UFCW

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Local 1262

and

Employers Health and Welfare Fund

Summary Plan Description and Plan Document for

Part-time Employees and Service Clerks Life Insurance, AD&D, Annual Physical, Vision, Legal Services and Dental Benefits

Effective January 2022

* * * **IMPORTANT** * * *

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

This SPD, which also serves as the Plan document, contains a summary in English of your rights and benefits under the UFCW Local 1262 and Employers Health and Welfare Plan of benefits (Plan) relating to your life, accidental death and dismemberment, Service Clerk Annual Physical, vision, legal services and dental benefits.

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

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

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

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INTRODUCTION

This SPD describes the life insurance, accidental death and dismemberment, Service Clerk Annual Physical, vision, legal services and dental benefits provided by the UFCW Local 1262 and Employers Health and Welfare Fund (Fund) to Part-time Employees and Service Clerks. Benefits provided to other groups of employees, and medical and prescription drug benefits, are contained in separate SPDs.

The SPD is made up of two sections.

- The first section of this SPD (pages 1 through 33) includes information about eligibility, enrollment, when coverage starts, when coverage ends, and the administrative provisions for the Plan. It also includes information required by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

- The second section of this SPD (pages 34 through 64) provides a description of the Plan's benefits and any exclusions and limitations that may apply. It describes the coverage that is in place for you and your enrolled Dependent Children.

The information in this SPD makes up the Plan Document and SPD for your Plan benefits in effect as of January 1, 2021. This SPD replaces any previous SPD, Plan Document, or summaries of material modifications (SMMs) describing these benefits.

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

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

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

Have a Question?

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

WHO IS ELIGIBLE

Employee Eligibility Requirements

The benefits you are eligible for depends on how long you have worked in Qualifying Service. Please see the table for "Coverage For Employees" under "When Coverage Begins."

Employees classified as Part-time Porters are not eligible for legal services benefits.

Employees classified as Service Clerks are eligible only for vision benefits, the Service Clerk Annual Physical Benefit, and dental benefits.

Dependent Child(ren) Eligibility Requirements

Part-time Employees who work on average 30 hours or more per week in Qualifying Service during an initial Measurement Period or an Ongoing Measurement Period as described below are eligible for Dependent Child coverage for vision and dental benefits if they have enrolled them for medical and prescription drug coverage and pay the required contribution for Dependent Child coverage in the amount established by the Trustees.

Eligible Dependent Children include:

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

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

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

If you are eligible for Dependent Child coverage, and you are required by a Qualified Medical Child Support Order (QMCSO) to cover your Dependent Children, you will be allowed to enroll your Dependent Children in the Plan. Please review the "Qualified Medical Child Support Orders" section on page 31 for more information.

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

WHEN COVERAGE BEGINS

Coverage For Employees

Coverage for the following benefits for employees hired on or after April 17, 2005, begins on the first day of the month following a period of Qualified Service according to the following table:

	Coverage Begins 1st of the Month After:	
Type of Benefit	**Morton Williams Tier B Employees**	**All Other Employees**
Life insurance and accidental death and dismemberment benefits	12 months of Service	6 months of Service
Service Clerk Annual Physical Benefit	12 months of Service	12 months of Service
Vision benefits	12 months of Service	12 months of Service
Legal benefits	12 months of Service	18 months of Service
Dental benefits	12 months of Service	24 months of Service

For information on when benefits began for employees hired prior to April 17, 2005, please contact the Fund Office.

Coverage for Dependent Children

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

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

<u>Imputed Hours</u>

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

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

Enrollment and Employee Contribution Requirements

If the eligibility requirements listed above are met, you **must** enroll your Dependent Children for medical, prescription drug, vision and dental coverage in the Plan each year during "open enrollment." Your enrollment materials will provide more information on all your enrollment options, including the deadlines for completing enrollment. If enrollment is not completed prior to the deadline, coverage for your Dependent Children will be waived for the remainder of the Calendar Year. For more information on Dependent Children coverage, contact the Fund Office.

Moving Between UFCW Local 1262–Represented Employers

If your employment ends with one contributing employer and you begin working within 30 days for an employer who contributes to another health fund that is affiliated with UFCW Local 1262, your coverage from that second health fund for the benefits described in this SPD will become effective on the later of the first day of the month following your new date of hire or when your combined service with the two employers meets the service requirements described in the table on page 6.

To maintain continuous vision and dental coverage during periods when moving between contributing employers or different health plans that will cause you to lose coverage, you should consider purchasing COBRA continuation coverage. See page 22 for more information on purchasing continuation coverage through COBRA for vision and dental benefits.

HOW TO ENROLL

Part-time Employees are automatically enrolled in coverage for the life insurance, accidental death and dismemberment, Service Clerk Annual Physical, vision, legal services and dental benefits they are eligible for.

Part-time Employees must enroll their Dependent Children during the annual enrollment period described above and will be provided with the necessary enrollment materials upon request to the Fund Office. If you do not enroll your Dependent Children during the annual enrollment period, you may enroll later in accordance with the special enrollment rights described in the medical and prescription drug coverage booklet. For more information on special enrollment rights, contract the Fund Office.

Part-time Employees may waive dental and vision coverage they are automatically enrolled in for themselves by completing a General Waiver Form. Please contact the Fund Office for more information. Once waived, the coverage cannot be reinstated.

