United Food & Commercial Workers
Local 1000 Oklahoma
Health & Welfare Plan
"CARE-1000"

Summary Plan Description

RESTATED EFFECTIVE: July 1, 2020

HEALTH CARE INFORMATION FOR
UFCW LOCAL 1OOO OKLAHOMA
HEALTH & WELFARE PLAN
"CARE-1000"
PARTICIPANTS

United Food & Commercial Workers Local 1000 Oklahoma Health & Welfare Plan UltraCare

SUMMARY PLAN DESCRIPTION
EFFECTIVE: July 1, 2020

The Board of Trustees of the United Food and Commercial Workers Local 1000 Oklahoma Health and Welfare Plan, "CARE-1000", believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Manager at (866) 363-2733. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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ARTICLE I – DEFINITIONS

Section 1.01 – Actively at Work or Active Work
Actively at Work or **Active Work** means that You are performing Your regular job on a regular (full or part-time) basis. If You are Actively at Work, as defined above, on Your last regular working day, then You shall be deemed to be Actively at Work on each day of paid vacation, regular non-working day or any day of absence for health-status related reason.

Section 1.02 – Additional Buy Up Benefit
Additional Buy Up Benefit means the optional Life Insurance and AD&D Insurance that is available. The cost of the Additional Buy Up Benefit is paid by the Employee on a payroll deduction basis.

Section 1.03 – Allowable Covered Expense
Allowable Covered Expense(s) or Covered Expense(s) are those Medically Necessary services, supplies, and/or treatments that are covered under this plan. Covered Expenses do not necessarily mean the actual charges made or the specific services or supplies furnished by a provider to a Plan Participant. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider's error are not considered Covered Expenses. A finding of Provider negligence and/or malpractice is not required for services and/or fees to be considered not Reasonable and Allowable or not Covered Expenses.
Allowable Expense means the dollar amount upon which benefits will be determined.

Section 1.04 – Allowable Dental Expense
Allowable Dental Expenses means those Reasonable and Customary Charges, as determined by the Board of Trustees, that are actually incurred for treatment of any dental disease, defect or accidental Injury after the effective date of Your eligibility, provided such treatment is rendered by a Dentist or other duly licensed person under the supervision of a Dentist.

Section 1.05 – Amendment
Amendment means a formal document that changes a provision of this Plan, duly signed by authorized person or persons as designated by the Board of Trustees.

Section 1.06 – Calendar Year
Calendar Year means January 1 through December 31 of the same year.

Section 1.07 – Claim and Clean Claim
Claim means any Claim for benefits (including medical care, prescription drugs, vision care, dental care, Weekly Accident and Sickness Benefits or death benefits) which follows the Plan's procedures for filing a Claim, including the procedures of filing Pre-Service and Post-Service Claims, submitted on a Claim form that has been approved by the Board of Trustees of the Plan.
Clean Claim is a Claim for a Covered Expense that (a) is timely received by the Administrative Manager; (b) (i)when submitted via paper has all the elements of the UB 04 or CMS 1500 (or successor standard) forms; or (ii) when submitted via an electronic transaction, uses only permitted

transaction code sets (e.g. CPT4, ICD9, ICD10, HCPCS) and has all the elements of the standard electronic formats required by applicable Federal authority; (c) is a Claim for which the Plan is the primary payor or the Plan's responsibility as a secondary payor has been established; and (d)contains no defect, error or other shortcoming resulting in the need for additional information to adjudicate the Claim; and (d) that does not lack necessary substantiating documentation to completely adjudicate the Claim.

A Clean Claim does not include a Claim that is being reviewed for the Reasonable and Allowable Amount payable under the terms of the Plan. Additionally, any Claim over $50,000 must be accompanied by a valid itemization, and submitted to the Third Party Administrator before it will be deemed a Clean Claim.

Section 1.08 – Claimant
Claimant means any Employee or Dependent who files a Claim. References to Claimant include Claims filed by a duly authorized representative, as permitted by current regulations.

Section 1.09 – Coinsurance
Coinsurance is a percentage of medical or dental Claim cost that the participant pays after the deductible is exceeded.

Section 1.10 – Compound Medications
Compound Medications are medications in which two or more ingredients are mixed together in exact strength and dosage form that is not available on the commercial market.

Section 1.11 – Contributing Employer
Contributing Employer means the employer that is required to make contributions to the Fund under the terms of a Collective Bargaining Agreement with the Union or a written Participation Agreement.

Section 1.12 – Copayment
Copayment means the dollar amount of a charge that a Covered Person must pay for certain covered services.

Section 1.13 – Covered Employee
Covered Employee means an individual who is offered and accepts coverage by the Plan by virtue of meeting the Eligibility requirements outlined in this document, who pays the required weekly Employee contribution, and for whom the Contributing Employer has made sufficient contributions to the Fund pursuant to a Collective Bargaining Agreement or Participation Agreement.

Section 1.14 – Dentist
Dentist is an individual licensed to practice Dentistry in the state where the dental service is performed and operating within the scope of his or her license.

Section 1.15 – Dependent
Dependent means:

1. The Employee's child or children, including stepchildren, legally adopted children, children placed for adoption, or children for whom You have been appointed the legal guardian by a court of competent jurisdiction, if the adoption or placement occurs before the child reaches his or her eighteenth birthday, who:

    a. Has not reached the end of the month in which his or her 26th birthday occurs; or

    b. is incapable of self-sustaining employment because of a physical or mental handicap and is dependent on You for support and maintenance, provided his/her incapacity started prior to attaining the age at which his eligibility would otherwise terminate. However, children described in 2 (b) are not eligible for Dependent's Life Insurance, or

2. A child for whom coverage must be provided because of a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order, decree or a State administrative order that has the force and effect of law, relating to child support which provides for a child's coverage under the Plan's benefit program. To be qualified, the QMCSO must contain specific information and be submitted to the Fund Office.

The term Dependent will not include:

1. The Employee's spouse; or

2. any person who is in full-time military, naval or air service; or

3. any child whose non-custodial parent, if other than an eligible Employee, is required to contribute to his/her support by order of any court and is providing medical care protection for such child unless the child is named in a QMCSO. In that case, the child will be eligible for benefits in accordance with the order.

For the purpose of determining the status of a Dependent child, an Employee shall be required to submit to the Administrative Manager a properly executed birth certificate or court order or other legal document, acceptable to the Fund, from a court or government agency of competent jurisdiction, establishing the adoption or legal guardianship.

Section 1.16 – Durable Medical Equipment
Durable Medical Equipment means medical equipment designed for repeated use and which under the Plan is Medically Necessary for the treatment of a Sickness or Injury, or to improve or prevent further deterioration of Your medical condition and has no value to the patient or the patient's family in the absence of the bodily Injury or Sickness.

Section 1.17 – Emergency
Emergency means a condition causing intractable pain or a condition which could jeopardize life, cause serious impairment in bodily functions or cause serious or permanent dysfunction of a bodily organ if immediate medical or surgical intervention were not provided.

Section 1.18 – Employee
Employee means a person for whom the Contributing Employer has made contributions to the Fund pursuant to a Collective Bargaining Agreement or Participation Agreement.

Section 1.19 – Excess Charges
Excess Charges are the part of the Claim that is over and above the Reasonable and Allowed Amount.

Section 1.20 – Expense
Expense is a charge a person is legally obligated to pay. An Expense is deemed to be incurred on the date the service or supply is furnished.

Section 1.21 – Experimental or Investigative
Experimental or **Investigative** means the use of treatment, procedures, facility, equipment, drugs, devices or supplies not yet generally recognized as accepted medical practice and any of such services, facilities, equipment, drugs or supplies requiring federal or other governmental agency approval and for which such approval had not been granted at the time services were rendered.

Section 1.22 – Formulary
Formulary means the list, as updated from time to time, of Prescription brand name drugs selected by the PBM.

Section 1.23 – Fund or Trust Fund
Fund or Trust Fund means the entire trust estate of the UFCW Local 1000 Oklahoma Health & Welfare Plan, also referred to as Care-1000, as it may from time to time be amended.

Section 1.24 – Generic Drugs
Generic drugs mean drugs which contain the same active ingredients as brand name drugs but usually are less expensive.

Section 1.25 – Health Maintenance Organization (HMO)
Health Maintenance Organization, or **HMO**, is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an Emergency. An HMO may require You to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Section 1.26 – Hospice Care
Hospice Care means care given to a terminally ill (6 months or less to live) person by a Hospice Care Agency.

Section 1.27 – Hospital
Hospital means a place which is licensed as a Hospital, which is operated for the care and treatment of resident in-patients and which has a laboratory, registered graduate nurses always on duty and an operating room where major surgical operations are performed by legally licensed Physicians. In no event will the term "Hospital" include an institution which is used principally as a clinic, convalescent home, nursing home or home for the aged, drug addicts or alcoholics. The term "Hospital" does apply to institutions accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

Section 1.28 – Hour Bank
Hour Bank is a record maintained by the Fund Administrative Manager of hours worked in excess of the minimum required to maintain eligibility in the Plan. The Plan has a maximum number of Hours that may be accumulated. The accumulated Hours may be withdrawn to help the participant maintain eligibility if he or she works less than the required amount in a month.

Section 1.29 – Injury
Injury means a bodily injury sustained accidentally by external means.

Section 1.30 – Mandatory Generic
Mandatory Generic means that the Plan will pay for Generic Drugs and brand name drugs which have no generic equivalent at the Generic Percentage Payable. On all other drugs, the Plan will pay the generic cost, and the participant is responsible for all additional cost, plus an increased Copayment.

Section 1.31 – Medically Necessary
Medically Necessary means treatment necessary for the diagnosis or treatment of a Sickness, Injury or pregnancy recommended or prescribed by a Physician. This does not include charges for non-medical services or personal comfort items even if prescribed by a Physician, such as training, education or instruction materials, air conditioners, purifiers, humidifiers or dehumidifiers, corrective shoes, heating pads, whirlpools, hot tubs, waterbeds, hot water bottles and any other clothing or equipment whose sole purpose is not for the therapeutic treatment of a medical Sickness or Injury.

Section 1.32 – Mental or Nervous Disorder
Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind. For purposes of determining benefits under the Plan, treatment for alcohol and substance abuse are considered to be Mental or Nervous Disorders.

Section 1.33 – Network
Network refers to service providers having an agreement regarding allowed pricing in force with a Preferred Provider Organization, Pharmaceutical Benefit Manager or other organization that has been retained by the Fund.

Section 1.34 – Non-Formulary
Non-Formulary Prescriptions are those brand name Prescription drugs which do not appear on

the PBM's Formulary list.

Section 1.35 – Non-Participating Provider
Non-Participating Provider - Doctors who provide care and materials to You but who are not associated with any of the vendors that the Plan has contracted with to provide benefits to Participants.

Section 1.36 – Over-the-Counter (OTC)
Over-the-Counter (OTC) medications or products are commonly available without a Prescription. In general, OTC products are not covered by the Plan. The Plan does make an exception for certain OTC products – Prilosec OTC, Claritin and Claritin D OTC, and Zyrtec and Zyrtec D OTC. These OTC products are covered at the Generic Copayment. Please note that You will need to have Your Physician write a Prescription for the OTC products listed above in order for the Pharmacist to be able to process the Claim under Your Prescription drug plan.

Section 1.37 – Panel Doctor or Panel Provider
Panel Doctor or **Panel Provider** means medical or vision service providers having an agreement in force with a Preferred Provider Organization or Vision Care Service Organization that has been retained by the Fund.

Section 1.38 – Participating Provider
Participating Provider - Medical professionals and/or facilities who agree to furnish medical services and be paid on a negotiated fee schedule.

Section 1.39 – Pharmacist
Pharmacist means, with respect to an eligible Expense covered by this Plan, any person who is legally licensed and authorized to practice such profession by the governmental authority having jurisdiction over such licensure in the area in which he or she performs such function, provided such person is operating within the scope of his or her license in dispensing the Prescription with respect to which eligible Expense is incurred while this Plan is in force as to the Individual making a Claim.

Section 1.40 – Physician
Physician means a medical doctor (MD) or a doctor of osteopathy (DO). The term "Physician" also refers to a licensed Dentist, podiatrist, chiropractor or psychologist. Physicians also include any other licensed or certified practitioner who performs services that are covered under the Plan and are within the scope of his or her license. Physician will not include the covered person's Dependents or any person who is in the immediate family of said covered person, i.e. the spouse, parent, child, brother or sister of a covered person.

Section 1.41 – Plan
Plan means this Welfare Plan of the UFCW Local 1000 Oklahoma Health & Welfare Plan, also referred to as UltraCare.

Section 1.42 – Preferred Provider Organization (PPO)
Preferred Provider Organization, or PPO**,** is a Network or panel of medical service providers

who agree to furnish medical services and be paid on a negotiated fee schedule. You and Your Dependents are given incentives to use providers within the PPO, but You may also seek covered services from outside the PPO Network, but for a higher charge.

