Michigan United Food and Commercial Workers Unions and Employers Retiree Health Plan

Summary Plan Description
for Retiree Plan Participants

2007 Edition

Effective September 1, 2007

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Unions and Employers Retiree Health Plan
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This booklet has been prepared for retired Participants of the Michigan United Food and Commercial Workers Unions and Employers Retiree Health Plan (the Plan). This booklet describes benefits available to eligible, active participants in the Plan as of September 1, 2007. Full details are contained in legal documents that establish this Plan. If there is a discrepancy between this booklet and the legal documents, the legal documents will govern. The Trustees reserve the right to modify, amend, or terminate the Plan or any of its benefits at any time.

The Board of Trustees has full discretion and authority to interpret the terms of the documents establishing the Fund and the Plan, including but not limited to, the rules of eligibility, and to decide any factual question related to eligibility for and the type and amount of benefit. The decision of the Trustees shall be binding, unless determined by a court of law to be arbitrary and capricious. Benefits will only be paid under the Plan if the Trustees, in their discretion, determine that the applicant is entitled to them.

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Introduction

The benefits described in this booklet apply to all Eligible Retirees and Eligible Dependent spouses who are covered under this Plan as of September 1, 2007, as well as those who elect retiree coverage under the Michigan UFCW Unions and Employers Retiree Health Plan on or after September 1, 2007. If you elect to continue coverage under the Active Plan, through COBRA continuation coverage (see below), those benefits are described in a separate booklet.

Retiree Medical Plan

It's your choice at ***Retirement***:

- Pay for comprehensive medical coverage under the Retiree Health Plan, including prescription drug benefits; or
- Elect COBRA continuation coverage under the Plan for active employees.

If you are between age 55 and 65 and meet the eligibility requirements shown on page 3 when you retire, you and your spouse may choose to be covered by the Michigan UFCW Unions and Employers Retiree Health Plan. This comprehensive coverage includes medical and prescription drug benefits.

If you are eligible for this coverage and you choose this Plan, you will be required to pay a monthly premium for your benefits.

If you retire between age 55 and 57 and elect COBRA under the Active Plan, you may elect to participate in the Retiree Plan after your 18 months of COBRA expires. You must make your election within 60 days of exhausting COBRA coverage. If you reach age 57 before your COBRA coverage period expires, you may elect to participate in the Retiree Plan, provided your election is made within 60 days of turning age 57.

If you retire between age 57 and 60, you may immediately elect Retiree Plan coverage. If you elect COBRA under the Active Plan when you retire, you may not elect to participate in the Retiree Plan before the full 18-month COBRA period expires.

If you reach age 60 before your COBRA period expires, you may elect at that time to participate in the Retiree Plan. If you do not elect Retiree coverage at that time, you may not elect the Retiree Plan before your full 18-month COBRA period expires.

If you don't elect Retiree Plan coverage immediately upon retiring, you may elect coverage at any time after attaining age 60. If you elect coverage at age 60, your coverage will be effective the first day of the month following the month in which you attain age 60.

If you retire at or after age 60, you may elect, at any time before reaching age 65, to participate in the Retiree Plan. If you elect coverage at age 60, your coverage will be effective as described in the paragraph above. However, if you elect COBRA coverage when you retire, you may not participate in the Retiree Plan until the full 18-Month period has expired from the date you first commenced COBRA continuation coverage. Separate provisions apply to a disabled Retiree.

Active Plan COBRA Continuation Coverage

You may choose to elect COBRA continuation coverage when your eligibility for coverage under the Plan for active employees ends. You will be notified of your COBRA continuation rights at that time.

You should review the Summary Plan Description for active employees or contact the Fund Office for details about COBRA continuation coverage under the Active Plan.

Network Providers

- ***Medical Care***. The Plan offers you medical benefits through a Preferred Provider Organization (PPO). Within this network, you have access to many participating Physicians and Hospitals throughout the area where you live. By using the services of network Providers – Physicians and Hospitals that participate in the network – you receive services at pre-negotiated discounted rates and you receive the higher network level of benefits.
- ***Prescription Drugs.*** The Retiree Health Plan offers Prescription Drug Benefits through a Pharmacy Benefit Manager (PBM). Contact the Fund Office for a list of participating pharmacies. You must show your prescription drug program ID card when you fill your prescription at a Participating Pharmacy to receive your prescription drug medications at discounted prices. If you do not use a Participating Pharmacy when you fill your prescription, you will be responsible for the entire cost of the prescription medication. In Michigan, participating pharmacies are listed on the back of your prescription drug card. Retirees who live outside of Michigan may use any participating pharmacy.

