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UFCW

Local One Benefit Funds

UNITED FOOD & COMMERCIAL WORKERS

Dear Sisters & Brothers,

We are pleased to present you with this updated Plan Document and Summary Plan Description covering all of the benefits provided through the Fund. We suggest you review this material carefully in order to take full advantage of the benefits provided. The potential impact that bills for medical services can have on a total household budget is immense. However, as a Participant in the UFCW Local One Health Care Fund, you can be assured that we have made every effort possible to eliminate or significantly reduce medical-related expenses and out-of-pocket costs.

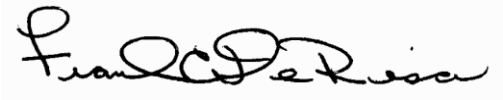
Benefits are provided to eligible Employees and their eligible Dependents as a result of collective bargaining between your Employer and U.F.C.W. District Union Local One (or another Local Union accepted by the Fund) or pursuant to a Participation Agreement between your Employer and the Fund. Under the terms of your Collective Bargaining Agreement or Participation Agreement, your Employer is required to make specified contributions to the Fund.

Your Fund is administered by a Board of Trustees comprised of representatives from the contributing Employers and U.F.C.W. District Union Local One. The Board of Trustees has the power to interpret, apply, construe, and amend the provisions of the Plan and make factual determinations regarding its construction, interpretation and application. Any decision made by the Board of Trustees in good faith is binding upon Employers, Employees, Participants, Beneficiaries, and all other persons who may be involved or affected by the Plan.

If you need any information or explanation, or need assistance in filing a claim for benefits, please feel free to contact the Fund Office at 5911 Airport Road, Oriskany, NY 13424, or by telephone at (315) 797-9600 or (800) 959-9497.

We hope that you are as proud of your Plan as you are to be a member of a dynamic and progressive labor organization - U.F.C.W. District Union Local One.

With warmest regards



Frank DeRiso
Chairman, Board of Trustees

UFCW LOCAL ONE HEALTH CARE FUND

PLAN DOCUMENT

and

SUMMARY PLAN DESCRIPTION

Revised October 1, 2019

UFCW LOCAL ONE HEALTH CARE FUND

5911 Airport Road
Oriskany, NY 13424
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ACTUARIES AND CONSULTANTS

The Segal Company

TABLE OF CONTENTS

GENERAL INFORMATION

This document is both the Plan Document and Summary Plan Description. The provisions of this document are subject to amendment and interpretation by the Board of Trustees and to the rules and procedures of the Plan in effect at the time of a claim.

The Board of Trustees retains professionals to assist in administering the Plan. A Fund Director manages the day-to-day operations of the Fund, directing a staff dedicated to administering the Fund (referred to as "the Fund Office" in this booklet). The Fund Office receives participating Employer contributions, keeps eligibility records, pays claims, and assists Participants with their benefits. Benefits are limited to the assets available in the Fund for all Fund provided benefits.

This document contains a summary in English of the rights and benefits that apply to you under the UFCW Local One Health Care Fund. If you have trouble understanding any part of this material, get in touch with the Fund Office. The address is UFCW Local One Health Care Fund, 5911 Airport Road, Oriskany, NY 13424. Telephone: (315) 797-9600 or (800) 959-9497. You can also email us at ufcwone@ufcwone.org.

It is important that you verify coverage with the Fund Office before incurring expenses under the Plan so that you can confirm that you or your Dependents are covered under the Plan for the services you are seeking. Please remember that no one other than the Fund Office can verify your coverage. Do not rely upon any statement regarding coverage or benefits under the Plan made by your Employer, Union Steward or other Union representative.

Preferred Providers are independent medical facilities or individual Doctors that have entered into a reduced fee agreement with the Fund. This is not meant to be a recommendation or instruction to use the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Fund. Neither the Fund, the Trustees nor the Union have conducted a quality review of the Preferred Providers as part of the providers' agreements with the Fund. In other words, while the providers make a discounted fee available, the Fund in no way guarantees the quality of care provided by them and makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The Fund, the Trustees, and the Union have no financial interest in or direct control of any of these medical offices. Providers are independent contractors, not employees of the Fund. The provider is solely responsible for the services and treatments rendered.

It is extremely important that you keep the Fund Office informed of any change in address or desired changes in Dependents and/or beneficiary. This is your obligation and you could lose benefits if you fail to do so. The importance of a current, correct address on file in the Fund Office cannot be overstated. It is the ONLY way the Trustees can keep in touch with you regarding Plan changes and other developments affecting your interests under the Plan.

INFORMACION GENERAL

Este libreto contiene el Plan y un bosqueto y descripcion del mismo. Esta sujeto a la modificacion administrativa, reglas, regulaciones y procedimientos del Plan en efecto al tiempo de reclamo. Cuando se trata de situaciones que no estan cubiertas por los terminos generales del Plan, las reglas y regulaciones son adaptadas al reclamo en una manera consistente con el intento y limites de los beneficios particulares.

Este documento contiene, en Ingles, un sumario de beneficios y derechos que pertenesen a Usted bajo el UFCW Local One Health Care Fund. Si Usted tiene difcultad entendiendo cualquier parte de este material, contacte a la oficina del Fondo. La direccion es UFCW Local One Health Care Fund, 5911 Airport Road, Oriskany, NY 13424. Telefono: (315) 797-9600 y (800) 959-9497.

De acuerdo, es absolutamente necesario que Usted verifique lo que le cubre el Plan y consulte primero con nosotros antes que Usted verifique lo que le cubre el Plan y consulte primero con nosotros antes que Usted incurra gastos bajo el Plan. De esa manera, Usted se pueda asegurar cuales beneficios seran cubiertos bajo el Plan para Usted y sus dependientes.

Por favor queriamos recordarle que solamente el Fondo puede verificar los derechos y benificios que a Usted le cubre el Plan. No dependa sobre ningun tipo de informacion sobre su Plan hecho por parte de su Empleador, Agente Union Steward, o Agente de Union.

Es de suma importancia que usted mantenga la oficina del fondo informada de cualquier cambio do beneficiaros. Esta es su obligacion. La importancia de una direccion corriente y correcta en los records de nuestra oficina no puede serpasada por alto. Es la unica manera en la cual los fiduciarios pueden mantenerse en contacto con usted, referente a combios en el Plan y otros acontecimientos que afectensus intereses del Plan.

SECTION 1
DEFINITIONS

The following definitions are used throughout this booklet. The definitions will help you understand your benefits. Wherever the following terms are used, they are capitalized and have the following meanings:

Actively Employed or Active Employment means actually performing an occupation in person at the Employer's usual and customary place of business. However, if you are not Actively Employed due to Illness or Injury, you will be treated as being Actively Employed for purposes of eligibility for all benefits under the Plan except death benefits and accidental death and dismemberment benefits, so long as you actually began Employment for an Employer.

Active Plan means the UFCW Local One Active Health Care Plan established and maintained under the Fund to provide welfare and related benefits to Participants employed in Covered Employment, and their Dependents.

Allowable Charge for Covered Expenses means the lowest of: (1) the health care provider's actual charge; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the maximum amount that the Fund has determined it will pay for the service or supply; (4) the amount that is reasonable and customary for the locality in which incurred; or (5) with respect to a health care provider that is party to an agreement with the Fund or a provider to the Fund to provide services to Covered Persons, the charge agreed to by the provider under such agreement.

Annual Deductible or Deductible means the dollar amount of Covered Expenses incurred during a calendar year that is the responsibility of the Covered Person.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, and all related regulations, as amended from time to time. COBRA provides for the continuation of benefits under certain circumstances for Participants and their eligible Dependent(s) who experience a qualifying event that causes them to lose coverage.

Co-Insurance means the percentage (subject to the Allowable Scheduled Fee) that the Plan will pay of the Covered Expense after the patient pays any required Deductible amount for the year. This percentage will depend upon which Plan covers you. Consult the Schedule of Benefits to see which Co-Insurance rate applies to your situation.

Collective Bargaining Agreement or CBA means an agreement or agreements between an Employer and the Union that requires contributions to the Fund.

Covered Employment means a position with an Employer for which contributions are required to be made to the Fund.

Covered Expense means the expense for medical services or supplies that are covered by this Plan, subject to the Allowable Charge, Co-Insurance and Annual Deductible.

Covered Person means a Participant and his or her Dependent(s).

Dentist means a duly licensed Doctor of dentistry acting within the scope of his license and licensed in the jurisdiction where the services are rendered.

Dependent (a) If you are a Full-Time Employee, your Dependents include your legal spouse (provided that you and your spouse are not legally separated and have not been living separate and apart for more than three years) and your child(ren). "Child" includes your:

- biological children;
- adopted children and children placed with you for adoption;*
- step-children who normally reside with you and are dependent on you for support; and
- any other child you have a legal obligation to support.

*A child will be considered placed with you for adoption if you assume a legal obligation for the total or partial support of the child in anticipation of adopting him or her. The child's placement with you will be considered terminated when you no longer have a legal obligation to support the child. You will be required to supply evidence of placement for adoption.

Generally, your biological children, adopted children and children placed with you for adoption are eligible for Dependent coverage under the Plan if they are under age 26.

Your stepchildren, and children you are otherwise legally obligated to support, generally are eligible for coverage as your Dependent if they are:

- Under age 19 (unless eligible for student coverage or living at home and dependent on you for support);
- Not married; and
- Not in active military service

*Additional rules apply to qualify for education benefits, as described in Section 24.

Student Coverage. If your stepchild, or child you have a legal obligation to support, would otherwise lose coverage under the Plan due to age, you may continue to cover that child as your Dependent under the Plan if the child is:

- enrolled as a full time student in an accredited school, or is living with you and is dependent on you for support;
- not married; and
- under age 23

In order to ensure continued coverage for yourself and your Dependents under the Plan, you must complete any request for information issued by the Fund for the purpose

of confirming continued eligibility for benefits. Failure to respond to any such requests may result in the suspension or termination of coverage.

"Your legal spouse" includes a legal spouse of the same gender.

(b) **Dependent Child with Mental Retardation or Physical Handicap.** A child incapable of self-sustaining employment by reason of mental retardation or physical handicap who became incapable prior to age 19, who was covered under the Plan at age 19 and who is supported by you may continue to qualify as your Dependent under certain circumstances. Contact the Fund Office within 31 days before the child's coverage would otherwise terminate for information on continuing the child's coverage.

~~(c)~~ Effective January 1, 2010, if your Dependent child is on a medically necessary leave of absence from post-secondary school because of a serious Injury or Illness, coverage under this Plan will be extended during his/her leave of absence until the earlier of (i) the one-year anniversary of the date on which his/her leave of absence began, or (ii) the date on which the Dependent child's coverage under the Plan would otherwise terminate. To be eligible for this extended coverage, you must provide the Fund with written certification from your Dependent child's treating physician that the leave of absence from school is medically necessary as a result of a serious Illness or Injury. The extended coverage will begin on the date such certification is received by the Fund, but will be retroactive to the date the Dependent child's leave of absence began. Extended coverage under this paragraph is concurrent with, and not in addition to, coverage under COBRA. This means that if the Dependent child receives one year of extended coverage under this rule and, after the expiration of this one-year period, he/she is not eligible for Fund coverage ~~(~~for example, because she did not return to school, has attained age 26), the child can elect to continue coverage under COBRA, for a maximum of 24 months~~.~~

Doctor means a licensed doctor of medicine, chiropractor, doctor of osteopath sciences, Dentist (in special situations), podiatrist or certified and registered psychologist acting within the scope of his or her license, and licensed in the jurisdiction where services are rendered.

Emergency Condition is an accidental Injury or the sudden beginning of a medical or behavioral condition. The symptoms of your Emergency Condition (for example, severe pain) must be serious enough that a prudent layperson with average knowledge of medicine and health could reasonably believe that, if you did not receive immediate care:

a. Your health, or in the case of a behavioral condition, your health or the health of others could reasonably be in danger;

b. Your bodily functions could be seriously impaired;

c. One of the organs or other parts of your body could be seriously harmed; or

d. You could be seriously disfigured.

Employee means a person who is Actively Employed in Covered Employment by an Employer that is required to make contributions to the Fund on the person‘s behalf as required by a Collective Bargaining Agreement or other written agreement.

Employer means an employer that is a party to a Collective Bargaining Agreement with the Union, or other written agreement with the Fund, requiring contributions to the Fund for its Employees. The Union, this Fund, the UFCW Local One Pension Fund and the UFCW Local One 401k Savings Fund are Employers only to the extent that they make contributions to the Fund for coverage of their Employees.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Experimental means any treatment, procedure, facility, equipment, drug, device or supply (collectively “service”) that meets one of the following requirements:

1. The service is considered experimental by the Excellus BlueCross BlueShield Association, an association of independent BlueCross and BlueShield Plans, or any appropriate technological assessment body established by a state or federal government;

2. The service does not have appropriate governmental or regulatory approval when it is provided;

3. Reliable Evidence shows that the service is not customarily recognized as standard medical treatment for your condition; or

4. Reliable Evidence shows that the service is, or there is a consensus among experts that it should be, the subject of further study or ongoing clinical trials to determine maximum tolerated dosage, toxicity, safety, or effectiveness as specifically compared with the standard means of treatment or diagnosis for your condition.

Reliable Evidence includes: (a) the views and practices of medical communities throughout the country; (b) reports and articles published in authoritative medical and scientific literature; (c) the opinion of professional consultants; (d) written protocols used by your provider or any other provider studying substantially the same service; and (e) informed consent forms used by your provider or any other provider studying substantially the same service.

Fund means the UFCW Local One Health Care Fund, established under the Trust Agreement.

Home Health Care Agency means: (a) an agency or Hospital that has been issued a certificate as a certified home health agency by the New York State Department of Health to provide home health services; (b) an agency or Hospital that has been issued a license by the New York State Department of Health as a licensed home care agency;

or (c) if outside of New York State, a home health care agency that meets the same criteria required to obtain the certificate of license in New York State.

Hospital means an establishment that meets all of the following requirements: (a) holds a license as a general Hospital (if licensing is required in the state); (b) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (c) provides 24-hour a day nursing service by registered or graduate nurses on duty or call; (d) has a staff of one or more licensed Doctors available at all times; (e) provides organized facilities for diagnosis and surgery either on its own premises or at an institution with which an establishment has a formal arrangement for the provision of such facilities; (f) is not primarily a clinic, nursing, rest or convalescent home or an extended care facility or a similar establishment, (g) is not (other than incidentally) a place for treatment of alcoholism or drug addiction, and (h) is not a health resort, spa, hospice, sanitarium or infirmary, including infirmaries at schools, colleges and camps. Confinement in special unit of a Hospital used primarily as a nursing, rest, convalescent home or extended care facility is deemed to be confinement in an institution other than a Hospital.

Illness means any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Doctor.

Injury means damage to a body part caused by an accident independent of all other causes, and resulting in a loss that is covered by the Plan.

Medically Necessary Care means medical technologies, services and supplies that are: (a) medically appropriate for the diagnosis and treatment of your symptoms, condition, Illness, or Injury; (b) provided for the diagnosis or the direct care and treatment of your condition, Illness or Injury; (c) in accordance with the standards of good medical practice; (d) not primarily for your or your family's convenience; and (e) the most appropriate level of service or supply that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered, or your condition, and you cannot receive safe or adequate care as an outpatient. The fact that a Doctor or other health care professional may prescribe, order, recommend or approve a service, supply or technology does not, in itself, make the services Medically Necessary. Services supplies and technologies that are not medically necessary include, but are not limited to:

1. Services provided over a longer period of time than is necessary for effective diagnosis and treatment of your Illness or Injury; and

2. Services provided, if you fail to fully comply with the medical regime established by the provider of services or the Doctor.

Medicare means benefits under Title XVIII of the Social Security Act of 1965, as amended.

Participant is an Employee who meets the eligibility requirements of Section 2 of the SPD. A former Employee who continues to be eligible for coverage under Section 2 or under COBRA Continuation coverage will be a Participant until the coverage ends. A Retiree also will be a Participant, to the extent of the coverage described in Section 26 of this SPD, until such coverage ends. Additional rules apply to qualify for education benefits, as described in Section 24.

Participating Pharmacy means a Pharmacy that is part of the pharmaceutical network with which the Fund has a contract.

Participation Agreement is an agreement between the Fund and an Employer requiring the Employer to contribute to the Fund.

Plan of Benefits means the written description of benefits available under the Active Plan and the Retiree Plan, as amended from time to time.

Preventive Care means those services determined to be preventive care under the Patient Protection and Affordable Care Act that must be covered without a copayment, Co-Insurance or Deductible when provided by an in-network provider. A complete list of such services can be found at www.healthcare.gov.

Qualified Medical Child Support Order (QMCSO) is a court or state administrative agency order that complies with requirements of federal law and requires the Fund to provide health coverage for a Dependent of a Participant.

Retiree means an individual who retires from Covered Employment after reaching age 60 but before reaching age 65, and who was covered under the Active Plan as a Full-Time Employee for at least the five consecutive years immediately preceding retirement (other than as a result of self-payment).

Retiree Plan means the UFCW Local One Retiree Health Care Plan established and maintained under the Fund to provide welfare and related benefits to retired Participants and their Dependents.

Room and Board means all charges commonly made by a Hospital on its own behalf for a room and meals and for general services and activities that are Medically Necessary for the care of bed patients.

Trust Agreement means the Agreement and Declaration of Trust of the Fund.

Trustees means the Board of Trustees of the Fund.

Union means the United Food and Commercial Workers (UFCW) District Union Local One.

You means the Participant, unless the context clearly indicates otherwise.

SECTION 2
ELIGIBILITY RULES

Who is Eligible

As an Employee covered by a Collective Bargaining Agreement with the Union, or other written Agreement with the Fund, when you have completed your probationary period in accordance with the Collective Bargaining Agreement or other agreement, your Employer is required to contribute on your behalf as of the 1st of the month following the completion of such period.

You should refer to the Collective Bargaining Agreement, or other agreement, applicable to your Employer for clarification of when Employer contributions are due and for the definitions of Full-Time and Part-Time Employment.

If your Employer makes a contribution to the Fund under the Employer's CBA to provide Health Care benefits to its Employees, you will be eligible to receive a scholarship benefit under the Plan for the scholarship period in which the contributions are made. You and your Dependents do not qualify for Scholarship Benefits if your participation in the Fund is under an Employer's Participation Agreement and not a Collective Bargaining Agreement. If you are covered by a Collective Bargaining Agreement that provides for participation in the Fund but are not yet a Participant because you have not satisfied the minimum eligibility requirements, you and your Dependents may still qualify for Scholarship Benefits. Contact the Fund Office for more information.

When Your Coverage Begins

If you are employed by an Employer in the retail food industry and you have met the eligibility conditions for Plan coverage under the Collective Bargaining Agreement between your Employer and the Union, you will become covered under the Plan on the earlier of: (1) the date you complete the applicable eligibility requirements for your Plan of Benefits; or (2) the 90th day after you complete 1,200 hours of Covered Employment.

If you are employed by an Employer that is not in the retail food industry, you will become covered under the Plan on the earlier of: (1) the date your Employer makes its first required contribution to the Fund on your behalf; or (2) the 90th day after you complete 1,200 hours of Covered Employment.

If your status changes from Full-Time employment under the Plan to Part-Time employment under the Plan, whether voluntarily or involuntarily, you will lose your Full-Tiime benefits under the Plan, effective the 1st of the month following your reduction in hours.

When An Employee Ceases To Be Covered

An Employee will cease to be a Participant on the last day of the last month for which a contribution is required to be made to the Plan on his/her behalf, or on the date the Plan terminates, whichever occurs earlier. Continuation of certain coverage's will be available in accordance with "COBRA" regulations. (*See Section* 6)

Benefits for your Dependents terminate (a) when your coverage terminates; or (b) when the individual no longer meets the definition of a Dependent under the Plan.

A Full-Time Employee who voluntarily reduces to Part-Time, or is involuntarily reduced to Part-Time, will lose his/her Full-Time benefits the 1st of the month following the reduction.

Special Rules with Respect to the Termination of Qualification for Education Benefits
If you lose qualification for education benefits:

a. You may complete any course, seminar or training that you enrolled in prior to the termination of your eligibility.

b. You may keep any scholarship award of which you were notified prior to the termination of your eligibility.

c. You will continue to be eligible for Dislocated Worker Benefits for at least six months from the date of the store closing or layoff that resulted in your eligibility for such benefits.

When An Employer Is Delinquent

Different rules apply if your Employer owes contributions to the Fund on behalf of its Employees under a collective bargaining or other written agreement but does not pay these contributions as required. These rules take precedence over the other rules on when your coverage will terminate.

If an Employer fails to make the required contributions for three months (even if the months are not consecutive), the Board of Trustees, in its discretion, may suspend the payment of claims for that Employer's participating Employees and their Dependents, including the death benefits payable on your behalf. This suspension of benefits is applicable to benefits that you are eligible to receive as an active Participant, as well as benefits you are eligible to receive while Permanently and Totally Disabled.

If your benefits are suspended under this provision, and your Employer later makes the required contributions, your benefits will be reinstated. However, your benefit coverage will not be reinstated on an ongoing basis until your Employer has fully repaid its delinquent contributions. For example, if your Employer owes contributions to the Fund for January, February, and March, your benefits may be suspended effective March 31st. If your Employer later pays the Fund two months of contributions, these

contributions will be applied to the benefits coverage you received in January and February. Your benefit coverage for April will not be reinstated until your Employer pays the Fund for the March delinquency, plus contributions for April. If your benefits terminate because your Employer is delinquent, continuation coverage under COBRA will NOT be available unless you otherwise experience a qualifying event, such as a termination, reduction in hours or layoff. (*See Section* 6.)

If you are on extended coverage due to layoff, and your benefits are suspended under this provision, the suspension will be effective as of the first day of the month for which your Employer fails to make a contribution on your behalf. For example, if you are laid off on December 31, 2018, you are eligible for benefits, but if your Employer doesn't make the required contribution for January 2019, your benefits will terminate effective January 1, 2019.

If your Employer is delinquent and subject to suspension under this Section at the time that you first become eligible as a new Employee under the Plan rules, your benefits will be suspended effective immediately until the Employer has repaid its delinquency.

If you are a non-collectively bargained Employee (meaning that you are not in the bargaining unit) and your Employer is required to contribute to the Fund on your behalf pursuant to the terms of a Participation Agreement between your Employer and the Fund, the Board of Trustees may, in its discretion, suspend the payment of claims to or on behalf of the Employer's participating non-collectively bargained Employees and their Dependents effective for the first day of the month for which your Employer fails to make a contribution on your behalf. For example, if your Employer does not make the required contribution for January, 2019, your benefits may be suspended effective January 1, 2019. This rule means that your coverage may be suspended sooner than coverage would otherwise be suspended under the rules of this Section. When your Employer pays the Fund the full amount of the contributions that it is required to contribute on your behalf, your benefits will be reinstated. However, if after the reinstatement of your benefits, your Employer again fails to make the required contributions on your behalf, your benefits may again be suspended for no less than six months. Employees whose coverage is suspended under this paragraph are not entitled to COBRA continuation coverage, unless you otherwise experience a COBRA qualifying event, such as a termination, reduction in hours or layoff. Final determinations of eligibility are made by the Fund's Board of Trustees.

When Your Dependent's Coverage Begins

If you are a covered Full Time Employee, your Dependent will be covered by the Plan on the same date your coverage becomes effective, or on the date you acquire such Dependent, whichever occurs later. Newborn infants are eligible for coverage from birth.

Dependents of Part-Time Employees are not eligible unless the Employee purchases Dependent coverage. You must pay the difference between the Employer contribution for a Part-Time Employee and Family Buy Coverage each month.

Note: If both a husband and wife, or a parent and Dependent child, are eligible for coverage under the Plan, as Employees, then they also may be eligible for coverage as a Dependent.

Changes in Amounts

If your coverage changes because of a change in your job classification or because of a change in coverage from one program to another as a result of a change in the terms of your Collective Bargaining Agreement, this change will become effective in accordance with the provisions of your Collective Bargaining Agreement. However, if you are not Actively at Work due to sickness or Injury, you will be treated as being Actively at Work for purposes of changes in coverage.