Section 1.43 – Pre-certification

Pre-certification of a Hospital Admission is the process of reviewing Hospital services. All inpatient hospitalizations, as well as some outpatient services, are subject to Pre-Certification. Your provider should contact the Toll Free Pre-Certification number which You will find located on Your ID card. Failure to obtain Pre-Certification for inpatient hospitalizations will result in a $400 penalty deductible. This deductible is in addition to the annual deductible. Pre-certification is not required for a Hospital stay in connection with childbirth for the mother or newborn child of up to 48 hours following a normal vaginal delivery, or up to 96 hours following a cesarean section.

All services requiring Pre-certification are to be certified in advance by the Plan's Designated Utilization Review Organization except for emergencies. The Member, their representative, or their Provider is required to call the phone number for Pre-certification located on the back of their ID card for the services specified above at least seven (7) business days prior to services being rendered. The Member, their representative, or their Provider must identify the services to be rendered for Pre-certification determinations and service pre-pricing.

Section 1.44 – Prescription

Prescription means, with respect to an eligible Expense covered by this Plan, an order issued by a Physician to a Pharmacist for any federal legend drugs or medicines, drugs requiring a Prescription under State Law or Compounded drugs unless specifically excluded by this Plan. A Prescription is a separate order given by a Physician for each Individual. Insulin shall be deemed to be an eligible Expense covered by this Plan.

Section 1.45 – Primary Care Physician (PCP)

Primary Care Physician (PCP) is a Physician who provides general healthcare guidance, evaluation, and management. They are Physicians who practice Family Medicine, General Medicine, Internal Medicine and Pediatrics (for children). An OB/GYN may serve as a Primary Care Physician **ONLY** during the course of a woman's pregnancy.

Section 1.46 – Provider

Provider means any person or company that provides a health care service including, without limitation, Physicians, Hospitals, ambulatory surgery centers, pharmacies, skilled nursing facilities, and residential treatment centers.

Section 1.47 – Reasonable and Allowed Amount

"Reasonable and Allowed Amount" or **"Reasonable and Allowable Amount"** means the maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Expense. The Reasonable and Allowable Amount is the lesser of: 1) the charge made by the Provider that furnished the care, service, or supply; 2) the negotiated amount established by a discounting or negotiated arrangement; 3) the reasonable and customary charge for the same treatment, service, or supply furnished in the same geographic area by a Provider of like service of similar training and experienced as further described below; or 4) an amount equivalent to the following:

1. For inpatient or outpatient facility Claims, an amount equivalent to 140% of the Medicare equivalent allowable amount;

2. For Physician and ancillary Claims, an amount equivalent to the contractually negotiated amount established between the Provider and the Fund's Preferred Provider Organization;

3. For specialty drugs, the lesser of the average wholesale price (AWP) or the amount set by the Plan's Prescription drug service vendor.

The term 'reasonable and customary charge' shall mean an amount equivalent to the lesser of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and utilized by the Plan from time to time.

The term 'geographic area' shall be defined as a metropolitan area, county, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, service or supply for which a specific charge is made. For Covered Expenses rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law may dictate the maximum amount that can be billed by the rendering Provider, the Reasonable and Allowed Amount shall mean the lesser of amount established by applicable law for that Covered Expense or the amount determined as set forth above.

If there is insufficient information submitted for a given procedure, the Plan will determine the Reasonable and Allowed Amount based upon charges made for similar services. Determination of the reasonable and customary charge will take into consideration the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider.

The Board of Trustees or its designee has the ultimate discretionary authority to determine the Reasonable and Allowable Amount, including establishing the negotiated terms of a Provider arrangement as the Reasonable and Allowable Amount even if such negotiated terms do not satisfy the "lesser of" test described above.

Section 1.48 – Restatement Date
Restatement Date is the date this revised Plan document is effective, or July 1, 2020.

Section 1.49 – Sickness
Sickness means illness or disease (including pregnancy and resulting childbirth, miscarriages, non-elective abortion or complications, all of which shall be treated the same as any other disability or illness) that requires treatment by a Physician.

Section 1.50 – Special Enrollment Period
Special Enrollment Period means that Employees and Dependents who do not enroll when initially eligible because of coverage under another plan, or newly acquired Dependents (Dependents acquired through marriage, birth, adoption or placement for adoptions) may enroll in this Plan within 30 days of losing the other coverage or the date that the newly acquired

Dependent(s) are acquired.

Section 1.51 – Special Enrollment Rights
Special Enrollment Rights apply if an Employee declines enrollment in the Plan for himself or his Dependents because of other insurance coverage, and the other coverage ends. The Employee shall be able to enroll himself and his Dependents in this Plan in the future, provided that enrollment be requested within 30 days after the other coverage ends.

Section 1.52 – Specialist Physician (Specialist)
Specialist Physician (Specialist) is a Physician who specializes in a specific area of medicine. Specialists include, but are not limited to: Cardiologists, Dermatologists, Gastroenterologists, Psychiatrists, Rheumatologists, Endocrinologists (Diabetes Specialist), Oncologists, Radiologists, Obstetricians and Gynecologists, Surgeons (General, Plastic, Orthopedic).

Section 1.53 – Specialty Medications
Specialty Medications are typically high-cost drugs, including but not limited to the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of Specialty Medications are:

- drugs that are used to treat and diagnose rare or complex diseases
- require close clinical monitoring and management
- frequently require special handling
- may have limited access or distribution structure

Section 1.54 – Third Party Administrator
Third Party Administrator (TPA), or Administrative Manager, is the business organization hired by the Trustees to handle the day to day administration of the Plan. This includes billing, Claim processing and adjudication, record keeping, eligibility and enrollment, amongst others. The TPA for the Fund is National Employee Benefits Administrators, Inc. (NEBA).

Section 1.55 – Total Disability or Totally Disabled
Total Disability or **Totally Disabled** means an Injury or Sickness that wholly and continuously keeps an Employee from performing the material duties of his or her occupation. The Trustees reserve the right to require You to be examined by a Physician selected by the Trustees to determine whether You are or continue to be disabled. The Trustees reserve the right to discontinue benefits under this Plan that are available by virtue of a Total Disability if, in the Trustees' discretion, You are no longer Totally Disabled.

Section 1.56 – Trust Agreement
Trust Agreement means the Trust Agreement establishing the UFCW Local 1000 Oklahoma Health & Welfare Plan, also referred to as UltraCare.

Section 1.57 - Utilization Review
Utilization Review is the process of evaluating if services, supplies or treatment are Medically Necessary, appropriate and priced at the prevailing rates to help ensure cost-effective care. Utilization Review can eliminate unnecessary services, hospitalizations, and shorten confinements while improving quality of care and reducing costs to the Member and the Plan.

Pre-certification establishes the medical necessity of certain care and services covered under the Plan. It ensures that the pre-certified care and services will not be denied on the basis of medical necessity (as defined by this Plan). The Pre-certification process will also establish the reference prices for requested services. However, Pre-certification does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as, Plan limitations, exclusions, and eligibility at the time care and services are provided.

Section 1.58 – You or Your
You or Your means an eligible Employee and each of his or her eligible Dependents.

Section 1.59 – Welfare Plan Participant (or Plan Participant)
Plan Participant is an Employee or Dependent who is covered under this Plan at the time services are rendered.

ARTICLE II – ELIGIBILITY

Section 2.01 – Initial Eligibility
If You are not eligible for the Plan on the Restatement Date, You can become eligible as follows:

1. Life Benefits
   You will become eligible for the Life Only benefits on the first day of Your second month of employment. There is no minimum hours requirement for initial eligibility for Life Only Benefits.

2. Medical Benefits

   a. Variable Hour Employees
      If You worked a total of at least 130 hours in two consecutive months and have completed six (6) consecutive months of employment, You can become eligible for Medical benefits on the first day of the second month following that two month period, but not before the first day of the seventh month.

   b. Known Full-Time Employees
      If You were hired as a Known Full-Time Employee, You will become eligible for Medical benefits on the first day of the month following 60 days of employment. Your Employer will notify the Plan if You are considered a Known Full-Time Employee.

Section 2.02 – Continuing Eligibility and Hour Bank
After You become eligible for UltraCare Life and Medical Benefits, all hours worked and reported in excess of 65 hours per month shall be credited to an Hour Bank account established and maintained on Your behalf. You will continue to be eligible for UltraCare coverage during any month in which the Hours reported for the corresponding eligibility month, including any Hours withdrawn from Your Hour Bank, equal at least 65. If You are a Known Full-Time Employee, You will continue to be eligible for UltraCare coverage without working a minimum number of hours, provided that You remain a Known Full-Time Employee.

Your Hour Bank can accumulate up to a maximum of 50 hours.

If You do not meet these continuing eligibility rules, You must meet the Initial Eligibility in Section 2.01 to begin coverage in the Plan again.

To maintain coverage in Life Benefits only, which were effective the first day of the second month of employment, You must remain an Employee. There is no minimum hours requirement for continuing eligibility for Life Only Benefits.

Section 2.03 – Skip Month Eligibility
For purposes of determining eligibility, hours worked for a month shall be used to determine Your eligibility status two months after the work month. For example, the 65 Hours reported for

November will provide eligibility for January.

Section 2.04 – Employee and Dependent Contributions
Contributions are required to access coverage. These contributions are pre-tax dollars which are collected by Your Employer via payroll deductions and remitted to the Plan on a monthly basis. Your employer submits these contributions directly to the Fund Office along with their required contributions for Your hours worked during the same work month. Payment of these contributions is a contingency of coverage. Effective January 1, 2018, the Employee and Dependent Contribution Rates are as follows.

Family Tier	Weekly Contribution Amount (via Payroll Deduction)
Employee Only	$5.00
Employee + Child(ren)	$15.00

The Trustees reserve the right to adjust Employee contribution requirements periodically.

Section 2.05 – Continuing Eligibility During Disability
After You become eligible, if You are unable to work because of a certified Total Disability, the Plan will continue Your eligibility for benefits without charging Your Hour Bank for up to the Accident and Sickness Maximum Benefit Period during periods of time lost due to Sickness or Injury (on or off the job). A certified Total Disability is one for which the participant is being paid Weekly Accident and Sickness benefits through the Plan or submits evidence of receiving Workers' Compensation benefits as the result of a Total Disability incurred while performing work for which Contributions were paid to the Plan.

Section 2.06 – Family and Medical Leave Act (FMLA)
If You qualify, the Family and Medical Leave Act of 1993 (FMLA) permits You to take up to 12 weeks of unpaid leave for Your serious illness, after the birth or adoption of a child, or to care for Your seriously ill spouse, parent or child. The law requires employers who meet specific requirements to maintain health care coverage for their Employees and Eligible Dependents during a qualified period. If You qualify and take a leave, Your Employer must contribute to this benefit program on Your behalf during Your approved leave. In the event that the Plan provides for a contribution by You for a portion of the total contributions, then You remain obligated to make payment of such co-contributions which are due during the period of qualified leave. If You think this law may apply to You, please contact Your employer. Any disputes over Your eligibility for an FMLA leave are between You and Your employer.

Section 2.07 – Termination of Eligibility
Your eligibility for benefits will terminate on:

1. the date Your employment with Your Contributing Employer terminates; or

2. the date You enter the Armed Forces of the United States on full-time active duty; or

3. the date You fail to meet the eligibility requirements; or

4. the first of the month following the month for which Employee and/or Dependent contributions are not received.

Section 2.08 – Reinstatement of Eligibility

If You are no longer eligible for medical benefits under UltraCare due to insufficient Hours worked, including those supplemented by Your Hour Bank, the remaining Hours in the Hour Bank will be retained for up to three (3) months from the last month of Your eligibility and used, along with Hours actually worked, in determining eligibility. If You do not work sufficient Hours, with those supplemented by Your Hour Bank, to become eligible during this three month period of time, You will forfeit all Hours in Your Hour Bank and again be required to meet the initial eligibility requirements in Section 2.01 of the Plan for medical benefits.

If Your status as a participant terminates because of entrance into full-time military service, upon leaving military service You shall resume being a participant in the same eligibility status and with the same Hour Bank credit, if any, as of the date You entered military service, provided You return to work within 90 days from date of discharge or within 90 days following recovery from a disability continuing since discharge. If You do not meet these requirements, You shall forfeit all hours credited to Your Hour Bank.

ARTICLE III – SCHEDULE OF BENEFITS

Once a participant becomes eligible under the Plan, the participant qualifies for a variety of Benefits. The following chart highlights the Benefit Plan. Other Plan maximums and limitations may apply to specific Benefits. Please refer to the appropriate Sections of this Booklet or contact the Fund Office for more information.

Accidental Death and Dismemberment Benefit (participant only)
Coverage reduces with age.

Basic	$20,000
Additional Buy Up Benefit (optional with additional participant cost)	$20,000
Loss of:	
Life	Principal Sum
Both Hands, Both Feet, Both Eyes or Combination of any Two	Principal Sum
One Hand, One Foot or One Eye	Half of Principal Sum

Life Insurance (participant)
Coverage reduces with age.

Basic	$20,000
Additional Buy Up Benefit (optional with additional participant cost)	$20,000

Life Insurance (Dependent child)

Basic per Dependent child	$500

Weekly Accident and Sickness Benefit (participant Only)
Any Participant receiving Loss of Time will have this reported to their Employer and the amount included in their W-2 form at the end of the year.

