

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

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations;

2. Enrollment information can be provided to the Trustees;

3. Summary health information can be provided to the Trustees for the purposes designated above;

4. When required by law;

5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law;

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

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

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

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

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

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

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

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

Uses and disclosures that require your written authorization.

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

Section 2
Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right.

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

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

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

Right to Inspect and Copy PHI

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

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

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

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

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

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

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

Right to Amend PHI

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

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

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

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

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

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

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

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

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice.

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

A Note About Personal Representatives

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

1. a power of attorney for health care purposes;

2. a court order of appointment of the person as the conservator or guardian of the individual; or

3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

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

Section 3
The Plan's Duties

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

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

If the revised version of this Notice is posted on the Plan's website, www.ufcwcentralohiohw.com, you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

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

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

1. disclosures to or requests by a health care provider for treatment;

2. uses or disclosures made to the individual;

3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;

4. uses or disclosures that are required by law; and

5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

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

Summary Health Information

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

Notification of Breach

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

Section 4
Your Right to File a Complaint With the Plan or the HHS Secretary

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

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

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

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official.

Conclusion

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

IMPORTANT NOTICE

This SPD is not complete unless a Summary of Benefits insert is included.

If you do not have a Summary of Benefits insert, please contact the Plan Office.

You must use this booklet with the Summary of Benefits insert for an explanation of your coverage under the Plan.

Also, if you are eligible for Vision Expense and Dental Expense Benefits under the Plan, you should have a Vision Expense Benefit insert and a Dental Expense Benefit insert. You must use this booklet with these inserts for an explanation of the Plan's Vision Expense and Dental Expense Benefits. If you believe you are eligible for the Plan's Vision Expense and Dental Expense Benefits, but do not have the inserts for these benefits, please contact the Plan Office.

THIS BOOKLET SHOULD BE RETAINED

FOR CONTINUOUS FUTURE REFERENCE.

**To precertify Hospital inpatient admissions,
including inpatient admissions for
mental health or substance abuse treatment
and certain colonoscopies
please call the Plan's utilization review provider
at the phone number on the back of your
Plan identification card**

**For additional information on claim forms or questions
regarding your benefits, call or write:**

UFCW UNIONS AND EMPLOYERS HEALTH
AND WELFARE PLAN OF CENTRAL OHIO

4150 East Main Street, 1st Floor
Columbus, Ohio 43213
(614) 237-7618
800-282-6483

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