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

Dependent Child Verification

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

You should send all enrollment documents:

By fax to: (973) 778-1725

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

If Two or More Family Members Are Eligible for Coverage

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

If Family Members Are Eligible Under Different UFCW Local 1262 Funds

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

COST FOR COVERAGE

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

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

CLAIMS AND APPEALS PROCEDURES

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

Overpayment of Benefits

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

No Assignment of Benefits

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

Claims for Benefits

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

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

The following are not considered claims for benefits:

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

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

How to File Claims

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

Life Insurance and Accidental Death and Dismemberment Claims

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

Vision Claims

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

Legal Services Claims

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

Dental Claims

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

Claim Forms

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

- Member name
- Patient name
- Patient date of birth
- Social Security number of Employee
- Date of Service
- Billed charge(s)

- Federal taxpayer identification number (TIN) of the Provider
- Billing name and address of the Provider
- Any other information reasonably requested to determine eligibility and coverage for the treatment

Authorized Representatives

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

Please contact the Fund Office for an authorized representative form.

Reviewing Claims

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

Claims Denial Notification

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

- information sufficient to identify the claim, including the date of service, the health care Provider, the claim amount (if applicable), and a statement describing the availability, upon written request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- the specific reason(s) for the denial, including any denial code and its corresponding meaning;
- a reference to the specific Plan provision(s) on which the denial is based, including a description of the Plan's standard, if any, that was used in denying the claim;
- an explanation of whether an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, and a statement that you may obtain free of charge a copy of such rule, guideline, protocol or similar practice or procedure upon request;

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

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

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

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

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

Appealing a Denied Claim

First-Level Appeal

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

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

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

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

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

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

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

Second-Level Appeal for Dental Claims Only

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

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

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

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

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

- review your claim file.

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

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

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

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

Notification of Decision on Appeal

In the case of an appeal of a claim that was denied for eligibility or coverage reasons, the Trustees will hear your appeal at the quarterly Appeals Committee meeting that is at least 30 days after your appeal is received by the Trustees. If the appeal is received less than 30 days from the quarterly Appeals Committee meeting, the appeal will be heard at the next following quarterly Appeals Committee meeting. If special circumstances require an extension of the time for review by the Appeals Committee, you will be notified in writing of the circumstances requiring the extension and the date on which a decision is expected. In

no event will a decision be made later than the third quarterly Appeals Committee meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within five days of the date on which the decision is made. The Appeals Committee consists of the entire Board of Trustees.

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

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

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

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

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

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

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

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

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

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

Exhaustion and Statute of Limitations

You must use and exhaust the Plan's administrative claims and appeals procedure before bringing a suit in New Jersey federal court. Similarly, if you do not follow the Plan's claims procedures in a timely manner, you will lose your right to bring a lawsuit regarding an adverse benefit determination. You do not have the right to assign your claim to any other party; however, as a convenience to you, a Provider, as your

authorized representative, may submit for benefits on your behalf. If the Provider, as your authorized representative, seeks benefits on your behalf, he or she is only entitled to what you would be entitled to under the Plan and shall not have any rights greater than yours.

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

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

- the date your first benefit payment was made or due;
- the date your request for a Plan benefit was first denied; or
- the earliest date you knew or should have known the material facts on which your lawsuit is based (collectively, the "24-month Claims Period").

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

OTHER BENEFIT SOURCES AND COORDINATION OF BENEFITS

Subrogation and Third-Party Reimbursement

General Principle

There is no coverage for claims incurred, including medical, prescription drug, and dental care claims, due to injuries that give rise to a claim by you or your enrolled Dependent Children against a third-party tortfeasor, or against any person or entity as the result of the actions of a third party. In such cases, benefits otherwise payable under the Plan will be provided to or on behalf of you or your Dependent Children only on the following terms and conditions.

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

Specific Requirements and Plan Rights

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

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

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

If you or any of your Dependent Children do not cooperate in attempting to obtain recovery from the responsible third party, or if the Fund should become aware that you or your Dependent Child has received a third-party payment or recovery and not reported such amount, the Fund, in its sole discretion, may suspend all further benefits payments related to you or any of your Dependent Children until the reimbursable portion, plus interest (calculated pursuant to the Fund's policy for the collection of

overpayments), is returned to the Fund or offset against amounts that would otherwise be paid to or on behalf of you or your Dependent Children. The Plan also has the right to commence a lawsuit against you and/or your Dependent Children to recover any amounts owed under its right of subrogation and reimbursement.

Covered Person Duties and Actions

By participating in the Fund, you and your Dependent Children consent and agree that a constructive trust, a lien or an equitable lien by agreement in favor of the Fund exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your Dependent Children agree to cooperate with the Fund in exercising its rights of subrogation and reimbursement. Any amount received by you or your Dependent Child, or your representatives (including your or your Dependent Child's attorneys) that is due to the Fund under this provision shall be deemed to be held in trust by you or them for the benefit of the Fund until paid to the Fund. The Fund shall have a lien on any amount received by you or your Dependent Child, or your representatives (including your or your Dependent Child's attorneys), that is due to the Fund under this provision, and any such amount shall be deemed to be held in trust by them for the benefit of the Fund until paid to the Fund.