Maximum Benefit	10 weeks per Injury or Sickness
Weekly Benefit Amount	50% of salary; not to exceed $200
Waiting Period (Accident or Sickness)	7 days

Vision Benefit
Benefits vary based on whether provider is participating or is non-participating.
1. ***Eye Examinations*** - Eye Examinations will be provided at no charge to You provided that such services are not used more frequently than once every 24 months.
2. ***Eyeglass Lenses*** - Basic standard clear lenses (single or standard lined multifocal lenses) will be provided at no charge to You provided lenses are obtained not more frequently than once every 24 months. You will be charged and the Plan will not be responsible for paying charges for "extras", including but not limited to coatings, tints, or no-line bifocals.
3. ***Frames*** - Frames supplied by Panel Doctors will be provided at no charge to You, provided frames are not obtained more frequently than once every 24 months and that the frame is included in the covered selection. If You select a frame from outside the covered selection, You will be responsible for paying the wholesale cost plus an additional $15.00 handling fee.
4. ***Contact Lenses*** - Contact Lenses are not an allowable expense.

Comprehensive Medical Benefit

Deductible Amount	
Individual Deductible Amount (every Plan Year)	$ 400
Coinsurance (Fund pays)	
In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	40%
Ambulance	
Coinsurance (Fund pays)	
In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	40%
Chiropractic Benefit	
Coinsurance (Fund pays)	
In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	40%
X-rays (In- or Out-of-Network)	50%
Maximum Number of Visits	1 visit per week and 26 visits per Calendar Year
Durable Medical Equipment	
Coinsurance (Fund pays)	
In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	40%
Outpatient Hospital Services (Facility)	
Coinsurance (Fund pays; after Deductible)	75%
Outpatient Hospital Services (Professional)	
Coinsurance (Fund pays)	
In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	40%
Inpatient Hospital Services (Facility)	
Coinsurance (Fund pays; after Deductible)	75%
Additional $400 penalty applies for failure to pre-certify	
Inpatient Hospital Services (Professional)	
Coinsurance (Fund pays)	
In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	40%

Hospital Emergency Room Services
Employee Copayment *(Copayment waived if admitted to same Hospital within 48 hours)*

Sickness	$66.69
Accident	$33.34
Coinsurance (Facility; Fund pays)	
(after Employee Copayment and Deductible)	75%
Coinsurance (Professional; Fund pays)	
In-Network (after Employee Copayment and Deductible)	75%
Out-of-Network (after Employee Copayment and Deductible)	40%

Podiatric Benefit

Coinsurance (Fund pays)	
In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	40%
Maximum Number of Visits	1 visit per week, 6 visits per Calendar Year
Services following surgery, if Medically Necessary	Under General Medical Benefit

Preventive Care Benefit
In-Network Benefits Only

Routine Checkups	
Coinsurance (Fund pays)	
In-Network (no Deductible)	$20 Copayment
Calendar Year Maximum	$125

Once the Calendar Year Maximum has been met the benefit is subject to the In-Network Deductible and Employee Coinsurance

Primary Care Physician Office Visit

Copayment	
In-Network (no Deductible)	$20 Copayment
Coinsurance (Fund pays)	
Out-of-Network (after Deductible)	40%

Specialist Care Physician Office Visit

Copayment	
In-Network (no Deductible)	$20 Copayment
Coinsurance (Fund pays)	
Out-of-Network (after Deductible)	40%

Urgent Care Physician Office Visit

Copayment	
In-Network (no Deductible)	$20 Copayment
Coinsurance (Fund pays)	
Out-of-Network (after Deductible)	40%

Prescription Drug Card Benefit – In-Network Benefits Only

Copayments (participant pays)

Retail Participating Pharmacies (up to 30-day supply)

$15.00 Copayment	Generic
$33.34 Copayment	Brand Formulary
$46.68 Copayment	Brand Non-Formulary

Mail Order Participating Pharmacies (90-day supply)

(see Section 4.12 C for approved walk-in pharmacies that allow a 90-day supply)

$33.34 Copayment	Generic
$86.36 Copayment	Brand Formulary
$116.71 Copayment	Brand Non-Formulary

Retail Prescriptions must be filled at HAC owned pharmacies for coverage except for certain exceptions. Please see Section 4.07 for more details.

All Specialty Medications are limited to no more than a 30-day supply per fill and require Prior Authorization by the Pharmaceutical Benefit Manager. Please see Section 4.07 for a description of Specialty Medications.

All Compound Medications will have a $250 Prior Authorization Threshold. Claims over $250 are to be reviewed by the Pharmaceutical Benefit Manager for clinical appropriateness. The Pharmaceutical Benefit Manager (PBM) will ensure that the ingredients are covered by the Plan and are safe and effective. Please see Section 4.07 for a description of Compound Medications.

The Fund participates in Optum's Opioid Utilization Management Program, which monitors for abuse by Participants who visit multiple doctors or pharmacies to get additional Prescriptions filled or who utilize several different opioid medications. Optum utilizes the morphine equivalent metric to measure for abuse across different medications.

WAYS YOU CAN SAVE $$$

There are a number of ways to utilize Your benefits that can save You money. Below are three examples designed to illustrate the financial incentives for utilizing Your benefits in the most effective, efficient manner.

1. *Using In-Network Providers*:
   In the example below, both Kate and Jack require a medical procedure. Kate uses an in-network provider, while Jack uses an out-of-network provider.

   KATE:

   a. Kate's doctor normally bills $3,200 for the procedure. The allowed amount is $2,600 and, because the doctor is in network, Kate is not responsible for the difference.
   b. Kate is required to pay the $400 individual deductible.
   c. Kate also pays 25% of the remaining $2,200 in charges ($2,600 - $400 deductible), or $550.
   d. **Kate's total payments to the doctor = $950** ($400 deductible + $550 in Coinsurance)

   JACK:

   e. Jack's doctor bills $3,500 for the procedure. The allowed amount is $2,600. Because the doctor is out of the network, Jack is responsible for paying the difference, or $900.
   f. Jack is required to pay the $400 individual deductible.
   g. Jack also pays 60% of the remaining $2,200 in charges ($2,600 - $400 deductible), or $1,320.
   h. **Jack's total payments to the doctor = $2,620** ($900 for amounts over allowed amounts + $400 deductible + $1,320 in Coinsurance)

   Kate's total cost of $950 for using an in-network provider represents a savings of $1,670 compared to Jack's total cost of $2,620 for using an out-of-network provider.

2. *Generic vs brand drug Prescription*:
   In the example below, both Tom and Heather require a Prescription for cholesterol medication. Tom requests a generic medication from his doctor, while Heather does not and is instead prescribed a brand name medication.

   TOM:

   a. Tom receives a Prescription for a generic cholesterol lowering drug and fills at a retail pharmacy. He pays a $15 Copayment at the pharmacy for each 30-day fill.
   b. **Tom's total payments to the pharmacy for one year's worth of medication = $180** ($15 per month x 12 months).

HEATHER:

c. Heather receives a Prescription for a brand name cholesterol lowering drug that is not on the Plan's Formulary. She fills at a retail pharmacy and pays a $46.68 Copayment at the pharmacy for each 30-day fill.
d. **Heather's total payments to the pharmacy for one year's worth of medication = $560.16** ($46.68 per month x 12 months)

Tom's total cost of $180 for filling a generic Prescription represents a savings of $380.16 compared to Heather's total cost of $560.16 for filling a Non-Formulary brand Prescription.

3. *Emergency room vs urgent care facility visit*:
In the example below, both Jay and Bob have mild allergic reactions. Jay visits an in-network urgent care facility while Bob goes to the closest Emergency Room.

JAY:

a. Jay visits an in-network urgent care facility. The visit yields $400 in allowable charges, of which Jay is only responsible for paying a **$20 Copayment** towards.

BOB:

b. Bob visits an Emergency Room. The visit yields $2,000 in allowable charges. Bob pays the following for the visit:
    i. $400 deductible
    ii. + $66.69 Sickness Emergency Room Copayment
    iii. + $383.33 = 25% Coinsurance on the remaining $1,533.31
    iv. = **$850.02 total**

Jay's total cost of $20.00 for going to the in-network urgent care facility represents a savings of $830.02 compared to Bob's total cost of $850.02 for going to the Emergency Room.

ARTICLE IV – DESCRIPTION OF BENEFITS

Section 4.01 – Life Insurance (Employees and Dependent Children Only)

Life Insurance Benefits are provided according to the Schedule of Benefits on a fully-insured basis for participants and their Eligible Dependent children.

Benefits
If You die while eligible for benefits under this provision, the Plan will pay the amount of Life Benefit shown in the Schedule of Benefits. Benefits will be paid to:

1. the beneficiary You name; or

2. Your estate, if You do not name a beneficiary or if no beneficiary survives You

Benefits will be paid equally among surviving beneficiaries unless You have requested otherwise in writing.

If Your Dependent child dies while eligible for benefits under this provision, the Plan will pay the amount of Life Benefit shown in the Schedule of Benefits. Benefits will be paid to the Employee.

The Plan will pay benefits:

1. in a lump sum; or

2. in a form of payment other than a lump sum if:

    a. another form of payment is requested as described below; and

    b. the Board of Trustees agrees to the requested change in writing.

Change of Beneficiary or Form of Payment
The beneficiary and form of payment may be changed from time to time. You must request the change in writing and send it to the Administrative Manager. After the request is recorded and acknowledged, in writing, the change will take effect as of the date You signed the request. However, the change will not apply to any payments or other action taken by the Plan before the request was acknowledged.

Section 4.02 – Accidental Death and Dismemberment Benefits (Employees Only)

Accidental Death and Dismemberment Benefits (AD&D) are provided according to the Schedule of Benefits on a fully-insured basis for Employees.

Benefits
If, while eligible for benefits under this provision, You suffer an Injury and sustain a loss, the Plan will pay the amount of the benefit shown in the Schedule of Benefits. If You do not survive the Injury, the benefit will be paid to Your beneficiary or to Your estate, if You do not name a beneficiary or no beneficiary survives You.

Loss of hands and feet means severance at or above the wrist or ankle joint. Loss of an eye means the total loss of sight in that eye which is not recoverable.

Limitations and Exclusions
AD & D benefits are not payable for any loss caused by, contributed to by, or resulting from, either directly or indirectly:

1. Suicide, attempted suicide, or intentionally self-inflicted Injury;

2. Sickness, bodily or mental infirmity or disease, or any diagnosis or treatment thereof;

3. participation in an insurrection or riot;

4. a state of war or any act of war, declared or undeclared, whether or not You are in the armed forces of any country or international authority, or participating in an illegal occupation;

5. committing or attempting to commit an assault or felony;

6. Your voluntary use of any drug, hallucinogen, or controlled substance, drug, medication or sedative, unless taken as prescribed by a Physician;

7. Your being intoxicated at the time of the incident and You are the operator of a vehicle or other device involved in the incident;

8. travel or flight in, or descent from, any kind of aircraft, including balloons and gliders (except as a fare paying passenger on a regularly scheduled commercial route or charted flight).

Section 4.03 – Weekly Accident and Sickness Benefit (Employees Only)

Benefits
Weekly Accident and Sickness Benefits are payable according to the Schedule of Benefits if You are an Employee and are Totally Disabled, as certified by a Physician.

Before the Weekly Benefit is payable, You must be continuously and Totally Disabled during the seven-day Waiting Period. Benefits will then begin on the first day after the Waiting Period.

Weekly Accident and Sickness Benefit payments will continue until the earlier of:

1. the date You are no longer Totally Disabled, or

2. when You have received benefits for the Maximum Benefit Period set forth in the Schedule of Benefits.

Weekly Accident and Sickness Benefits are computed on a weekly basis. If payment is to be made for a period of less than a full week, then You will receive a proportional benefit. The amount for each day of the Total Disability will be one-seventh of the Weekly Benefit.

Period of Disability
Successive or different periods of Total Disability, separated by less than two calendar weeks of continuous Active Work at Your regular occupation, will be considered as one period of Total Disability, unless the subsequent Total Disability is due to an Injury or Sickness entirely unrelated to the causes of the previous Total Disability and commences after Your return to Active Work for at least one day. You must work a number of hours during one or more consecutive work days that is at least equal to the average number of daily hours You worked during the three-month period preceding Your previous period of disability. Average daily hours are calculated by dividing the total number of hours You worked by the number of days during which You worked one or more hours during the three-month period.

Limitations and Exclusions
No benefits are payable if:

1. You are not under the direct care of a Physician;

2. the Injury or Sickness was caused by a war or any act of war, whether declared or undeclared;

3. the Total Disability is due to any Injury or Sickness arising out of or in the course of any employment or occupation for compensation or profit, or any Injury or Sickness compensable under any Workers' Compensation Law or similar law;

4. Your Total Disability begins after Your employment has terminated, even if You are still eligible for other coverage under the Plan;

5. for any period while You are on paid vacation; or

6. Your Total Disability results from an intentionally self-inflicted Injury.

Section 4.04 – Dental Benefit

Benefits
If You are treated by a Dentist and incur Allowable Dental Expenses during any Calendar Year, the Plan will pay the applicable Percentage Payable of the Allowable Dental Expenses, as shown

in the Schedule of Benefits.