Health Care Providers Contact Information

Contact the Fund Office at 248-585-9610 or 800-322-8190 for a PPO network directory of providers or for information on participating pharmacies.

Be a Wise Health Care Consumer

To help save money for you and the Plan, be a wise health care consumer. You can do so by taking advantage of cost-saving features built into the Plan. Whenever possible:

- **Use network Providers.** Hospitals, Physicians, pharmacies, and other health care providers that participate in the network have agreed to negotiated rates, which are generally less than other providers.
- **Request generic equivalents.** The cost of generic medications can be significantly less than the cost of a brand name medication and, by law, both medications are required to be equivalent.
- **Review your medical bills to ensure that they are accurate.** If something does not seem right, or if you are charged for a procedure or supply you never received, question the bill. Keep copies of explanation of benefits and Provider bills for your files for later reference.

Questions about Your Benefits

Please take some time to review this booklet. If you are married, share the information with your spouse and let your spouse know where you file this information for future reference.

Questions? If you have any questions about the benefits described in this booklet, contact the Fund Office at 248-585-9610 or 800-322-8190.

Eligibility

Once you decide to retire from covered employment, you should contact the Fund Office. Depending on your age and prior work history, you may be eligible to elect coverage under the Retiree Health Plan. A monthly premium is required. You must file an application with the Fund Office if you wish Retiree coverage.

Retiree Eligibility

General Retiree Plan Eligibility

You are eligible for retiree coverage if you:

- are at least age 55 but not yet 65;
- participated as an active full-time employee in the Michigan United Food and Commercial Workers Unions and Employers Health And Welfare Fund for at least 15 years;
- retired directly from active employment with a Contributing Employer with eligibility for an immediate pension from the Michigan United Food And Commercial Workers Unions and Employers Joint Pension Plan or United Food and Commercial Workers International Union - Industry Pension Fund and have applied for such pension;
- for five years immediately preceding retirement, you were employed by one or more Contributing Employers in a position covered by the collective bargaining agreement; and
- for at least three of the five years immediately preceding retirement, you worked as a full-time employee for whom employer contributions were made to the Plan, (or for the entire time your Contributing Employer has participated in the Plan if that is less than three years)

> **Active employment** includes your continuation on your Employer's seniority list with recall rights, for up to 12 months after your Employer stops making contributions to the Plan on your behalf. You must apply for and be entitled to receive a pension effective no later than the expiration of the 12-month period.

Disabled Retiree Eligibility

If you retire with a disability pension benefit under the Michigan United Food and Commercial Workers Unions and Food Employers Joint Pension Fund or United Food and Commercial Workers International Union - Industry Pension Fund, you may participate in the Retiree Health and Welfare Plan on a contributory basis if you:

- have completed at least five years of service as a full-time employee of a Contributing Employer immediately prior to your disability retirement; and
- have not attained age 65.

If you elect COBRA continuation coverage under the Active Plan instead of coverage under the Retiree Plan, you may elect Retiree Plan coverage when your full COBRA coverage period is exhausted. You may not participate in the Retiree Plan until your full COBRA period has expired.

Returning to Covered Employment After Retirement

If you return to covered employment after you retire, your coverage under the Retiree Health Plan will end on the first day of the month in which you are employed for 40 or more hours per month in the retail food, drug or discount industry in Michigan. You will not be eligible for COBRA continuation coverage.

You may regain eligibility for coverage under the Active Plan following the completion of the required number of hours.

You are required to report any changes in your retirement status, including re-employment, to the Fund Office. Failure to report information regarding your employment status, or refusing to provide information when requested by the Fund Office, may result in immediate termination of your participation in the Plan.

Spouse Eligibility

If you are participating in the Retiree Plan, you may enroll your spouse under the following conditions:

- your spouse must not have attained age 65;
- your spouse must commence participation in the Retiree Plan at the same time as you do or, if your spouse has other health insurance through his or her employer, immediately upon the loss of that other coverage. If your spouse does not commence participation at the same time you do, you must file an application with the Fund Office for coverage for your spouse. The spouse will not be covered before the application is filed with the Fund Office;
- if you get married while participating in the retiree Plan, your new spouse may enroll immediately upon marriage.