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

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

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

Coordination of Benefits

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

Other plans include:

- Group blanket or franchise insurance coverage

- Hospital service prepayment plan, medical service prepayment plan or group practice plan
- Any coverage under a labor-management trusteed plan, union welfare plan, or employer organization or employee benefit organization plan
- Any coverage under governmental programs, to the extent permitted by law, and any coverage required or provided by any statute
- Any coverage sponsored by or provided through a school or other educational institution
- Any personal insurance
- Any plan considered an "excess" plan
- Any other group health plan or individual plan, including those purchased through the Health Insurance Marketplace
- Medical payments available through a homeowner's insurance policy

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

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

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

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

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

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

LENGTH OF COVERAGE

When Coverage Ends

For You

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

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

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

For Your Dependent Children

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

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

When coverage ends for either you or your covered Dependent Children, you or they may be eligible to extend coverage at your or their own expense through COBRA as described on page 22.

Suspension of Benefits

Discontinuance of Coverage for Nonpayment of Employer Contributions

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

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

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

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

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

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

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

For more information on the Plan's subrogation processes, please see the "Subrogation and Third-Party Reimbursement" section on page 17.

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

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

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

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

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

You may continue this coverage up to the earlier of:

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

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

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

Family and Medical Leave Act

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

General Notice of Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage Rights For Vision and Dental Benefits

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

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for coverage. Continuation coverage is the same health benefit coverage that the Plan gives to all other Covered Persons. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other Covered Persons covered under the Plan. Life insurance and legal plan coverage are not continued under COBRA, but please see the conversion options available to you on pages 37 and 54.

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

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

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

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

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

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

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

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

Paying for Coverage

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

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

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

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

Duration of Coverage

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

Qualifying COBRA Events		
If You Lose Coverage Because:	**These People Would Be Eligible:**	**For COBRA Coverage For Up To:**
Your employment terminates for a reason other than gross misconduct	You and your eligible Dependent Children	18 months
Your working hours are reduced	You and your eligible Dependent Children	18 months
You are determined to be disabled by the Social Security Administration	You and your eligible Dependent Children	29 months
You die	Your eligible Dependent Children	36 months
You divorce or legally separate	Your eligible Dependent Children	36 months
Your Dependent Children no longer qualify as dependents	Your eligible Dependent Children	36 months
You become entitled to Medicare benefits	Your eligible Dependent Children	36 months

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

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

If the qualifying event is the end of your employment or a reduction in your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for your qualified Beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA continuation coverage for your Dependent Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Certain qualifying events, or a second qualifying event during the initial period of coverage, may also permit a qualified Beneficiary to receive a maximum of 36 months of coverage.

Extension of 18-Month COBRA Coverage Period for Disability

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

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

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

Second Qualifying Event

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

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

Acquiring New Dependents While Covered by COBRA

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

Address Changes

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

Financial Responsibility for Failure to Give Notice

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

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

PLAN ADMINISTRATION AND LEGAL INFORMATION

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

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

Plan Amendment or Termination

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

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

Key provisions of these privacy standards include:

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

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

- **Limits on Use of Personal Medical Information** – The privacy rule sets limits on how covered Providers may use your identifiable health information. These limits do not restrict the ability of health care professionals to share any medical information needed for treatment. They do restrict its use for purposes not related to health care. Covered Providers may use or share only the

minimum amount of protected information needed for a particular purpose. In no case will a covered Provider use or disclose your personal medical information that is Genetic Information for underwriting purposes. You must provide written authorization for the following medical information to be disclosed:

- Psychotherapy notes if maintained by the Plan.
- Personal medical information for marketing purposes. For example, your written authorization will be required for the covered Provider to share your medical information to promote health care products or services or alternative treatments, or provide appointment or treatment reminders. Your written authorization will not be required for prescription refill reminders, general health and wellness communications or communications about government or government-sponsored programs, such as eligibility for Medicare or Medicaid.
- Disclosures that constitute a sale of your personal medical information. A sale means that the covered entity receives direct or indirect remuneration in exchange for personal medical information. Your authorization is not required if remuneration for personal medical information is required to perform activities or provide services, such as for research or for the services provided by the health information exchange.
- Personal health information released to a life insurer, a bank, a marketing firm or another outside business for purposes not related to your health care.

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

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

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

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

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

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

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

Genetic Information Nondiscrimination Act of 2008 (GINA)

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

Qualified Medical Child Support Orders

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

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

YOUR RIGHTS UNDER ERISA

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

Receive Information About the Plan and Your Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a Plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial, and you have a right to obtain, without charge, copies of documents relating to the decision. You also have the right to have the Trustees review and reconsider your claim, as described in the "Appealing a Denied Claim" section on page 13.

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

control of the Plan Administrator. After exhausting your appeal rights, you may file suit in a state or federal court if you have a claim for benefits that is denied or ignored, in whole or in part. After exhausting your appeal rights, you may file suit in a federal court if you disagree with the Plan's decision. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