SECTION 3
COORDINATION OF BENEFITS WITH MEDICARE

Active Employees Age 65 and Over and Their Dependents

The following rules apply:

a. This Plan will be primary for any person age 65 and over who is an active Employee, or the spouse age 65 or over of an Employee of any age.

b. You or your Dependent may decline coverage under the Plan and elect Medicare as primary. However, you will automatically continue to be covered by this Plan as primary unless you notify the Fund Office in writing that you wish to elect Medicare as primary, or unless your coverage under this Plan ceases. However, if you or your spouse choose Medicare as your primary carrier, the Fund is not allowed by law to provide secondary coverage for any expenses that are covered by Medicare.

Disabled Dependents Under 65

If you or one of your Dependents, while under age 65, are entitled to Medicare benefits solely on the basis of a total and permanent disability (except End Stage Renal Disease) as defined by the Social Security Administration, this Plan will be primary for your Covered Expenses provided you are covered under this Plan as an active Employee or as a Dependent of an active Employee. Medicare will provide coverage on a secondary basis. Therefore, any Covered Expenses should be submitted first to this Plan for payment. Afterwards, any unpaid balance should be submitted to Medicare for its consideration.

End Stage Renal Disease

The Plan will remain primary for all covered items and services for the first 30 months of your entitlement to Medicare due to End Stage Renal Disease, to the extent required by law. Please contact the Fund Office for a more detailed explanation if this may apply to

you.

Enrolling in Medicare

It is important that you or your spouse visit the Social Security Administration office during the three-month period prior to age 65, or as soon as you or a Dependent becomes disabled, to learn all about Medicare. There is a special Medicare enrollment rule for persons under age 65 who have Lou Gehrig's Disease (ALS); contact the Social Security Administration for more information. For questions on coverage by this Plan and Medicare, please contact the Fund Office.

SECTION 4
COORDINATION OF BENEFITS WITH OTHER HEALTH CARE PROGRAMS

Motor Vehicle Insurance

If a person covered by this Plan has a claim that involves a motor vehicle accident covered by other insurance (including MVAIC), health care expenses must be reimbursed first by the other insurance. Only when the claimant has exhausted health care benefits under the other insurance will the claimant be entitled to receive health care coverage under this Plan. If there are Covered Expenses under this Plan that are not completely reimbursed by the other insurance carrier, this Plan will consider such claims subject to all the Plan provisions. If a valid automobile policy is not in force, no benefits will be payable under this Plan.

Other Health Care Programs

1. **When A Covered Person Has Other Health Benefits.** It is not unusual for a Covered Person to be covered by two health insurance contracts, plans or policies ("plans") issued through or to groups providing similar benefits. When that is the case and the Covered Person receives an item of service that would be covered by both plans, this Plan will coordinate benefit payments with any payment made under the other plan. One plan will pay its full benefit as the primary plan. The other plan will pay secondary benefits if necessary to cover all or some of the Covered Person's remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be plans for purposes of this Section:

    a. Any group or blanket insurance contract, plan or policy, including an HMO or other prepaid group coverage, except that blanket school accident coverages or blanket coverage's offered to substantially similar groups (e.g., Boy Scouts, youth groups) are not considered a plan;

    b. Any self-insured or noninsured plan, or any other plan arranged through any Employer, trustee, union, Employer organization, or employee benefit organization.

c. Any Blue Cross, Blue Shield, or other service type group health plan;

d. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid or any other plan whose benefits are, by law, required to cover only the excess expenses not covered under the person's other health coverage are not considered a plan; and

e. Medical benefits coverage in group or individual mandatory automobile "no-fault" or traditional "fault" type contracts.

2. **Rules to determine payment.** The Fund has established certain rules to determine which plan is primary. The first of the rules listed below which applies shall determine which plan shall be primary:

a. If the other plan does not have a coordination of benefits section or other section similar to this one, then it will be primary.

b. If the Covered Person is covered under one plan as an Employee and covered under another plan as a Dependent, the plan that covers him or her as an Employee will be primary.

c. Subject to the provisions regarding separated or divorced parents below, if the Covered Person is covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan that covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

There are special rules for a child of separated or divorced parents:

i. If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.

ii. If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are paid in the following order:

(1) First, by the plan of the parent with custody of the child;

(2) Then, by the plan of the spouse of the parent with custody of the child;

(3) Finally, by the plan of the parent not having custody of the child.

d. If the Covered Person is covered under one plan as an active Employee, neither laid-off nor retired, or as the Dependent of such an active Employee, and is covered under another plan as a laid-off or retired Employee or a laid-off or retired

Employee's Dependent, the plan covering him or her as an active Employee or the Dependent of the active Employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

e. If none of the above rules determine which plan shall be primary, then the plan that has covered the Covered Person for the longest time will be primary.

3. **Payment of benefits when this Plan is secondary.** When this Plan is secondary, its benefits will be reduced so that the total benefits payable under the other plan and this Plan do not exceed Covered Person's expenses for an item of service. However, this Plan will not pay more than it would have paid if it were primary.

This Plan counts as actually paid by the primary plan any items of expense that would have been paid if the Covered Person had made a proper and timely claim. To maximize the benefits available to the Covered Person, the rules and protocols established under both the primary and secondary plans should be followed. If the primary plan claims it is "excess only" or "always secondary", information will be requested from that plan so that claims for benefits under this Plan can be processed. If the primary plan does not respond within 30 days, it will be assumed that its benefits are the same as this Plan's. If the primary plan sends the information after 30 days, the Plan's payment will be adjusted, if necessary.

Questions and Answers

Q: Why does the Plan always inquire whether my spouse or Dependent is employed?

A: *Your Plan contains a coordination of benefits provision. The Plan must know whether your spouse has other coverage and, if so, whether the other coverage contains a coordination of benefits provision in order to properly administer this provision. This rule protects the Fund and you, by making this Plan pay only the charges it is responsible for.*

Q: Does this coordination of benefits provision mean that I can’t collect from both coverages?

A: *No. You are entitled to reimbursement from both coverages, as long as the total amount you receive does not exceed 100% of the Plan's allowances or your actual expenses, whichever is the lesser amount.*

SECTION 5
SUBROGATION AND REIMBURSEMENT

Were you or your Dependent injured in an accident for which someone else is liable? If so, that person or his/her insurance may be responsible for paying your or your Dependent's related Medical expenses and these expenses would not be covered under the Plan. However, waiting for a third party to pay for these injuries may be difficult; recovery from a third party may take a long time (you may have to go to court) and your creditors may not wait patiently. Because of this, as a service to you, the Fund will advance you or your Dependent benefit payments related to such an accident based on the Fund's rights of reimbursement and subrogation. You must reimburse the Fund if you obtain any recovery from any person or entity.

You and/or your Dependent are required to notify the Fund within ten days of any accident or Injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident.

If you or your Dependent receive any benefit payments from the Fund for an Injury or Illness and you or your Dependent recover *any* amount from *any* third party or parties in connection with such Injury or Illness, you or your Dependent must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your Dependent's behalf in connection with such Injury or Illness.

In addition, if you or your Dependent receive any benefit payments from the Fund for any Injury or Illness, the Fund is subrogated to all rights of recovery available to you or your Dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such Injury or Illness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your Dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Illness in your or your Dependent's name and also has a right to intervene in any such action brought by you or your Dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable to any extent for the Injury or Illness, and regardless of whether you or your Dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the Injury and Illness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your Dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the *full* amount of *all* related benefits payments; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by you or your Dependent in obtaining recovery.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your Dependent or a representative of you or your Dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your Dependent for the benefit of the Fund until paid to the Fund. You and your Dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent agree to cooperate with the Fund in reimbursing it for Fund expenses, fees, and costs related to the collection of those benefits.

Consistent with the Fund's rights set forth in this Section, if you or your Dependent submit claims for or receive any benefit payments from the Fund for an Injury or Illness that may give rise to any claim against any third-party, you and/or your Dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" ("Subrogation Agreement") affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Agreement must also be executed by your attorney or your Dependent's attorney, if applicable.

However, even if you or your Dependent or a representative of you or your Dependent (including your or your Dependent's attorney) do not execute the required Subrogation Agreement and the Fund nevertheless pays benefits to or on behalf of you or your Dependent, you or your Dependent's acceptance of such benefits shall constitute your or your Dependent's agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your Dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your Dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your Dependent recovers from a third party.

Any refusal by you or your Dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery you receive, no matter how characterized, up to the full amount paid by the Fund on your or your Dependent's behalf relating to the applicable Injury or Sickness, will be considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependent affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your Dependent's claims will not be considered filed and will not be paid until the fully signed Agreement is received by the Fund. This means that, if you file a claim and your Subrogation Agreement is not received promptly, the claim will be untimely and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your Dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your Dependent, or your attorney may receive as a result of the accident or Injury, no matter how these amounts are characterized or who pays these amounts, as provided in this Section.

Under this provision, you and/or your Dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your Dependent's receipt of any recovery. You or your Dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your Dependent choose not to pursue the liability of a third party, you or your Dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. Where you or your Dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your Dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your Dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your Dependent waive any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your Dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or your Dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

This reimbursement and subrogation program is a service to you and your Dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays for your injuries.

If the Fund is required to pursue legal action against you or your Dependent to obtain repayment of the benefits advanced by the Fund, you or your Dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in

connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

SECTION 6
CONTINUATION OF COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), generally requires that group health plans offer Employees and their Dependents the opportunity to pay to temporarily continue their health care coverage at group rates when coverage under the Plan would otherwise end, in accordance with the provisions of federal law. This extended coverage is called "COBRA Coverage." COBRA Coverage will include all benefits that the person was entitled to before the Qualifying Event except Death Benefits, Accidental Death and Dismemberment Benefits and Education Benefits.

If you, your spouse and/or your Dependent child(ren) are covered under the Plan, you and/or your spouse or children can continue coverage for a time if coverage ends, or if the amount of the premium that you are required to pay to maintain coverage increases, for one of several reasons (called "Qualifying Events"), even if you or they are already covered by another group health plan or Medicare.

You may have other options available to you if you lose coverage under the Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace and you may qualify for government assistance with 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.

Qualifying Events

If any of the following events results in loss of Plan coverage or an increase in premiums, the Covered Person can elect to continue their current coverage under the Plan:

1. Participant's voluntary or involuntary termination of Employment (for reasons other than gross misconduct) or retirement;

2. Participant's reduction in hours of Employment;

3. Participant's entitlement to Medicare;

4. Participant's death;

5. Participant's divorce or legal separation from a Dependent spouse; and

6. A Dependent child ceasing to be a Dependent under the terms of the Plan.

If one of these Qualifying Events occur and you and/or your Dependent(s) do not elect COBRA Coverage or, if applicable, do not elect to continue your coverage at a higher premium, you and/or your Dependent's health coverage will end.

The Fund offers COBRA coverage to qualified beneficiaries even when the beneficiary has other coverage at the time the COBRA election is made. However, if a Participant obtains coverage, including Medicare, after he or she has elected COBRA under the Fund, such COBRA coverage will terminate.

Reporting Requirements

Your Employer must notify the Fund Office if Qualifying Events (1) to (4) occur. This notification must be in writing and must be provided within thirty days of the Qualifying Event. Failure to provide timely notice may subject the Employer to federal excise taxes.

You or the affected Dependent must notify the Fund Office within 60 days of Qualifying Events (5) or (6) – divorce, legal separation or loss of eligibility by a Dependent child. Both you and the affected Dependent are jointly responsible for this notice. If you or your Dependent fail to give written notice to the Fund Office within the required sixty days, the affected person will lose the right to COBRA Coverage.

All notifications under COBRA must comply with these provisions. Notice should be mailed or hand delivered to the Fund Office, Attention: COBRA Department, at 5911 Airport Road, Oriskany, NY 13424.

The written notice of a Qualifying Event must include the following information: name and address of affected Participant and/or beneficiary, Participant's Social Security number, date of occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example: a copy of: divorce decree, separation agreement, death certificate, Dependent's birth certificate). Once the Fund receives timely notification that a Qualifying Event has occurred, COBRA coverage will be offered to the Participant and Dependents, as applicable.

As discussed below, Participants and beneficiaries covered under COBRA Continuation Coverage also must provide notice of a second Qualifying Event or Disability to the Fund within 60 days of the date of occurrence of the second Qualifying Event or the date of disability determination, and before the end of the 18-month COBRA Continuation Coverage period. The written notice must conform to the requirements for providing notices described above. The notice must include evidence of the second

Qualifying Event or disability (for example a copy of the: divorce decree, separation agreement, death certificate, Medicare eligibility / enrollment, Dependent's birth certificate, SSA disability determination). Failure to provide the Fund notice of a disability or second qualifying event within 60 days will result in the loss of the right to extend coverage.

Change of Address Notification

It is crucial that Participants and beneficiaries keep the Fund informed of their current addresses. If you or a covered family member experience a change of address, immediately inform the Fund Office.

Financial Responsibility for Failure to Give Notice

If a Covered Person fails to give written notice within sixty days of the date of the Qualifying Event, or an Employer within thirty days of the Qualifying Event, and as a result, the Plan pays a claim for a Covered Person whose coverage terminated due to a Qualifying Event and who does not elect COBRA Coverage under this provision, then the Covered Person or the Employer, as appropriate, must reimburse the Plan for any claims that should not have been paid. If a Covered Person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the Covered Person was his or her Dependent.

Notice and Election Form

COBRA Coverage requires timely election of the coverage. The Fund Office will, within fourteen days of receiving notice of the Qualifying Event, send the affected Covered Person a COBRA Notice and Election Form. These forms will describe your COBRA rights, the cost of COBRA coverage and the conditions under which the COBRA Coverage will terminate. In order to obtain COBRA Coverage, the Election Form must be completed and returned to the Fund Office within sixty days after receipt.

Details of Continuation Coverage

If you choose COBRA Coverage, the health coverage provided is identical to the coverage provided under the Plan to similarly situated Covered Persons. If the coverage provided under the Plan is modified after you elect COBRA Coverage, your coverage also will be modified.

If you or your eligible Dependent spouse gives birth to a child, or if a child is placed for adoption with you, you may elect COBRA continuation coverage for that child provided you first complete a Fund enrollment form and file it with the Fund Office. Coverage for the newborn or adopted child will continue until such time as coverage for Dependent children who were properly enrolled in the Fund on the date before the event resulting in loss of eligibility would otherwise end.

Even if you reject COBRA continuation coverage, each eligible Dependent has the independent right to elect or reject COBRA continuation coverage. An election on behalf of a minor Dependent child can be made by the child's parent or legal guardian.

You do not have to show that you are in good health to elect COBRA Coverage. However, under COBRA, you will have to pay the cost for your Continuation Coverage.

Payment Provisions

COBRA Coverage requires timely monthly payments. The payment due date is the first day of the month in which COBRA Coverage begins or within 45 days of the election. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of COBRA Coverage must include payment for the period of time dating back to the date that coverage terminated. If you fail to pay the full payment by each due date (or within the thirty day grace period), you will lose all COBRA Coverage.

The cost that you must pay to continue benefits is 102% of the cost of coverage, as determined annually by the Fund. The cost will be specified in the notice of right to elect continuation of coverage sent to you by the Fund office. However, the COBRA premium for the 11-month disability extension period (if applicable) is increased to 150% of the cost of coverage. If your former Employer alters the level of benefits provided through the Fund to similarly situated active Employees, your coverage and cost also will change.

The Trustees will determine the premium for the continued coverage. The premium will not necessarily be the same as the amount of the monthly contribution that an Employer makes on behalf of a covered Employee. The premium will be fixed, in advance, for a 12 month period. The same 12 month period applies to all individuals that become eligible for COBRA Coverage. Consequently, if the rate has been set for the period of January 1 to December 31, and you begin to receive COBRA Coverage on November 1, you may experience a premium increase on January 1.

There is an initial grace period of 45 days to pay the first amounts due starting with the date COBRA Coverage was elected. There is then a grace period of 30 days to pay any subsequent amounts due. If payment of the amounts due is not received by the end of the applicable grace period, the COBRA Coverage will terminate.

Once a timely election of COBRA Coverage has been made, it is the responsibility of the Covered Person seeking COBRA Coverage to make timely payment of all required payments. The Fund will <u>not</u> send notice that a payment is due or that it is late, or that COBRA Coverage is about to be or has been terminated due to the untimely payment of a required payment.

Maximum Periods of COBRA Coverage for Each Qualifying Event

	<u>Participant</u>	<u>Spouse</u>	<u>Child</u>

Participant Terminated (for other than gross misconduct)	18 months	18 months	18 months
Participation reduction in hours worked (making) Participant in-eligible for same coverage)	18 months	18 months	18 months
Participant dies	N/A	36 months	36 months
Participant becomes divorced or Legally separated	N/A	36 months	36 months
Dependent child ceased to be Dependent	N/A	N/A	36 months

If you become eligible for *COBRA* Continuation Coverage, the 18-month coverage period may be extended for your spouse or Dependent children for an additional 18 months in some circumstances if a second qualifying event occurs within the 18-month period of *COBRA* Continuation Coverage. However, in no event will COBRA Continuation Coverage extend beyond 36 months. Such second qualifying events that may extend coverage for an additional 18 months include the death of the Participant, the divorce or separation from the Participant or a Dependent child's ceasing to be eligible for coverage as a Dependent under the *Fund.* However, these events are second qualifying events (they extend the COBRA coverage period) only if they would have caused a loss of coverage had they occurred prior to the termination of employment. On the other hand, the Plan eligibility rules permit the Employee and his Dependents to remain covered after an active Employee becomes eligible for Medicare and, consequently, eligibility for Medicare is not a second qualifying event (it does not extend COBRA). A second qualifying event extension can be granted only to the qualified beneficiary spouse and qualified beneficiary Dependent children who elected COBRA continuation coverage due to the Participant's termination of employment and who are still enrolled in continuation coverage at the time of the second event. You must notify the *Fund office* in writing and in accordance with the notification procedures described in this Section in order to extend the period of continuing coverage.

Entitlement to Social Security Disability Income Benefits

If you, your Dependent spouse or your Dependent child(ren) are entitled to COBRA Coverage for an 18 month period, that period can be extended for the Covered Person who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if all of the following conditions are satisfied:

1. The disability occurred on or before the start of COBRA Coverage, or within the first 60 days of COBRA Coverage; and

2. The disabled Covered Person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and

3. The Plan is notified that the Social Security determination was received no later than 60 days after it was received; and before the 18-month COBRA period ends.

This extended period of COBRA Coverage will end at the earlier of the end of 29 months from the date of the Qualifying Event or the date the disabled individual becomes entitled to Medicare.

If any individual or family coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits, the cost of COBRA Coverage is based on 150% of the full monthly cost of COBRA coverage during the 11-month extension of COBRA Coverage. The Fund Office will tell you the cost of COBRA Coverage at the time you receive your notice of entitlement to COBRA Coverage.

Termination of COBRA Coverage

If you and/or your Dependent elect COBRA Coverage, the COBRA Coverage will cease on the first of the following dates:

1. The date the Plan terminates or the Plan no longer provides coverage to similarly situated Participants or Dependents.

2. The date a required payment is due and unpaid after the applicable grace period.

3. The date you and/or your Dependent(s) first become covered under another group health plan as long as it is after the Qualifying Event. This may not apply if you and/or your Dependent have a pre-existing condition that is not covered under the new plan. Contact the Fund for additional information when you and/or your Dependent(s) become covered under another group plan.

4. The date you or your Dependent(s) first become eligible for Medicare, as long as it is after the Qualifying Event. This does not apply where the qualifying event is the Employer's bankruptcy proceeding under the United States Bankruptcy Code.

5. The date the applicable period of COBRA Coverage ends; or

6. The first month that begins more than thirty days after the date of the Social Security Administration's determination that you or your Dependent(s) are no longer disabled, in situations where coverage was being extended for eleven months, so long as the period of Continuation Coverage does not exceed twenty-nine months.

7. If your Employer stops participating in the Plan, your COBRA Coverage will end on the date your Employer establishes a new plan, or joins an existing plan, that makes health coverage available to a class of Employees formerly covered under the Plan.

You cannot continue the Death Benefit under the COBRA continuation coverage. If you do want to continue your Death Benefit, you must contact the Fund Office for details about conversion to a direct payment policy.

Other Rights

This notice describes your rights under COBRA. It is not intended to describe all of the rights available under ERISA, the Health Insurance Portability and Accountability Act (HIPAA), the Trade Act of 2002, and other laws.

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp. This program is offered by the federal government and the Fund Office has no role in its administration.

Contact Information

If you have questions or wish to request additional information about COBRA coverage or the health plan, please contact the Fund Office as follows:

COBRA Department
UFCW Local One Health Care Fund
5911 Airport Road
Oriskany, NY 13424
315-797-9600

SECTION 7

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Under Federal law, there are several important changes that affect a Participant's ability to cover children in the Fund.

(a) The Fund will provide coverage to a Participant's child if required to do so under the terms of a Qualified Medical Child Support Order (referred to as a "QMCSO"). The Fund will provide coverage to a child under a QMCSO even if the Participant does not have legal custody of the child, the child is not Dependent on the Participant for support, the child does not reside with the Participant and regardless of any waiting period that otherwise may exist for Dependent coverage. If the Fund receives a QMCSO and if the Participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained from the Fund.

(b) A QMCSO may require that accidental death and dismemberment benefits payable by the Fund be paid to satisfy child support obligations with respect to a child of a Participant. If the Fund receives such an order and benefits are currently payable, or become payable in the future while the order is in effect, the Fund will make payments either to the child support agency, or recipient listed in the order.

A copy of the Fund's Procedures for determining whether an order is a Qualified Medical Child Support Order ("QMCSO") can be obtained free of charge from the Fund Office.

If you need a copy of the Fund's QMCSO Procedures, write or call the Fund Office at:

UFCW Local One Health Care Fund
5911 Airport Road
Oriskany, NY 13424
Attn: QMCSO Procedures
Telephone No. 315-797-9600

**Note: this Section does not apply to education benefits described in Section 24 of this booklet.

SECTION 8

COVERAGE WHILE IN THE ARMED SERVICES

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that the Fund provide the right to elect continued health coverage for up to 24 months to Participants who are absent from employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

Coverage Under USERRA

A Participant who is absent from employment by reason of service in the uniformed services can elect to continue coverage for the Participant and his or her Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to Dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage begins on the date on which the Participant's absence begins and ends on the earlier of:

1. The end of the 24-month period beginning on the date on which the absence begins; or

2. The day after the date on which the Participant is required to but fails to apply under USERRA for or return to a position of employment covered under the Fund. (For example, for periods of service over 180 days, generally the Participant must reapply for employment within 90 days of discharge.)

This right to temporarily continue group health coverage does not include any life insurance benefits, accidental death and dismemberment benefits, or other similar non-health benefits provided under the Fund. In addition to the right to continued coverage under USERRA, Participants or Dependents also may have rights to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Please refer to the COBRA Section of your SPD for more information.

If the Participant met the Plan's eligibility requirements at the time he or she entered the uniformed services, the Participant will not be subject to any additional exclusions or a waiting period for coverage under the Fund upon return from uniformed service, as required under USERRA.

Notice and Election of USERRA Coverage

The Participant must notify his or her Employer or the Fund Office of the absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. If the Participant wishes to elect USERRA coverage, he or she also must notify the Fund Office within 60 days of the last day of employment unless the Participant is excused from giving advance notice of service under the provisions of

USERRA. While an Employee may notify an Employer of service orally, the Fund requires that Participants elect USERRA coverage in writing. The Fund will provide you with the necessary forms.

Paying for USERRA Coverage

The Participant may be required to pay all or a portion of the cost of these benefits. If the period of military service is less than 31 days, there is no charge for this coverage beyond the normal Deductible or co-payments that would be paid if the Participant were employed. If the military service extends more than 31 days, the Participant must pay 102% of the cost of the coverage unless the Employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the costs for COBRA continuation coverage. Participants should contact the Fund Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if the Participant had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If the Participant timely elects and pays for USERRA coverage, coverage will be provided retroactive to the date of the Participant's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If the Participant fails to pay the full payment by each due date (or within the 30-day grace period), the Participant will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is the responsibility of the Participant to make timely payment of all required payments. The Fund will <u>not</u> send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to the untimely payment of a required payment.