The Maximum Amount Payable for Diagnostic Dental Benefits, or Restorative Benefits, or any combination thereof, shall be as shown in the Schedule of Benefits. Benefits paid during each Calendar Year shall not exceed the Maximum Amount Payable per person. Semi-annual Routine Oral Examinations and Routine Cleaning and X-Rays do not apply to the Maximum Amount Payable per Calendar Year.

Routine Oral Examination Benefits
The Plan will pay the percentage shown in the Schedule of Benefits for all Allowable Expenses actually incurred for a Routine Oral Examination made by a Dentist while coverage under this Plan is in effect.

The following services are considered Routine Oral Examination Benefits:

1. Initial and periodic examinations - once every six months;

2. Dental x-rays, bitewings each six months; full-mouth or panoramic x-rays once every five years;

3. Prophylaxis - once every six months.

Dental Exclusions

1. Replacement of lost or stolen appliances or artificial tooth replacements.

2. Laboratory examinations.

3. Oral surgical and periodontal services performed on an inpatient basis or in a surgical day care unit.

4. A Sickness or Injury that the Plan Administrative Manager determines arose out of or in the course of Your employment.

5. Services or treatment for which an individual would be eligible for full or partial payment under any state, municipal, or federal law or regulation.

6. Services that are meant primarily to change or improve appearance.

7. A method of treatment more costly than is customarily provided (Benefits will be based on the least costly method of treatment).

8. Orthodontic services, including exam, treatment or orthodontic appliances.

9. Implants, Prescription medication, charges for broken appointments.

10. Dental Expenses incurred in connection with any dental procedure started prior to the participant's eligibility.

11. Procedures, appliances or restorations to correct congenital, developmental or medically induced disorders, including but not limited to temporomandibular joint dysfunctions (TMJ).

12. Fluoride treatments are limited to once every six months to age 19.

13. Crowns are covered only if there is not enough retentive quality left in a tooth to hold a filling.

14. Dental Expenses incurred after the termination of eligibility under the Plan.

15. Charges received in the Administrative Manager's office more than one year after they were incurred.

Section 4.05 – Vision Care Benefits

The Plan has contracted with Group Vision Service (GVS) to provide You and Your Dependents, when eligible, with various vision care services through EyeMed Vision Care Network. Benefits are subject to the provisions of the contract between the Fund and GVS.

How to Use the Vision Care Benefits

1. To locate a Participating Provider call GVS at 1-866-265-4626 and follow the voice prompts, or visit their website at www.groupvisionservice.com.

2. Contact the provider and schedule an appointment.

Benefits - Participating Providers

1. Eye Examinations - Eye Examinations will be provided at no charge to You provided that such services are not used more frequently than once every 24 months.

2. Eyeglass Lenses - Basic standard clear lenses (single or standard lined multifocal lenses) will be provided at no charge to You provided lenses are obtained not more frequently than once every 24 months. You will be charged and the Plan will not be responsible for paying charges for "extras", including but not limited to coatings, tints, or no-line bifocals.

3. Frames - Frames supplied by Panel Doctors will be provided at no charge to You, provided frames are not obtained more frequently than once every 24 months and that the frame

is included in the covered selection. If You select a frame from outside the covered selection, You will be responsible for paying the wholesale cost plus an additional $15.00 handling fee.

4. Contact Lenses - Contact Lenses are not an Allowable Expense.

Section 4.06 – Comprehensive Medical Benefits

Comprehensive Medical Expense Benefits provide broad and extensive coverage to help You pay the costs of most types of medical care. The Medical Expense Benefits will not pay 100% of the medical Expenses that You may incur. You will be required to pay a portion of all medical Expenses.

Deductible Amount

Comprehensive Medical Benefits become payable after You have satisfied the annual deductible of Covered Medical Expenses each Calendar Year as set forth in the Schedule of Benefits. The deductible applies only once in any Calendar Year to each individual even though You may have different disabilities. Covered Expenses must be submitted to the Plan in order for Your deductible to be satisfied. Claims incurred for medical services are applied toward Your deductible in the order they are received by the Administrative Manager.

Covered Medical Expenses

Medical Expenses covered by the Plan for Medically Necessary care and services ordered by a Physician for a non-occupational Injury or Sickness are listed below. For list of services that are excluded from coverage please refer to Article V – General Limitations on page 37.

1. Hospital Care - the Room and Board charges and miscellaneous charges during a Hospital confinement, and outpatient charges if outpatient treatment is provided as an alternative to a Hospital confinement.

2. Physician Care - treatment by a Physician, whether in or out of a Hospital, for an Injury or Sickness, including diagnosis, x-ray and laboratory services, in-Hospital visits or Physician's office visits.

3. Surgical Care - Physician Expenses incurred in connection with a surgical procedure, including anesthetist's charges.

4. Nursing Services - Private duty nursing services of a registered graduate nurse (RN) or licensed practical nurse (LPN) or treatment by a licensed physical therapist.

5. Prescription drug charges for drugs and medicines obtained on a Physician's written Prescription while Hospital confined.

6. Ambulance service to the Hospital or transfer between Hospitals, if Medically Necessary.

7. Anesthesia, oxygen and their administration.

8. X-ray and laboratory tests.

9. Radium, radioactive isotope or similar therapy.

10. Blood or blood plasma and their administration.

11. The rental of Durable Medical Equipment such as a Hospital bed, wheelchair, CPAP machines, or crutches. This covers the rental of original equipment only, up to the purchase price of such equipment, and not replacement of such equipment.

12. Braces, casts or splints.

13. Dental treatment for the repair or replacement of sound natural teeth that were harmed while You were eligible, removal of tumors or cysts or extraction of impacted teeth.

14. Physician's services provided in connection with spinal treatment, not to exceed the maximum shown in the Schedule of Benefits.

15. Outpatient surgery benefits are payable for covered surgeries and all related charges, if the surgery is performed in a Physician's office, or as an outpatient in a Hospital or Ambulatory Surgical Facility.

16. Pregnancy related Expenses, other than Expenses incurred for Elective Abortion, except for complications which are the result of an Elective Abortion; Hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, will not be restricted to less than 48 hours, or following a Cesarean section, to less than 96 hours.

17. Initial prosthetic devices for a loss or Injury while You are covered, and not for replacement of these devices.

18. Charges made by an Alternative Birthing Center for medical care and treatment received in connection with a birth.

19. If You receive necessary Home Health Care Services upon the recommendation of a Physician, Expenses incurred will be payable for the following services and supplies furnished in Your home, not to exceed 30 days in a Calendar Year for:

    a. Part-time or intermittent home nursing care from or supervised by, a registered nurse;
    b. part-time or intermittent home health aid services;
    c. physical therapy, occupational therapy, and speech therapy; and
    d. Physician and laboratory services by or on behalf of a Hospital to the extent such items would have been covered under the Plan if the individual was confined in the Hospital or in a skilled nursing facility.

20. Room and board and miscellaneous services for an eligible stay in an Extended Care Facility or Long Term Acute Care Facility but only up to a total of 30 days in each Calendar Year. A stay in an Extended Care Facility is covered only if:

    a. the stay begins within 7 days after a Hospital stay;
    b. the stay is due to the same or related causes as the Hospital stay;
    c. a Hospital stay would otherwise be needed;

21. Charges for breast cancer screening and mammograms, as set forth in the Schedule of Benefits.

22. Charges made by a Hospice Care Facility or Hospice Care Agency.

23. Charges for Hospital Emergency room care for treatment of an Injury or Sickness subject to the Copayments set forth in the Schedule of Benefits.

24. Hospital outpatient care for a Sickness.

25. Pre-admission Tests or Exams - Exams made before You enter the Hospital for inpatient surgery, when:

    a. the tests or exams pertain to the planned surgery and are ordered by a Physician;
    b. the Physician requests Hospital admission for surgery and the Hospital confirms the request; and
    c. the Hospital admits the covered individual within 7 days after the test or exam results are known. The seven-day rule will be waived if:

        i. the planned Hospital stay is canceled; or
        ii. a change in the person's condition precludes the need for surgery.

26. In compliance with the Women's Health and Cancer Rights Act of 1998, this Plan provides medical and surgical benefits in connection with a mastectomy for certain reconstructive surgery. If a participant or beneficiary undergoes a mastectomy and elects breast reconstruction, coverage in a manner determined in consultation with the attending Physician and patient will be provided for:

    a. specialty bra used prior to reconstruction;
    b. reconstruction of the breast on which the mastectomy was performed;
    c. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    d. prosthesis and treatment of physical complications at all states of the mastectomy, including lymphedema.

    The coverage provided by the Plan is subject to the Plan's annual deductibles, Coinsurance provisions and annual maximums.

27. Charges incurred for care provided to a newborn infant while still in the Hospital. Under Federal law, the Plan may not restrict benefits for any Hospital stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. owever, a mother and her Physician may agree to discharge the mother (and infant) after a shorter Hospital stay than those described above.

28. Dialysis Services, diagnostic testing, laboratory tests, equipment and supplies are a Covered Expense under the Plan only to the extent they are Medically Necessary and only insofar as their cost does not exceed the Reasonable and Allowable Amount specified on the Schedule of Benefits, specific to Dialysis Services.

    Dialysis Services, diagnostic testing, laboratory tests, equipment and supplies are those services and items used in the dialysis treatment for acute renal failure or chronic irreversible renal insufficiency (treatment of anemia and other diagnoses related to renal failure). This also includes injectable and intravenous medication including, but not limited to, Heparin, Epogen, Procrit, and other medications administered directly before, during or after a dialysis procedure. Dialysis procedures are for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis regardless of whether they are provided on an inpatient or outpatient basis.

Section 4.07 – Prescription Drug Benefits

Prescription Drug Benefits are available through the Pharmaceutical Benefit Manager (PBM). When You purchase a drug or medicine that requires a doctor's written Prescription, You will be required to pay a Copayment, or a portion of the discounted price that the pharmacy will charge for the drug. The Copayments are outlined in the Schedule of Benefits. A valid prescription drug card issued through this Plan must be presented to a participating pharmacy in order to have the benefit paid in full after payment of the applicable Copayment amount. In the event the prescription drug card is lost and a Prescription is filled for You, the Plan will reimburse You, after completion of a prescription drug Claim form, an amount equal to the wholesale cost of the Prescription, plus a pharmacy dispensing fee, less the applicable Copayment amount.

Effective February 1, 2018, the participating pharmacy Network will depend on whether or not a Participant a.) works in a store with a HAC-owned pharmacy; or b.) lives within twenty (20) miles of a store with a HAC-owned pharmacy.

Participants who work in a store with a HAC-owned pharmacy or Participants who reside within twenty (20) miles of a store with a HAC-owned pharmacy must use the HAC-owned pharmacy in order to access their prescription drug benefits. *Prescription drugs obtained from other pharmacies will not be covered unless the Participant was unable to obtain their Prescriptions because the store's HAC-owned pharmacy was closed, the Prescription was unavailable at the store's HAC-owned pharmacy or extenuating circumstances prevented the Participant from obtaining the Prescriptions at the store's HAC-owned pharmacy.*

Participants living within a 20-mile radius from a HAC-owned pharmacy have access to Optum's Broad Network under the following circumstances:

- Monday- Friday: Broad Network opens at 9:00 PM and closes at 9:00 AM
- Saturday: Broad Network opens at 7:00 PM and closes at 9:00 AM
- Sunday: Broad Network open all day

In addition, the Broad Network is only available for acute Prescriptions and not maintenance medications, which are required to be filled at HAC-owned pharmacies. One grace fill of a maintenance medication at a Broad Network pharmacy is permitted for the instance in which a participant is getting the maintenance medication for the first time.

Participants who do not work in a store with a HAC-owned pharmacy and who reside more than twenty (20) miles from a store with a HAC-owned pharmacy may continue to use the broad Optum pharmacy Network at all times. Please note that effective February 1, 2018, Walmart is no longer a participating pharmacy in the Optum Care-1000 broad pharmacy Network.

Prescription Limitations and Exclusions

In addition to the Plan General Limitations, the Prescription Drug Benefit does not cover any loss caused by, incurred for or resulting from:

1. Drugs procured without a Physician's Prescription.

2. Drugs prescribed for any dietary purpose.

3. Infertility medication.

4. Immunization agents, unless specified in the Schedule of Benefits.

5. Appliances, supports, and prosthetic devices such as, but not limited to, canes, crutches, wheelchairs, or any means of conveyance or locomotion prescribed for an ambulatory patient, braces, splints, bandages, heat devices, hypodermics, or syringes or needles other than for insulin.

6. Drugs dispensed by a Hospital for resident bed patients or by a rest home or sanatorium.

7. Drugs for which no charge is made or for which You are not required to pay.

8. Drugs furnished by or payable for which You are entitled to compensation under any federal government plan or law or under any plan or law of a state or political subdivision thereof, including any Worker's Compensation Law or similar legislation.

9. Drugs prescribed for Injury or Sickness resulting from war or any act of war.

10. Drugs obtained prior to the effective date or subsequent to the termination date of Your coverage.

11. Drugs that can be legally dispensed without a Prescription, such as aspirin, even though the Physician may have prescribed them, other than as specifically provided for herein.