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

Assistance with Your Questions

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

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

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

BENEFITS AT A GLANCE

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

		For more information, go to page:
For Life Insurance and Accidental Death and Dismemberment Benefits for Part-Time Employees (Not Including Service Clerks) Only (No Dependent Benefits)		
What benefits are paid in case of my death?	Your Beneficiary (or your estate, if you have not named a Beneficiary) will receive $7,500 in a lump sum if you are under age 70 at the time of your death, or $3,750 if you are over age 70.	37
What benefits are paid if I am dismembered?	You will receive a benefit of $7,500 (or $3,750 if you have attained age 70), depending on the extent of your loss.	38
For Vision Benefits		
Does the Plan provide vision benefits?	The Plan helps pay the cost of covered vision care expenses, which include an eye exam and one pair of eyeglasses or contact lenses. You can use any vision care Provider. However, your out-of-pocket costs will generally be less if you use a participating Provider.	40-43
For Legal Services Benefits for Part-Time Employees (Not Including Service Clerks and Part-Time Porters) Only (No Dependent Benefits)		
Does the Plan provide benefits if I need the services of an attorney?	You have access to a network of participating attorneys for many Covered Services, including: ■ Bankruptcy ■ Child Support Enforcement ■ Consumer Protection Defense ■ Court Adoption ■ Criminal Misdemeanor Defense ■ Debt Collection Defense ■ Divorce	 48 49 48 47 52 48 49

		For more information, go to page:
	■ Document Preparation and Review	50
	■ Domestic Violence Protection	49
	■ Driving Privilege Protection	53
	■ Financial Education and Counseling Services	47
	■ Foreclosure	50
	■ Immigration	46
	■ IRS Audit Protection and IRS Collection Defense	51
	■ Juvenile Court Proceedings/Parental Responsibilities	52
	■ Real Estate – Purchase, Sale and Refinancing (primary residence)	50
	■ Social Security/Veterans/Medicare	51
	■ Telephone Legal Services	45
	■ Tenant Matters	51
	■ Wills/Powers of Attorney/Codicils	52
For Dental Benefits		
What dental expenses are covered?	You can obtain dental care from any dentist. However, your out-of-pocket costs will generally be less if you use a participating dental office. In addition, if you use a non-participating dentist, you must meet an annual deductible before the Plan pays benefits for Covered Services, except preventive care. Covered Services include: ■ Crowns and bridges ■ Examinations and X-rays ■ Extractions ■ Fillings ■ Oral surgery	56-61

		For more information, go to page:
	■ Prosthetics (dentures) ■ Repairs ■ Root canal therapy	

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS (EMPLOYEES, NOT INCLUDING SERVICE CLERKS, ONLY) (NO DEPENDENT BENEFITS)

Life Insurance Plan

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

If your death occurs:	Your death benefit is:
Before age 70	$7,500
After age 70	$3,750

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

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

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

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

Termination of Coverage

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

Converting Coverage

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

AD&D Plan

Only Employees are entitled to AD&D benefits. As a Part-time Employee, the full amount of your AD&D benefit is $7,500 ($3,750 if you have attained age 70). It will be paid to your named Beneficiary if you die as the result of and within 90 days of an accident. Payment will be made in a lump sum.

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

If you lose:	Your dismemberment benefit is:	
	If you are under age 70	If you are 70 or over
Total, irrecoverable loss of sight in both eyes	$7,500	$3,750
Loss of both hands, severed at or above the wrist joints	$7,500	$3,750
Loss of both feet, severed at or above the ankle joints	$7,500	$3,750
Loss of one hand at or above the wrist and one foot at or above the ankle	$7,500	$3,750
Loss of one hand at or above the wrist, one foot at or above the ankle and sight in one eye	$7,500	$3,750
Total, irrecoverable loss of sight in one eye	$3,750	$1,875
Loss of one hand, severed at or above the wrist joint	$3,750	$1,875
Loss of one foot, severed at or above the ankle joint	$3,750	$1,875
Loss of thumb and index finger of same hand	$1,875	$937.50

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

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

Exclusions

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

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

Claiming AD&D Benefits

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

VISION BENEFITS

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

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

For:	If you use a participating Provider, the Plan pays the following:	If you use a non-participating Provider, you will be reimbursed the following amounts:
Frames (one pair every Calendar Year) (see below for more information related to eyeglass frames)	$100 or $150 allowance; 20% savings on amounts over allowance **Covered–in-Full Frames:** Any Fashion level frame from Davis Vision's Collection[1] (retail value, up to $100). **OR, Frame Allowance:** $100 toward any frame from provider plus 20% off any balance.[2] No copayment required. **OR, Visionworks Frame Allowance:** $150 allowance plus 20% off any balance toward any frame from a Visionworks retail store.[3] No Copayment required.	Up to $50*
Contact lenses if Medically Necessary (e.g., following cataract surgery) (one pair every Calendar Year)	**Covered in Full**: With prior approval	Up to $225
Contact lenses in lieu of eyeglasses (one pair every Calendar Year)	**Contact Lens Allowance**: $100 toward any contacts from Participating Provider's supply plus 15% off any balance[2] No Copayment required **Contact Lens Exam Fitting and Evaluation**: 15% discount	Up to $80 Not covered

Additional Frames and Lenses Costs Not Covered by the Plan	Price You Will Pay at Participating Provider
Davis Vision Collection Frames: Fashion | Designer | Premier	$0 | $15 | $40
Tinting of Plastic Lenses	$15
Oversize Lenses	$0
Scratch-Resistant Coating	$0
Ultraviolet Coating	$15
Anti-Reflective Coating: Standard | Premium | Ultra	$40 | $55 | $69

[1] The Davis Vision Collection is available at most Participating provider locations. Collection is subject to change.
[2] Additional discounts not applicable at Walmart, Sam's Club or Costco locations.
[3] Enhanced Allowance is available at Visionworks store locations nationwide.