**Note: this Section does not apply to education benefits described in Section 24 of this booklet.

SECTION 9

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 ("FMLA") requires Employers with 50 or more Employees to provide Participants with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of a Participant's child or for the Participant to care for their own Illness, or to care for a seriously ill child, spouse or parent, or for a qualifying exigency that arises in connection with the active military service of the Employee's child, spouse, or parent..

Under the Family and Medical Leave Act, you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons;

1. To care for your newly born or adopted child;
2. To care for a spouse, child or parent who has a serious health problem; or
3. If you have a serious health problem that prevents you from performing your job.
4. For a qualifying exigency that arises in connection with the active military service of a child, spouse, or parent.

In order for you to be eligible for such leave, your Employer must have been obligated to make contributions to the Fund on your behalf for at least 1,250 hours in the preceding twelve (12) month period. You must also have worked for that Employer for at least twelve (12) months immediately preceding the date your leave will commence.

However, not all Employers are covered by the Family and Medical Leave Act. To be subject to the Act, an Employer must have at least fifty (50) Employees for each working day for each of twenty (20) work weeks in the current or preceding calendar year. Additionally, you must:

1. Work at a location where the Employer has at least 50 Employees; or

2. Work within 75 miles of one or more work sites where the Employer has 50 or more Employees.

Your Employer must notify the Fund that you are on leave for one of the purposes described in the Act, must continue to include you on its monthly remittance report to the Fund, and must continue to make contributions on your behalf.

While you are on leave, you (and your Dependents, if any) will continue to participate in the Plan just as if your Active Employment had not stopped, unless your Employer fails to make the required contribution for you.

You may be entitled to up to 26 weeks of FMLA leave if you are injured in military service or to care for a family member who is injured in military service. Contact the Fund Office for more information.

Under the New York State Paid Family Leave ("PFL") Act, private Employers in New York State must provide a period of paid family leave to eligible Employees beginning January 1, 2018. Contact your Employer for information about this benefit..

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon occurrence of any of the following events:

1. Your Employer fails for any reason to make the required contributions to the Fund on your behalf while you are on leave; or

2. You exhaust the twelve (12) weeks of leave which you are entitled to under federal law; or

3. You or your Employer notify the Fund that you do not intend to return to the Employer's Employment. (Note: If you do not return to work for your Employer at the end of your leave, you may be responsible for repaying the Employer contributions made on your behalf during the leave.)

In the event your Employer ceases to make contributions on your behalf, you will be provided an opportunity to elect continuation coverage in accordance with COBRA.

SECTION 10
HEALTH CARE BENEFITS

The following benefits are applicable to Full-Time and Part-Time Participants and Dependents.

Purpose of These Benefits

This coverage is designed to pay an amount toward the expenses resulting from bodily Injury or Illness not connected with Employment.

The UFCW Local One Health Care Plan has contracted with Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield, Central New York Region ("Excellus BlueCross BlueShield"), to administer Medical Benefits. If you disagree with a denial of your claim for Medical Benefits, before you appeal to the Board, you or your Doctor may send Excellus BlueCross BlueShield your written reasons for the disagreement within 60 days of the date of Excellus BlueCross BlueShield's initial decision. If Excellus BlueCross BlueShield does not reverse the denial, you still have the right to appeal to the Board of Trustees. Please see Section 27 of this SPD for information on filing an appeal with the Board of Trustees.

Throughout the next four Sections, the Fund is referred to as "we" "us" or "our." The word "you" refers to the Participant and your Dependents.

Date Expenses Are Incurred

An expense is incurred on the date the service or treatment is received or a purchase is made, rather than on the date the bill is received.

SECTION 11
HEALTH CARE MANAGEMENT

General Health Care

General: Pre-certification Toll Free Number 1-800-363-4658

In an effort to insure proper treatment at a reasonable cost and avoid medically unnecessary charges, the Fund participates in a case management/pre-certification program. This Section describes how this program works.

Pre-Admission Review

Pre-admission review is a program for assessing all elective inpatient admissions before they occur.

Excellus must be provided with certain information before an elective admission occurs. Excellus's determination does not guarantee that benefits will be provided. Excellus's decision will be made only after it reviews the actual services you receive.

In order to provide you with the maximum benefit under the Plan, Excellus must conduct a pre-admission review before your admission. This can be done in one of several ways:

1. You may call the toll-free number listed above and ask the nurse reviewer to obtain the necessary information from your provider;

2. You may ask your provider to send Excellus your pre-admission request form or call us at the toll-free number;

Excellus' response to the information it receives will be sent to you, the Hospital or alcohol and substance abuse facility, and your provider. Excellus will respond within 48 hours after it receives all necessary information.

If you are an inpatient for Medically Necessary care and you did not obtain the pre-admission review, payment for your inpatient care will be reduced by $500. You will be responsible for payment of the $500. This includes admission for maternity. However, you will never be penalized more than $500 for each inpatient stay, or 50% of the maximum allowable charge, whichever is less.

Admission Review

Admission review is Excellus BlueCross BlueShield's program to review the Medical Necessity and appropriateness of Emergency admissions. Admission review takes place after the Emergency admission has occurred under the following guidelines.

Emergency admissions. You are responsible for calling the toll-free number 1-800-363-4658 and notifying Excellus BlueCross BlueShield of an Emergency admission within 48 hours after the admission. You may ask a family member, attending provider, or the Hospital or alcohol and substance abuse facility to provide the necessary information by calling Excellus BlueCross BlueShield at the toll-free number.

If you are an inpatient for Emergency care and do not obtain an admission review, payment will be reduced by $500. You will be responsible for payment of the $500. However, you will never be penalized more than $500 for each inpatient stay, or 50% of the maximum allowable charge, whichever is less.

Concurrent Review

Concurrent review is an ongoing review of your inpatient treatment to assure that the care being rendered is Medically Necessary and appropriate for your continued inpatient Hospital, skilled nursing facility, or alcohol and substance abuse treatment facility stay. Concurrent review of your treatment will begin when you are admitted to a Hospital, skilled nursing facility or alcohol and substance abuse treatment facility. Excellus BlueCross BlueShield's staff, with the support of Doctors, will continually review your medical records until your discharge.

If, during the concurrent review process, Excellus BlueCross BlueShield believes that continued acute care is not Medically Necessary, Excellus BlueCross BlueShield's Doctor consultant will contact your attending Doctor to discuss the case. If your attending Doctor does not agree with the consulting Doctor that continued acute care is not Medically Necessary, then a second consulting Doctor will be contacted. If the second consulting Doctor agrees that continued acute care is Medically Necessary, the concurrent review process will continue. If the first and second consulting Doctors agree that your stay in a Hospital, skilled nursing facility or alcohol and substance abuse treatment facility is no longer Medically Necessary, benefits for your inpatient Hospital care, skilled nursing facility care or inpatient alcohol and substance abuse facility treatment will be terminated.

Excellus BlueCross BlueShield will notify you, the attending Doctor and the Hospital or facility prior to termination of benefits.

Discharge from the Hospital or Alcohol and Substance Abuse Facility

Planning for your discharge begins with your admission to a Hospital or alcohol and substance abuse treatment facility. This planning is done so you do not have to stay in the Hospital or alcohol and substance abuse treatment facility longer than necessary. Your Doctor, Hospital or alcohol and substance abuse facility personnel, and Excellus BlueCross BlueShield's staff work together to develop a continuing care program, if you

need it after discharge. Your discharge-planning program could include care in a skilled nursing facility or home health care visits that might be covered under your Plan. The discharge-planning program may also include outpatient alcohol and substance abuse care.

Individual Case Management Program

Through Excellus BlueCross BlueShield's concurrent review and discharge planning programs, if you are a potentially long-term inpatient, you may be identified by Excellus for possible care in an alternative setting or specialized program. If Excellus BlueCross BlueShield determines, that alternative services may be more beneficial than the services currently being provided, Excellus BlueCross BlueShield will consult with you and your providers to develop a proposed individual management program. Excellus BlueCross BlueShield will continue to cover only the benefits covered under the Plan, and under the individual management program. However, the total paid for the alternative services will not be more than the amount Excellus BlueCross BlueShield would have paid for services covered under the Plan to treat your condition or Illness.

Appeals

If you or your Doctor disagree with any decision by Excellus BlueCross BlueShield regarding payment for an inpatient admission, or services Excellus determined were not Medically Necessary, you or your Doctor may send Excellus BlueCross BlueShield your written reasons for the disagreement within 60 days of the date of Excellus BlueCross BlueShield's decision. Whether or not you or your Doctor choose to write to Excellus BlueCross BlueShield, you also have the right to appeal an adverse benefit determination to the Board of Trustees. Please see Section 27 of this SPD for information on filing an appeal with the Board of Trustees.

Maternity Program

This benefit can help identify potential problems early in a pregnancy. The benefit seeks to reduce the incidents of pre-term deliveries and low-birth weight babies by offering educational materials and a 24-hour maternity hotline. Call the Health Care Fund at 1-800-959-9497,(Option 9 for maternity) at any time for support, guidance and helpful information during your pregnancy.

If you enroll in the Maternity Program during the first trimester of your pregnancy by calling the above number, you will be eligible to receive a free infant car seat. Please note: Expectant mothers MUST be covered under the UFCW Local One Health Care Plan at time of enrollment to receive this benefit.

Employee/Member Assistance Program (EMAP)

Mental Health/Alcohol-Substance Abuse

The Trustees have implemented an Employee Member Assistance Program (EMAP),. This program provides you and your family with help in difficult times by providing

prompt, professional assistance for Participants who may be experiencing personal, mental health, or chemical dependency related problems, such as: marital and family, child or adolescent, family Illness or death, stress, depression, anxiety, drug or alcohol abuse, and other types of emotional or mental health related problems.

Under the EMAP, Participants and their Dependents may receive up to five (5) counseling sessions with an EMAP counselor at no cost. Calling the toll free number below is the first step toward using this benefit.

Call Toll Free 866-269-7357 or the Health Fund at 1-800-959-9497,(Option 7 for EMAP)**.** Trained professionals will provide telephone consultations, problem assessment, information, referral and follow-up to all Participants who receive medical coverage through the UFCW Local One Health Care Fund. If further treatment is needed, these services may be covered by the Fund.

APS Work Life

APSWorkLife.com is a secure confidential web-site that provides a host of web-based resources and tools for Participants and Dependents. This web-site is available 24 hours a day, seven days a week. To use this web-site, go to APSWorkLife.com and type in the user name: “UFCW One” and the password “Local One”. Please contact the Fund Office if you have any questions regarding this web-site.

Nurse Help Line

This service is offered through Excellus Blue Cross Blue Shield to provide you and your Dependents with a free and easy way to receive answers to your healthcare questions without leaving home. The UFCW Local One Nurse Help Line is available 24 hours a day, seven days a week, and is staffed with registered nurses. Just call **800-348-9786** or the Fund at 1-800-959-9497(Option 8 for Nurse Help Line), and a registered nurse will assist you with any of your healthcare concerns.

In addition, you can call the Nurse Help Line to request that information on certain health topics be mailed directly to your home at no charge.

Tobacco Cessation Program

The “Quit for Life” Program is offered through the Funds’ contract with Excellus at no cost to eligible Participants who are 18 or older. To enroll in this Program, call **1-800-442-8904**. Participants will receive both phone and web support through this program. Upon enrollment and assessment, Participants will receive non-prescription medications directly from the program at no cost.

If it is determined that a better outcome will be achieved with a prescription medication, this medication will be supplied through the Fund’s drug card program. A Doctor’s prescription along with confirmation of enrollment in Quit for Life is required.

Telemedicine Services

The Fund offers access to health care services in real time through a secure video-based telehealth application installed on a patient's smartphone, desktop or tablet computer. The Fund provides this benefit through an independent medical vendor. This benefit connects individuals to a network of health care professionals that are contracted with or employed by professional organizations contracted with Doctor on Demand.

This benefit allows you to connect with a healthcare professional 24 hours a day if you are located in the U.S. (except Alaska, Arkansas, and Louisiana). Since you need to register for this service by downloading the secure app and completing a health history before you can use this benefit, you should sign up before you want to use the benefit. For more information, please contact the Fund Office.

Living Well Program

IF YOU ARE COVERED BY ONE OF THE FUND'S ELIGIBLE PLANS OF BENEFITS, YOU MAY BE ABLE TO REDUCE YOUR COST-SHARING AND OUT-OF-POCKET REQUIREMENTS BY PARTICIPATING IN A BIOMETRIC SCREENING AND PREVENTIVE EXAM WELLNESS PROGRAM KNOWN AS LIVING WELL. Participants and spouses who do not complete the Living Well program will remain under the Fund's standard plan design. For more information about Living Well and to find out if you are eligible to participate, please contact the Fund Office **1-800-959-9497, Option 2.**

Biometric and Preventive Exam Wellness Incentive Program

Members and eligible spouses in the Health Care Fund under Plans R, RD, UU & U are eligible to participate in the Living Well PCP Biometric and Preventative Exam Wellness Program. Please contact the Fund Office for more information.

SECTION 12
HOSPITAL BENEFIT

Differences between Member and Nonmember Institutional Providers

Excellus BlueCross BlueShield's Member or "in-network" institutional providers will accept the Allowable Charge as payment in full. When the covered services you receive in an emergency room are for a non-Emergency Condition, you are responsible for the Co-Insurance. Refer to the Schedule of Benefits for the amount of the Co-Insurance. Most member institutional providers of another Blue Cross and Blue Shield Plan will also accept the Allowable Charge as payment in full. However, some Blue Cross and Blue Shield Plans do not require their member institutional providers to

accept the Allowable Charge as payment in full. (This does not currently apply to any New York State Blue Cross and Blue Shield Plan.) You are responsible for any applicable Co-Insurance, penalties and/or other amounts not paid.

Nonmember, or out-of-network, institutional providers are not required to accept the Allowable Charge as payment-in-full. You are responsible for any applicable Co-Insurance, penalty and/or other amounts not paid.

A. Inpatient Hospital Services (Subject To Pre-Approval)

Benefits will be provided for the following Covered Expenses when you are: a registered bed patient in a Hospital; required to stay in a Hospital for acute care; and not admitted for mental health care or alcoholism and/or substance abuse treatment services. The services must be billed by, and the bill must be payable to, the Hospital.

1. Diagnostic And Treatment Services. Diagnostic and treatment services necessary for your medical or surgical care. These services must be available in the Hospital in which you are a patient and must be performed by an employee of the Hospital.

2. Room Charges. Bed, board and general nursing service in a semi-private room. A semi-private room is a room that the Hospital considers to be semi-private.

   If you occupy a private room, you will have to pay the additional charges for the private room. The program will only cover the Hospital's average semi-private room charge. However, benefits will be provided for the private room if the Fund determines it is Medically Necessary.

3. Maternity care. Services of a Hospital related to childbirth. Benefits will be provided for inpatient Hospital services for:

   a. A covered mother and her newborn; or
   b. A newborn covered at birth whose mother is not covered;

   For at least 48 hours of care after a non-caesarean delivery, and at least 96 hours after a caesarean delivery.

   Benefits for the care or treatment of a newborn's Illness or Injury are only available if the newborn is a covered Dependent.

   The services of the Hospital must include, and the payment must cover, parental education; assistance and training in breast or bottle-feeding; and the performance of any necessary maternal and newborn clinical assessments.

   If you choose to be discharged from the Hospital before the recommended time frames described above, benefits will be provided for one home health care visit

rendered by a Home Health Care Agency.

A home health maternity care visit must be requested within 48 hours of the time of the delivery (96 hours in the case of a caesarean delivery). The visit must be rendered within 24 hours after discharge or of the time of the request, whichever is later.

4. Inpatient Stay After Lymph Node Dissection, Lumpectomy, Or Mastectomy. Benefits will be provided for the inpatient Hospital stay that your attending physician, in consultation with you, determines is appropriate after you undergo a lymph node dissection or lumpectomy for the treatment of breast cancer; or after a covered mastectomy.

B. Outpatient Hospital Services

Benefits will be provided for the following outpatient Hospital covered services, if you receive the services at the Hospital, but are not admitted as a registered bed patient. The services must be billed by, and the bill must be payable to, the Hospital.

1. Surgery. Benefits will be provided for Hospital services in connection with surgery. Surgery is an operation or procedure that requires cutting. Surgery also includes the setting of a fracture and other procedures that you may not think of as surgery, such as certain injections.

2. Pre-Surgical Testing. Benefits will be provided for tests ordered by your surgeon before surgery, if:

   a. Proper diagnosis and treatment required the tests;
   b. Your surgery has been scheduled and an operating room has been reserved before the tests are given;
   c. You are present at a Hospital for the tests; and
   d. Your surgery takes place within 14 days after the tests are given.

3. Kidney Dialysis. Benefits will be provided for dialysis if your chronic kidney disease cannot be controlled by medicine. When you become entitled to primary coverage for dialysis benefits under Medicare, this program's payments will be reduced by the amount Medicare would pay. This reduction will be made even if you fail to apply for or receive Medicare dialysis benefits.

4. Routine Mammography Screening. Benefits will be provided for one routine mammography screening each calendar year for breast cancer for Covered Persons of any age; and mammography screenings, recommended by a physician, for Covered Persons who or whose family has a prior history of breast cancer.

5. Routine Cervical Cancer Screening. Benefits will be provided for one routine cervical cytology screening each calendar year for cervical cancer for covered women age 18 or older. Cervical cytology screening includes a pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services for examining and evaluating the Pap smear.

6. Elective Sterilization. Benefits will be provided for outpatient Hospital services for elective sterilization, even though elective sterilization is not Medically Necessary. Services in connection with the reversal of elective sterilization are never covered.

7. Diagnostic Services And Therapy. Benefits will be provided for covered diagnostic services and therapies. The diagnostic service or therapy you receive must be ordered by your physician or other professional provider who is licensed to order the service or therapy. The service or therapy must be necessary for the diagnosis or treatment of your Illness or Injury, and must be rendered by a professional provider. A Report of the service or therapy must be given by the Hospital to the professional provider who ordered the service.

   Covered diagnostic services and therapies are as follows:
   a. Diagnostic x-ray examinations;
   b. Diagnostic laboratory tests;
   c. Diagnostic machine test;
   d. Radiology services (treatment by x-ray or any radioactive substance). The benefit for radiology services includes the cost of the radioactive matter;
   e. Physical therapy, up to the limits described in the Schedule of Benefits, for outpatient Hospital, skilled nursing facility (SNF), and professional provider visits, in connection with and following: surgery in a Hospital or ambulatory surgery center; a Hospital stay; an SNF stay; or when otherwise determined to be Medically Necessary.
   f. Respiratory therapy;
   g. Chemotherapy services and medications for non-experimental cancer chemotherapy and cancer hormone treatment;
   h. Speech therapy for active treatment of organic medical, traumatic, or surgical conditions. Benefits for speech therapy will continue only until it is determined that the patient is able to be understood or that verbal understanding is not possible. Benefits will not be paid: for congenital or inherited speech defects; after therapeutic goals are met; or when there is no longer any measurable improvement; and
   i. Occupational Therapy

   Benefits will not be provided for any separate Hospital charges for use of the emergency or outpatient room in connection with diagnostic services or therapies; or in connection with non-emergency care or follow-up care.

C. Hospital Outpatient Emergency Room Services

If Excellus BlueCross BlueShield determines that Hospital outpatient emergency services are Covered Expenses, benefits will be provided. You must receive these services at the Hospital, but not be admitted as a registered bed patient. The services must be billed by, and the bill must be payable to, the Hospital.

1. Emergency Condition. Benefits will be provided for outpatient emergency care given

in the emergency or outpatient room of a Hospital for an Emergency Condition.

2. Non-Emergency Condition. Benefits will be provided for outpatient covered services given in the emergency or outpatient room of a Hospital for a condition that is not an Emergency Condition.

3. Follow-up care. Benefits will not be provided for any separate Hospital charges for use of the emergency or outpatient room of a Hospital for outpatient follow-up care.

Payments

1. Emergency Condition. The Plan's payment for outpatient emergency room care for a condition that is an Emergency Condition is the Allowable Charge.

2. Non-Emergency Condition. The Plan's payment for outpatient emergency room care for a condition that is not an Emergency Condition is 100% of the Allowable Charge, subject to the applicable copayment and penalty. Refer to the Schedule of Benefits for the amount of the copayment and penalty.

D. Ambulatory Surgery Center Services

What is an Ambulatory Surgery Center? An ambulatory surgery center is a health care facility that is not part of a Hospital, and that:

1. Has an operating certificate issued by the New York State Department of Health to provide surgery on an ambulatory basis; or

2. If outside of New York State, meets the same criteria required to obtain an operating certificate in New York State. Excellus BlueCross BlueShield will determine if the facility meets the applicable criteria.

Ambulatory Surgery Center covered services. Benefits will be provided for the following Covered Services that you receive in an ambulatory surgery center. The services must be billed by, and the bill must be payable to, an ambulatory surgery center.

1. Pre-Surgical testing. Tests ordered by your surgeon before surgery, if:

   a. Proper diagnosis and treatment require the tests;
   b. Your surgery has been scheduled before the tests are given;
   c. You are present at an ambulatory surgery center for the tests; and
   d. Your surgery takes place within 14 days after the tests are given.

2. Center services. The ambulatory surgery center's services related to your surgery.

3. Elective sterilization. The ambulatory surgery center's services related to your elective sterilization, even though elective sterilization is not Medically Necessary. Services in connection with the reversal of elective sterilization are never covered.

E. Birth Center Services

What is a Birth Center? A Birth Center is a diagnostic and treatment center that is not part of a Hospital and that:

1. Has an operating certificate issued by the New York State Department of Health to provide birth center services during pregnancy, labor, and delivery; or

2. If outside of New York State, meets the same criteria required to obtain an operating certificate in New York State. Excellus BlueCross BlueShield will determine if the center meets the applicable criteria.

Birth Center covered services. Benefits will be provided for the following covered services when you are formally admitted to a birth center program for maternity care services. The services must be billed by, and the bill must be payable to, the birth center.

1. Admission screening. Required admission screenings.

2. Center services. The same services related to your maternity care that would be covered if you were in a Hospital.

F. Inpatient Skilled Nursing Facility Services (subject to pre-approval)

What is a skilled nursing facility (SNF)? An SNF is a health care facility or a distinct part of an institution that is:

1. Certified as a participating SNF with Medicare; or

2. Accredited as an SNF by the Joint Commission on Accreditation of Healthcare Organizations.

Inpatient SNF covered services. Benefits will be provided for, and the Plan's one payment per day covers, the following services when: you are a registered bed patient in an SNF; you have to stay in the SNF for skilled care for treatment; you would otherwise require skilled care as a Hospital inpatient if you did not stay in an SNF; and you were an inpatient in a Hospital for a minimum of 3 days immediately preceding your admission to the SNF. The services must be billed by, and the bill must be payable to, the SNF.

1. Nursing services. Nursing care given or supervised by a registered nurse;

2. Room charges. Bed and board in a semi-private room. A semi-private room is a room that the SNF considers to be semiprivate.

3. Therapies. Physical, occupational, respiratory, or speech therapy given by the SNF or by others under an agreement with the SNF;

4. Medicines, equipment, and supplies. Medicines, equipment, and supplies used in and furnished by the SNF; and

5. Other SNF services. Other services generally provided by the SNF that would be covered if you were an inpatient in a Hospital.

G. Outpatient Skilled Nursing Facility Services

What is the outpatient department of a skilled nursing facility (SNF)? The outpatient department of an SNF is the department that the state law decrees, or the SNF determines, is the outpatient department.