12. Diabetic supplies other than Insulin and Insulin syringes.

13. Oral Fertility agents.

ARTICLE V – GENERAL LIMITATIONS

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.**

IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS COVERED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

In addition to any other limitations, either specific or general, set forth in the Plan, benefits are **NOT** payable for any loss caused by, incurred for or resulting from:

1. treatment that is not Medically Necessary;

2. cosmetic surgery, unless it is performed as soon as medically feasible and is needed for:

    a. repair of an Injury received while You are covered under this Plan;
    b. reconstruction that is incidental to or follows surgery resulting from an Injury or Sickness;
    c. correction of a congenital defect that results in a functional defect of a Dependent Child; or
    d. correction of a normal bodily function needing repair as a result of an Injury or Sickness.

3. dental care or treatment, except as otherwise provided;

4. hearing aids or the fitting thereof, or eye care for or in connection with:

    a. exams to determine the need or changes of eyeglasses or lenses of any type, except initial replacements for loss of the natural lens; or
    b. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring);

5. transportation, except Emergency ambulance service, as otherwise provided;

6. charges incurred prior to the effective date or subsequent to the termination date of Your coverage;

7. services or supplies in connection with a service related disability in a Service Facility or Veteran's Administration Hospital owned or operated by the U.S. Government, unless

otherwise required by law;

8. an elective abortion unless the mother's life would be endangered if the fetus were carried to term and excluding any complications that are the result of an elective abortion;

9. any self-inflicted Injury unless the result of a medical condition (including both physical and mental conditions);

10. any Injury or Sickness arising out of or in the course of any employment or occupation for compensation or profit, or any Injury or Sickness compensable under any Workers' Compensation Law or similar law;

11. an Injury or Sickness caused by war, or by any act of war, declared or undeclared, or by participating in a riot or as the result of participation in the commission of a felony except when the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions);

12. charges in excess of the Reasonable and Customary Charge or Charges for unnecessary care or treatment;

13. charges for which no charge is made that You are required to pay;

14. service, supplies or treatment in connection with or related to trans-sexuality or reverse sterilization or any attempt of these procedures;

15. any treatment, surgical procedure, facility, equipment, drugs, drug usage or supplies requiring Federal or other governmental agency approval that:

    a. is not granted at the time the services are rendered; or
    b. is determined to be Experimental or not accepted medical practice;

16. a weight control program or medical or surgical treatment of obesity, regardless of health reasons or if it is Medically Necessary;

17. routine physical exams or immunizations, (including routine physical exams or immunizations for children) except as shown in the Schedule of Benefits;

18. services provided by a rest home, home for the aged, nursing home, residential care facility, or any other similar facility that is primarily for custodial care;

19. charges made by a Physician, registered nurse, licensed practical nurse or physical therapist if such person is a member of Your immediate family or resides with the person receiving treatment;

20. any Injury sustained as a result of being under the influence of a narcotic, alcohol, chemical or drug, unless prescribed by a Physician;

21. Home Health Care benefits other than services specifically included in the Home Health Care Plan. In addition, Home Health Care benefits are not payable for:

    a. any period during which You are not under the continuing care of a Physician;
    b. transportation services; or
    c. services, supplies or treatment not otherwise payable under this section;

22. any organ transplant procedures that are Experimental in nature;

23. personal hygiene, comfort or convenience items such as humidifiers, or exercise equipment;

24. routine foot care, flat foot conditions, supportive devices for such conditions, corrective shoes or diabetic shoes;

25. orthotics;

26. sexual dysfunction, impotence or infertility treatment or procedures;

27. failure to keep a scheduled visit or to complete a Claim form;

28. charges to the extent that You are entitled to receive benefits under any governmentally mandated no-fault motor vehicle insurance;

29. non-Prescription medicines, contraceptives, vitamins, nutrients and food supplements, even if prescribed by a Physician;

30. treatment of temporomandibular joint disorder or dysfunction by surgery of the temporomandibular joint or mandible, intra-oral prosthetic devices, orthodontics, dental splints or extractions, or any other means, regardless of if it is Medically Necessity;

31. charges received in the Administrative Manager's office more than one year after they were incurred;

32. charges incurred for treatment outside of the United States or Puerto Rico;

33. charges for which You did not complete and file the Fund's Medical Statement of Claim (Claim Form) or other requested information such as a Subrogation and Restitution Agreement, accident/Injury details, etc. when requested by the Fund.

ARTICLE VI – MISCELLANEOUS PROVISIONS

Section 6.01 – Coordination of Benefits

If You are entitled to benefits under any Other Plan that will pay part or all of the Expense incurred for necessary Reasonable and Customary charges for treatment of Injuries or Sickness, the amount of benefits payable under this Plan and any Other Plan will be coordinated so that the aggregate amount paid will not exceed 100% of the Allowable Expense incurred, as defined below. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if there were no Other Plan involved.

The Plan will not coordinate Benefits with Health Maintenance Organizations (HMOs). If a Dependent(s) of an Employee is covered by an HMO as their primary carrier, this Plan will not pay any Benefits. If the Dependent fails to follow the rules of the HMO and voids his coverage, this Plan will have no liability.

Definitions

Other Plan means any policy, contract, or other arrangement to pay the cost of hospitalization, medical, surgical, Prescription drug, dental, or vision care. This includes:

1. group or blanket insurance including no-fault automobile insurance, but excluding school accident insurance;

2. any Blue Cross/Blue Shield and other prepayment coverage provided on a group basis;

3. coverage under any labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, and professional association plans;

4. coverage under governmental programs, and any coverage required or provided by any statute; and

5. Hospital and medical benefits under Social Security (Medicare), or any other arrangements of insured or self-insured group coverage.

Primary means that a plan pays out benefits before any Other Plan and generally to the full extent provided under the plan.

Secondary means that a plan pays benefits after the Primary plan has paid out its full benefits. The Secondary plan generally pays a reduced benefit.

Effect on Benefits

The effect on benefits is that the amount of Allowable Expense that would otherwise be payable under this Plan may be reduced if benefits are payable under any Other Plan for the same Expenses. Plan Participants who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Plan

Participant incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

Order of Benefit Determination

If a person is covered under this Plan and under one or more Other Plans, the rules set forth below apply. The plan that pays first does so without regard to coverage under Other Plans. The plan that pays secondary does so with regard to, or in coordination with the allowed amounts and inclusions of coverage in excess of the Primary Plan.

1. When the Other Plan does not contain a Coordination of Benefits provision, the Other Plan is considered Primary and will pay first, regardless of the other coverage. This Plan is considered Secondary and will then pay toward the remaining Allowable Expenses.

2. The benefits of Plans that cover the Individual as an Employee will pay its benefits before the plan that covers the person as a Dependent.

3. The Plans covering the Individual as a Dependent of a parent whose birthday (excluding year of birth) falls earlier in the Calendar Year pays before the Plans of the parent whose birthday (excluding year of birth) falls later in the Calendar Year. If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

4. In situations of divorce, separation and/or divorce and remarriage, benefits for a Dependent child shall be determined as follows:

    a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of Other Plans that cover the child as a Dependent of the parent with custody of the child shall be determined before the benefits of Other Plans that cover the child as a Dependent of the parent without custody;

    b. when the parents are divorced and the parent with custody of the child has remarried, the benefits of Other Plans that cover the child as Dependent of the parent with custody shall be determined before the benefits of Other Plans that cover the child as a Dependent of the step-parent, and the benefits of Other Plans that cover the child as a Dependent of the step-parent shall be determined before the benefits of Other Plans that cover the child as a Dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree or Qualified Medical Child Support Order which would otherwise establish financial responsibility for the Hospital, medical, surgical, or other health care Expenses with respect to the child, benefits under the Plans of the natural parent with such financial responsibility shall be determined before the benefits under the Plans of the other natural parent, and the benefits under the Plans of the other natural parent shall be determined before the benefits under the Plans of the spouse of the parent with court-decreed financial responsibility. If the Other Plan with which this Plan is

coordinating does not provide for the same procedures in the case of a Dependent child, the Plans which cover the Individual as a Dependent of a male participant shall be determined before the benefit of the Plans which cover such Individual as a Dependent of a female participant.

5. The benefits of Other Plans that cover an Individual who is neither laid-off nor retired are determined before the benefits of Plans that cover the Individual as a laid-off or retired Employee.

6. When rules in subsection (2) and (3) do not establish an order of benefit determination, the benefits of Plans that have covered the Individual on whose Expense the Claim is based for the longer period of time shall be determined before the benefits of Plans that have covered such Individual the shorter period of time.

Medicare and this Plan

Active Employees - Medicare Benefits Secondary
When an Employee becomes eligible for Medicare and if that Employee is Actively at Work, the Employee and his or her eligible Dependents will remain eligible for all the same benefits which are provided to all other Employees and Dependents of any age. However, if the Employee enrolls under Medicare Part A and/or Part B, the Medicare coverages will become Secondary to the benefits provided by this Plan. This Plan will always provide Primary coverage and Medicare will always be considered to be the Secondary as long as the Employee is Actively at Work, unless the Employee elects otherwise in accordance with this provision, or the Board of Trustees elect Medicare as Primary for Employees in accordance with this Provision.

Disabled Employees Under 65 - Medicare Benefits Secondary
If You are under 65, and eligible for Medicare by reason of disability, Medicare will provide Secondary coverage and the Plan will be Primary.

Active Employees - Election of Medicare as Primary
An Individual eligible for Medicare benefits may elect Medicare as Primary and thereby waive all coverage under the Plan for those benefits covered by Medicare. However, an Employee or Dependent will continue to receive Primary coverage under this Plan unless the Administrative Manager is notified in writing to the contrary.

Employees – Declining Plan Coverage
A Plan Participant that is an active Employee (ages 65 and over) may, at the option of such Employee, elect or decline coverage under this Plan at open enrollment or some other specified Special Enrollment Period. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is declined by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare. The Plan will at all times, when applicable, adhere to the requirements set forth in the Medicare Secondary Payer regulations**.**

Medicare Eligibility due to Kidney Disease
An Employee or Dependent becomes eligible for Medicare when afflicted by kidney failure, also

called end stage renal disease (ESRD) that is treated by dialysis or transplant. Medicare coverage begins the third month after the month Your course of maintenance dialysis treatments began. It will continue until 12 months after the month You no longer require dialysis or 36 months after the month of the kidney transplant.

Benefits provided by this Plan are:

1. The same benefits as those provided to Active Employees and Dependents for the first 30 months following the date dialysis began, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law;

2. Medicare becomes the Primary payer after the 30th month;

3. Medicare becomes the Secondary payer once the Employee or Dependent recovers from ESRD.

All Other Plan Participants Eligible for Medicare Benefits
To the extent required by Federal regulations, this Plan will pay Covered Expenses at the Reasonable and Allowable Amount before Medicare makes any secondary payment for benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Plan Participant will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Plan Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare allowable amount.

Section 6.02 – Identification Card
After You become initially eligible, You will be issued an Identification Card which should be kept in Your possession at all times so that when hospitalization is necessary, the card can be presented at the admissions desk.

PLEASE REPORT CHANGES PROMPTLY

It is important that you notify the Administrative Manager whenever:

1. You acquire a new Dependent;
2. You change Your home address; or
3. You change Your marital status.
4. You change Your last name.

Section 6.03 – How to File a Claim
In order to assure Yourself the fastest possible service, all Physician Claims should be reported to HealthSmart and all Facility Claims should be reported to HSTechnologies (HST), as soon as

possible. For care received by Participating Providers, those Participating Providers will file Your Claims for You. HST and/or HealthSmart will furnish You with the Claim forms necessary for filing a medical Claim and for dental and Accident and Sickness Claims.

Do not wait until You return to work before making a Claim for benefits - do it immediately. It is Your responsibility to provide the Administrative Manager with adequate information needed to process Your Claim.

Section 6.04 – Time Limit to File a Claim
Written Notice of Claim, including necessary information as requested by the Administrative Manager, must be given to the Administrative Manager within 12 months after a Claim is incurred. Failure to give written notice, including additional information as requested by the Administrative Manager, within the time specified above will result in the Claim being denied.

Section 6.05 – Claim Forms
The Administrative Manager, upon receipt of a notice of Claim, shall furnish to You such Claim forms as are necessary for use in filing proof of loss.

Section 6.06 – Physical Examination and Autopsy
The Plan, at its own expense, will have the right and opportunity, while a Claim is pending, to examine any participant whose Injury or Sickness is the basis of a Claim when and so often as it may reasonably require, and to make an autopsy in the case of death where it is not prohibited by law.

Section 6.07 – Assignment of Benefits
The term "Assignment of Benefits" shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment from the Plan for eligible Covered Expenses to a Provider, in strict accordance with the conditions and limitations of such rights provided under the terms of this Plan Document.

Conditions and Limitations of an Assignment of Benefits:

1. The validity of an Assignment of Benefits by a Plan Participant to a Provider is limited by the terms of this Plan Document. An Assignment of Benefits is considered valid on the condition that Provider accepts the payment received from the Plan as consideration, in full, for Covered Expenses for services, supplies and/or treatment rendered. This amount does not include any cost sharing amounts (i.e. Copayments, deductibles, or Coinsurance), or charges for non-covered services; the Provider may bill the Plan Participant directly for these amounts.

2. An Assignment of Benefits cannot be inferred, implied or transferred. An Assignment of Benefits must be made by the Plan Participant to the Provider directly through a valid, written instrument that is signed and dated by the Plan Participant.