Polycarbonate Lenses	$0[4]–$35
High-Index Lenses	$60
Progressive Lenses: Standard | Premium | Ultra	$65 | $105 | $140
Polarized Lenses	$75
Photochromic Lenses (i.e., Transitions®, etc.)[5]	$70
Intermediate-Vision Lenses	$30
Scratch Protection Plan: Single Vision | Multifocal Lenses	$20 | $40

The above prices are subject to change. For current prices, contact Davis Vision toll-free at (800) 278-7753. If you obtain the above special frames, lenses or coatings from a non-participating Provider, you are responsible for 100% of the charges.

* If you choose to be reimbursed for contact lenses, you will not get reimbursed for new frames until 12 months have passed since you were reimbursed for your first pair of contact lenses.

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

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

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

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

- An itemized receipt with the following information
  - the name, address and phone number of the non-participating Provider
  - date of service

[4] For Dependent Children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.
[5] Transitions® is a registered trademark of Transitions Optical Inc.

- a complete description of each service provided
- amount paid for each service

- The group name
- Your name, address, phone number and Social Security number
- The patient's name and birth date (and phone number and address if they are different from yours)
- The patient's relationship to you.

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

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

How Can I Contact Davis Vision's Member Services?
Call 1.800.278.7753 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.–11 p.m. | Saturday, 9 a.m.–4 p.m. | Sunday, 12 p.m.–4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

For Options Not Covered by the Plan
If you use services or products not covered by the Plan—such as eyeglass frames that exceed the Plan allowance, sunglasses, oversized lenses or blended lenses—you must pay the additional cost. Your doctor can help you choose the best frame for you based on your coverage.

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

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

Vision Plan Insurance Policy Controls

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

LEGAL SERVICES PLAN (EMPLOYEES, NOT INCLUDING SERVICE CLERKS AND PORTERS, ONLY) (NO DEPENDENT BENEFITS)

The Legal Services Plan (LSP) provides Part-time Employees (not including Service Clerks and Part-time Porters) with legal assistance in certain incidences. If you need legal assistance, you can call ARAG at (800) 247-4184 or visit its website at **www.ARAGLegalCenter.com** and type in access code 17997wf for detailed information on Plan benefits and how to use the LSP, and FAQs. You can also:

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

How the LSP Works

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

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

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

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

Covered Services

The LSP covers a range of personal legal services for you. Covered Services include the following:

Legal Services That Are Not Performed in an Attorney's Office	Plan Pays
Learning Center An extensive online library of easy-to-understand legal articles, guidebooks and videos created to help you: • Learn more about dealing with common legal and financial matters, such as estate planning, identity theft and consumer protection	Paid in full

Legal Services That Are Not Performed in an Attorney's Office	Plan Pays
• Understand how the legal insurance plan works and the coverages, services and resources it provides.	
Do-It-Yourself Legal Documents You have online access to more than 350 state-specific documents authored and reviewed by attorneys for accuracy and state-specific compliance in all 50 states.	Paid in full
Identity Theft Services Identity theft services help you protect your privacy, identity, reputation and your property. Services include: • Legal advice and representation: you can work with an attorney in-person or via telephone for legal advice and representation. Most covered legal matters—including IRS audit protection, IRS collection defense and debt collection—are 100% paid in full when you work with a network attorney • Prevention and recovery tools: you have access to several online tools to help you prevent and recover from identity theft. These tools include an identity theft tracking sheet, personal information organizer, identity theft prevention and victim action guidebooks and more • Assisted identity restoration: identity theft case specialists are available to help you assess your situation and identify your objectives. They will assist you with tracking activities and progress until the conclusion of each case.	Paid in full
Telephone Legal Services • Toll-free telephone advice on how the law relates to your personal legal matter and which actions may be taken • Follow-up correspondence and telephone calls to third parties regarding your personal legal matter • Specific document preparation and review • You will receive legal assistance from the Telephone Legal Access Law Firm for the preparation or review of a standard will or codicils. A "standard will" means a will document without trust provisions other than a support trust for dependent children limited to appointing a guardian and placing assets for dependent children until they reach their age of majority.	Paid in full

Legal Services That Are Not Performed in an Attorney's Office	Plan Pays

Immigration Services
You have access to network attorneys over the telephone for:
• Legal advice and consultation on:
  • Immigration processes and guidelines
  • Filing and processing of applications or petitions
  • Laws and regulations governing various types of immigration benefits, including asylum, adjustment of status, business visas and employment authorizations
  • Deportation and removal proceedings
• Document review of any immigration forms
• Document preparation of affidavits and powers of attorney
• Preparation for immigration hearings
	Paid in full

For additional immigration services, network attorneys provide a reduced rate of at least 25% off their normal rates for any representation-based immigration services. Network attorneys will bill you directly.	At least a 25% reduced rate
Reduced-Fee Network Attorneys • If your legal matter is not fully covered under the LSP terms and is not listed under "Exclusions" later in this LSP section, you may be eligible to work with a network attorney and pay a reduced fee that will be at least 25% off the attorney's normal hourly rate. The initial consultation for each legal matter will be provided at no cost. Payment of attorney fees is handled directly between you and the network attorney. Access to a reduced-fee network attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to a network attorney within legal practice areas. • For matters that include a cap on the number of hours the LSP will pay a network attorney, and where your legal matter will exceed the cap set, the network attorney will bill you directly at reduced rates of at least 25% off the attorney's normal hourly rate. Payment of attorney fees is handled directly between you and the network attorney. • For telephone advice, if your matter cannot be resolved over the phone and is not fully covered under the LSP terms and not excluded under "Exclusions" later in this LSP section, you may be eligible to receive at least 25% off the attorney's normal hourly rate. Payment of the attorney fees is handled directly between you and the network attorney. If you retained the services of a network attorney prior to the effective date of your LSP coverage, the reduced fee benefit is not available.	At least a 25% reduced rate