Outpatient SNF covered services. Benefits will be provided for, and the Plan's one payment per day covers, the following covered outpatient SNF services and therapies, when you receive them at a SNF but are not admitted as a registered bed patient. The service or therapy must be ordered by your Doctor or other professional provider who is licensed to order the service; must be Medically Necessary for the diagnosis or treatment of your Illness or Injury; and must be rendered by a professional provider who is licensed to provide the services, if New York law provides for licensing, and a provider who is recognized by the Fund. A report of the service or therapy must be given by the SNF to the professional provider who ordered the service or therapy. The service or therapy must be billed by, and the bill must be payable to, the SNF.

1. Diagnostic x-ray examinations.

2. Diagnostic laboratory tests.

3. Diagnostic machine tests.

4. Radiology services. Treatment by x-ray or any radioactive substance. The benefit for radiology services includes the cost of the radioactive matter.

5. Physical therapy. Physical therapy, up to the limits described in the Schedule of Benefits, for outpatient Hospital, SNF, and professional provider visits, in connection with and following: surgery in a Hospital or ambulatory surgery center; a Hospital stay; SNF stay; or when otherwise determined to be Medically Necessary. Benefits will not be provided for any separate SNF charges for use of the outpatient room in connection with the above services or therapies.

H. Inpatient Rehabilitation Facility Services (subject to pre-approval)

What is a Rehabilitation Facility? A rehabilitation facility is a health care facility or a distinct part of a health care facility that is:

1. Certified as a participating rehabilitation facility with Medicare; or

2. Accredited as a rehabilitation facility by the Joint Commission on Accreditation of Healthcare Organizations or by the Commission on Accreditation for Rehabilitation Facilities.

Inpatient Rehabilitation Facility covered services. Benefits will be provided for the following covered services when: you are a registered bed patient in a rehabilitation facility following an inpatient stay in a Hospital for a minimum of 3 days immediately preceding your admission to the rehabilitation facility; and you would otherwise require skilled care as an inpatient in a Hospital or SNF if you did not stay in a rehabilitation facility. The rehabilitation services must be considered by Excellus BlueCross BlueShield to be therapeutic and restorative. The services must be billed by, and the bill must be payable to, the rehabilitation facility.

1. Nursing services. Nursing care given or supervised by a registered nurse;

2. Room Charges. Bed and board in a semi-private room (a semi-private room is a room that the rehabilitation facility considers to be a semi-private);

3. Therapies. Physical, occupational, respiratory, or speech therapy given by the rehabilitation facility or by others under an agreement with the rehabilitation facility;

4. Medicines, equipment and supplies. Medicines, equipment, and supplies used in and furnished by the rehabilitation facility; and

5. Other rehabilitation facility services. Other services generally provided by the rehabilitation facility that would be covered if you were an inpatient in a Hospital or SNF.

I. Home Health Care Agency Services

What is a Home Health Care Agency? A Home Health Care Agency is:

1. An agency or Hospital that has been issued a certificate as a certified home health agency by the New York State Department of Health to provide home health services;

2. An agency or Hospital that has been issued a license by the New York State Department of Health as a licensed home care agency; or

3. If outside of New York State, a home health care agency that meets the same criteria required to obtain the certificate or license in New York State. Excellus BlueCross BlueShield will determine if the agency meets the applicable criteria.

Home health care covered services. Benefits will be provided for the following home health care services, if, you would need to receive skilled care in a Hospital or SNF if

you did not receive home health care (in other words, home health care is in place of Hospital or SNF skilled care), and a plan for your home health care is set up and approved, in writing, by a Doctor. The services must be billed by, and the bill must be payable to, the home health care agency.

1. Nursing care. Part-time or periodic home nursing care. A registered nurse must give or supervise the care.

2. Home health aide care. Part-time or periodic care by home health aides. Their services must be mainly for patient medical care. (This means that the aides' services are not primarily assistance in daily living skills.)

3. Rehabilitative care. Physical, occupational, respiratory, or speech therapy, if provided by the home health care agency.

4. Medical supplies. Medicines and medical supplies ordered by a physician and provided by the home health care agency.

5. Laboratory services. Laboratory tests, if they would have been covered if you had been a bed patient in a Hospital or SNF.

Number of home health care visits. Benefits will be provided up to the limits described in the Schedule of Benefits, for home health care visits. Each visit by a member of a home health care team is counted as one home visit. For home health aides, four hours of service are counted as one home health care visit.

Here is an example of how visits are counted: On one day, a registered nurse treats you at home. On that same day, a home health aide attends to your needs for four hours. In this example, two home health care visits are counted.

J. Hospice Services

What is a Hospice? A Hospice is an organization that:

1. has an operating certificate issued by the New York State Department of Health to provide hospice services; or

2. if outside of New York State, meets the same criteria required to obtain an operating certificate in New York State or that is approved by Medicare. Excellus BlueCross BlueShield will determine if the organization meets the applicable criteria.

Hospice covered services. Benefits will be provided for covered hospice care, including medicines and medical supplies, provided by the hospice in the home, a hospice center, or a Hospital. Benefits will also be provided for bereavement counseling services for family members of the patient. You must meet all of the following conditions:

1. You experience an Illness for which the attending physician's prognosis for life

expectancy is estimated to be six months or less;

2. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate;

3. The attending physician refers you to the hospice program and is in agreement with the plan for care of your condition; and

4. You are formally admitted to the hospice.

Hospice covered services must be appropriate in light of the patient's condition. The services must be billed by, and the bill must be payable to, the hospice.

Number of days of hospice care. Benefits will be provided for unlimited days of hospice care for the patient.

K. Inpatient Mental Health Care Services (subject to Pre-Admission Review)

What is a psychiatric Hospital? A psychiatric Hospital is:

1. an acute care general Hospital, as defined in this program; or

2. a Hospital:

   a. as defined in Section 1.03(10) of the New York Mental Hygiene Law; or

   b. if outside of New York State, that meets the same criteria contained in Section 1.03 of the New York Mental Hygiene Law. Excellus BlueCross BlueShield will determine if the facility meets the applicable criteria.

Inpatient mental health care covered services. Benefits will be provided for the same covered services that would be covered under the program if you were in an acute care general Hospital for the diagnosis and treatment of a condition other than a mental Illness. You must be in need of diagnosis and treatment of a mental Illness; and you must meet the following conditions:

1. You are a registered bed patient in a psychiatric Hospital covered under this Section;

2. You have to stay in the psychiatric Hospital for acute care; and

3. You are admitted to a member psychiatric Hospital in New York State or a member psychiatric Hospital located in the Blue Cross and Blue Shield Plan area where you reside.

Benefits will not be provided for days of care that consist primarily of participation in programs of a social, recreational, or companionship nature.

The Fund will cover the residential treatment of eating disorders under the Inpatient Mental Health Care Services benefit if the Fund's utilization review provider recommends that the patient be placed in a residential facility rather than a Hospital The Fund's utilization review provider will provide case management for patients receiving residential treatment for eating disorders.

L. Inpatient Alcoholism and/or Substance Abuse Treatment Services (subject to pre-approval)

What is an alcoholism and/or substance abuse treatment facility? An inpatient alcoholism and/or substance abuse treatment facility is a private or non-profit facility or an acute care general Hospital that:

1. In New York State, is certified by the Office of Alcoholism and Substance Abuse Services to provide inpatient alcoholism and/or substance abuse detoxification and to provide an inpatient alcoholism treatment program and/or medically supervised inpatient substance abuse program; or

2. If outside of New York State, is certified or licensed under its state's criteria, if required to do so, and is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for inpatient alcoholism and/or substance abuse treatment programs.

   For persons whose primary diagnosis is alcohol abuse or alcoholism, benefits will be provided only if the inpatient alcoholism and/or substance abuse treatment facility is certified to treat alcoholism. For persons whose primary diagnosis is substance abuse or substance dependence, benefits will be provided only if the inpatient alcoholism and/or substance abuse treatment facility is certified to treat substance abuse.

   Benefits will be provided even if the inpatient alcoholism and/or substance abuse treatment facility is owned, operated, or maintained by a state government or any local government, although coverage is normally excluded in government Hospitals. However, the inpatient alcoholism and/or substance abuse treatment facility must be certified as described above and must usually charge for its services.

Inpatient alcoholism and/or substance abuse treatment covered services. Benefits will be provided for covered services received in an inpatient alcoholism and/or substance abuse treatment facility, for the diagnosis and treatment of alcoholism and/or substance abuse. Covered services consist of a 24-hour-live-in program of services for the active treatment of alcoholism and/or substance abuse. You must be in need of diagnosis and treatment of alcoholism and/or substance abuse, and you must meet the following conditions:

1. You are a registered bed patient;

2. You are required to stay in the inpatient alcoholism and/or substance abuse treatment facility for treatment; and

3. You are admitted to a member inpatient alcoholism and/or substance abuse treatment facility that is located in New York State or in the Blue Cross and Blue Shield Plan area where you reside.

The program must be non-medical, except for detoxification, and must provide rehabilitation and treatment for the addictive, loss-of-control phase in a controlled environment. Trained, professional personnel must provide the treatment. Benefits will not be provided for days of care that consist primarily of participation in programs of a social, recreational, or companionship nature.

An employee of the inpatient alcoholism and/or substance abuse treatment facility must provide the services. Payments must be made directly to the facility. No payments will be made to the person who provides any of the covered services; nor will payments be made if the inpatient alcoholism and/or substance abuse treatment facility turns the payments over to the person who provided the service.

M. Outpatient Alcoholism and/or Substance Abuse Treatment Services

What is an outpatient alcoholism and/or substance abuse treatment facility? An outpatient alcoholism and/or substance abuse treatment facility is a facility that:

1. In New York State, is certified by the Office of Alcoholism and Substance Abuse Services to provide an ambulatory alcoholism treatment program and/or a medically supervised ambulatory substance abuse program; or

2. Outside of New York State, is certified or licensed under its state's criteria, if required to do so, and is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide outpatient and alcoholism and/or substance abuse treatment programs.

For persons whose primary diagnosis is alcohol abuse and/or alcoholism, benefits will only be provided if the outpatient alcoholism and/or substance treatment facility is certified to treat alcoholism. For persons whose primary diagnosis is substance abuse or substance dependence, benefits will only be provided if the outpatient alcoholism and/or substance abuse treatment facility is certified to treat substance abuse.

Benefits will be provided even if the outpatient alcoholism and/or substance abuse treatment facility is owned, operated, or maintained by a state government or any local government, although the Plan normally excludes from benefits services rendered in government Hospitals. However, the outpatient alcoholism and/or substance abuse treatment facility must be certified as described above and must usually charge for its services.

Outpatient alcoholism and/or substance abuse treatment covered services. Benefits will be provided for outpatient visits to an outpatient alcoholism and/or substance abuse treatment facility, for the diagnosis and treatment of alcoholism and/or substance abuse. You must be in need of diagnosis and treatment of alcoholism and/or

substance abuse.

Each visit must consist of at least one of the following: individual or group counseling; activity therapy; or diagnostic evaluations by a physician or other licensed medical professional to determine the nature and extent of your Illness or disability. Benefits will not be provided for visits that consist primarily of participation in programs of a social, recreational, or companionship nature.

An employee of the outpatient alcoholism and/or substance abuse treatment facility must provide the services. Payments must be made directly to the facility. No payments will be made to the person who provides any of the covered services; nor will any payments be made if the outpatient alcoholism and/or substance abuse treatment facility turns the payments over to the person who provided the services.

The Plan's payment for a family therapy session will be the same amount, regardless of the number of family members who attend the family therapy session. Benefits will only be provided for one visit each day, except when a family therapy visit takes place on the same day that the person with the abuse problem has a visit separate from the family visit.

N. Ambulance Service.

The following benefits are provided for Hospital, professional, air or licensed voluntary ambulance service.

1. **Hospital and professional ambulance**. Benefits will be provided for Hospital or professional ambulance service to the nearest Hospital or to transfer you from a Hospital to an SNF. This service must be for a Hospital or SNF inpatient admission, or emergency outpatient Hospital care. Excellus will determine whether your condition was serious enough to require immediate ambulance transport. If the nearest Hospital cannot treat your disability or condition, benefits will be provided for ambulance service to the nearest Hospital that can provide the necessary medical treatment.

   Payments.
   The ambulance services described above are payable at 100% of the Allowable Charge, with the following exceptions.
   - Claims for ambulance services provided by in-network providers will be paid at the applicable negotiated rate.
   - If, in a life-threatening situation, you are transported to the nearest available facility capable of providing the necessary medical care by an out-of-network ambulance provider, the Plan will pay 100% of the ambulance service's charges.
   - If there are no in-network providers of ambulance services in your area, the Plan will pay for Hospital or professional ambulance services at 100% of the ambulance provider's charges.

2. **Air ambulance.** When you are transported by air ambulance, benefits will be provided if the transport is determined to be Medically Necessary, up to the Fund's applicable negotiated rate, if the provider is in-network, or the maximum Allowable

Charge, if the provider is out-of-network. Excellus will make the determination whether transport is Medically Necessary and Excellus or the Fund may negotiate an allowance with the air ambulance provider.

Please contact the Fund Office if you have any questions.

O. Kidney Dialysis Facility and Home Dialysis Services

What is a kidney dialysis facility? A kidney dialysis facility is:

1. A facility that has an operating certificate issued by the New York State Department of Health to provide dialysis services;

2. If outside New York State, a dialysis facility that meets the same criteria required to obtain an operating certificate in New York State or that is approved by Medicare. Blue Cross and Blue Shield will determine whether the facility meets the applicable criteria.

Kidney dialysis facility benefits. Benefits will be provided for the same services related to kidney dialysis that would have been covered if rendered in the outpatient department of a Hospital. You are eligible for this benefit only if your chronic kidney disease cannot be controlled by medicine. The services must be billed by, and the bill must be payable to, the kidney dialysis facility.

Home kidney dialysis benefits. Benefits will be provided for home kidney dialysis if you meet the following conditions:

1. You would need to receive dialysis in the outpatient department of a Hospital, a kidney dialysis facility, or a professional provider's office if you did not receive home dialysis benefits. In other words, home kidney dialysis is in place of outpatient Hospital, kidney dialysis facility, or professional provider services;

2. A plan for your home dialysis treatment is set up and approved, in writing, by a Doctor; and

3. Your chronic kidney disease cannot be controlled by medicine.

If you are on home dialysis, benefits will be provided for related laboratory tests and consumable and expendable supplies. Benefits will also be provided for equipment Blue Cross and Blue Shield determines is Medically Necessary. Benefits will not be provided for expenses such as: alterations; installation of electrical power; water supply or sanitary waste disposal; and air conditioning, convenience or comfort items.

Coordination with Medicare. When you become eligible for primary coverage for dialysis benefits under Medicare, the Plan's payments will be reduced by the amount Medicare would pay.

SECTION 13
BASIC MEDICAL BENEFIT

Introduction. The following describes the professional provider benefits available to you for covered services to diagnose and treat your Illness or Injury. Unless otherwise specified in this booklet, the program only covers services that Excellus determines are Medically Necessary and that are usually billed by the provider.

Payments for covered professional providers' services. With the exception of provider inpatient visits and prescriptions supplied in a provider's office, the Plan's payment for the following professional provider services is the Allowable Charge.

Excellus' participating, In-Network professional providers will accept the Allowable Charge as payment in full. Most participating professional providers of another Blue Cross and Blues Shield Plan will also accept the Allowable Charge as payment-in-full. However, some Blue Cross and Blue Shield Plans do not require their participating professional providers to accept the Allowable Charge as payment in full. (This does not currently apply to any New York State Blue Cross and Blue Shield Plan.) In this event, you are responsible for any amounts not paid. However, there is one exception with respect to the Plan's benefit for cancer-related second medical opinions. If the physician who provided you with an initial positive or negative diagnosis of cancer refers you in writing to a participating professional provider of any other Blue Cross Blue Shield Plan, you will not be responsible for any payments.

Nonparticipating, Out-of-Network professional providers are not required to accept the Allowable Charge as payment-in-full. If a nonparticipating professional provider does not accept the Allowable Charge as payment-in-full, you are responsible for any amounts not paid.

For example, an out-of-network diagnostic provider services are covered at a certain percentage of the Allowable Charge, subject to your annual out-of-network Deductible. Once you have met your annual individual out-of-pocket maximum, these services will be reimbursed at 100% of the Fund's Allowable Charge. The Allowable Charge is the maximum amount the Fund will pay to a provider(s) after any applicable Deductible, Co-Insurance and copayment amounts have been subtracted. Please refer to your schedule of benefits for the applicable cost-sharing information for your Plan of Benefits.

Covered Services

A. Surgery

Benefits will be provided for surgery. Surgery is an operation or procedure that requires cutting. Surgery also includes the setting of a fracture and other procedures that you may not think of as surgery. Payment for surgery includes the usual care given by a provider before and after your surgery.

When more than one surgical procedure is performed during an operation:

1. The Allowable Charge will be paid for a major procedure; and

2. 50% of the Allowable Charge will be paid for a secondary (less expensive) procedure.

When more than one procedure is performed through the same incision, benefits will not be provided for secondary procedures that are determined to be incidental.

B. Breast Reconstruction Surgery

Benefits will be provided for professional provider services and related supplies in connection with breast reconstruction surgery after a mastectomy for:

1. All stages of reconstruction of the breast on which a mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

C. Assistance at Surgery

Benefits will be provided for a Doctor to assist your surgeon, when Excellus BlueCross BlueShield determines that the assistance of the second Doctor is necessary. If the surgery is performed in a Hospital, there must be no qualified house staff available to assist your surgeon. If an assistant surgeon is required by the institutional provider, but is not considered by Excellus BlueCross BlueShield to be necessary for the procedure, no benefit will be provided for the assistant.

D. Second Surgical Opinion

Benefits will be provided for a second surgical opinion when your surgeon recommends an operation. A Board-certified specialist who examines you and is competent to consider the proposed surgery must give the second surgical opinion. If the second surgical opinion does not confirm the original physician's opinion, you may obtain a third surgical opinion under the same conditions. The specialist who gives the second or third surgical opinion may not perform the surgery.

E. Anesthesia Service

Benefits will be provided for anesthesia service during covered surgery or maternity service. The provider cannot be your surgeon or the assistant. Payment includes the consultation before anesthesia service is given, and the provider's services during and after surgery or maternity service.

F. Maternity Service

Benefits will be provided, including for your Dependent children, for services provided in connection with childbirth, including routine nursery care, or termination of pregnancy, including abortion or miscarriage.

Newborns and Mothers Health Protection Act of 1996. Group health plans and health insurance issuers 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 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

G. Elective Sterilization

Benefits will be provided for elective sterilization, even if the surgery is not Medically Necessary. Reversal of sterilization is never covered.

H. Professional Provider Inpatient Visits

Benefits will be provided for professional provider visits when you are a registered inpatient in a Hospital, skilled nursing facility, or psychiatric Hospital provided the care is not in connection with surgery or maternity service. (The program's payments for surgery or maternity service include payment for the inpatient professional provider visits.) The payments for provider visits will be based on the level of care given by the provider. Benefits will be provided for only one visit a day. When benefits are not provided for the inpatient stay, benefits will not be provided for a provider visit when you are in a Hospital, skilled nursing facility, or psychiatric Hospital.

When the payment is different.

1. **Intensive care visit**. Sometimes your Illness or Injury is so critical or serious that it requires constant personal attention by your professional provider while you are hospitalized. This Plan may pay a higher amount for this intensive care visit. If benefits are provided for an intensive care visit, the intensive care visit will be counted as a professional provider inpatient visit for that day.

2. **Concurrent care**. If you are an inpatient in a Hospital, and two or more professional providers treat you for separate and different conditions, the program may provide benefits for the visits of each provider. Benefits will be provided only when Excellus BlueCross BlueShield determines that the visits of each provider are Medically Necessary for the treatment of the separate conditions.

Number of professional provider inpatient visits. Benefits will be provided for the following professional provider inpatient visits up to the Allowable Charge:

Inpatient Medical Services. We cover medical visits by a health care professional on any day of inpatient care covered.

The health care professional's services must be documented in the facility records. We will cover only one visit per day per health care professional.

Rehabilitation Services. We cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy.

We cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
2. The therapy is ordered by a Physician.

Skilled Nursing Facility. We cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not covered.

Benefits under this subparagraph will be provided for the same covered professional provider inpatient visits, and are subject to the same conditions and limitations, that apply to covered professional provider inpatient visits under subsection (2).

I. Cancer-Related Second Medical Opinion

Benefits will be provided for a second medical opinion when you receive a positive or negative diagnosis of cancer or recurrence of cancer or when a course of treatment for cancer is recommended to you. The second medical opinion must be given by a Board-certified specialist, including, but not limited to, a specialist affiliated with a specialty care center for the treatment of cancer. The charges associated with the second medical opinion will be covered as an in-network specialist office visit up to the maximum Allowable Charge whether the second opinion is provided by a participating or non-participating provider.

J. Diagnostic Services and Therapies

Benefits will be provided for service related to covered diagnostic services and therapies. The diagnostic service or therapy you receive must be ordered by your physician or other professional provider who is licensed to do so. The service or therapy must be necessary for the diagnosis or treatment of your Illness or Injury; and must be rendered by a professional provider who is licensed to provide the service or therapy, if New York law provides for licensing. A report of the service or therapy must be given to the professional provider who ordered the service.

Covered diagnostic services and therapies are as follows (refer to Schedule of Benefits for extent of coverage):

1. Diagnostic x-ray examinations;

2. Diagnostic laboratory tests;

3. Diagnostic machine tests;

4. Routine mammography screening for breast cancer, once each calendar year for Covered Persons of any age; and mammography screenings, recommend by a Doctor, for Covered Persons who or whose family has a prior history of breast cancer;

5. Routine cervical cancer screening for cervical cancer, once each calendar year for female Covered Persons age 18 or older, including a pelvic examination, collection and preparation of a Pap smear, and services for examining and evaluating the Pap smear;

6. Radiology services (treatment by x-ray or any radioactive substance); the benefit for radiology services includes the cost of the radioactive matter;

7. Chemotherapy services and medications for non-Experimental cancer chemotherapy and cancer hormone treatment;

8. Physical therapy and occupational therapy service, up to the limits described in the Schedule of Benefits, for outpatient Hospital, SNF, and professional provider visits per calendar year, in connection with and following: surgery in a Hospital or ambulatory surgery center; a Hospital stay; an SNF stay; or when otherwise determined to be Medically Necessary;

9. Speech therapy for active treatment of organic medical, traumatic, or surgical conditions. Benefits for speech therapy will continue only until it is determined that the patient is able to be understood or that verbal understanding is not possible. Benefits will not be paid: for congenital or inherited speech defects; after therapeutic goals are met; or when there is no longer any measurable improvement. This benefit is limited, please refer to the Schedule of Benefits for the maximum allowable number of visits;

10. Respiratory therapy;

11. Shock therapy;

12. Kidney dialysis, if your chronic kidney disease cannot be controlled by medicine. When you become eligible for primary coverage for dialysis benefits under Medicare, the Plan's payments will be reduced by the amount Medicare would pay. This reduction will be made even if you fail to apply for or receive Medicare dialysis benefits; and

13. Cardiac rehabilitation.

K. Professional Provider Office Visits

Benefits will be provided for the diagnosis and treatment, in the provider's office or your home, of a non-occupational Illness or Injury. Benefits also are provided for outpatient mental health care and outpatient alcoholism and/or substance abuse treatment services as outlined in the enclosed Summary of Plan Benefits.

L. Lab/X-Ray Benefit

Benefits will be provided for laboratory and x-ray services based on the payment schedule described in the Schedule of Benefits.

M. Well Child Visits

In addition to Preventive Services that are required by law, benefits will be provided for periodic well child visits to detect possible medical problems. Medically Necessary professional provider visits to diagnose or treat a symptom or Injury are not covered under this paragraph. The covered services for well child visits provided under this paragraph are intended to be consistent with the clinical standards set forth by the American Academy of Pediatrics. The covered services differ, depending upon the age of the patient.

1. **Covered services.** The professional provider services covered under the program will include: initial Hospital examination; screening and early detection; health history; routine physical examination; laboratory tests; developmental assessments; immunizations including diphtheria, pertussis, tetanus, polio, measles, rubella, chicken pox, mumps, hemophilus influenza Type B, and hepatitis B. The immunization includes the vaccine, supplies, and materials.