3. Unless specifically prohibited by a Participant, a Provider with a valid Assignment of Benefits may exhaust, on behalf of the Plan Participant, any administrative remedies

available under the terms of the Plan Document, including initiating an internal or external appeal of an adverse benefit determination in accordance with the terms of the Plan Document. Notwithstanding the foregoing, the Plan Participant does not, under any circumstances, have the right to assign to any Provider (or their representative) through an Assignment of Benefits any right to initiate any cause of action against the Plan that the Plan Participant them self may be afforded under applicable law. This includes, but is not limited to, any right to bring suit as such is afforded to Plan Participants under the Employee Retirement Income Security Act ("ERISA") section 502(a). The assignment of any right to initiate suit against the Plan to a Provider is strictly prohibited.

4. An Assignment of Benefits does not grant the Provider any rights other than those specifically set forth herein.

5. The Administrative Manager may disregard an Assignment of Benefits at its discretion and continue to treat the Plan Participant as the sole recipient of the benefits available under the terms of the Plan.

6. An Assignment of Benefits by a Participant to a Provider will not constitute the appointment of an Authorized Representative.

By submitting a Claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the terms of the Plan Document. The Provider further agrees that the payments received constitute an 'accord and satisfaction' and consideration, in full, for the Covered Expenses for services, supplies and/or treatment rendered. The Provider agrees that the conditions and limitations of an Assignment of Benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider agrees to the specific condition that the patient not be balance billed for any amount beyond applicable cost sharing amounts (i.e. Copayments, deductibles, or Coinsurance), or charges for non-covered services; the Provider may bill the Plan Participant directly for these amounts.

If a Provider refuses to accept an Assignment of Benefits under the conditions and limitations as set forth herein, any Covered Expenses payable under the terms of the Plan Document will be payable directly to the Plan Participant, and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expense.

Section 6.08 – Facility of Payment of Benefits

If a participant is a minor or, in the opinion of the Trustees, not competent to give a valid receipt of any benefit due him, and if no request for payment has been received by the Plan from a duly appointed guardian or other legally appointed representative of the participant, the Plan may make direct payment to the participant or institution appearing to the Plan to have assumed the custody of or the principal support of the participant.

If a participant dies while benefits for Hospital, nursing, medical or surgical services remain unpaid, the Plan may make direct payment to the individual or institution on whose charges Claim

is based, or to any of the following surviving relatives of the participant: wife, husband, mother, father, child or children, brothers or sister, or to the participant's executors or administrators.

Any payment by the Plan in accordance with this provision will discharge the Plan from all further liability to the extent of the payment made.

Section 6.09 – Initial Claims Decisions and Claims Appeals Procedures

A Claim is a request for a Plan benefit made by a Claimant on a form provided by the Fund, or in the case of an urgent care Claim either orally or on such a form. A Claimant is a person who participates or Claims to participate in the Plan. For such a form to be considered, the Claimant must mail or deliver it, completed and executed, to the Administrative Manager at the following address:

United Food & Commercial Worker Local 1000 Oklahoma
Health & Welfare Plan
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, FL 33028

For an urgent care Claim to be considered, it must be communicated in writing as provided above, or by phone to UltraCare Fund Office using these phone numbers:

UltraCare - 1 (866) 363-2733

The Fund Administrator shall decide the Claim. None of the following constitutes a Claim:

1. The presentation of a Prescription to a pharmacy to be filled at a cost to the participant determined by reference to a formula or schedule established in accordance with the terms of the Plan and with respect to which the pharmacy exercises no discretion on behalf of the Plan.

2. A request for prior approval of a benefit or service when the prior approval is not required under the terms of the Plan.

3. Interactions between participants and PPO providers under arrangements by which the providers provide services or products at a predetermined cost to participants and with respect to which the providers exercise no discretion on behalf of the Plan.

Urgent Care Claims

A Claim involving urgent care is any Claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or,

2. in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Except as provided below, whether a Claim is a "Claim involving urgent care" is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any Claim that a Physician with knowledge of the Claimant's medical condition determines is a "Claim involving urgent care," shall be treated as a "Claim involving urgent care." The nature of a Claim or a request for review of an adverse benefit determination shall be judged as of the time the Claim or review is being processed. If requested services have already been provided between the time the Claim was denied and the request for review was filed, the Claim no longer involves urgent care. The Administrative Manager may request specific information from the Claimant regarding whether and what medical circumstances exist that may give rise to a need for expedited processing of the Claim. A post-service Claim never constitutes a Claim involving urgent care. In the case of a Claim involving urgent care, the Administrative Manager shall notify the Claimant of the Plan's benefit determination (whether adverse of not) as soon as possible, taking into account the medical requirements, but not later than 72 hours after receipt of the Claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent benefits are covered or payable under the Plan. In the case of such a failure, the Administrative Manager shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the Claim by the Plan, of the specific information necessary to complete the Claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Administrative Manager shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the Claimant to provide the specified additional information.

Pre-Service Claims

The term "pre-service Claim" means any Claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit in whole or in part, on approval of the benefit in advance of obtaining medical care. In the case of a pre-service Claim, the Administrative Manager shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to medical circumstances, but not later than 15 days after receipt of the Claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Administrative Manager both determines that such an extension is necessary due to matters beyond control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Failure to Follow Pre-Service Claim Procedures

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service Claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a Claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five days (24 hours in the case of a failure to file a Claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the

Claimant. This subsection shall apply only in the case of a failure that:

1. Is a communication by a Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

2. is a communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

Concurrent Care Decisions

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Plan of such course of treatment (other than by an Amendment of the Plan or its termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Administrative Manager shall notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination before the benefit is reduced or terminated. Moreover, any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim involving urgent care shall be decided as soon as possible, taking into account the medical circumstances, and the Administrative Manager shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in compliance with the provisions relating to the Notification of the Decision section, which follows, and the appeal shall be governed by the Notification of the Decision on Appeal sections, which follow, as appropriate.

Post-Service Claims

The term "post-service Claim" means any Claim for a benefit under the Plan that is not a pre-service Claim. In the case of a post-service Claim, the Administrative Manager shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the Claim. This period may be extended one time by the Plan for up to 15 days, provided that the Administrative Manager both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary, due to a failure of a Claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Notification for Disability Claims

In the case of a Claim for disability benefits, the Administrative Manager shall notify the Claimant of the Fund Administrator's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the Claim by the Administrative Manager. This period may be extended by the Administrative Manager for up to 30 days, provided that the Administrative Manager both determines that such an extension is necessary due to matters beyond the control

of the Administrative Manager, and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring an extension of time and the date by which the Fund Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Fund Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Administrative Manager notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund Administrator expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent the decision on the Claim, and the additional information needed to resolve those issues. The Claimant should be afforded at least 45 days within which to provide the specified information.

Calculating Time Periods for Claims.

The period of time within which a benefit determination is required to be made shall begin at the time a Claim is filed without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event a period of time is extended due to a Claimant's failure to submit information necessary to decide a Claim, the period for making the benefit determination shall be started from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

Notification of the Decision

The Administrative Manager shall provide a Claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by regulation issued by the Department of Labor under ERISA. The notification shall set forth in a manner calculated to be understood by the Claimant:

1. the specific reason or reasons for the adverse determination;

2. a reference to the specific Plan provisions on which the determination is based;

3. a description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary;

4. a description of the Plan's review procedure and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502 (a) of ERISA following an adverse benefit determination on appeal;

5. in the case of an adverse benefit determination,

    a. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to

the Claimant upon request; or

b. if the adverse benefit determination is based on a medical necessity or Experimental treatment of similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

6. in the case of an adverse benefit determination concerning a Claim involving urgent care, a description of the expedited review process applicable to such Claims. In the case of an adverse benefit determination concerning a Claim involving urgent care, the information in this subsection may be provided in accordance with this subsection is furnished to the Claimant not later than three days after the oral notification.

Authorized Representative

An authorized representative of the Claimant may act on his or her behalf in pursuing a benefit Claim or appeal of an adverse benefit determination. The Administrative Manager may require, as a prerequisite to dealing with a representative, that the Claimant verify in writing authority of the representative to act on behalf of the Claimant. In the case of a Claim involving urgent care, a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with State law, with knowledge of the Claimant's medical condition, may act as the authorized representative of the Claimant. An assignment of benefits by a Claimant to a health care provider does not constitute the designation of an authorized representative.

Consistency

The Trustees, the Administrative Manager, or both, shall conduct or have conducted on their behalf periodic reviews to verify that benefit Claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan's provisions have been applied consistently with respect to similarly-situated Claimants.

Deciding the Appeal

A Claimant may appeal an adverse benefit determination to the Trustees by mailing or delivering to the Administrative Manager a written notice of appeal. The Claimant may submit written comments, documents, records, or other information relating to the Claim for benefits to the Administrative Manager. The Administrative Manager shall provide to the Claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits. Whether a document, record or other information is relevant to a Claim for benefits shall be determined in accordance with standards issued by the Department of Labor. The Trustees shall decide the appeal. In cases where a Medically Necessary issue is decided by the Utilization Review provider, the provisions dealing with appeals shall be applied, to the extent that they are more stringent or extensive than the rules set forth, by substituting the phrase "Physicians" in place of the word "Trustees" wherever it appears. The Trustees' decision shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Trustees will not, however, consider a Claimant's appeal unless the Administrative Manager receives it within

180 days following receipt by the Claimant of a notification of an adverse benefit determination. The appeal will be considered by the Trustees without deference to the original decision made by the Administrative Manager. In deciding an appeal of any adverse benefit determination where the determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, investigational, or not Medically Necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Administrative Manager shall, when requested to do so by a Claimant, identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Any health care professional engaged for purposes of a consultation under this subsection shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Appeal of Urgent Care Claims

In the case of a Claim involving urgent care:

1. a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant; and

2. all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

Notification of the Decision on Appeal; Urgent Care Claims

In the case of a Claim involving urgent care, the Administrative Manager shall notify the Claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

Notification of the Decision on Appeal; Pre-Service Claims

In the case of a pre-service Claim that is not a Claim involving urgent care, the Administrative Manager shall notify the Claimant of the Plan's benefit determination review within a reasonable period of time appropriate to the medical circumstances. That notification shall be provided not later than 30 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

Notification of the Decision on Appeal; Post-Service Claims

In the case of a post-service Claim, The Trustees will decide a Claimant's appeal no later than the first meeting following the Administrative Manager's receipt of the appeal, unless the Administrative Manager received the appeal within 30 days prior to that meeting, in which case the Trustees will decide the Claimant's appeal no later than the second meeting following receipt of the request for review. If special circumstances require further extension of time for processing, the Trustees will decide the appeal no later than the third meeting following receipt by the Administrative Manager of the Claimant's request for review. If such an extension of time for

review is required because of special circumstances, the Administrative Manager shall notify the Claimant which the benefit determination will be made, prior to the commencement of the extension. The Administrative Manager shall notify the Claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

Content of the Notification of the Decision on Appeal

The Administrative Manager shall provide a Claimant with written or electronic notification of the Plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by the Department of Labor by regulations issued under ERISA. In the case of an adverse benefit determination, the notice shall set forth, in a manner calculated to be understood by the Claimant:

1. the specific reason for the adverse determination;

2. reference to the specific Plan provisions on which the benefit determination is based;

3. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim for benefits (whether a document, record, or other information is relevant to a Claim for benefit shall be determined by reference to regulations issued under ERISA by the Department of Labor;

4. a statement of the Claimant's right to bring an action under Section 502 (a) of ERISA;

5. if an internal rule, guideline, protocol or similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such rule, guideline, protocol or similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request; and

6. if the adverse benefit determination is based on a Medically Necessary determination or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

7. The following statement: "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U. S. Department of Labor Office and Your State insurance regulatory agency."

Calculating Time Periods on Appeal

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Claimant's failure to submit information necessary to decide a Claim, the period for making the benefit determination on review shall be started on the date on which notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

Extension of Time
A Claimant may voluntarily agree to provide the Plan additional time within which to make a decision on a Claim or an appeal.

Section 6.10 – Legal Action
Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable. Further, any legal action brought against the Plan must be brought in Federal Court, exclusively in the County and State of the Defendant. The Participant, or any Authorized Representative, submits to and accepts the exclusive jurisdiction of such courts for the purpose of such legal action. To the fullest extent permitted by law, Participant, and any Authorized Representative, irrevocably waive any objection which they may now or in the future have as to venue, as well as any Claim that any legal action or proceeding brought in such court has been brought in an inconvenient forum. Please refer to "Article XIII – Statement of ERISA Rights" for additional information.

Section 6.11 – Patient Physician Relationship
You and Your eligible Dependents will have free choice of any Physician, Dentist, chiropractor or nurse-midwives practicing within the scope of their license. The Plan will in no way disturb the patient-Physician relationship.

Section 6.12 – Altered or Forged Claim Forms
Any Claim form submitted by or on Your behalf that contains false or forged information, will be rejected by the Plan.

Section 6.13 – Right to Receive Information
If You file a Claim for benefits under this Plan, You may be required to furnish to the Plan such information as is necessary to process Your Claim.