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

In-Office Legal Services	Plan Pays When Using a Network Attorney	Plan Pays When Using a Nonnetwork Attorney
Name Change For legal services for you to legally change your name.	Paid in full	$240*
Court Adoption Legal services in an uncontested or contested adoption for you to become an adoptive parent. For international adoptions, where a foreign attorney is necessary, you are eligible to receive reimbursement in addition to the benefits available in the United States.		

In-Office Legal Services	Plan Pays When Using a Network Attorney	Plan Pays When Using a Nonnetwork Attorney
Uncontested	Paid in full	$400*
Contested		
Advice, negotiation and office work prior to trial	Paid in full	$800*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
Consumer Protection		
Legal services for you as a defendant regarding written contracts or warranties relating to consumer goods or services (excluding residential contractor insurance disputes).		
Advice, negotiation and office work prior to trial	Paid in full	$800*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
Defense of Debt Collection		
Legal services for you as the defendant in a legal action related to consumer goods or services (excluding foreclosure, garnishment, mechanic's line and student loan debt collection).		
Advice, negotiation and office work prior to trial	Paid in full	$480*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
Small Claims Court		
Legal services for you to obtain advice and counseling to bring a claim in Small Claims Court (or similar court of limited civil jurisdiction). This does not include representation in court.	Paid in full	$320* (to bring claim)
Legal services to defend an action in Small Claims Court (or similar court of limited civil jurisdiction) including representation in court where allowed by law.	Paid in full	$400* (to defend claim)
Bankruptcy		
Legal services for you up to and including filing of a Chapter 7 bankruptcy final report or confirmation of a Chapter 13 bankruptcy. This does not include ongoing maintenance of a Chapter 13 repayment plan.		
Chapter 7	Paid in full	$880*
Chapter 7 post-discharge amendment/modification	Paid in full	$240*
Chapter 13	Paid in full	$1,200*
Chapter 13 post-confirmation amendment/ modification	Paid in full	$240*

In-Office Legal Services	Plan Pays When Using a Network Attorney	Plan Pays When Using a Nonnetwork Attorney
Protection from Domestic Violence Legal services for you to obtain a protective order related to domestic violence	Paid in full	$320*
Divorce Legal services for you in an uncontested or contested divorce, legal separation and/or annulment of marriage.		
Uncontested	Paid in full	$640*
Contested	Paid in full up to 20 hours per covered event	$1,600*
Child Custody, Child Support and Child Visitation Agreement Legal services for the creation of initial child custody, child support or child visitation agreements. This benefit does not include the modification of current agreements.		
Uncontested	Paid in full	$320*
Contested	Paid in full up to 8 hours per covered event	$640*
Alimony, Child Support, Child Custody and Child Visitation Enforcement Legal services for a motion brought by you or against you to enforce a final decree for child support, child custody, child visitation or alimony.		
Uncontested	Paid in full	$320*
Contested	Paid in full up to 8 hours per covered event	$640*
Alimony, Child Support, Child Custody and Child Visitation Modification Legal services for you for a motion brought by you or for you to modify a final decree for child support, child custody, child visitation or alimony.		
Uncontested	Paid in full	$320*

In-Office Legal Services	Plan Pays When Using a Network Attorney	Plan Pays When Using a Nonnetwork Attorney
Contested	Paid in full up to 8 hours per covered event	$640*
Foreclosure Legal services for you regarding written notice of foreclosure related to your primary residence.		
Advice, negotiation and office work prior to trial	Paid in full	$480*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
Document Preparation and Review Legal services for you for the preparation and review of deeds, mortgages, promissory notes, affidavits, lease contracts, demand letters and installment contracts, bills of sale, HIPAA authorization forms and certifications of trust.	Paid in full	$40 per document
Mechanic's Lien Legal services for you to remove a mechanic's lien		
Advice, negotiation and office work prior to trial	Paid in full	$480*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
Student Loan Debt Collection Legal services for you as the defendant in a legal dispute related to your student loan		
Advice, negotiation and office work prior to trial	Paid in full	$480*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
Purchase of Real Estate Legal services for you for the purchase of your primary residence for the review and preparation of documents, including contract for purchase and attendance at closing.	Paid in full	$320*
Sale of Real Estate Legal services for you for the sale of your primary residence for the review and preparation of documents, including contract for purchase and attendance at closing.	Paid in full	$320*
Refinancing – Primary Residence Advice and review of relevant documents for you regarding refinancing of your primary residence.	Paid in full	$160*