2. **Number of well child care visits.** Benefits will be provided for well child care visits as follows:

    a. **Baby visits**. 9 visits from birth up to the Dependent's 2nd birthday. If benefits are provided for the child's initial Hospital examination at birth, this visit will be counted toward meeting the 9 visits.

b. **Child visits**. 5 visits for Dependents from their 2nd birthday to their 7th birthday.

N. Additional Routine Physical Examinations

Age 7 and older: benefits will be provided for not more than one routine physical examination each calendar year for Covered Persons. Services covered as part of these physical examinations include the administration of chicken pox, influenza, and pneumonia vaccinations. The physical examinations and vaccinations need not be Medically Necessary or required because of specific symptoms or diagnosis.

Women over 19 years of age: 1 GYN Pap test annually, covered at 100% of the Allowable Charge, with no Deductible.

O. Prescription Medicines and Injectable Materials Supplied in a Professional Provider's Office.

Covered services. Benefits will be provided for prescription medicines and injectable materials (except allergy serum, which is covered under Paragraph T below) ordered through the Ascend mail order pharmacy and administered in, and billed separately by, a professional provider's office.

Excellus BlueCross BlueShield's participating, In-Network professional providers will accept the Allowable Charge as payment in full. Most participating professional providers of another Blue Cross and Blue Shield Plan will also accept the Allowable Charge as payment in full. However, some Blue Cross and Blue Shield Plans do not require their participating professional providers to accept the Allowable Charge as payment in full. (This does not currently apply to any New York State Blue Cross and Blue Shield Plan.) You are responsible for the remaining Co-Insurance and any other amounts not paid.

Non-participating, Out-of-Network professional providers are not required to accept the Allowable Charge as payment in full. You are responsible for the remaining Co-Insurance, and any other amounts not paid.

P. Consultation Service.

Benefits will be provided for office or inpatient Hospital consultations by professional providers for the evaluation of your Illness or Injury, when requested by your attending physician. A report of the services must be given to the attending physician who ordered the consultation.

Q. Emergency Care

Benefits will be provided for emergency care given by a professional provider either in

or outside of a Hospital for an Emergency Condition.

Special rule for accidental Injury. When an Emergency Condition results from an accidental Injury, the care must be given within 72 hours, or a reasonable period of time after the Injury.

Benefits will not be provided for outpatient follow-up care in the Hospital.

R. Chiropractic Care

Benefits will be provided up to the limits described in the *Schedule of Benefits* for care rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and its effects; where the interference results from, or is related to, distortion, misalignment, or subluxation of the vertebral column.

The chiropractic care services must be within the scope of licensure of the professional provider rendering the services. Benefits will not be provided under the Plan for maintenance chiropractic care. Maintenance care may be for a chronic condition or may follow completion of a course of therapeutic care. Maintenance care may be for a chronic condition or may follow completion of a course of therapeutic care. Continued treatment after a patient has achieved maximum chiropractic medical improvement, resolution and/or stabilization of a condition will generally constitute maintenance chiropractic care.

S. Diabetes Education

Benefits will be provided for diabetes self-management education, which includes education relating to proper diet, as specified below, to ensure that you are educated as to the proper self-management and treatment of your diabetic condition. Benefits are only available for the Covered Person with the diabetic condition. Benefits will only be provided for self-management education when:

1. You are initially diagnosed with diabetes;

2. A physician diagnoses a significant change in your diabetic symptoms or condition that requires changes in your self-management; or

3. Excellus BlueCross BlueShield determines that reeducation is necessary.

The self-management education must be provided by:

a. A physician, nurse practitioner or staff member during your office visit for diabetes diagnosis or treatment. When the self-management education is provided during an office visit, the one payment for the office visit will include payment for the self-management education;
b. A certified diabetes nurse educator, certified nutritionist or certified or registered

dietician when referred by a physician or nurse practitioner. This education must be provided in a group setting. If Excellus BlueCross BlueShield determines that group education is not available in your area, benefits will be provided for the education when provided by a professional provider that New York State law requires Excellus BlueCross BlueShield to recognize; or

c. A professional provider described above during a visit in your home. Benefits will be provided for only such education in your home when Excellus BlueCross BlueShield determines that it is Medically Necessary for you to receive the education at home.

Your Living Well Program also includes a Health Management Education program that identifies and supports individuals who have diabetes and other chronic conditions. For more information, call 1-877-739-3956 or go online to ufcwonelivingwell.hmchealthworksco.com.

T. Allergy Testing and Treatment

Benefits will be provided for allergy testing, and for allergy injections and treatment material.

U. Podiatry Care

Benefits will be provided under the Plan for visits to a podiatrist. Benefits will not be provided under this Section for services in connection with nail clipping, corns, calluses, flat feet, fallen arches, weak feet, foot strain, or chronic problems of the feet.

V. Preventive Services

This Fund provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided on an in-network basis only, with no cost-sharing (for example, no Deductibles, Co-Insurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

In-network preventive services that are identified by the Fund as part of the ACA guidelines will be covered with no cost-sharing. This means that the service will be covered at 100% of the Fund's Allowable Charge, with no Co-Insurance, copayment, or Deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit.

The Fund will determine whether a particular benefit is covered under this Preventive Services benefit.

W. Durable Medical Equipment – Over $200.00 must be pre-approved by calling 1-800-363-4658

1. Covered services. Benefits will be provided for the rental or purchase of durable medical equipment. Durable medical equipment is used to serve a medical purpose and designed to withstand repeated use. Durable medical equipment is generally not useful to a person in the absence of Illness, Injury, or disease. Your physician must order the equipment for the treatment or care of your condition before its rental or purchase. Although it is required that a physician order the equipment, this does not mean that it will automatically be determined that you need it. The Fund will determine if the equipment is essential; if so, the Fund will determine whether it should be rented or purchased. Benefits will only be provided for equipment that is determined to adequately meet the needs of your condition.

   Durable medical equipment includes, for example: respirators; canes; crutches; walkers; and wheelchairs. Durable medical equipment does not include, for example: air conditioners; dehumidifiers; physical fitness equipment; eyeglasses; contact lenses; or articles of clothing (including shoes), regardless whether those items are Medically Necessary.

   Benefits will be provided for the necessary repair and maintenance of purchased equipment, unless covered by a warranty or purchase agreement. Benefits will not be provided for delivery charges.

2. Payments. The Allowable Charge is reduced by any applicable Deductible amounts you owe, and then the payment is a percentage of the remaining amount. You are responsible for the applicable Deductible, Co-Insurance, and any other amounts not paid.

X. Prosthetic Devices

1. Covered services. Benefits will be provided for prosthetic devices and their replacements necessary to relieve or correct a condition caused by an Injury or Illness. Your physician must order the prosthetic device for your condition before its purchase. Although it is required that a physician prescribe the device, this does not mean it will automatically be determined that you need it. The Fund will determine if the prosthetic device is essential. Benefits will only be provided for a prosthetic device that is determined to meet the needs of your condition.

   Prosthetic devices include, for example: braces and artificial arms, legs, and eyes used to replace functioning natural parts of the body. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; cosmetic devices; or wigs, regardless of the Medical Necessity of those items. Dentures or other devices used in connection with the teeth are also not covered unless required due

to accidental Injury to sound natural teeth. Benefits will be provided for contact lenses when they perform the function of the human lens and are medically required because of intra-ocular surgery (limited to 1 pair every 2 calendar years).

Benefits will not be provided for delivery or service charges, or for routine maintenance, related to prosthetic devices.

2. Payments. The Allowable Charge is reduced by any applicable Deductible amounts you owe, and then the payment is a percentage of the remaining amount. You are responsible for the applicable Deductible, Co-Insurance, and any other amounts not paid.

Y. Medical Supplies

1. Covered services. Benefits will be provided for medical supplies when you are not an inpatient at an institutional provider. Benefits for medical supplies are limited to the following: ostomy bags and supplies required for their use, catheters, and dressings, when it is determined that a large quantity is necessary for the treatment of conditions such as cancer, diabetic ulcers, and burns. Your physician must order the use of these supplies.

2. Payments. The Allowable Charge is reduced by any applicable Deductible amounts you owe, and then the payment is a percentage of the remaining amount. You are responsible for the applicable Deductible, Co-Insurance, and any other amounts not paid.

Z. Wigs

1. Covered services. Benefits will be provided for wigs, when hair loss is due to a medical condition, such as following chemotherapy or radiation therapy for the treatment of cancer.

2. Payments. The Deductible and Co-Insurance amounts apply.

AA. Diabetic Equipment and Supplies

1. Covered services. Benefits will be provided by an independent diabetic supply vendor for the following equipment and supplies that are determined to be Medically Necessary for the treatment of your diabetic condition:

- Blood glucose monitors;
- Blood glucose monitors for the legally blind;
- Injection aids
- Data management systems;
- Insulin pumps and necessary accessories; and
- Insulin infusion devices.

Benefits will also be provided for additional designated diabetes equipment and supplies when the Fund is required to provide such equipment and supplies pursuant to a regulation of the New York State Commissioner of Health.

2. Payments. The Allowable Charge is reduced by any applicable Deductible amounts you owe, the payment is then a percentage of the remaining amount. You are responsible for the applicable Deductible, Co-Insurance, and any other amounts not paid.

SECTION 14
HEARING AID BENEFIT

Costs incurred by you or your Dependents will be Covered Expenses up to the Allowable Charge for a hearing aid, once every 3 years. Claims will be processed through Excellus Blue Cross Blue Shield.

See the Schedule of Benefits for the maximum coverage amount per hearing aid.

SECTION 15
ADOPTION BENEFITS

Adoption benefits are payable for adoption agency fees up to the maximum of the Allowable obstetrical Charges paid for a normal delivery. Legal or other charges in connection with adoption are not covered; only agency fees are reimbursable.

To apply for this benefit, contact the Fund Office for the appropriate claim form.

Claims Procedures for Adoption Benefits

Benefits concerning adoption are provided directly by the Fund. If a claim for adoption benefits is denied in whole or in part, or if a claim is denied because the Fund believes it was filed on behalf of someone who is ineligible for benefits under the Plan, you will be notified in writing within 60 days and advised of the specific reason for the denial, the specific Plan provision on which the denial is based, any additional information needed to perfect the claim and an explanation of why such information is necessary, a description of the Plan's appeal procedures and time limits, and your right to bring suit against the Plan under ERISA if your appeal is denied. You (or your authorized representative) may, within 60 days from the denial, request a review by writing to the Board of Trustees at 5911 Airport Road, Oriskany, NY 13424.

Please refer to Section 27 for information on appeal procedures relating to adoption benefits.

SECTION 16
QUESTIONS AND ANSWERS

Q: What is the Blue Cross and Blue Shield Network?

A: *It is a network of selected providers. These health care providers have contracted with Blue Cross and Blue Shield to provide services at preferred rates. Throughout Local One's jurisdiction, the majority of health care providers participate with Blue Cross and Blue Shield.* ***To achieve the maximum benefit from the Plan, be certain to present your Excellus BlueCross BlueShield card to your participating provider at the time of service.***

Q: What happens if I require medical services in Pennsylvania or anywhere outside of New York State?

A: *Again, simply present your UFCW Blue Cross and Blue Shield I.D. Card. The network is on a national level, including Hospital services.*

Q: What are the major advantages of a Participating Provider Net-work?

A: *To provide easy access to "quality health care" without limiting your choice of provider in most cases. In some instances, it can decrease your coinsurance costs due to lower negotiated rates. In most instances, use of claim forms is eliminated. Generally, the Fund is billed directly by the Provider and reimbursement of the allowable amount is paid directly to the Provider.*

Q: Is my current provider participating in this Network?

A: *In most cases, your current Doctor or provider is participating in this Network. Call* Excellus Blue Cross Blue Shield at 1-877-223-2993 *to see if your Doctor participates in the Network.*

Q: What is the Claim Procedure for services of a Network Provider?

A: *Upon receiving services within the Network, simply present your UFCW Blue Cross and Blue Shield I.D. Card. The claim will be filed automatically on your behalf and the provider will be paid directly in most cases.*

Q: What if I choose to use Non-Participating Providers?

A: *If you use a Non-Participating Provider, your claim must be submitted by you directly to BCBS Ask your provider to supply you with an itemized bill for submission to the Plan. Reimbursement for your expenses will be no greater than that allowable to a participating provider. However, you likely will incur additional expenses when obtaining services out-of-network. If there is no network provider (that provides the required services) within a reasonable distance of the patient, the claim will be paid up to the Allowable Charge that the Fund would have paid to a participating provider.*

Q: What should I do if I have any questions concerning my benefits, a submitted claim, or a provider; or need a new Blue Cross and Blue Shield Identification Card?

A: *You may contact your Excellus Blue Cross Blue Shield Customer Care Unit at 1-877-223-2993*

Q: Do I need a primary physician or a referral?

A: *No, not under this Plan.*

Q: How does my provider bill Excellus BlueCross BlueShield?

A: *Your provider must bill their local Excellus BlueCross BlueShield Plan.*

Q: Where do I find out if my Doctor participates in the Blue Cross Blue Shield Network?
A: *Since Blue Cross no longer prints provider directories, you can either search online at* ***www.excellusbcbs.com/ufcwone*** *or contact your Doctor.*

Note on New York State Surcharges

New York State law has many rules regarding how health care is financed in New York State. New York State adds a surcharge (an additional amount added to the usual charge) to expenses for services provided by any of the following facilities located in New York State: Hospitals, both inpatient and outpatient (including emergency room), diagnostic and treatment centers, and ambulatory surgical centers. This surcharge changes from year to year and is to pay for the care of low income patients. It is the responsibility of the Plan to pay the surcharge on any portion of the charges that are paid for by the Plan. This surcharge will be considered a paid claim and will count toward each individual's maximum annual and maximum lifetime benefit. The surcharge will be considered a paid claim for subrogation and overpayment purposes under the Plan as well. No surcharge amounts will be paid once an individual has reached the annual maximum. It is the Participant's and/or the Dependent's responsibility to pay the surcharge to the provider on any amounts that are not paid for by the Plan.

In addition to the expense surcharge, there is a monthly surcharge that the Plan must pay directly to the State of New York for each Participant and/or Dependent residing there. This surcharge is to help fund medical education. This surcharge varies based on individual or family coverage and the geographic region in which the Participant and/or Dependent lives. This monthly surcharge will not be counted toward each Participant's and/or Dependent's annual and lifetime maximum.

SECTION 17
PRESCRIPTION DRUG BENEFIT

Purpose of Benefit

This benefit is designed to help cover the cost of certain prescribed drugs and medications.

What Costs Are Covered?

Covered Drug Charges incurred in connection with accidental bodily Injury or Illness not related to Employment are covered. Each Covered Person will be entitled to reimbursement, after a Co-Insurance payment is made by the Covered Person, for Covered Drug Charges for drugs prescribed by a Doctor or Dentist and dispensed by a licensed pharmacist.

Prescription Drugs

Benefits will be provided under the Prescription Card Program based on the payment schedule described in the *Schedule of Benefits*. (30-day supply at a retail pharmacy/ 90-day supply via mail order or at a pharmacy that has an agreement with the Fund to provide 90-day supplies to Covered Persons.)

What Are Covered Drug Charges?

Covered Drug Charges are charges for the following items when dispensed by a licensed pharmacist, as ordered by a Doctor or Dentist by written prescription:

- Drugs requiring compounding (please note: certain compound drugs may be subject to utilization management requirements);
- Legend drugs (a legend drug is a medicine that requires a label bearing the legend "CAUTION": Federal Law Prohibits Dispensing Without a Prescription", or similar wording);
- Insulin, insulin syringes, non-insulin syringes, injectables, prenatal vitamins, fluoride products, inhalation therapy devices (aerochamber inspirease), retin-A (when Medically Necessary), oral contraceptives, depo provera contraceptives, fertility medications, legend vitamins, and over-the-counter diabetic supplies (see Section 13(AA));
- Appetite suppressant drugs (12-month supply per lifetime); and
- Preventive medications, such as aspirin, folic acid, and smoking cessation products.

Covered Drug Charges also include charges for Prilosec OTC, Claritin, and Zyrtec. There is no Co-Payment applicable with respect to these drugs.

Non-Covered Charges

In addition to the General Exclusions outlined in Section 20 of this SPD, coverage will not be provided for the following drugs:

1. Drugs obtained without a prescription.

2. In excess of a 30-day supply of pharmacy drugs, with the exception of Maintenance Drugs at Participating Pharmacies, or a 90-day supply of mail-order drugs.

3. A beauty aid, cosmetic or dietary supplement.

4. Drugs that are provided to you when you are a Hospital inpatient, or provided by a Doctor or Dentist, incidental to his or her professional services rendered to the patient.

5. A non-federal legend drug.

6. A drug labeled “Caution: New Drug-Limited by Federal (or United States) law to investigational use,” or an Experimental drug.

7. Medication that is to be taken or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent Hospital, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.

8. Any prescription refilled in excess of the number of refills specified by the Doctor, or any refill dispensed after one year from the Doctor’s original order.

9. Ulcer therapy combination drug products.

Prescription Card Program

Once you become eligible to receive benefits under the Plan, you will receive your Prescription Card for purchasing covered prescription drugs.

Your card will identify you as a covered Participant to a Participating Pharmacy. You simply present this card, along with your Co-Insurance and the remaining cost will be billed directly to the Fund.

A list of the pharmacies participating in the current Participating Pharmacy network will be available to you at the Fund Office or online at www.ufcwone.org.

If you use a pharmacy that does not participate in the Plan, you must pay the pharmacies’ full charge and you will need to send a completed claim form to the Fund Office. You likely will incur additional out-of-pocket expenses.

IT IS EXTREMELY IMPORTANT THAT YOU REQUEST FROM YOUR DOCTOR OR DENTIST THE GENERIC SUBSTITUTE WHEN A PRESCRIPTION IS WRITTEN (IF AVAILABLE). THIS WILL SAVE YOU AND THE FUND MONEY.

Maintenance Drugs

Maintenance Drugs are those prescribed for chronic and long-term conditions (for example, insulin to control diabetes). Such drugs are usually prescribed for a minimum 30-day supply.

For those maintenance drugs prescribed for more than a 30-day supply, you may use mail order or fill the prescription at a 90-day retail Participating Pharmacy. Participating Pharmacies include Tops and Parkway Drugs.

If you use the mail-order pharmacy, your filled prescription will be mailed to you after you mail the prescription. You may phone in to order your next refill 90 days after your prior order was filled. The mail order refill number is **[877-201-7262]**. Also, your Doctor may phone in a prescription by calling **[877-201-7262]**. Your physician must be prepared to provide your member I.D. number with the prescription.

If you use an approved walk-in pharmacy, your prescription will be filled in the usual way. In either case, you will pay the Co-Insurance and the balance of the bill will be sent directly to the Fund by the pharmacy.

Certain Core Therapy drugs may qualify for a lower Co-Coinsurance payment. Core Therapy drugs are those dispensed to treat a specific disease, such as diabetes, heart disease or asthma. The diseases and drugs covered under Core Therapy are reviewed and updated by the Fund regularly. For a listing of current Core Therapy drugs, please contact the UFCW Local One Health Care Fund Customer Service Unit at 1-800-959-9497.

If you have any questions about the following Programs and whether they may apply to you or if you need to request Prior Authorization, please contact Our UFCW Local One Health Care Fund Customer Service Unit at 1-800-959-9497.

Step Therapy

The Fund uses a Step Therapy program to help ensure the safe and effective use of medications.

Step Therapy is a process that requires the use of an alternative drug before certain drugs can be approved. If a prescription for a medication requiring Step Therapy is presented to the pharmacy, your prescription profile is instantly reviewed when the claim is electronically submitted to HealthSmartRx. Based on the history in your file, the prescription claim may be approved automatically. If the prescription is rejected, the pharmacist may call the *physician* to obtain a prescription for the alternative drug, or you may pursue approval of the prescription through our prior authorization process.

The alternative drug must be used before a prescription requiring Step Therapy can be

obtained. **Exhibit A to this SPD contains a listing of drugs affected by the Step Therapy Program.**

If you had a prescription for one of the drugs subject to Step Therapy filled within a prior period, you may be entitled to continuing coverage of that prescription under the Plan, without participating in the Step Therapy process. Please see the "Step Therapy" insert for details or contact ***our UFCW Local One Health Care Fund Customer Service Unit at 1-800-959-9497.***

To avoid an extra trip to the pharmacy before filling a prescription for the types of drugs covered under Step Therapy, determine whether you need to try an alternative first or need to obtain prior authorization.

Quantity Limits and Prior Authorization

The Fund applies the limits developed by its prescription drug manager, HealthSmartRx, based on the Food and Drug Administration's (FDA's) and the manufacturers' recommended dosages. These limits were established to help ensure the safe and effective use of these medications.

For medications requiring a prior authorization, you, your *physician* or your pharmacist will need to contact HealthSmartRx customer service to initiate the prior authorization process. Based on the information that is provided by your physician, a determination will be made as to whether or not the approval criteria have been met and both the pharmacy and your *physician* will be notified. A listing of the drugs affected by Quantity Limits and Prior Authorization are enclosed with this SPD.

Therapeutic Interchange Program

The goal of the Therapeutic Interchange Program is to help you and the Fund save money. This program is designed to assist Participants and Dependents who are currently taking a brand name medication that does not have a generic equivalent to find alternatives to such medication. In many cases, there may be another generic medicine in the same therapeutic class that provides similar benefits at a much lower cost.

Enclosed with this SPD is a chart that provides examples of certain drug classes and the alternate generic drugs that may be available within those classes.

Consult with your Doctor to determine whether another generic medication may be right for you. If you and your Doctor agree, simply fill your new generic prescription and the Fund will cover the full cost of that prescription for the first three months. **You will not be obligated to make any co-payments for those three months.**

Special Medications To be covered under the Plan, all specialty drugs must be ordered through the Accredo specialty pharmacy program.**

Specialty medications are generally self-injectable medications (excluding insulin) and oral medications for oncology and transplants. You can get your prescriptions for specialty medications sent to you directly through **the Accredo specialty pharmacy program**, rather than purchasing these medications through your Doctor or your local pharmacy.

Under the **Accredo** program, you can order your specialty drugs over the phone by calling **[877-222-7336]**. If you have a new prescription, you can contact **Accredo** for further instructions. The medication will be mailed by priority overnight mail directly to your door. **Accredo** also has a pharmaceutical consulting staff available to answer any questions you may have about your medication.

Questions and Answers

Q: What is a generic drug?
A: *The generic name of a drug is its chemical name. A generic drug is a drug that is sold under its chemical name and not under its brand name. The brand name is the trade name under which the drug is advertised and sold.*

Q: Are birth control pills covered under the Prescription Drug Benefit?
A: *Yes.*

Q: Are Tobacco Cessation Medications covered under this benefit?
A: *When you are enrolled in the Fund's Tobacco Cessation Program (see page 38), prescription tobacco cessation medications will be covered under the Fund's prescription drug benefit, if prescribed by your physician. Medications not requiring a Doctor's prescription, such as the nicotine patch and gum, will be provided to eligible Participants and Dependents who enroll in the Program. The Program will provide these over the counter medications directly to the enrollee at no cost.*

SECTION 18
DENTAL BENEFIT

Purpose of Benefit

This Benefit is designed to help cover the cost of dental expenses resulting from an Illness, defect or Injury to teeth not related to Employment.

Eligibility for Coverage

You and your Dependents will become covered for the Covered Dental Charges listed under the General Dentistry section of this SPD following six consecutive months of contributions to the Fund on your behalf. For example, if contributions are received for the months of January through June, you will become covered for General Dentistry on July 1st.

You and your Dependents will become covered for the Covered Dental Charges listed under Extensive Dentistry and Orthodontic Care following 12 consecutive months of contributions to the Fund on your behalf. For example, if contributions are received for the months of January through December, you will become covered for Extensive Dentistry on January 1st of the following year.