When Your Eligibility Ends

Your eligibility for benefits under the Retiree Plan ends at the earliest of the following:

- The first day of the month in which you return to covered employment;
- The date you die;
- The date you reach age 65;
- When you are a disabled Eligible Retiree, the date the Eligible Retiree has five years of participation in the Retiree Plan;
- For a disabled retiree, when you recover from your disability;
- The first day of the month after your Employer ceases to contribute to the Plan;
- The last day of the month prior to the month that you fail to make your monthly payment under the Plan's self-payment provision.

When Your Spouse's Eligibility Ends

Your spouse's eligibility for benefits under the Retiree Plan ends at the earliest of the following:

- The date your coverage terminates: Exception: spouses who were covered under the Plan prior to January 1, 2007 may elect to continue in the Plan upon your termination of coverage due to your re-employment, death or attainment of age 65, for up to 36-months (or age 65 whichever occurs first) as long as they make the required self-payments.
- The date your spouse dies;
- The date your spouse reaches age 65;
- The date your spouse fails to make monthly payments under the Plan's self-payment provision.
- The date of a legal separation or divorce of your spouse from you. Continuation of coverage under COBRA coverage may be available.

- The date a disabled Eligible Retiree has five years of participation in the Retiree Plan.

Certificate of Creditable Coverage

When your coverage under the Plan or under COBRA ends, the Fund Office, to the extent required by law, will provide you and/or your covered spouse with a Certificate of Creditable Coverage. The Certificate indicates the period of time you and your spouse were covered under the Plan and certain additional information that is required by federal law. The Fund Office will send you the certificate by first class mail within 45 days after coverage under the Plan ends.

In addition, a Certificate will be provided within 45 days after the Fund Office receives your request for such a certificate. The Fund Office must receive your request within two years after the later of the date coverage under the Plan ended or the date COBRA continuation coverage ended. Contact the Fund Office at the address or phone number on page 35.

Changes in Eligibility Rules

The Trustees reserve the right, at their discretion, to change, modify, rescind or discontinue all or part of the eligibility rules or the benefits provided under the Retiree Plan, at any time. The Trustees have the authority to establish monthly premium rates and rules and they reserve the right to change them at any time in their sole and unrestricted discretion.

Continuation of Coverage

Self Payment Plan Continuation Coverage

In the event the Employer from whom you retired ceases to make contributions to the Retiree Plan, your participation in the Plan will terminate on the first day of the month following your Employer's last contribution.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), your spouse may continue health care coverage past the date coverage would normally end. The COBRA Continuation Coverage will be identical to the coverage your spouse had under the Plan on the day before the qualifying event.

Your spouse could become a qualified beneficiary if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

For COBRA Continuation Coverage, you or your spouse must notify the Fund Office within 60 days of:

- Your death;
- Divorce; or
- Legal separation.

If you or your spouse do not notify the Fund Office, your spouse will lose the right to continue coverage under COBRA.

Qualifying Events

Your spouse does not have to show that he or she is insurable for COBRA Continuation Coverage. It is offered if your spouse loses coverage under the Plan because of a qualifying event.

Qualifying events for your spouse include:

- Your death;
- Legal separation or divorce of you and your spouse;

Notifying the Fund Office

You or your spouse must inform the Fund Office of a legal separation or divorce within 60 days of the event. In the event of your death, your spouse must inform the Fund Office within 60 days of your death. If you or your spouse do not notify the Fund Office within 60 days of such an event, your spouse loses the right to elect COBRA Continuation Coverage. To ensure that your spouse does not suffer a gap in coverage, we urge you or your family to notify the Fund Office of any qualifying events as soon as they occur.

When the Fund Office is notified that one of these events has occurred, your spouse will be notified of their right to elect COBRA Continuation Coverage. Once your spouse receives a COBRA notice, he or she has 60 days from the later of the date coverage ended or the date of the COBRA notice to respond to the Fund Office if they wish to elect COBRA Continuation Coverage; this is called the election period.

Paying For COBRA Continuation Coverage

The Fund Office will notify your spouse of the cost of COBRA Continuation Coverage when it notifies him or her of their right to coverage. The Trustees determine the cost for COBRA Continuation Coverage each year. It will not exceed 102% of the cost to provide this coverage.

> **COBRA Payments**
>
> You must pay your COBRA payments on time. Your coverage will be cancelled and cannot be reinstated if your payments are not received by the due date.

Your spouse must remember to remit premiums each month. Simply electing COBRA Continuation Coverage does not make him or her eligible.