Section 6.14 – Right to Recovery
Whenever payments have been made by the Plan in a total amount, in excess of the maximum allowed under the Plan, the Plan will have the right to offset such excess against future or other benefits payable, or to recover such payments, to the extent of such excess, from any persons to or for whom such payments were made, any insurance company or any other organization.

Section 6.15 – Savings Clause
Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Plan.

Section 6.16 – Construction
All questions of interpretation of the Plan provisions shall be decided exclusively by the Trustees in their sole discretion under the express authority granted to them by the Trust Agreement of the UFCW Local 1000 Oklahoma Health & Welfare Plan. The Trustees shall be the sole arbiter of

questions of eligibility and the amounts of benefits. This Fund is intended to comply with the terms and conditions of the Trust Agreement of the UFCW Local 1000 Oklahoma Health & Welfare Plan.

Section 6.17 – Notice No Fund Liability
The use of the services of any Hospital, clinic, doctor, Dentist, podiatrist, optician or any other person or establishment rendering health care or services whether specifically designated by the Fund or otherwise (hereinafter referred to as "provider") under the Plan is the VOLUNTARY ACT of the EMPLOYEE AND/OR HIS DEPENDENT. Some benefits may only be obtained from providers designated by the Plan. In such situations, the designation is not meant to be a recommendation or instruction to use such provider. An Employee and/or his Dependent should select a provider or course of treatment based on all appropriate factors, only one of which is coverage under the Plan. Said providers are independent contractors, not Employees of the Fund.

The Plan and Fund make no representation regarding the quality of service or treatment provided by any provider and ARE NOT RESPONSIBLE FOR ANY ACTS OF COMMISSION OR OMISSION OF ANY PROVIDER in connection with the services or treatments provided herein. THE PROVIDER IS SOLELY RESPONSIBLE for the services and treatments to be rendered under this Plan.

Section 6.18 – Worker's Compensation
Benefits under this Plan are not in lieu of nor do they affect any requirements for worker's compensation insurance.

Section 6.19 – HIPAA Privacy Rule

Plan's Designation of Person/Entity to Act on its Behalf
The Plan has determined that it is a "group health plan" within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan sponsor, the Board of Trustees, to take all actions required to be taken by the Plan in connection with the Privacy Rule *(e.g.,* entering into Business Associate contracts; accepting certification from the Plan Sponsor). Such responsibility may be delegated by the Board to the Administrative Manager.

The Plan has adopted policies and practices to comply with the privacy and security rules of HIPAA. A copy of the policy can be obtained free of charge from the Plan Administrative Manager.

Section 6.20 – HIPAA Security Rule
The Welfare Fund (as defined in Section 7.19 subsection 5.) shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan, consistent with the requirements of the Standards for the Security of Electronic protected Health Information as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C (the "Security Standards"). For this purpose, the Welfare Fund shall be deemed a hybrid entity under the Security Standards and the provisions of this Article shall be administered and interpreted to apply only to that portion of the Welfare Fund that constitutes a Covered Entity under the Security Standards.

Section 6.21 – Qualified Medical Child Support Order

All Claims for benefits under a Medical Child Support Order shall be submitted, in writing to the Board of Trustees along with a copy of the Medical Child Support Order.

1. **Medical Child Support Order** means any judgment, decree or order issued by a Court of competent jurisdiction which provides for child support with respect to a child of a Covered Employee under the Plan or provides for coverage to such child pursuant to state domestic relations law, or enforces a law relating to medical child support described in Section 1908 of the Social Security Act.

2. **Alternate Recipient** means any child of a Covered Employee who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan with respect to such Covered Employee.

3. Notice of Receipt of Claim

a. Within 30 days of receipt of a Medical Child Support Order, the Board of Trustees shall notify the Covered Employee, the alternate recipient and their representatives of receipt of the Medical Child Support Order.

b. At the same time, the Board of Trustees shall notify the Covered Employee, the alternate recipient and their representatives of the procedures for determining whether the Order is a "qualified" Medical Child Support Order by providing a written copy of these procedures.

c. Notice to the alternate recipient shall be given at the address as shown in the Order.

4. Designation of Representative

The Covered Employee and the alternate recipient may designate an attorney or other representative to receive notice and communication from the Fund instead of the Covered Employee or alternate recipient. This designation must be in writing and signed by the Covered Employee or the alternate recipient.

5. Payment of Benefits Pending Trustees' Decision

Pending a decision by the Board of Trustees as to whether a Medical Child Support Order is "qualified", any amount which would be payable for benefits on behalf of such alternate recipient may be withheld.

6. "Qualified" Medical Child Support Order

a. Review by Legal Counsel
All Medical Child Support Orders shall be immediately submitted to legal counsel for the Fund. A legal opinion as to whether the Order is a "qualified" Medical Child Support Order within the meaning of ERISA shall be provided the Board of

Trustees within 60 days, if possible.

b. Trustees Decision
The Board of Trustees shall decide whether an Order is a "qualified" Medical Child Support no later than 120 days after receipt of the Order, unless circumstances require more time. If the Trustees decide that a Medical Child Support Order is not "qualified" the notice of denial of the Claim shall be provided in the same manner as other Claims are denied by the Trustees.

c. Appeal of the Trustees' Decision
A party may file an appeal of the Trustees' decision by filing a notice of appeal within 60 days after receipt of the Trustees' decision. The appeal shall be governed by the Claims Review Procedure.

d. Notices
The Board of Trustees shall notify the Covered Employee, the alternate recipient or their designated representative of all Trustees' decisions.

The procedures followed by the Plan in processing a QMCSO are available from the Fund Office at no charge upon request.

7. Trustee Responsibility

If the Trustees act in accordance with the provisions of these procedures and ERISA in treating a Medical Child Support Order as being (or not being) a QMCSO, the Plan's obligation to the Covered Employee and each alternate recipient shall be discharged to the extent of any payment made pursuant to such act of the Trustees.

8. Reimbursements to Alternate Recipient

Any payment for benefits made pursuant to a QMCSO in reimbursement for Expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient's custodial parent or legal guardian.

Section 6.22 - Balance Billing and Patient Advocacy Center

It is the Plan's position that the Provider should not balance bill the Claimant for amounts in excess of the Reasonable and Allowable Amount. It is the Plan's position that these Excess Charges are clearly excessive and exorbitant. However, balance billing for such amounts can occur for out of network Claims and the Plan has no control over the actions of the Providers or their desire to pursue you for such amounts.

In the event you receive a balance-bill for an amount in excess of the Reasonable and Allowable Amount payable, please immediately email pac@hstechnology.com or call the Patient Advocacy Center toll free at (888) 837-2237.

Please Note: The Patient Advocacy Center provides assistance to Employees and Dependents with the understanding that (i) the Patient Advocacy Center is not acting in a fiduciary capacity under

this Plan, (ii) that Employees and Dependents must make their own independent decision with respect to any course of action in connection with any balance-bill, including whether such course of action is appropriate or proper based on the Claimant's specific circumstances and objectives, and (iii) the Patient Advocacy Center does not provide legal or tax advice.

ARTICLE VII – SUBROGATION AND RESTITUTION

The Plan has no obligation to pay benefits if a third party may be financially responsible for any damages, including medical Expenses, arising from an accident, Injury or Sickness. If a third party is withholding payment of Your Claim pending investigation or legal action, You may request that the Plan pay the standard benefits to which You would be entitled if no third party liability existed.

In exchange for the Plan's payment of Your benefits, You agree to assign the Plan all Your rights against any third party arising out of the Injury. You "subrogate" all such rights to the Plan, meaning that the Plan has the legal right to take Your place to recover any amounts from the third party for the Injury. You authorize the Plan or its designees to act as Your attorney-in-fact, with the right to institute or intervene in lawsuits, assert, demand, collect, receive, compromise and give releases for the amount of its Claim.

In addition, You agree to provide the Plan with all information and documents it requests, and to otherwise assist the Plan in recovering all amounts it paid that are subject to this Agreement. You also agree to execute and deliver all instruments or documents requested by the Plan, and to cooperate fully with any and all other requests made by the Plan in connection with the Injury.

You may not settle the Claim or give a release to any party without the Plan's consent. You also may not to assign or otherwise transfer Your right to collect from the third party to any other party without the written consent of the Plan. You may not do anything that would otherwise prejudice the Plan's rights to subrogation and restitution.

The Plan also has a first priority lien on any recovery from the third party for the Injury. You or Your representative hold the proceeds of any recovery in trust for the exclusive benefit of the Plan. The value of the lien and the extent of the trust are equivalent to the amount of benefits the Plan paid on Your behalf, plus any reasonable costs or attorney's fees incurred by the Plan in enforcing this provision. Pursuant to this lien and trust, You agree to pay the Plan the amount of benefits it paid on Your behalf from the proceeds of any settlement, judgment or award against the third party arising out of the Injury.

The Plan may notify any third party of the subrogation/restitution right at any time, and You authorize all such third parties to pay the Plan directly from the proceeds of any recovery on Your Claim. You may not authorize any third party to pay proceeds to any individual or entity other than You, Your legal representative (if any) or the Plan. You may not release any proceeds from Your Claim to any individual or entity before repaying the Plan the amount of benefits it paid on Your behalf.

If You recover any damages from an Uninsured/Underinsured Motorist Policy or Your own homeowner's insurance policy, the proceeds of that policy are subject to the same lien and trust as any proceeds You recovered from the third party. The first priority lien applies to the proceeds from such policy, and You also hold these proceeds in trust for the exclusive benefit of the Plan.

Any recovery will be presumed to be recovery for medical Expenses, regardless of allocation or designation.

Pursuant to the above lien and trust, Your obligation to repay the Plan for any benefits You received takes first priority over Your other Claims against the third party. This priority applies regardless of whether the recovery from the third party fully compensates You for all Claims or whether You have been "made whole." The "make whole" doctrine does not apply to this provision and is specifically disclaimed. Your obligation to repay the Plan from any recovery also takes first priority over any deduction from the recovery for attorney's fees or costs of litigation unless otherwise agreed by the Plan in writing.

The Plan has no obligation to pay or reimburse You, Your legal representative or any other party for any costs or attorney's fees arising out Your Claim for personal Injury or tort. You agree to repay the Plan for any attorney's fees and costs it incurred pursuing any litigation or administrative action to enforce the terms of this provision.

In the event You fail to fully cooperate with the Plan in accordance with this provision, the Plan may cease paying benefits on Your behalf until all benefits related to the Injury are recouped, and all amounts previously paid by the Plan will immediately become due and payable to the Plan. A violation of this provision constitutes a violation of the Plan, and the Plan has the right to seek equitable relief to enjoin such violation.

ARTICLE VIII - COBRA CONTINUATION OF MEDICAL COVERAGE

(Not applicable to Life and AD&D and Accident and Sickness Benefits)

Federal law mandates that group plans provide individuals with the option of continuing their medical coverage through self-payment of contributions when their coverage terminates under a plan.

The provisions relative to the COBRA continuation of medical coverage are discussed below. It is important that all family members be aware of these provisions in the event that coverage terminates.

Section 8.01 – Qualifying Event

You and Your Dependent(s) (including a child born or placed for adoption within the period of COBRA continuation coverage if reported to the Administrative Manager within 30 days of the birth or the placement for adoption) have the right to continuation coverage if Your regular coverage terminates for certain reasons, **provided the Employee or Dependents make the required self-payment of contributions.** Continuation coverage is available in the event coverage terminates due to:

1. Termination of the Employee's employment for any reason, except gross misconduct;

2. a reduction in hours worked by the Employee;

3. death of a Covered Employee;

4. divorce or legal separation of the Employee and spouse;

5. a Dependent child ceasing to be an Eligible Dependent, under the provisions of the Plan; or

6. a Dependent ceasing to be eligible due to the Employee becoming entitled to Medicare.

7. a proceeding in bankruptcy under Title 11 of the United States Code with respect to a Contributing Employer from whose employment a Covered Employee retired at any time.

Section 8.02 – COBRA Notice Requirements

1. Notice from Contributing Employers

Your Employer must notify the Administrative Manager in writing within 30 days after the date of the following Qualifying Events:

a. reduction of hours and/or termination of Your employment;
b. Your death;
c. Your eligibility for Medicare, when known; and
d. bankruptcy proceeding under Title 11, United States Code.

This requirement may be met by timely filing a notification in a form prescribed by the Plan with the Administrative Manager.

2. Notice from You and Your Dependents

You or Your Dependent, as applicable, must notify the Administrative Manager in writing no later than 60 days after the following Qualifying Events:

a. divorce or legal separation from Your spouse; or
b. Your child ceasing to be a Dependent;
c. determination by Social Security that the person is disabled;
d. within 30 days of the date that the covered person is determined by Social Security to no longer be disabled.

3. Financial Responsibility for Failure to Give Notice

If an Individual fails to give proper notice within 60 days of the date of the qualifying event or date coverage terminates, whichever is later and, as a result, the Fund pays a Claim for an Individual whose coverage terminated due to a qualifying event, and who does not elect continuation of coverage under this provision, then the Individual shall be obligated to reimburse the Fund for any Claims that should not have been paid. If an Individual fails to reimburse the Fund, then all amounts due may be deducted from other benefits payable on behalf of that Individual.