Amount of Coverage

Payment will be made as outlined in the Schedule of Benefits for Covered Dental Charges. Benefits will be paid under the Plan up to the maximum shown in the Schedule of Benefits for all expenses (including expenses for orthodontic care) incurred in a calendar year. The maximum benefit for a course of orthodontic care is also described in the Schedule of Benefits.

Scope of Coverage

Covered Dental Charges will be the Allowable Charge for the following services, supplies and treatment.

General Dentistry (eligibility requires six months of contributions on the Participant's behalf)

1. Diagnostics and preventive services as follows:
   a. Examinations, including x-rays, but no more than two per calendar year;
   b. X-rays, including bitewings, periapicals and full mouth;
   c. Tests and laboratory procedures including biopsies, pulp and vitality tests;
   d. Prophylaxis (cleaning of teeth) limited to two per calendar year;
   e. Fluoride treatments, and
   f. Sealants, up to age 18.

2. Extractions, fillings, non-porcelain inlays, root-canal therapy and periodontal treatment, and certain other treatment of teeth and gums.

3. Oral Surgery.

Extensive Dentistry (eligibility requires 12 months of contributions on the Participant's behalf)

1. Initial installation of, or addition to, full or partial dentures or fixed bridgework required as the result of the extraction of one or more injured or diseased natural teeth, (excluding wisdom teeth), provided that the denture or bridgework includes the replacement of the tooth, or teeth, so extracted, and that such installation or addition is completed within 24 months of the extraction.

   Note: *Where a full upper or lower denture is covered under the Benefit, the replacement of the opposing full denture will be covered for the first time only in order to prevent malocclusion.*

2. The replacement of a partial denture by a new partial or full denture, or the addition of teeth to an existing partial denture when such replacement or addition is due to extraction of one or more natural teeth (excluding wisdom teeth) provided that such replacement or addition is completed within 24 months of the extraction.

3. The replacement or alteration of full or partial dentures or fixed bridgework required as the result of the following events, (a) accidental Injury necessitating oral surgical treatment, (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided that the replacement or alteration is completed within 12 months of the Injury or oral surgical treatment.

4. The replacement of a full denture required as the result of structural change within the mouth, provided (a) the replacement is made more than five years after the date of the denture's installation, and (b) the original denture cannot be made serviceable.

5. Replacement of a removable partial denture and/or fixture bridgework will also be covered if it is at least five years old and the person is eligible for Extensive Dentistry coverage.

6. Initial installation of fixed bridgework to replace one or more natural teeth (excluding wisdom teeth), that have been extracted but only to the extent of the covered dental charge that would have been made if the replacement had been accomplished by a partial denture and only if such installation is completed within 24 months of the extraction.

7. The repair, including relining and rebasing, necessary to restore a denture or bridgework to its original function.

8. A crown, if the tooth is broken down due to dental decay. Replacement of a crown

will be covered only if due to decay, irreparable fracture or severe wear when the existing crown is at least five years old. A pre-treatment plan is required and, in some instances, diagnostic models.

Orthodontic Care (eligibility requires 12 months of contributions on the Participant's behalf).

Orthodontic appliances and treatment are covered under the Plan if incurred during a course of orthodontic treatment that occurs while the person is covered for Orthodontic Care. Orthodontic benefits will be paid according to the following schedule: up to $300 for the initial placement of the appliance and $50 monthly thereafter, until the applicable maximum benefit amount is reached. Please refer to your schedule of benefits for the applicable maximum amount of the Orthodontic Care benefit.

Non-Covered Expenses

1. Services provided by a dental or medical department maintained by any Employer, a mutual benefit association, labor union, Trustee other similar type of group;

2. Expenses for repair or replacement of dentures except as specified under Covered Dental Charges;

3. Expenses for loss or theft of denture or bridgework;

4. Expenses for the replacement of congenitally missing teeth; or

5. Services rendered or furnished in connection with an optional method of treatment, as opposed to a standard procedure, except to the extent of the reasonable charge (subject to the Allowable Scheduled Fee) for the procedure carrying the lesser fee (see **Claim Procedures as noted in this Section.)**

Percentage Paid by the Plan

The Plan pays a percentage of the Allowable Charge, as outlined in the enclosed Summary of Plan Benefits. Preventive care is paid at 100% of the Allowable Charge. Other types of care are paid at a percentage of the Allowable Charge and you are responsible for the Co-Insurance and any amount greater than the Allowable Charge.

Preferred Providers

The Fund has entered into special pricing agreements with certain Dentists (called preferred providers). These preferred providers have agreed to charge no more than the

Plan's Allowable Charge to Covered Persons for covered dental charges, other than for orthodontic care. Thus, by using a preferred provider, the amount that you are required to pay may be reduced. The names and locations of the preferred providers are available from the ***Our UFCW Local One Health Care Fund Customer Service Unit at 1-800-959-9497*** and online at *www.ufcwone.org*.

Services received from providers who are not preferred providers are covered under the Plan up to the Allowable Charge; however, the provider may bill you for any amounts beyond this charge, in addition to any applicable Co-Insurance.

Allowable Charge

The Plan has determined the maximum Allowable Charge for each procedure covered under the Dental Benefit. This price is known as the Allowable Charge. The part of any Dentist's charge for a particular procedure that is in excess of the Allowable Charge for that procedure will not be reimbursed under the Plan.

Claim Procedures

All Dental Claims should be submitted to The Loomis Company for processing and payment. Claims can be submitted by your dental provider or by you directly to:

The Loomis Company
P.O. Box 7011
Wyomissing, PA 19610
Or visit their website @ www.loomisco.com

For Questions regarding your claim(s), please contact *Our UFCW Local One Health Care Fund Customer Service Unit at 1-800-959-9497.*

As part of the proof of claim, the Covered Person is responsible for furnishing all diagnostic and evaluative material as may be required by the Plan to establish its payment responsibilities. Such material may include, but is not limited to, dental X-rays, models, charts and written reports.

If the anticipated cost of the proposed course of treatment is more than $250, a "treatment plan" must be submitted to the Fund Office before treatment begins. Treatment should not start until the Fund Office considers the treatment plan, eligibility is approved and the Covered Person and Dentist are notified of the allowance available. This allows the Covered Person to know how much of the charge for a proposed course of treatment will be covered by the Plan.

Blank treatment plan forms may also be obtained from The Loomis Company.

The INITIAL claim form involving a treatment plan must be submitted within 20 days of

the examination made by a Dentist where bridgework, denture, or orthodontics is involved.

An INTERIM or FINAL claim must be submitted to the Fund Office every 90 days, or upon completion of the treatment, whichever occurs first.

The Covered Person is responsible for the timely submission of the claim forms. Generally, an expense is incurred when the service is performed. However,

- In the case of dentures or fixed bridgework, the expense is incurred when the impression is taken;

- In the case of crown work, the expense is incurred when preparation of the tooth has begun; and
- In the case of root canal therapy, the expense is incurred when work on the tooth has begun.

Course of Orthodontic Care

A course of orthodontic care is the period that begins when the first orthodontic appliance is installed on a Covered Person and ends when the last orthodontic appliance is removed, provided that successive courses of orthodontic care will be considered as one course of orthodontic care unless the succeeding course begins more than five years after the end of the preceding course.

Alternate Procedures

Frequently there is more than one way to treat a dental problem. For example, either a crown or a filling could be used to restore a tooth. The same holds true in decisions about the use of precious metals versus plastic. The Plan will pay for the least costly procedure that meets acceptable dental standards. If the alternate procedures provision is applied, the Fund will review the claim to determine the appropriate service, supply or treatment necessary to treat the dental problem. The treatment plan is important because, under the alternate procedures provision, the Fund has the right to pay for the most economical method of treatment that does the job properly. If you and the Dentist decide you want the more costly treatment, you are responsible for the charges in excess of the least costly appropriate treatment paid by the Plan.

Extended Coverage

If a person’s coverage terminates after the beginning but before the completion of dental work for which a 90 day pre-certification was granted, dental charges incurred for such unfinished dental work after termination of coverage will be covered as though they had been incurred while the person was eligible, provided such charges were included in a treatment plan received at the Fund Office prior to termination of coverage.

Questions and Answers

Q: I had a tooth extracted in the lower jaw and had teeth missing in the upper jaw. The Dentist wants to make upper and lower partial dentures. Would you allow both dentures?
A: *No. The lower partial would be covered if it replaced a tooth that had been extracted within the past 24 months and if the claim had been timely filed with the Fund Office. The upper partial would not be covered.*

Q: If I quit work and then went to the Dentist the next day and the Dentist submits a treatment plan for dental work, would you allow the claim?
A: *Yes, as long as the treatment plan is received in the Fund Office before the date coverage terminates and work is completed within three months after coverage terminates.*

Q: I had an examination that included X-rays, prophylaxis, and preparation of complete dental chart on January 1st. When will I be eligible for these procedures again?
A: *You can have these procedures done again at any time but not more than a total of two times in the same calendar year to be considered for the reimbursement under this benefit.*

Q: I had full upper and lower dentures on the effective date of my coverage. If I now go to the Dentist for new dentures, will my new dentures be covered under the Plan?
A: *No, unless the replacement is due to a structural change within the mouth, the replacement is made more than five years after the date of the denture's installation and the old denture cannot be made serviceable.*

Q: I had a partial upper denture on the effective date of my coverage. If I now go to my Dentist for a new partial denture, will my new partial denture be covered under the Plan if it does not include replacement of a tooth extracted within the past 24 months?
A: *No, unless the replacement is made two years or more after the date you become covered under the Extensive Dentistry Benefit and only then if the replacement is due to a structural change within the mouth, and the replacement is made more than seven years after the date of the denture's installation.*

Q: If I was covered for six consecutive months of contributions under the Plan and then laid off, when would I become eligible for General Dentistry and for Extensive Dentistry and Orthodontic Care if I was rehired?
A: *If you were rehired within one year of your layoff date, you would be given credit for the time you were previously covered. Therefore, you would be covered for General Dentistry immediately and for Extensive Dentistry and orthodontic care after six more consecutive months of contributions have been received.*

Q: If I was eligible for Dental Benefits as a Dependent and then I become an Employee, is a new "waiting period" required for dental coverage?
A: *No. You would be given credit for time covered as a Dependent.*

Q: If a dental service is covered under both the Dental Benefit and the Medical Benefit, what benefits would I be entitled to if expenses were incurred before the Dental Benefit becomes effective but after the Medical Benefit becomes effective?

A: *You would not be entitled to any benefits under the Dental Benefit but would be entitled to appropriate reimbursement under the Medical Benefit. This would include oral surgery charges, injuries to sound natural teeth, and the extraction of impacted teeth.*

SECTION 19
VISION BENEFIT

Please refer to the Vision Care Plan Benefit Description attached to this SPD for specific information regarding your vision benefits under the Plan.

Eligibility for vision care benefits is determined by the same rules that apply to your other health care benefits. If you have any questions regarding your vision benefits under the Plan, contact ***the UFCW Local One Health Care Fund Customer Service Unit at 1-800-959-9497*** or the Vision Care Coordinator at 1-800-999-5431. You can also log on to their website @ www.davisvision.com.

How to receive services from a provider in the network

Call the network provider of your choice and schedule an appointment. Identify yourself as a UFCW Local One Participant or Dependent. Provide the office with the Participant's Social Security number and the date of birth of any covered Dependents needing services. The provider's office will verify your eligibility for services, and no claim forms or ID cards are required.

The network providers. These are licensed providers who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please call 1-800-999-5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you, or you may utilize our "Find a Doctor" feature, on our website at **www.davisvision.com.**

**** Dependent children up to the age of 19 (or 23, if the child is a full-time student and meets the Plan criteria) are entitled to vision care services every 12 months. If you are between the ages of 23-26 or an adult, coverage is every 24 months.**

** New (to the provider, or first-time) contact lens wearers will receive an initial supply (two multi-packs) of lenses, along with all necessary visits for proper fitting and recommended follow-up care. Existing contact lens wearers will receive four multi-packs of lenses. Please note: Contact lenses can be worn by most people; once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

Receipt of ordered eyewear. Your eyeglasses will be sent to your provider from the laboratory generally within two to five business days. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coating), specialized prescriptions or non “Tower Collection” frames are selected.

Out-of-network provider benefits. You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges an then submit a claim for reimbursement to the Fund office.

A one-year unconditional breakage warranty is provided for all eyeglasses completely supplied by Davis Vision.

Exclusions and limitations. The following items are not covered by this vision program:

- Medical treatment of eye disease or Injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
- Replacement of lost eyewear.
- Non-prescription (plain) lenses.
- Services not performed by licensed personnel.
- Contact lenses and eyeglasses in the same benefit cycle.

For more information, please visit Davis Vision’s website at www.davisvision.com or call Davis Vision at 1-800-999-5431 to:

- Access the Interactive Voice Response Unit which will provide network providers nearest you.
- Verify eligibility for yourself or your Dependents.
- Request an out-of-network provider reimbursement form.
- Understand emergency care.
- Speak with a Member Service Representative.
- Ask any questions about your Vision Care benefits.
- Member Service Representatives are available: Monday through Friday, 8:00a.m. to 8:00p.m. Eastern Time, and Saturday, 9:00a.m. to 4:00p.m. Eastern Time.

Participants who use TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling **1-800-523-2847**.

Questions and Answers

Q: If I go to the Doctor for an eye examination and the Doctor finds that I have a medical diagnosis, how will the exam be covered?
A: *If the Doctor actually examines the eyes and completes a vision claim form answering all questions, the initial examination will be considered under the Vision Benefit.*

Q: Assume in the above case that the Doctor, after finding a medical diagnosis, prescribes further treatment?
A: *Any visits after the initial visit will be considered under the Basic Medical Benefit.*

Q: How will contact lenses be covered following eye surgery?
A: *The initial pair of contact lenses or cataract eyeglasses following cataract surgery is considered a covered medical charge, and the charges are covered under your Basic Medical Benefit rather than your Vision Benefit.*

Q: May I get my exam at one visit and get my eyeglasses at a later visit?
A: *No. You must receive all of the vision services at one time. Under certain circumstances, this requirement may be waived.*

SECTION 20
GENERAL EXCLUSIONS

The following exclusions and limitations apply to all benefits payable under the Plan except as otherwise specifically noted under the Plan or applicable law.

1. Any services, supplies, drugs or treatments, including any period of Hospital confinement, that are not Medically Necessary.

2. Any services, supplies, drugs or treatments that are not prescribed as Medically Necessary by a legally qualified Doctor.

3. Dental work, treatments or dental x-rays, except as described under the Dental Benefit Section of this SPD, and certain surgical procedures.

4. Eye refractions or the fitting or cost of eyeglasses except as provided under the Vision Benefits Section of this SPD.

5. Transportation except as provided under the ambulance provisions of the Hospital Benefit Section of this SPD.

6. Expenses covered under Titles XVII and XIX of the Social Security Act (Medicare and Medical Assistance to the Needy), except to the extent required by law. When you are eligible for a government program, this Plan's benefits will be reduced by the amount the government program pays, or would have paid, for the services, to the extent permitted by law. If you are eligible for a government program, this reduction will

be made, even if: you fail to enroll; you do not pay the charges for the program; or you choose to receive services at a Hospital that cannot bill Medicare.

See Section 3 for information on the coordination of the Fund's benefits and benefits under Medicare.

7. Cosmetic surgery. This exclusion applies when the Fund determines that the service is not Medically Necessary and is intended only to improve your appearance. The term "cosmetic surgery" will not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, or reconstructive surgery to correct a functional birth defect of a covered Dependent, or reconstructive surgery on breasts following a mastectomy, as required by law.

8. Expenses resulting from an act of war, including armed aggression.

9. Benefits received under other plans.

10. Expenses incurred for, or in connection with, educational testing, or training on account of nervous or emotional disorders.

11. All charges that the Covered Person does not have a legal obligation to pay will be excluded, including, but not limited to:

    a. Charges where a provider charges you a reduced amount for prompt payment, etc. but charges a higher amount to the Plan; and

    b. Charges by a Health Maintenance Organization ("HMO") where the HMO agreement does not have a provision that allows the HMO to bill other carriers for charges which exceed the pre-paid amount.

12. Sterilization reversals.

13. Charges for service or care related to conception by artificial means, including, but not limited to, in vitro fertilization, and artificial insemination.

14. A fixed amount of the Hospital charges for non-emergency use of Hospital emergency room. Refer to the Schedule of Benefits for the exact amount.

15. Membership or per diem fees for use of health clubs, fitness centers, diet or nutritional centers, sports medicine centers, swim clubs, and other similar facilities that are not maintained exclusively for medical rehabilitation purposes, even though prescribed or recommended by a Doctor.

16. Services for any Injury, condition or disease, or charges for any drug, if payment is available to you under a Workers' Compensation Law or similar legislation, whether or not you followed the procedural requirements for obtaining such coverage.

17. Charges for any service, supply or treatment for which coverage is provided under any government program or is required by statute, except as provided under Section 12 on Hospital Benefits.

18. Any service furnished to you without charge or that would usually be furnished to you without charge. This exclusion also applies if the service would have been furnished to you without charge if you were not covered under this Plan or under any other insurance.

19. Any service or treatment furnished by or at the discretion of the United States or any government, except as provided under Section 12 on Hospital Benefits.

20. Coverage for all Fund benefits for you and your Dependent(s) if a third party is or may be liable for the expense or the expense may be recovered or recoverable by, or on behalf of, you or your Dependent in any action, judgment, compromise or settlement of any claims against any party. The Fund also excludes coverage for future benefits in connection with any accident or Injury for which any third party payment was made. These exclusions apply to all benefits under the Fund, including but not limited to medical, Hospital, dental, vision and prescription drug benefits. These exclusions include, but are not limited to, any payment you, your Dependent, or you or your Dependent's attorney may receive as a result of the accident or Injury, no matter how these amounts are characterized, who pays these amounts, or whether the amounts are designated as compensation for past or future medical expenses. However, under certain circumstances, the Fund may advance benefits to you or your Dependent with the understanding that you or your Dependent will repay the benefits to the Fund. See Section 5, "Subrogation and Reimbursement" for more information about whether the Fund will advance benefits.

21. Any Injury or Illness arising from an automobile, motorcycle or related accident with respect to which personal Injury protection coverage or no-fault benefits are recoverable under state law, up to the limit of such coverage. This exclusion applies, even if coverage is denied by the insurance carrier for any reason such as, for example, because you or your Dependent are injured while intoxicated, or there is a no-fault insurance Deductible. If your claim for no-fault benefits is denied, you must file for an arbitration hearing if the Trustees request that you do so. Benefits also will not be covered for any service or care eligible for coverage under an optional automobile insurance policy for situations involving driving while intoxicated (DWI), driving under the influence (DUI), or driving while ability is impaired (DAI) is involved.

22. Any service or treatment resulting from you or your Dependent's participation in an illegal or criminal act or while in police custody. This exclusion is not affected by any subsequent official action or determination with respect to prosecution of the Covered Person (including acquittal or failure to prosecute) in connection with the acts involved.

23. Any service, treatment, supply or drug that is Experimental.

24. Any service or treatment arising from a self-inflicted Injury or Illness, and any complications thereof.

25. No payment shall be made for expenses incurred for custodial care. For the purposes of this limitation, expenses incurred for care comprised of accommodations (including Room and Board and other institutional services) and nursing services provided an insured person because of age or other mental or physical condition, primarily to assist the insured person in the activities of daily living, shall be deemed custodial care. The fact that the insured person is concurrently receiving maintenance medical care that cannot reasonably be expected to contribute substantially to the improvement of a medical condition does not preclude the application of this limitation.

26. Any service or care furnished by a medical department or clinic provided by your Employer, unless your Employer is a health care industry employer.

27. Any service or care that is custodial in nature or any therapy that Excellus Blue Cross Blue Shield determines is not expected to improve your condition.

28. An institutional provider stay that is mainly for testing purposes. For example, benefits will not be provided for inpatient services that are mainly for diagnostic x-rays, laboratory tests, physical checkups, and other types of diagnostic studies.

29. Any service or care covered under the Plan if billed by a person employed by an institutional provider, except when required by state or federal law.

30. Any pharmacy, clinical laboratory, x-ray, radiation therapy, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.

31. Any Hospital stay or any other service or care related to, or leading up to, transsexual surgery.

32. Charges for telephone consultations, missed appointments, or fees that may be added for completing a claim form.

33. A Hospital Stay or any service or care for treatment of obesity unless surgery is Medically Necessary and weight is at least twice the ideal amount specified for frame, age, and height.

34. Any service or care related to the treatment of sexual dysfunction, when not caused by organic disease.

35. If you are receiving benefits through an HMO, any service or care that is, or would

have been, covered under the HMO plan, even if coverage is denied because you fail to follow the rules of the HMO.

36. Injuries resulting from an act of domestic violence or from a medical condition, including mental health medical conditions, are not excluded solely because the source of the Injury was an act of domestic violence or a medical condition.

Exclusions and Limitations Applicable Specifically to Hospital Benefits

1. **Services starting before your coverage begins.** If you are receiving inpatient, home health, or hospice care on the day your coverage under the Plan begins, benefits will not be provided for the service or care you receive:

   a. Prior to the first day of your coverage under the Plan; or

   b. On or after the first day of coverage under the Plan, if that service or care is covered under any other health benefits contract, program, or plan.

Benefits will be provided for services rendered on or after the first day of coverage, if you have no other health benefits coverage for that service or care.

2. **Veterans Administration/Government/Uniformed Service Hospitals.** To the extent allowed under the law, benefits will not be provided for any service or care you receive in an institution owned or operated by: the Veterans Administration; a federal, state, or local government; or by the United States uniformed services, except as follows:

   a. **Veterans Administration Hospitals.** Benefits will be provided for service and care for non-service related conditions received in an institution owned or operated by the Veterans Administration.

   b. **Government Hospitals.** Benefits will be provided for service and care received in an institution owned or operated by a federal, state or local government if:

      i. The Hospital is an Excellus BlueCross BlueShield member Hospital or a member Hospital of another Blue Cross or Blue Shield Plan; or

      ii. You are a patient in a Hospital that is state or municipally owned and operated and the Hospital usually charges for its services; or

      iii. You receive care for inpatient or outpatient alcoholism and/or substance abuse treatment, as provided for in Section 12.

   c. **Uniformed Service Hospitals.** Benefits will be provided for service and care for retired military personnel and their Dependents, and Dependents of military personnel on active duty, while an inpatient in a Hospital operated by the United

States uniformed services, for non-service related Conditions

d. **Emergency Care.** Benefits will be provided for service or care received in any of the above Hospitals if:

   i. You have an Emergency Condition, as defined in the Plan;

   ii. You are treated immediately at the Hospital because of its closeness;

   iii. It is impossible to transfer you to another institution; and

   iv. You stay in that Hospital only as long as emergency care is necessary.

To receive benefits for emergency care services, you must meet the applicable requirements of the program for those benefits.

3. **Services covered under hospice care.** If you have been formally admitted to a hospice program, and benefits are being provided for your hospice care under the Plan, no additional payments will be made under the program for any services related to your terminal Illness that have been or should be included in the payment to the hospice program for the care you receive. However, should you require services covered under the Plan for a condition unrelated to the terminal Illness or for services not provided by a hospice program, benefits will be available under the Plan for those covered services.

4. **Dental care.** Benefits will not be provided under the Hospital Benefits Section 12 of this SPD for any service or care related to dental treatment of the teeth or gums. For example, benefits will not be provided for x-rays, fillings, extractions, braces, diseases of the gums, or prosthetics. However, benefits will be provided for service and care for treatment of sound natural teeth due to accidental Injury. You must receive the care within 12 months of the accident. Benefits will not be provided under this Section for the dental treatment of temporomandibular joint (jaw hinge) syndrome or dysfunction, unless caused by physical trauma. In addition, institutional provider services for dental care will be covered when Excellus BlueCross BlueShield determines that there is an underlying medical condition requiring these services.

5. **Blood products.** Benefits will not be provided for the cost of blood, blood plasma, other blood products, or blood processing or storage charges when they are available free of charge in the local area. When not free in the local area, benefits will be provided for blood charges, even if you donate or store your own blood, if billed by a Hospital, ambulatory surgery center, or certified blood bank.