In-Office Legal Services	Plan Pays When Using a Network Attorney	Plan Pays When Using a Nonnetwork Attorney
Tenant Matters		
Legal services for you as a plaintiff or defendant with your landlord as a tenant of your primary residence, including, but not limited to, eviction and security deposit disputes.		
Advice, negotiation and office work prior to trial	Paid in full	$320*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
IRS Audit Protection		
Legal services for you involving Internal Revenue Service (IRS) audit(s) related to your personal tax return where the initial written notice is received after the effective date of your LSP coverage and while your coverage is in effect. This does not include audits related to your failure to file a personal tax return or pay taxes owed as indicated on a personal tax return that was filed.		
Advice, negotiation and office work prior to trial	Paid in full	$480*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
IRS Collection Defense		
Legal services for you in defense against collection actions by the IRS related to errors on your personal tax return where the initial written notice is received after the effective date of your LSP coverage and while your coverage is in effect. This does not include collection actions related to your failure to file a personal tax return or pay taxes owed as indicated on a personal tax return that was filed.		
Advice, negotiation and office work prior to trial	Paid in full	$480*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
Social Security/Veterans/Medicare		
Legal services for you in an administrative proceeding arising out of Social Security, Veterans, Medicare or Medicaid benefits.		
Advice, negotiation and office work prior to trial	Paid in full	$400*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***

In-Office Legal Services	Plan Pays When Using a Network Attorney	Plan Pays When Using a Nonnetwork Attorney
Wills and Durable Powers of Attorney Individual will or spousal will(s). Does not include any tax-planning services done in connection with the will(s). "Will" means a standard will that does not include trust provisions other than a support trust for dependent children that is limited to appointing a guardian and placing assets for dependent children until they reach the age of majority.	Paid in full	$320 single document $400 spousal documents
Codicil – Amendment to a Will	Paid in full	$40 single document; $80 spousal documents
Living Will/Health Care Directive	Paid in full	$40 single document; $80 spousal documents
Power of Attorney/Financial Power of Attorney	Paid in full	$40 single document; $80 spousal documents
Parental Responsibilities Legal services for you in juvenile court proceedings (except those involving traffic matters) where a state has brought an action regarding your parental responsibilities for an enrolled Dependent Child.		
Advice, negotiation and office work prior to trial Trial for three days or less Trial starting on day four until completion	Paid in full Paid in full Paid in full	$480* $1,800** $100,000***
Criminal Misdemeanor Defense Legal services for you in the defense against criminal misdemeanor charges, except those involving motorized vehicles and domestic violence charges. If a charge is escalated to a felony, coverage will cease as of the date of the escalation. If a felony charge is reduced or pled down to a misdemeanor, no coverage is available.		
Advice, negotiation and office work prior to trial Trial for three days or less Trial starting on day four until completion	Paid in full Paid in full Paid in full	$720* $1,800** $100,000***

In-Office Legal Services	Plan Pays When Using a Network Attorney	Plan Pays When Using a Nonnetwork Attorney
Minor Traffic Offenses Excluding DWI-Related Legal services for you in the defense of a traffic offense where a conviction would not result in the suspension or revocation of your driving privileges. This does not include driving while impaired or under the influence of drugs or alcohol.	Paid in full	$240*
Driving Privilege Protection Legal services for you in the defense of a traffic offense where conviction of the offense will directly result in the suspension or revocation of your driving privileges.		
Advice, negotiation and office work prior to trial	Paid in full	$480*
Trial for three days or less	Paid in full	$1,800**
Trial starting on day four until completion	Paid in full	$100,000***
Driving Privilege Restoration Legal services for you in an administrative proceeding for the restoration of your suspended or revoked driving privilege. This does not include driving while impaired or under the influence of drugs or alcohol or a related offense.	Paid in full	$240
* Non-network attorney benefits are up to the stated amount. ** Trial benefits are $300 per half-day of trial time up to the stated amount. *** Trial benefits are $400 per half-day of trial time up to the stated amount.		

What the LSP Does Not Cover

The LSP does not cover the following:

- Matters against the Fund;
- Matters against the Trustees, the Administrator, or any Employee of the Fund Office;
- Matters against UFCW Local 1262 or any of its officers, directors, Employees or agents;
- Matters against a contributing employer;
- Matters against ARAG;
- Matters against any person covered by the Legal Services Plan except as expressly listed in this SPD;
- Legal services arising out of a business interest, investment interests, employment matters, your role as an officer or director of an organization, and patents or copyrights;

- Legal services in class actions, post-judgments, punitive damages, personal injury, malpractice, appeals, small claims court or equivalent court in your state; or

- Legal services deemed by the Fund to be frivolous or lacking merit, or in actions in which you are the plaintiff and the amount we pay for your legal services exceeds the amount in dispute, or in which, in our reasonable belief, you are not actively and reasonably pursuing resolution of your case. However, this exclusion does not apply to the Small Claims Court benefit described above.

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

- Matters outside the jurisdiction of the United States of America.

- Matters that, in the opinion of the telephone legal access law firm, may not ethically or appropriately be handled over the telephone.

- Matters that require, in your and/or the telephone attorney's opinion, your personal presence in a firm's office or your direct and personal representation by another attorney.

Pre-existing Matters

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

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

Termination of Coverage

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

Converting Coverage

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

LSP Insurance Policy Controls

Information on the LSP benefit provided in this SPD is intended to provide a general overview of the LSP benefit and is not a contract. Only the insurance policy between the Fund and ARAG, which is incorporated

into this SPD, can give actual terms, coverages, amounts, conditions and exclusions. The insurance policy is available for review at the Fund Office.