Section 8.03 – Qualified Beneficiary

A qualified beneficiary is any individual who on the day before a qualifying event, is covered under the Plan or any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage. If a child is born to or placed for adoption with the Employee during the continuation period, the child is considered a qualified beneficiary only when the initial qualifying event is termination or reduction is hours of the Covered Employee's employment.

Section 8.04 – Election Requirements

You must elect to make self-payment contributions within the later of 60 days after Your eligibility terminates or within 60 days from the date You are notified by the Administrative Manager of Your right to maintain Your eligibility through self-payment. You must sign a written election form approved by the Board of Trustees. **If an election is not made and postmarked within the time periods stated in the notice, You cannot continue coverage under this Plan.**

Section 8.05 – Maximum Period Allowed Under Continuation Coverage

Up to a maximum of 18 months are allowed from the date coverage would have otherwise terminated, if coverage is being continued for You and Your Dependents because You ceased covered employment, including retirement, or had a reduction in hours of employment for any reason other than gross misconduct.

Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Continuation coverage of an additional 11 months is available for qualified beneficiaries with a

Total Disability, and their family, if the Total Disability occurs prior to, or within the first 60 days of COBRA continuation coverage. **A Total Disability means that You are eligible for Social Security Disability benefits. The COBRA contribution will be 150% of the then current normal contribution for coverage after the 18th month**. However, qualified beneficiaries may lose all rights to the additional 11 months coverage if notice of the determination is not provided within 60 days of the date of the determination and before the expiration of the 18-month COBRA continuation period.

If the Social Security Administration later determines that an individual is no longer disabled, that individual must notify the Contributing Employer within 30 days after the date of that second determination. The individual and other qualified beneficiaries' right to the 11-month extension of continuation coverage will terminate as of the first day of the month that begins more than 30 days after the second determination is issued. However, if another qualifying event occurs giving rise to 36 months of continuation coverage during the 11-month disability extension, the qualified beneficiaries receive the full 36 months of coverage beginning from the initial date of continuation coverage. This extension cannot be shortened if disability ceases.

Section 8.06 – Multiple Qualifying Events

If continuation coverage is elected following the Employee's termination of employment or reduction in work hours, and then another qualifying event occurs during that **COBRA** continuation period, covered Dependents (including Dependents born or adopted within the original 18-month continuation period) may continue their coverage for up to 36 months, rather than only18 months. Such 36-month period will be measured from the date of the termination of employment or reduction in work hours, rather than from the date of the second event. Only an event giving rise to a 36-month maximum coverage period can be considered a second qualifying event. Therefore, termination of employment that follows a reduction in hours of employment is not considered a multiple qualifying event.

Section 8.07 – Self-Payment

Self-payment, if elected, must be made from the date of termination. **No lapse in coverage is permitted.**

1. If You elect to continue coverage within 60 days after Your eligibility terminates, contributions due for the period between termination and the election date must be postmarked and sent to the Administrative Manager within 45 days after the election.

2. After the initial election and payment of contributions, subsequent payments are due at the Administrative Manager's Office on the first day of each month. There shall be a 30-day grace period following the due date. This grace period does not apply to the first payment but only to the monthly payments thereafter. Once You are initially notified, You will not receive any further notices from the Plan or the Administrative Manager.

3. If an Employee, former Employee, or covered Dependent makes payment for COBRA coverage of an amount that is less than the amount due for that month's contribution due but greater than 90% of the amount of the contribution due, the Plan will notify the individual of the deficiency. To maintain coverage the individual must pay that deficiency within 30 days of the date the Plan notifies the individual of it.

4. The contribution rate for continuation coverage will be determined according to the applicable laws and may be adjusted as permitted.

5. If benefits provided to active Employees and/or their Dependent change, Your continuation coverage will also change.

6. You will be notified of any change in contribution rates that You are required to pay.

Section 8.08 – Termination of COBRA Coverage (All Individuals)
COBRA continuation coverage will terminate on the earliest of the:

1. first day of the month for which contribution is not paid on time; or,

2. date You or the qualified beneficiary becomes covered under another employer sponsored group health plan that does not exclude or limit coverage for Pre-existing Conditions, or whose preexisting condition limitation or exclusion does not apply to You or the qualified beneficiary; or,

3. date You become entitled to Medicare benefits; or,

4. date the Contributing Employer ceases to provide group health coverage to any Employee; or

5. date the employer is no longer a Contributing Employer and does not have a Collective Bargaining Agreement requiring contribution to the Fund.

If You do not elect and pay contributions for COBRA continuation coverage on a timely basis, You will no longer be covered under the Plan, and any Claims filed during the election period or following termination for non-payment of contributions will not be paid by the Plan. **Reinstatement of coverage under COBRA is not permitted.**

Full details of COBRA continuation coverage will be furnished to You when the Administrative Manager receives notice that one of the qualifying events described above has occurred. Therefore, we urge You to contact the Administrative Manager as soon as possible after the occurrence of one those events.

Section 8.09 – Benefits Provided
The medical benefits provided to any Individual electing continuation coverage shall be the same benefits that he or she was eligible to receive on the date before the occurrence of any qualifying event. Any Amendment to the Plan of Benefits adopted by the Board of Trustees applicable to active Employees modifying coverage shall also apply to any person eligible for benefits under continuation coverage. However, Life, Accidental Death and Dismemberment, and Accident and Sickness Benefits shall not be available.

ARTICLE IX - CONTINUATION AND REINSTATEMENT OF COVERAGE ON ACCOUNT OF QUALIFIED UNIFORMED SERVICE

This Plan is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Accordingly:

1. Any eligible Employee who is absent from the employment on account of a period of Service in the Uniformed Services, may continue coverage, including Dependent coverage, on a self-pay basis for the 18-month period beginning on the date on which You are first absent from employment by reason of Qualified Uniformed Service.

2. If an eligible Employee on a period of USERRA leave does not continue his participation (and that of his eligible Dependents) in this Plan, he will become entitled to benefits on the first day of his reemployment with a Contributing Employer, provided he applied for such reemployment within 90 days after his discharge from military service. He will be placed in the same class as that in which he was classified at the time of entering military service.

3. Service in the Uniformed Services" means the performance of duties on a voluntary or involuntary basis in a Uniformed Service that includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period which a Covered Employee is absent for examination used to determine fitness for duty.

4. "Uniformed Services" shall include the Armed Forces, the Army National Guard, the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in time of war or Emergency.

ARTICLE X – NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

This Plan is subject to the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). Accordingly, benefits for a Hospital stay in connection with childbirth (for the mother and the newborn) may not be restricted below certain minimums provided by the NMHPA. Specifically, in cases of a vaginal delivery, the mother and newborn child may have a Hospital stay of at least 48 hours; and in case of a caesarian delivery, the mother and newborn may have a Hospital stay of at least 96 hours. If, however, the mother, attending Physician, and the Hospital all agree a shorter length of stay is sufficient, the mother and newborn child may leave the Hospital prior to the standard 48 hours or 96 hours prescribed by the NMPHA. Additionally, no provider shall be required to obtain prior authorization for prescribing a maternity Hospital stay unless it exceeds the 48 or 96 hours required by NMHPA.

ARTICLE XI – WOMAN'S HEALTH and CANCER RIGHTS ACT OF 1998

In compliance with the Women's Health and Cancer Rights Act of 1998, this Plan provides medical and surgical benefits in connection with a mastectomy for certain reconstructive surgery. If, while covered under this Plan, a participant or beneficiary undergoes a mastectomy and elects breast reconstruction, coverage in a manner determined in consultation with the attending Physician and patient will be provided for:

1. Reconstruction of the breast on which the mastectomy was performed;

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

3. prosthesis; and

4. treatment of physical complications at all states of the mastectomy, including lymphedema.

The coverage provided by the Plan is subject to the Plan's annual deductibles, Coinsurance provisions and annual maximums.

ARTICLE XII – IMPORTANT PLAN INFORMATION

Section 12.01 – Fund Name
UFCW Local 1000 Oklahoma Health & Welfare Plan

Section 12.02 – Board of Trustees
A Board of Trustees is responsible for the administration of this Health and Welfare Fund. The Board of Trustees consists of an equal number of Union and Employer representatives, selected by the Union and the Employers who have entered into a collective bargaining agreement which relates to the Health and Welfare Fund. The Trustees are the Fund Administrators.

The Board of Trustees shall have the absolute and sole discretionary authority to construe and interpret the provisions of the Plan, Plan Documents, Summary Plan Description, as well as any communications related to the Plan. The Board of Trustees will make all factual determinations, including determining the rights or eligibility of Employees or participants, Dependents and any other persons and the amounts of their benefits under the Plan. The Board of Trustees will remedy ambiguities, inconsistencies or omissions and such determinations shall be binding on all parties. Benefits will only be paid if the Board of Trustees, in its sole discretion, determines that the participant or beneficiary is entitled to them. The Board of Trustees has the authority to delegate any of its powers under the Plan (including, without limitation, its power to administer Claims and appeals) to any other person or committee. Such person or committee may further delegate its powers to another person or committee. Any delegation or subsequent delegation shall include the same sole, discretionary and final authority that the Board of Trustees has, as described in this paragraph and any decisions, actions or interpretations made by any delegate shall have the same ultimate binding effect as if made by the Board of Trustees. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or the Trust Agreement.

The current Trustees of the Fund are listed on page 6.

Section 12.03 – Fund Administrative Manager
The Trustees have hired a contract Administrative Manager to handle the day to day administration of the Plan. The contract Administrative Manager is National Employee Benefits Administrators, Inc. You may contact the Administrative Manager at:

National Employee Benefits Administrators, Inc.
2010 N. W. 150th Avenue, Suite 100
Pembroke Pines, FL 33028
(866) 363-2733

Section 12.04 – Sponsors
You may write to the Administrative Manager at the address in Section 13.03 to find out if a particular Employer is a sponsor of this Plan, and if so, to find out that Plan sponsor's address.

Section 12.05 – Identification Number
The Fund's identification number is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 02-0642001.

Section 12.06 – Fund's Fiscal Year End
The date of the end of the Fund year is December 31.

Section 12.07 – Source of Contributions
The amount of contributions from a Contributing Employer is determined by the provisions of its collective bargaining agreement with Employee representatives. Employee payroll deductions are also a source of contributions. You may review the Agreements at the Local Union Office or you may request a copy by writing to the Fund Office.

Section 12.08 – Agent for Service of Legal Process
The Fund's agent for service of legal process is:

Deborah Godwin
Godwin, Morris, Laurenzi, Bloomfield P.C.
50 N. Front Street, Suite 800
Memphis, TN 38103

Service of legal process may also be made upon a Trustee.

Section 12.09 – Funding Medium
Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and Trust Agreement, and are held in a Trust Fund for the purpose of providing benefits to covered persons and defraying reasonable administrative expenses. Your Employer is not responsible for any funding amounts above those which are required under the provisions of the Collective Bargaining Agreement with UFCW Local 1000.

Section 12.10 – Fund Assets
All assets and reserves are invested by the Board of Trustees.

Section 12.11 – Fund Termination
The right to terminate the Plan is reserved to the Board of Trustees and to the Contributing Employers and Union who are signatory to the Fund's Trust Agreement. Circumstances under which the Fund may be terminated include, but are not limited to:

1. in the event the Trust shall, in the opinion of the Trustees, be inadequate to carry out the intent and purpose of this Agreement, or be inadequate to meet the payments due or to become due under this Trust Agreement and under the Plan to participants and their Dependents already drawing benefits;

2. in the event there are no individuals living who can qualify as Employees hereunder;

3. in the event of termination by action of the Trustees; or

4. in the event of termination as may be otherwise provided by law;

5. upon a sale of the employer, unless any successor employer shall expressly agree to assume and continue the Plan; or

6. upon a termination of the Plan.

Section 12.12 – Filing Claims
Refer to Section 7.03 entitled "How to File a Claim" for information on filing Claims.

Section 12.13 – Appeal of Denied Claims
Refer to Section 7.08 entitled "Initial Claims Decisions and Claims Appeals Procedures" for information on appealing denied Claims.

Section 12.14 – Type of Plan
This Plan is maintained for the purpose of providing death benefits, accidental death and dismemberment benefits, weekly loss of time income, medical benefits, Prescription benefits, dental benefits and vision benefits. A detailed written description of the Plan benefits appears in this Booklet.

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Manager. You may also contact the Employee Benefits Security Administration, US Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section 12.15 – Plan and Fiscal Year
The fiscal records of the Plan are kept on a Calendar Year basis.

ARTICLE XIII – STATEMENT OF ERISA RIGHTS

As a participant in the UFCW Local 1000 Oklahoma Health & Welfare Plan, You are entitled to certain rights and protection under ERISA which provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Administrative Manager's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each participant with a copy of the summary annual report.

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish Eligibility Rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior Claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability.

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is

treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Pre-certification. For information on Pre-certification, contact your Administrative Manager.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and Copayments.

Continue Group Health Plan Coverage

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 summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to

know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrative Manager to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Manager. If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Administrative Manager. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Manager, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue 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 at (866) 444-3272.

IF YOU HAVE ANY QUESTIONS OR NEED INFORMATION CONCERNING YOUR BENEFITS CALL:

(866) 363-2733

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