6. **Prescription Medications.** Benefits will not be provided under the Hospital Benefits Section 12 of this SPD for prescription medicines unless billed by an institutional provider when rendering services covered under the Plan or dispensed in a professional provider's office as part of a covered office visit.

SECTION 21
DEATH BENEFIT FOR EMPLOYEES

Death benefits for Employees and their Dependents under the Plan are provided pursuant to an insurance policy with MetLife. Refer to the schedule of benefits for the amount of Death Benefits payable on your behalf.

When And To Whom Benefits Are Payable

The person you name as your beneficiary will receive this benefit in the event of your death from any cause, unless the cause of death is homicide and the beneficiary has been implicated in the crime. If the cause of a Participant's death is homicide, the named beneficiary under the Plan will be required to provide proof that he or she has not been implicated in the crime. The amount of your benefit is shown on the Schedule of Benefits that applies to you.

You may designate your beneficiary, and may change the designation at any time, in writing in the form and manner required by the Trustees. The designation or change will become effective only when it is filed with the Fund Office and then will take effect as of the date the written notice was signed, as long as the Fund has not made payment or taken other action before the entry was made. To be honored, your beneficiary designation must be filed at the Fund Office before your death. No such designation received after your death will be honored. The consent of the beneficiary is not required for any change of beneficiary.

A beneficiary also may be designated in an entered court order, provided that such order contains a clear designation of rights. The designation will become effective only when it is filed with the Fund Office and then will take effect as of the date the order was executed, as long as the Fund has not made payment or taken other action before the entry on its records was made. A beneficiary designation in a court order meeting the above requirements will supersede any prior or subsequent conflicting beneficiary designation that is filed with the Fund Office.

A beneficiary may waive his or her rights as a beneficiary under the Plan in an entered court order, provided that such order contains a clear waiver of rights. The waiver will become effective only when it is filed with the Fund Office and then will take effect as of the date the order was executed, as long as the Fund has not made payment or taken other action before the entry on its records was made. A waiver in a court order meeting the above requirements will supersede any prior conflicting beneficiary designation that has ben filed with the Fund Office. If a court order meeting the above requirements contains a waiver of rights by the beneficiary on file with the Fund Office, and you subsequently die without naming a new beneficiary, then the Fund may pay the death benefit as though you died without naming a beneficiary.

The Trustees shall be the sole judges of the effectiveness of the designation, change or waiver of a beneficiary pursuant to this Section.

How Benefits are Payable

This benefit can be paid in a single sum, or as a total control account if the benefit is over $7,500. Please contact the UFCW Local One Customer Service Unit at 1-800-959-9497, to learn more about receiving the death benefit in the form of a total control account. If you do not elect a method of payment, your beneficiary may do so after your death. Your beneficiary may, after your death, designate a second beneficiary to receive any remaining amount which may be payable, in the event of your beneficiary's death.

Naming a Beneficiary

Always provide the full name of the beneficiary, for example: Mary T. Doe, not Mrs. John Doe.

The following are *examples* of how to word the beneficiary designation:

One Beneficiary - MARY T. DOE, spouse.

Two Beneficiaries - In equal shares to my children, JOHN DOE and JANE DOE, if living at my death or to the survivor of them.

Three Beneficiaries - In equal shares to my mother, RUTH DOE, and my aunts, EDNA JONES and ANN BROWN, if living at my death or to such of them as shall then be living.

Unnamed Children - In equal shares to my children living at my death. (see below regarding the designation of a minor as your beneficiary)

Successive Beneficiaries - My spouse, JOHN L. SMITH, if living at my death; if not then living, in equal shares to my children if then living or to such of them as shall then be living.

Estate - The executors or administrators of my estate.

Trustee - The filing with the insurance carrier or the Fund of a copy of the Trust Agreement is not required. The Fund will not be responsible for any failure of a Trustee to perform the duties of Trustee nor for the application or disposition of any money paid to a Trustee and such payment will fully discharge the Fund for the amount so paid.

Important Points To Remember

An organization or endowment should not be designated as beneficiary unless the

organization or endowment has a recognized legal existence such as a corporation, trust, partnership, etc.

You should give careful consideration before designating your estate as beneficiary since it requires the application to a court for certification of the executor or appointment of an administrator. This may result in a delay in the payment of your benefit and may result in additional expense to your family that could be avoided by naming an individual as beneficiary.

Foreign Beneficiary: The designation of a beneficiary located in a foreign country may make it more difficult to locate such beneficiaries and to obtain proof of their identity, and there may also be foreign rules and regulations hampering prompt settlement of death claims. Existing political conditions in certain situations may even necessitate deferment of claim payments.

Please contact the UFCW Local One Customer Service Unit at 1-800-959-9497if you have any questions concerning the designation of a beneficiary or if you wish to change your beneficiary.

Distribution of Death Benefit if No Beneficiary Has Been Named

If, at the time of your death, you do not have a beneficiary designation form on file with the Fund Office, your Death Benefit will be payable in the following order of priority:

To your (a) surviving spouse; (b) surviving children including those legally adopted; (c) surviving parents; (d) surviving brothers and sisters including those of whole or half-blood; (e) the executors or administrators of your estate.

In the event that a Death Benefit becomes payable to a minor child, the legal guardian of the child is responsible for completing the necessary claim forms and providing the appropriate documentation noting guardianship. The benefit will then be paid in one of two ways:

1. The insurance carrier will hold the benefit in an interest bearing account until the minor child reaches the age of 18 years. Upon the minor's 18th birthday, the carrier will contact the beneficiary and make payment ; or

2. The insurance carrier will pay the benefit in the minor's name with stipulations.

The Fund office will assist with the application process and answer any additional questions.

What Happens To Your Death Benefit When You Leave Employment with a Participating Employer?

If you leave Employment for a reason other than retirement, your death benefit coverage will continue during the balance of the month in which your Employment terminates *plus* one more month. If you retire from Employment as an active Participant and you immediately begin receiving a monthly benefit under the UFCW Local One Pension Plan, your death benefit coverage will continue for three additional months after the last month for which a contribution was due to the Health Care Fund on your behalf.

During the 31-day period following the termination of your death benefit coverage, you can obtain, in replacement, individual life insurance. You can do this, without having to pass a medical examination, by applying to the insurance carrier and paying the premium for the individual insurance during this 31-day period. The rate for your individual insurance policy will be determined by your age on the effective date of the policy, the class of risk to which you belong and the form and amount of the policy. The group rate is not applicable. This is an individual rate that is determined by the Insurance Company.

Death Benefits Payable If You Die During a Period of Total Disability

If, before you reach age 65 and while covered for the Death Benefit, you become Totally Disabled so as to be prevented from engaging in any occupation for compensation or profit, your Death Benefit protection will be extended without cost to you. Your protection will be extended up to the first anniversary of the date you became disabled, so long as you remain Totally Disabled. Your protection will be extended further, if proof of your continued Total Disability is submitted to the Fund three months prior to each anniversary of the date you became Totally Disabled. When you reach age 65, your Death Benefit will be reduced to $1,000.

If you die prior to age 65, during a period of Total Disability, the amount of your Death Benefit will be the amount for which you were last covered under the Death Benefit prior to your discontinuance of Active Employment. If you die, on or after attaining age 65, the amount of your Death Benefit shall be reduced to $1,000.

Total Disability means you are eligible for Social Security Disability Insurance monthly payments.

Contact the Fund for the forms for filing proof of your Total Disability. The Fund will have the right to have its medical representative examine you when it may reasonably require, but after your Death Benefit protection has been extended for two years, not more than once a year.

Proof that Total Disability continued until your death must be submitted to the Fund within one year after the date of your death. ***Submitting proof to the Fund office is the responsibility of the person seeking the benefit.*** Upon receipt of that proof, the Fund will pay to your beneficiary the amount of your Death Benefit reduced by any amount of the Death Benefit payable as a death benefit under any other provision of the group policy.

The Death Benefit extension that is effective during your period of Total Disability will be discontinued when you are no longer Totally Disabled, fail to submit to an examination or fail to furnish proof of your Total Disability.

SECTION 22
EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Accidental Death and Dismemberment benefits for Employees under the Plan are provided pursuant to an insurance policy with an insurance carrier. Refer to the *Schedule of Benefits* for the amount of Accidental Death and Dismemberment benefits that are payable. This is only a summary of the rules under the policy. The insurance policy will govern whether the benefit is paid.

When And To Whom Benefits Are Payable

This benefit is payable in the event you, as a Full or Part-Time Active Employee, suffer a Covered Loss (discussed below) as a result of accidental Injury caused directly and exclusively by purely accidental means within 365 days following the accidental Injury which occurs either on or off the job.

However, if you die (within the 365 days) as a direct result of such accidental Injury, the benefit will be paid to your beneficiary.

COVERED LOSS	AMOUNT OF PAYMENT
For Loss of Life; or Loss of Both Hands; Both Feet; Sight of Both Eyes; or any two such Members	The amount set forth in the Schedule of Benefits

Note: Loss of hand means loss of at least three fingers of one hand in one accident. Loss of foot means loss, by severance, at or above the ankle joint. Loss of sight means total and irrecoverable loss of sight.

If you suffer more than one loss due to any one accident, payment will be made only for that loss for which the greatest benefit is payable. Payment will be made for the specific loss resulting from the accident without considering any previous loss. This benefit is payable in addition to any other benefit.

Losses That Are Not Covered

Losses resulting from, or caused directly or indirectly, wholly or partly by: (a) bodily or mental infirmity, bacterial infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound) or disease or Illness of any kind, (b) self- destruction or self-inflicted Injury, whether intentional or while insane, (c) war or an act of war, service in any military, naval or air force of any country while such country is engaged in war or performing police duty as a member of any military or

naval organization, or (d) participation in or in consequence of having participated in the committing of a felony.

SECTION 23
INSURED DEATH BENEFIT FOR DEPENDENTS

Death Benefits for Dependents under the Plan are provided pursuant to an insurance policy with an insurance carrier. Refer to the Schedule of Benefits for the amount of Death Benefits payable on behalf of your Dependent. This is only a summary of the rules under the policy. The insurance policy will govern whether the benefit is paid.

When Benefits Are Payable

This benefit will be payable to *you* in the event of the death of a covered Dependent. Your newborn Dependent child(ren) become covered under the Plan's Death Benefit as soon as they are born.

If you are not living at the time of your Dependent's death, payment will be made (a) in the case of the death of your spouse, to the executors or administrators of your spouse's estate; (b) in the case of the death of your child, to the first surviving class of the following classes of beneficiaries: the child's (1) surviving parents, (2) surviving brothers and sisters, (3) the executors or administrators of the child's estate.

In the event that a Death Benefit becomes payable to a minor child, MetLife will pay the benefits to the person who has been named as the guardian of the minor and who has the authority to hold and receive property on the minor's behalf.

What Happens To your Dependent's Death Benefit If you Die Or Leave Covered Employment

If you die while covered under the Plan, Death Benefit coverage for your Dependents will be continued for three months following your death. If your Plan coverage ceases other than as a result of your death, Death Benefit coverage for your Dependents will be continued until the end of the calendar month following the month in which you died. During the 31 days immediately following the termination of your Dependent's coverage, your Dependent can obtain replacement individual life insurance at the individual rate applicable to his/her age at the time he/she applies for the insurance. Contact the Fund Office for further details on the continuance of Death Benefit coverage.

In cases where both parents (or guardians) are covered as Full-Time Employees under the Plan, the maximum Death Benefit payable in the event of the death of a Dependent child shall be the child benefit shown in the Schedule of Benefits.

Note: Dependents of Part-Time Employees are not eligible for the Death Benefit, unless the Employees purchase family coverage.

SECTION 24

EDUCATION BENEFITS

Benefits Available to Participants and Dependents

Scholarship Benefits

The Fund provides scholarships to qualifying Participants, their eligible Dependents and grandchildren to help pay for tuition to attend college, graduate school, or certified trade school. A recipient may receive a maximum of four scholarship awards from the Fund, except that a recipient who is enrolled in an approved six-year Pharmacy Program may receive a maximum of six scholarship awards from the Fund. You and your Dependents do not qualify for Scholarship Benefits if your participation in the Fund is under an Employer's Participation Agreement and not a Collective Bargaining Agreement. If you are covered by a Collective Bargaining Agreement that provides for participation in the Fund but are not yet a Participant because you have not satisfied the minimum eligibility requirements (for example, if you do not work the minimum number of hours), you and your Dependents may still qualify for Scholarship Benefits. Contact the Fund Office for more information.

In addition to satisfying the qualifications described in Section 3 and this Section, you also must (1) have a General Equivalency Diploma ("GED") or high school diploma, be a graduating high school senior, be a college or certified trade school graduate, or be a current college, certified trade school, or graduate student; (2) intend to attend a college, certified trade school, or graduate school during the academic year for which you are applying for the scholarship; and (3) submit a completed application to the Fund Office by the deadline date stated on the application. If you are awarded a scholarship by a participating Employer, you will not be eligible for a Fund scholarship for the same period, regardless of whether you have met all scholarship eligibility criteria. Eligibility is determined as of April 1 immediately preceding the academic year for which you are applying for a scholarship.

Each year, the Fund awards scholarships based on the information provided in the scholarship applications received by the Fund Office from Participants. The Fund reviews and evaluates all applications submitted. When evaluating applications for scholarship awards to attend college, graduate school, or certified trade school, the Fund will consider the following criteria:

1. **The applicant's most recent grade point average ("GPA").** Attainment of a General Equivalency Diploma is treated as the equivalent of a 2.0 GPA. If an applicant's most recently attended educational institution provides for narrative evaluation of its students rather than a numerical or letter grade, a "satisfactory" evaluation is treated as the equivalent of a 2.0. If an applicant's official transcript cannot be obtained or if an applicant's transcript is provided in a language other than English and the Board of Trustees, upon reasonable effort, is unable to translate the transcript into English, the applicant may submit two reference letters for consideration by the Fund Office staff in place of the applicant's GPA .

In such a case, one reference letter must be from a past or present employer and the other letter may be a personal reference.

2. **The application essay**. The content and overall quality of the essay will be considered.

3. **The applicant's participation in extracurricular activities**. Participation in extracurricular activities that demonstrate commitment, leadership, self-discipline, and responsibility will be considered. Such activities include, but are not limited to, employment, participation in student government, drama, band, athletics, or volunteering in the community. If employment is considered, the Fund will not consider whether such employment is for a participating Employer.

4. **The applicant's hardship or financial need**. Circumstances that constitute hardship or financial need may include the following: one or both of the applicant's parents or the applicant's spouse is unemployed or disabled; the applicant is part of a single-parent household; one or more of the applicant's family members are currently attending college; and the applicant has limited financial resources.

5. **The timing of the application submission**. Scholarship applications are generally available in December of each year. The Fund will consider how soon after the applications are made available, completed applications must be received by the Fund Office.

6. For applications for scholarship awards to attend graduate school or for non-traditional students, the Fund also will consider the content of letter(s) of recommendation from current or former professor or academic advisor of applicant and, if the applicant participated in an internship within the year prior to submitting his or her application for a scholarship award, the content of the letter of recommendation from the applicant's internship supervisor.

To apply for a scholarship award, you can apply online at www.ufcwone.org. If you do not have online access, you can request an application from the Fund Office. Your completed application must be returned to the Fund Office by the deadline date stated on the application. The Fund Office will confirm your eligibility for this benefit as of March 1. After careful review of all applications submitted by eligible applicants, the Fund will select the scholarship recipients for the upcoming academic year.

During the months following the application deadline, scholarship applicants will be notified of the Fund's decision on their applications. If you are awarded a scholarship, the Fund will distribute your scholarship award to the college, graduate school, or certified trade school identified on your application to be applied to the cost of your tuition. Upon receipt of written proof that the amount of the scholarship exceeds the balance due on your tuition (due to, for example, your receipt of other scholarships or

grants in addition to the Fund scholarship), the Fund will instruct the college, graduate school, or certified trade school to apply your scholarship award to the cost of books, supplies, equipment or other fees required for courses of instruction at that institution.

If you are awarded a scholarship under the Fund, your right to retain that scholarship is conditioned on your honesty and integrity. Thus, if you reveal, through objective actions, a lack of honesty or integrity, your scholarship award may be terminated. The following are some examples of actions that would be considered, but these are not the only actions that could indicate a lack of integrity or honesty: conviction of a crime; termination from any employment or volunteer position for cause; and formal discipline by an educational institution for cheating or plagiarism. If you become the subject of any of these actions or other similar actions, you must notify the Fund immediately. If you fail to notify the Fund, you will be obligated to reimburse the Fund for the full value of the scholarship benefits paid on your behalf.

Benefits Available Only to Participants

Continuing Adult Education Benefit

This benefit offers a variety of courses through your local Board of Cooperative Education Services/Area Vocational Technical School (BOCES/AVTS). BOCES/AVTS course titles and availability may differ from area to area, but the following categories of courses are offered under this benefit: CPR and First Aid courses, Defensive Drive Course and Safety courses, Computer and Word Processing courses, and Language courses. Also offered are **job-related** courses in the categories of Cooking, Nutrition, and Crafts. There is a $400 cap per Participant per calendar year for this benefit, including materials.

You must register for all BOCES/AVTS courses through the Fund Office. To learn about what courses are offered in your area, contact your local BOCES/AVTS office and request a course catalog. When you have selected a course in which you are interested, contact the Fund Office to confirm that it falls into one of the approved categories. If the course falls into an approved category, and if you would like to register for the course, the Fund Office will ask you for required registration information and will instruct you to submit payment, refundable upon the completion of the course, of $25 by check or money order payable to the local educational institution offering the course for which you want to register. Upon receipt of your payment, the Fund Office will register you for the course you have selected. When you have completed the course, submit a copy of your completion certificate to the Fund Office and you will be refunded your $25 payment.

Additionally, depending on the course, the Fund may reimburse you for all or a portion of the materials costs of the course, including textbooks -- contact the Fund Office for information on specific courses. For approved reimbursement, simply retain your receipts and submit them to the Fund Office with your course completion certificate.

Dislocated Workers Benefit

This benefit assists Participants who have become unemployed due to a store closing or layoff by their participating Employer. This benefit provides materials and information to help these Participants with the emotional and financial stresses of unemployment and to aid their transition back to employment.

You are eligible for this benefit if you satisfy the eligibility requirements described in Section 3 and you become unemployed due to a store closing or layoff by your participating Employer. If you are eligible to receive the Dislocated Workers Benefit, you will be eligible for all benefits under this Section 24 until six months after the later of (1) the date of your store closing or layoff; or (2) the date your eligibility for benefits under the Plan terminates for any reason other than the termination of the Plan.

In the event of a store closing or a layoff by a participating Employer, the Fund will contact affected Participants with information and details concerning available resources and how to use them.

Stress Management Seminars

This benefit provides seminars on how to manage job-related stress. These seminars are held at locations throughout the Fund's jurisdiction.

Each time a Stress Management Seminar is to be held, the Fund Office will provide all Participants residing in the area surrounding the seminar location with notice of the Stress Management Seminar and information concerning how to attend.

The Fund contracts with Health Management Concepts to provide this benefit. For information, please contact the Fund's Wellness Coordinator at _1-800-959-9497.

Back Fitness Seminars

This benefit provides seminars on how to avoid back Injury on the job. These seminars are held at locations throughout the Fund's jurisdiction, usually at a Union office or participating Employer's store.

Each time a Back Fitness Seminar is to be held, the Fund Office will provide all Participants residing in the area surrounding the seminar location with notice of the Back Fitness Seminars and information concerning how to attend.

The Fund contracts with Health Management Concepts to provide this benefit. For information, please contact the Fund's Wellness Coordinator at _1-800-959-9497.

SECTION 25
RETIREE HEALTH AND DEATH BENEFITS

A limited Retiree Benefit is available to Participants meeting the following eligibility requirements:

1. You retire from Covered Employment after reaching age 60 but before reaching age 65, and
2. You were covered under this Plan as a Full-Time Employee for at least the five consecutive years immediately preceding your retirement (by other than self-payment).

When your status changes from an Active Participant to Retiree, the following changes in your coverage will take place.

1. All coverage for your Dependent child, if any, will stop, including the Dependent Death Benefit in Section 23.
2. Your medical, optical, Hospital and prescription benefits, and the benefits of your Dependent spouse, if any, generally will remain the same, except as explained below.
3. However, you will no longer be covered under the Dental Benefit, the Education Benefit or the Accidental Death & Dismemberment Benefits.
4. Further, the amount of the Death Benefit will be reduced to $1,000, $2,000 or $2,500, depending on the date you first became a Participant and the applicable CBA.
5. Your spouse, if any, will no longer be eligible for the Dependent Death Benefit, described in Section 23 of this SPD.
6. A lifetime maximum of $7500 will apply to you (and your Spouse separately) for all payments made by the Fund to you, or on your behalf, while you are covered as a Retiree. Payment of the Death Benefit will not fall under this maximum. Please refer to Section 27 for a description of the appeal procedures applicable with respect to your benefits under the Plan.

Your Retiree Benefit will terminate upon the earlier of:

1. Your 65th birthday, or
2. The date you begin work in any occupation, or
3. The exhaustion of the lifetime maximum described below.

If your Spouse is not working, certain coverage for your Spouse also will be continued, provided you and such Spouse were married and living together for at least the three years immediately preceding your retirement.

Coverage for your Spouse will end upon the earlier of (1) your Spouse's 65th birthday; (2) the date your Spouse begins to work in any occupation; (3) the date your coverage ends; or (4) the exhaustion of the lifetime maximum described below. However, in the event of your death while covered as a Retiree, your Spouse's coverage will continue until the earlier of (1) the end of the 3rd month following your death; or (2) the date your Spouse remarries.

All claims for benefits should be sent to the Fund Office, 5911 Airport Rd, Oriskany, NY 13424. The claim form or receipt for service should include the Covered Person's name, address, date of birth and social security number. The form also should include the provider's name, address and phone number, as well as a description of the service provided. Upon review by the Fund, payment will be made to you according to the terms of the Plan you were covered under at the time of retirement. Should any change in the Plan occur during your time as a Retiree, those changes will apply when determining your benefits under the Plan. Upon the exhaustion of this lifetime maximum amount, your benefits under the Plan will terminate.

SECTION 26
CLAIMS FILING PROCEDURES

Claim Forms

Hospital and Medical Services

When you have an appointment with a participating medical provider, be sure to present your Excellus BlueCross BlueShield card at the time of service. Your provider will submit the claim for benefits directly to Excellus BlueCross BlueShield for payment. (Providers should bill their local Excellus BlueCross BlueShield plan.)

For non-participating providers, you must submit your claims directly to Excellus. Ask your provider to supply you with an itemized bill for submission to the Plan. If you have a problem, call Excellus Customer Care at 1-877-223-2993.

All medical claims must be submitted within one year from the date of service.

The Provider can assist you with any Hospital or medical benefit claim you may have and can be reached by calling 1-877-223-2993.

Prescription Drugs

To receive the maximum benefit from our Plan, be certain to present your Prescription Drug Card to your Participating Pharmacy at the time of service. All Prescription Drug claims must be submitted within one year from the date of service.

Dental

All dental claims must be submitted to the Fund Office within 90 days of commencement of work or no reimbursement will be made. A pre-treatment estimate must be submitted when the cost of services is expected to exceed $250 or when the claim is for dentures, bridgework, crowns or orthodontic care. See Section 18 for more information.

Vision

You should contact Davis Vision at 1-800-999-5431 or www.davisvision.com to check your eligibility or locate a Davis Vision provider.

When you have an appointment with a Davis Vision Provider, the provider will submit your claim to the Fund and you will be covered according to the Plan of Benefits. The Fund contracts with a network of Davis Vision Providers and has negotiated discounts for some services.

If you have an appointment with a non-Davis Vision provider, you may pay more. To apply for your vision benefit when using a non-provider, you must pay the provider for the service and then mail a copy of your receipt, describing the type of care provided, to the Fund Office. You will be reimbursed directly for the benefit amount covered under the Plan.