LSP Administrator

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

DENTAL BENEFITS

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

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

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

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

Using a Participating Dentist

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

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

Using a Non-participating Dentist

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

Pre-Treatment Review

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

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

Alternative Treatment Benefits

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

Covered Dental Services

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

Orthodontic Treatment

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

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

Maximum Benefits

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

Extended Benefits

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

- Bridges
- Crowns
- Dentures
- Orthodontics

- Root canal

The Plan considers treatment to have begun when:

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

Dental Expenses the Plan Does Not Cover

the Plan does not cover the following dental expenses:

- Anesthesia other than general anesthesia for one hour in the dentist's office
- Any claim submitted more than 12 months after the treatment date
- Any dental or orthodontic treatment that began prior to your coverage under the Plan
- Any services that are Experimental or not generally accepted by the dental profession
- Charges for canceled appointments (and any associated cancellation fees)
- Charges for completion of claim forms
- Charges for any services necessitated by a motor vehicle accident that can be collected under the terms of any federal or state law mandating indemnification regardless of fault, whether or not the Covered Person asserts rights to obtain coverage under the applicable law.
- Cosmetic services, including procedures, treatments, drugs, biological products and complications of cosmetic surgery
- Costs or charges that exceed the Plan's fee schedule
- Duplication of dentures
- Examinations, diagnostic procedures or treatment by any method of jaw joint problems, including for temporomandibular joint (TMJ) dysfunctions syndrome, TMJ pain syndromes, craniomandibular disorders and myofascial pain dysfunction or other conditions of the joint linking the jaw bone (mandible) and skull and the complex muscles, nerves and other tissues related to the joint
- Expenses incurred after any payment, duration or visit maximum is or would be reached
- Experimental or Investigational treatments, procedures, biological products or devices

- Hospital visits or expenses
- Implants
- Instruction on dental hygiene and plaque control
- Orthodontic care for covered individuals older than age 23 (unless the Claims Administrator determines that the person has handicapping malocclusions)
- Replacement of a crown, inlay, onlay, bridge or full or partial denture that was installed less than five years earlier
- Restorations that are covered are limited to the replacement of lost teeth when due to decay, fracture, abrasion, attrition or erosion.
- Services or supplies
    - Connected with any procedure or exam not needed for the diagnosis or treatment of an Injury or Illness for which a bona fide diagnosis has been made because of existing symptoms
    - Eligible for payment under federal or state programs (except Medicare and Medicaid when, by law, the Plan is primary)
    - For which a charge is not usually made, such as a Provider treating a professional or business associate, or services at a public health fair
    - For which the Covered Person is not legally obligated to pay
    - For which the Covered Person would not have been charged if he or she did not have health care coverage
    - For which the Provider has not received a certificate of need or such other approvals as required by law
    - Furnished by a member of the Covered Person's family (spouse, child, parent, in-law, brother or sister)
    - Needed due to an Injury or Illness to which a contributing cause was the Covered Person's commission of or attempt to commit a felony, or to which a contributing cause was the Covered Person's engagement in an illegal occupation
    - Performed on teeth with a poor prognosis
    - Performed or provided by anyone who does not qualify as a Provider or who is paid by the facility and is not allowed to charge for the services

- Provided by a government Hospital or provided by or in a facility run by the Department of Defense or Veterans Administration for a service-related Illness or Injury unless coverage for the services is required by law

- Provided to treat an Injury or Illness resulting from war or an act of war if the Injury or Illness occurs while, or as a result of the special hazards incident to, the Covered Person's serving in the military, naval or air forces of any country, combination of countries or international organization, or serving in any civilian noncombatant unit supporting or accompanying the military, naval or air forces

- Provided to treat an Injury or Illness resulting from war or an act of war if the Injury or Illness occurs while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Illness occurs outside the home area

- Rendered prior to the Covered Person's coverage date or after his or her coverage under the Plan ends, except as stated in this SPD

- Required by an employer as a condition of employment, and services rendered through a medical department, clinic or other similar service provided or maintained by the employer

- That are not Medically Necessary and Appropriate, including court-ordered treatment

- That are specifically limited or excluded in this SPD

- Splinting of implants

- Surgical removal of bone tissue, tumors or cysts (which may be covered by the Medical Plan)

- Tests and laboratory examinations

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

Claiming Benefits

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

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

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

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

Send your claim form and bills to:

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

GLOSSARY OF KEY TERMS

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

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

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

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

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

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

Covered Person—A person properly enrolled in the Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury—Any damage caused by an accident.

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

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

service, treatment, supply or confinement does not, in and of itself, make it Medically Necessary and Appropriate.

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

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

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

Plan—The plan of benefits described in this SPD.

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

Provider—A person the Plan recognizes who:

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

Providers include, but are not limited to, dentists and optometrists.

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

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

Service Clerk Annual Physical Benefit—A routine physical examination once per calendar year. The examination may be performed by a participating Provider, at a physician's office, hospital outpatient clinic, or freestanding lab. The following services will be covered at 100% with no deductible or co-insurance as part of the Service Clerk Annual Physical Benefit: medical history review, EKG, blood pressure check, blood tests, urinalysis, pulmonary function check, audiometry, vision test, glaucoma test, tuberculin skin test, chest X-ray, height and weight measurement, pulse rate check, instructions on self-examination of the breasts, hemoccult test, cancer test (including breast exam), health appraisal, Pap smears, and mammogram for female patients over age 40.

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