Questions Regarding your Claim

If you have questions concerning the Plan, the status of your claim or a specific claim payment, contact the Excellus dedicated Customer Care Unit for medical claims at1-877-223-2993.

No Assignment

If a Doctor, Dentist or other health care provider that has an agreement with the Fund provided your services, the Fund will make payment to them directly. Otherwise, only you can receive reimbursement from the Fund. You cannot assign any reimbursement due to any person, corporation or organization. Any assignment by you will be void. Assignment means transferring your right to collect money for those services to another person or organization.

Plan Interpretation and Determinations

With respect to those benefits that are provided directly by the Fund, the Board of Trustees shall have exclusive authority and discretion to determine whether a claimant is eligible for any payments under this Plan; to make factual determinations about any matter under the Plan; to determine the amount of payment, if any, a claimant is entitled to under this Plan; to interpret all of this Plan's provisions; and to interpret all of the terms used in this Plan. All such determinations and interpretations made by the Trustees, or their designee, are final and binding upon any person claiming benefits under this Plan; and shall be given deference in all courts of law, to the greatest extent

allowed by applicable law; and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious.

Recovery of Certain Payments

If any incorrect payment is made by the Fund, the Board of Trustees has the right to recover any such amount from the Participant or from the Dependent to or on whose behalf the payment was made or from the service provider that received the payment. Such amount may be deducted from any future benefit payment to which a person may be entitled from the Fund. If an incorrect payment is made to or on behalf of a Participant or Dependent, the Participant and the Dependent are both responsible for the overpayment and the Fund has the right to recover any overpayment from either or both individuals, or any other Dependent of the Participant.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your Dependent or a representative of you or your Dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your Dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your Dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your Dependent to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your Dependent refuse to reimburse the Fund for any overpaid amount, the Fund has the right to recover the full amount by any and all methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your Dependents' future benefit payments payable by the Fund. For example, if the overpayment or advancement was made to you or on your behalf as the Fund Participant, the Fund may offset the future benefits payable by the Fund to you and any of your Dependents. If the overpayment or advancement was made to or on behalf of your Dependent, the Fund may offset the future benefits payable by the Fund to you and any of your Dependents.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Fund is required to pursue legal action against you or your Dependent to obtain repayment of the benefits advanced by the

Fund, you or your Dependent or beneficiary shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

The Fund reserves the right to retroactively terminate your and your Dependents' coverage under the Plan if you or any of your Dependents engage in fraud and/or intentionally misrepresent or omit a material fact relevant to your Plan coverage, or if you or your participating Employer fail to timely pay any applicable premium or contribution to the Fund relating to your benefits. Failure to follow the terms of the Plan, include but not limited to failing to notify the Fund of a change in Dependent status, accepting benefits in excess of what is covered under the Plan, and accepting benefits after you or your Dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having full knowledge of all the eligibility terms of this Plan.

SECTION 27
CLAIMS AND APPEALS PROCESS

Please note: If your claim for Medical Benefits is denied by Excellus BlueCross BlueShield and you disagree with the denial, before appealing to the Fund's Board of Trustees, you may first submit the reasons for your disagreement with the denial to Excellus. The notice from Excellus will explain how to request this reconsideration. If Excellus BlueCross BlueShield does not reverse the denial, you still have the right to appeal to the Board of Trustees as described in this Section.

General Information

You may name a representative to act on your behalf during the claims procedure. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number and authorize the Fund to release information (which may include medical information) to your representative. Please contact the Fund Office for a form to designate a representative. In the case of an Urgent Care claim (see below) a health care professional with knowledge of your medical condition will be permitted to act as your representative. The Fund does not impose any charges or costs to review a claim or appeal; however, regardless of the outcome of an appeal, neither the Board of Trustees nor the Fund will be responsible for paying any expenses that you might incur during the course of an appeal.

The Fund and Board of Trustees, in making decisions on claims and an appeal, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such

documents, and where appropriate, applied consistently with respect to similarly situated claimants. Additionally, the Fund and Trustees will take into account all information you submit in making decisions on claims and on appeal.

If your claim is denied in whole or in part, you are not required to appeal the decision. However, you must exhaust your administrative remedies by appealing the denial before you have a right to bring an action in federal or state court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your SPD. If the Trustees consider any new or addition evidence in connection with your appeal, that evidence will be provided to you, free of charge, as soon as possible. Further, if the decision is based on a new or additional rationale, the Fund will provide you with an explanation of the rationale, and will give you an opportunity to respond before a final determination is made by the Board of Trustees.

If you wish to file suit for a denial of a claim of benefits, you must first exhaust your administrative remedies by appealing to the Board of Trustees, and you must file suit within three years of the date the Trustees denied your appeal. For all other actions, you must file suit within three years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Plan or the Trustees, you must file suit in the United States District Court for the Northern District of New York. These rules apply to you, your spouse, Dependent, or beneficiary, and any provider who provided services to you or your spouse, Dependent or beneficiary. This Section applies to all litigation against the Fund, including litigation in which the Fund is named as a third party defendant.

The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

Please contact the Fund Office if you have any questions.

Medical Claims Review

Pre-Service Claim. A pre-service claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the Fund's approval of the benefit before you receive the medical care. For example, a request for services for which pre-certification is required, as described elsewhere in the Summary Plan Description, would be a pre-service claim.

If your pre-service claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within five (5) days of the date you filed the claim. The Fund will notify you of its decision on your pre-service claim (whether approved or denied) within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days after the claim is received by the Fund. The Fund may extend the period for a decision for up to fifteen (15)

additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial fifteen (15) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information. If you do not provide the information requested, or do not properly refile the claim, the Fund will decide the claim based on the information it has available, and your claim may be denied.

Urgent Care Claim. An Urgent Care claim is pre-service claim that requires a shorter time period for making a determination because a longer time period for making non-Urgent Care determinations (i) could seriously jeopardize your life or health or your ability to regain maximum function or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. It is important to note that the rules for an Urgent Care claim apply only when the Plan requires approval of the benefit *before* you receive the services; these rules do not apply if approval is not required before health care is provided, for example in the case of an Emergency. See the Summary Plan Description for more information on the Plan's pre-approval and pre-certification requirements.

If your Urgent Care claim is filed improperly, the Fund will notify you of the problem (either orally or in writing, unless you request it in writing) within 24 hours of its receipt of the claim. The Fund will notify you of the decision on your Urgent Care claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after the claim is received by the Fund, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If the Fund needs more information, the Fund will notify you of the specific information necessary to complete the claim as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Fund. You will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. The Fund will notify you of its decision as soon as possible, but not later than (48) hours after the earlier (i) the Fund's receipt of the specified information or (ii) the end of the period given to you to provide the specified information. Due to the nature of an Urgent Care claim, you may be notified of a decision by telephone, followed by a written notice of the same information within three (3) days of the oral notice.

If you do not provide the information requested, or do not properly refile the claim, the Fund will decide the claim based on the information it has available, and your claim may be denied.

Concurrent Care Claim. A Concurrent Care claim is a request for the Fund to approve, or to extend, an ongoing course of treatment over a period of time or number of treatments, when such approval is required by the Plan. If you have been approved

by the Fund for Concurrent Care treatment, any reduction or termination of such treatment (other than by Plan amendment or termination of the Plan) before the end of the period of time or number of treatments will be considered denial of a claim. The Fund will notify you of the denial of the claim at a time sufficiently in advance of the reduction or termination to allow you to appeal the denial before the benefit is reduced or terminated.

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care claims (see above), except the Fund will notify you of the decision (whether approved or denied) within twenty-four (24) hours after the Fund's receipt of the claim, provided that the claim is made to the Fund at least twenty-four (24) hours before the end of the previously approved period of time or number of treatments.

Post-Service Claim. A post-service claim is any claim under the Plan that is not a pre-service claim. Typically, a post-service claim is a request for payment by the Fund after you have received the services.

If the Fund denies your post-service claim, in whole or in part, the Fund will send you a notice of the claim denial within a reasonable period of time, but no later than thirty (30) days after the claim is received by the Fund. The Fund may extend the period for making a decision for up to fifteen (15) additional days due to matters beyond the control of the Fund, provided that the Fund gives you a written notice of such extension before the end of the initial thirty (30) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information. If you do not provide the information requested, the Fund will decide the claim based on the information it has available, and your claim may be denied.

With respect to any claim relating to Hospital, medical, prescription, optical, dental, substance abuse, hearing aid and pre-natal benefits, if the Fund denies the claim, in whole or in part, the Fund will send you a written notice of the denial, unless, as noted above, your claim is for Urgent Care, then this notice may be oral, followed in writing. The notice will provide (a) the specific reason or reasons for denial; (b) reference to specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary (d) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures, including the expedited review process applicable to Urgent Care claims (e) a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal; (f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline,

protocol, or other similar criterion will be provided free of charge upon request; and (g) if the denial is based on a determination of medical necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

Medical Claims Appeal Procedure

If your claim is denied, you (or your authorized representative) may, within 180 days from receipt of the denial, request a review by writing to the Board of Trustees at 5911 Airport Road, Oriskany, NY 13424. An appeal of an Urgent Care claim (see above) may also be made by telephone by calling (800-697-8329). You may (a) submit written comments, documents, records, and other information relating to your claim for benefits: and (b) request free copies of all documents, records, and other information relevant to your claim for benefits.

In making a decision on review, the Board of Trustees or a committee of the Board of Trustees will review and consider all comments, documents, records, and all other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing your claim, the Board of Trustees will not automatically presume that the Fund's initial decision was correct, but will independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is Experimental, investigational, or not medically necessary or appropriate), the Board of Trustees will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the Fund on the initial claim.

In the case of an appeal of a claim involving Urgent Care as defined above, the Board of Trustees will notify you of the decision on your appeal as soon as possible, taking into account the applicable medical emergency, but not later than seventy-two (72) hours after the Fund's receipt of your appeal. In the case of an appeal of a non-urgent pre-service claim, the Board of Trustees will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the Fund's receipt of your appeal. The Fund may also request that you voluntarily extend the period of time for the Board of Trustees to make a decision on your appeal.

In the case of an appeal of a post-service claim, the Board of Trustees or a committee of the Board of Trustees will hear your appeal at their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the Fund within 30 days of the date of the meeting. In that case, your appeal with be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting

after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within five days of the decision.

If the Board of Trustees denies your appeal, you will receive a written notice including (a) the specific reason or reasons for the denial; (b) references to specific Plan provisions on which the denial is based; (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and (d) a statement of your right to bring an action under Section 502 (a) of ERISA. In additional, the notice will state that (a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (b) if the denial of your appeal was based on a medical necessity or Experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees is final and binding.

Before filing an appeal with the Board of Trustees as described above, you may wish to contact the Fund's claims services department, at 1-800-959-9497 with any questions or concerns that you have regarding the claim denial.

External Review of Denied Claims

1. Standard External Review. If you receive an adverse benefit determination based on a medical judgment decision or a rescission of your coverage, you may appeal the adverse benefit determination to an external independent review organization (IRO). Claim denials for reasons other than medical judgment or rescission of coverage are not subject to external review.

A request for external review must be filed with the Fund within four months after you receive notice of the adverse benefit determination, or by the first day of the fifth month after you received the adverse benefit determination, if earlier.

Preliminary Review. Within five business days of receiving your external review request, the Fund and, if applicable, the IRO, will complete a preliminary review of your request to determine whether it is eligible for external review.

Within one business day after the preliminary review is complete, you will be advised of the decision. If your claim is not eligible for external review, the notice will state the reason(s) it is not eligible, and will provide you with contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to complete your request. You may submit the additional required information within the original four-month filing period or within the 48-

hour period following your receipt of the preliminary review decision, whichever is later.

Referral to Independent Review Organization. If your external review request is complete and your claim is eligible for external review, your claim will be forwarded to an IRO for review. The IRO will notify you in writing that your claim has been accepted for external review and that you may submit to the IRO in writing, within ten business days, additional information for the IRO to consider when conducting its external review. The IRO may, but is not required to, accept and consider additional information submitted after ten business days.

If you choose to submit additional information, the IRO will forward the information to the Fund within one business day. The Fund then may reconsider its adverse benefit determination. However, reconsideration by the Fund will not delay the IRO's review. If the Fund decides to reverse its adverse benefit determination based on the additional information, the Fund will provide written notice of its decision to you and the assigned IRO within one business day after making such a decision. Upon receipt of such notice from the Fund, the assigned IRO will terminate the external review.

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

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

1. A general description of the claim and the reason for the external review request, including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code and the reason for the previous denial);
2. The date the IRO received the external review assignment and the date of its decision;
3. Reference to the evidence considered in reaching its decision;
4. A discussion of the principal reason(s) for its decision, including any evidence-based standards that it relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law;
6. A statement that judicial review may be available to you; and
7. Contact information for any applicable consumer assistance office.

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

Reversal of the Fund's decision. If the Fund receives a final external review decision that reverses the Fund's adverse benefit decision, the Fund immediately will provide coverage or payment of the claim.

2. Expedited External Review.

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay or emergency service, if the claimant has not yet been discharged. You also may request an expedited external review at the same time as an appeal to the Fund's Trustees, if the claimant requires urgent care or is receiving an on-going course of treatment.

Preliminary Review. Immediately upon receiving your request for expedited external review, the Fund will determine whether your request is eligible for standard external review as described above. The Fund immediately will send you a notice of its eligibility determination.

Referral to Independent Review Organization. Upon determining that a request is eligible for external review, the request will be forwarded to an IRO, as quickly as possible, pursuant to the same procedures described above for the standard external review. The IRO will provide you and the Fund with notice of its decision as soon as possible but no later than 72 hours after it receives the review request.

Claims related to Death Benefits and Accidental Death and Dismemberment Benefits Insured under the Fund's Contracted Insurance Carrier.

Death benefits and Accidental Death and Dismemberment benefits under the Fund are provided pursuant to an insurance policy between the Fund and an insurance company. Please contact the Fund office for a description of the procedures that you must follow in order to submit a Death benefit claim or Accidental Death and Dismemberment benefit claim, and the procedures you must follow in order to appeal the denial of a Death benefit claim or Accidental Death and Dismemberment benefit claim.

Non-Medical Claims Review

If your request for a benefit is denied in whole or in part you will be notified in writing of the denial within 90 days of the Fund's receipt of your claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time is required, written notice of the extension, including a description of the special circumstances and the date by which the Fund expects to render a decision, will be provided to you prior to the end of the first 90-day period, and a decision will be made no later than 180 days after the claim was filed. The written denial will include the following information (a) specific reason(s) for the denial; (b) reference to the specific Plan provision(s) on which the denial is based; (c) a description of any additional material or information necessary to perfect the request for a benefit and the reason why such material or information is needed; (d) an explanation of the Plan's appeal

procedure; (e) a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied; and (f) if an internal rule, guideline, protocol or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline or protocol was relied upon and that a copy of the rule, guideline or protocol is available, free of charge, upon request.

Note regarding Scholarship Applications. While the Fund office will collect scholarship benefit applications beginning in November of each year, these applications will not be reviewed until after the March 1 deadline for submission of scholarship applications. Therefore, all applications received on or before March 1 of a given year will be considered to have been received on March 1 of that year, for the purpose of these claims review procedures.

Non-Medical Claims Appeal Procedure

When a request for a benefit has been denied in whole or in part, you may appeal the denial to the Board of Trustees. To do so, you or your representative must make a written request for review within 60 days of the date you receive written notice of the denial. You may review pertinent documents relating to the denial of your claim and you may submit issues and comments in writing for consideration. Submit appeals to:

Board of Trustees
UFCW Local One Health Care Fund
5911 Airport Road
Oriskany, NY 13424

Pursuant to your right to appeal, you will have the right (a) to submit written comments, documents, records, and other information relating to your claim for benefits; and (b) upon request, reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits. In making a decision on review, the Board of Trustees or a committee of the Board of Trustees will review and consider all comments, documents, records, and all other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing your claim, the Board of Trustees will not automatically presume that the Fund's initial decision was correct, but will independently review your appeal.

The Board of Trustees will take into account all information you submit in making its decision. The Board will make its decision at the next regular meeting following receipt of your appeal, unless there are special circumstances, such as the need to hold a hearing, in which case the Board of Trustees will decide the appeal at its second regular meeting. If the request for review is received within 30 days prior to the meeting, then a decision may be made at the second meeting following the request for review, or, if there are special circumstances, at the third meeting after the Board receives your appeal. If the Board of Trustees requires a postponement of the decision to the next meeting, you will receive a notice describing the reason for the delay and an expected date of the decision.

The Trustees shall send you notice of their decision in writing within 5 days of the date of the decision. If the Board of Trustees denies your appeal, the notice shall contain the specific reason(s) for the denial; the specific reference(s) to the Plan provisions on which the denial is based; a statement that you may receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to your claim; and a statement of your right to bring a lawsuit under ERISA.

The decision of the Board of Trustees is final and binding.

SECTION 28
IMPORTANT PLAN INFORMATION REQUIRED BY ERISA

Names of Plans	UFCW Local One Active Health Care Plan UFCW Local One Retiree Health Care Plan
Employer Identification # (EIN)	16-0915820
Plan Numbers	Active Plan :501 Retiree Plan: 502
Name and Address of Plan Sponsor	Board of Trustees of the UFCW Local One Health Care Fund 5911 Airport Road Oriskany, NY 13424 Attn: Funds Administrative Director
Funds Administrative Director	Michael R. Ciancaglini UFCW Local One Health Care Fund 5911 Airport Road Oriskany, NY 13424

Names and Addresses of Plan Trustees

EMPLOYER TRUSTEES

Raymond Wardynski, Co-Chairman
Frank Wardynski & Sons
336 Peckham Street
Buffalo, NY 14240

I. Stephen Davis
G&L Davis Meat Co.
111 Luther Avenue
Box 26
Liverpool, NY 13088

Joseph Sahlen
Sahlen's Packing Co.
P.O. Box 280
Buffalo, NY 14240

UNION TRUSTEES

Frank C. DeRiso, Chairman
UFCW Local One
5911 Airport Road
Oriskany, NY 13424

Robert G. Ciancaglini, Recorder
UFCW Local One
5911 Airport Road
Oriskany, NY 13424

Gregory P. Gorea, Secretary/Treasurer
UFCW Local One
5911 Airport Road
Oriskany, NY 13424

Roger Hemmitt
UFCW Local One
5911 Airport Rd
Oriskany, NY 13424

David Pardi
UFCW Local One
5911 Airport Rd
Oriskany, NY 13424

Alternate Trustees

Vacancy

Joseph LaPaglia
UFCW Local One
5911 Airport Road
Oriskany, NY 13424

Michael Westover
UFCW Local One
5911 Airport Road
Oriskany, NY 13424

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). The Board of Trustees complies fully with this law and encourages you to first seek assistance from the Fund Office when you have questions or problems that involve the Plan. ERISA provides that all plan Participants shall be entitled to:

(a) Examine without charge at the Fund Office and at other specified locations, such as worksites and union halls all Plan documents, including insurance contracts, Collective Bargaining Agreements, and copies of all documents filed by the Plan with the United States Department of Labor, such as annual reports and Plan descriptions.

(b) Obtain copies of all Fund documents and other Plan information including insurance contracts, Collective Bargaining Agreements, forms 5500 and the latest Fund SPD upon written request made to the Fund Director. The Director may make a reasonable charge for the copies and postage.

(c) Receive a summary of the Fund's annual financial report. The Plan Director is required by law to furnish each Participant with a copy of this report.

(d) File suit in a federal court, if any materials requested are not received within thirty (30) days of the Participant's request, unless the materials were not sent because of matters beyond the control of the Plan Director. The court may require the Plan Director to pay up to $110 for each day's delay until the materials are received.

(e) Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

(f) The reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for the plan Participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Employee Benefit Plan. These persons are referred to as "fiduciaries" in the law.

Fiduciaries must act solely in the interest of the Plan Participants, and they must

exercise their fiduciary duties in a prudent manner. Fiduciaries who violate ERISA may be removed and required to make good any losses that they have caused the Plan.

No one, including your Employer, your union or any other person may fire you or discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored in full or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. In addition, if you have a claim for a welfare benefit that is denied or ignored, in whole or in part, you have the right to file suit in a Federal or state court. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you believe plan fiduciaries are misusing the Plan's money, or if you are discriminated against for asserting your rights, you have the right to file suit in a Federal court or request assistance from the United States Department of Labor. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorneys' fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Fund Director. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Fund Director, you should contact the nearest Area Office of the Employee Benefits Security Administration of the United States 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 N.W., 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.

SECTION 29
GENERAL PLAN INFORMATION

Eligibility and Benefits

The Fund's requirements pertaining to eligibility for participation, the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits are enclosed with this booklet.

Circumstances That May Affect Benefits

Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are contained in the preceding pages of this booklet.

Sources of Plan Contributions

Contributions are made to a qualified tax-exempt trust fund. These monies are reserved for payments on behalf of Fund Participants and for administrative expenses. The funds cannot be used for any other purpose and cannot be withdrawn by either the contributing Employers or the Union. The financial activities of the trust fund are audited by a certified public accountant.

Medium for Providing Benefits

The Plan was established and is maintained pursuant to Collective Bargaining Agreements between the United Food & Commercial Workers District Union Local One and Employers that have agreed to make contributions to the Plan on behalf of their covered Employees; or pursuant to Participation Agreements between Employers and the Fund. Copies of the Collective Bargaining Agreements pursuant to which contributions are made to the Plan are also available for examination at the Fund Office, and may be obtained upon written request.

The Plan provides death benefits and accidental death and dismemberment benefits pursuant to a group insurance contract with an insurance company. Vision care, prescription drug, dental, hearing aid, adoption, education, Hospital and medical benefits are provided directly by the Plan.

The Plan Fiscal Year

For purposes of maintaining the Plan’s fiscal records, the Plan year begins January 1 and ends December 31 of each year.

Active and Retiree Plans

There are two separate Plans of benefits under the UFCW Local One Health Care Fund. Benefits available to active Participants and their Dependents are provided under the UFCW Local One Active Health Care Plan ("Active Plan"), and benefits available to Retirees and their Dependents are provided under the UFCW Local One Retiree Health Care Plan ("Retiree Plan"). This separation of the Retiree Plan and the Active Plan will not affect the benefits available to you under the Fund.

Benefit Rules and Changes

The Trustees intend to maintain the Fund indefinitely. However, the Trustees may at any time modify, reduce or terminate any benefit coverage or change any rule or regulation, in order to protect the financial soundness of the Fund or to better serve the Participants.

The Trustees shall have the sole power and discretion to construe the provisions of the Plan and the terms used herein. Any construction adopted by the Trustees in good faith shall be binding on the Union, the Employers and all Fund Participants.

The Plan is administered so as not to discriminate in favor of any member or group of members. The amount of Plan payment towards similar claims may vary because the charges by health care providers (Doctors, Hospital, etc.) are different.

This document serves as both the Plan Document and the Summary Plan Description of the UFCW Local One Health Care Plan purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Type of Plan

The Plan is a welfare employee benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA).

Type of Administration

The Fund is administered by the employees of the Fund Office. Claims are processed by service providers, such as Excellus Blue Cross/Blue Shield, and by the Fund Office.

Agent for Service of Legal Process

The Agent for service of legal process is:

The Board of Trustees of UFCW Local One Health Care Fund
5911 Airport Road
Oriskany, NY 13424
Attention: Funds Administrative Director

Service of legal process also may be made on any Fund Trustee.

Important Information

The Trustees shall resolve any question or dispute arising from any interpretation of any part of this booklet, as it pertains to self-funded coverage, and their decision shall be binding. Any question or dispute arising from any interpretation of any part of this booklet as it pertains to insured coverage shall be resolved pursuant to the contracts between the Fund and the relevant insurer.

Update Your Knowledge of UFCW Local One Benefits

The more familiar you are with Local One's programs, the more beneficial they will be for you. It is to your advantage to understand thoroughly the varied options and benefits available to you as a member.

Any Questions?

Call The UFCW Local One Customer Service Unit
At
1-800-959-9497
Visit our Website at www.ufcwone.org

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