The *first* payment for COBRA Continuation Coverage must include payments for any months retroactive to the day coverage under the Plan terminated. This payment is due no later than 45 days after the date your spouse signed the election form and returned it to the Fund Office.

Subsequent payments are due on the first day of each month for which coverage is provided, with a grace period of 30 days. If payment is not received by the due date, all benefits will terminate immediately. Once your spouse's COBRA Continuation Coverage is terminated, it cannot be reinstated.

Payments will not be made on Claims presented to the Fund Office if your premium payment is not received.

Coverage Period

Coverage Continues for 36 Months: Your spouse may elect to continue coverage for up to 36 months if coverage ends due to your:

- Death;
- Legal separation or divorce; or

When COBRA Continuation Coverage ends, your spouse will be provided with a Certificate of Creditable Coverage for their length of coverage under the Plan. This Certificate may help reduce or eliminate any pre-existing condition limitation under a new group medical plan.

Loss of Continued Coverage

The period of COBRA Continuation Coverage may be cut short for any of the following reasons:

- Your Employer no longer contributes to the Plan, except that where an employer does not maintain the Plan due to a complete cessation of business, coverage may be continued for 6 months after this event;
- Your spouse does not make the required COBRA payments within 30 days of the due date;
- The Plan stops providing any group health benefits;
- After the qualifying event your spouse becomes covered under another group health care plan (provided such plan does not contain any exclusions or limitations with respect to any pre-existing conditions); or
- After the qualifying event, your eligible spouse becomes entitled to Medicare.

Changes in Status

When you experience a change in family status, you should contact the Fund Office to report the change. The Fund Office will provide you with any forms you must complete to report the change. This helps ensure that the Fund Office has your correct address and family information on file. It also enables the Fund Office to keep updated information about your marital status and whether you or your spouse have other benefit coverage. This information helps in processing your claims quickly and accurately.

Notify the Fund Office

You are required to report any changes in your family status or retirement status including re-employment, to the Fund Office. You can help avoid delays in payment of benefits by notifying the Fund Office of any change in your family status, such as when a spouse has other coverage or is no longer eligible for coverage or to add your spouse after marriage.

- Call the Fund Office at 248-585-9610 or 800-322-8190 to notify them or any change in your employment or family status.

If You Divorce

If you obtain a divorce, you must notify the Fund Office immediately and submit a complete copy of your divorce decree. In the event of a divorce, your ex-spouse's coverage under your Plan will end on the date of the divorce. However, your ex-spouse may be entitled to COBRA continuation coverage. Contact the Fund Office for more information. If you do not notify the Fund Office, you will be required to repay the Fund for any benefits paid on behalf of your former spouse after the date of the divorce.

In the Event of Your Death

If you die, your surviving spouse or dependents should contact the Fund Office within 60 days of the date of your death.

If you and your spouse were covered under the Retiree Plan, your surviving spouse may elect to continue coverage under COBRA. Your surviving spouse must make the required monthly premium payment for coverage. Contact the Fund Office for more information.

Retiree Medical Plan

When you retire, you may choose to enroll in and be covered under the Retiree Health Plan if you meet the eligibility requirements and you make your monthly premium payments. Medical coverage under the Retiree Plan includes prescription drug coverage. Your coverage under the Active Plan of benefits may continue in retirement until your eligibility runs out. After that, you may elect coverage under the Retiree Plan or COBRA continuation coverage under the Active Plan.

To Find a Network Provider, contact:

Fund Office
248-585-9610, or
800-322-8190

Monthly Premium Payments

You must make monthly premium payments for coverage under the Retiree Health Plan. You must make monthly premium payments directly to the Fund Office.

Once you are eligible for retiree coverage, you will be notified of the current monthly premium payment rate for coverage. Monthly premium rates are subject to change and are reviewed annually by the Trustees; you will be notified of any change in rates.

How the Retiree Medical Plan Works

Annual Deductible:
$500 per person each year

Emergency Room Co-Pay - Illness
$25 co-pay per visit if not admitted to the hospital. Effective January 1, 2008, co-pay increases to $100 per visit if not admitted to the hospital.

Once you meet your deductible of $500 per person each calendar year, the Retiree Medical Plan pays a percentage of covered expenses (known as coinsurance). After the amounts you pay for coinsurance reach your out-of-pocket maximum of $5,000 ($15,000 for out-of-network expenses) during the calendar year, the Plan pays 100% of eligible covered medical expenses while you are eligible under the Retiree Plan for the remainder of that calendar year up to the lifetime maximum.

Annual Deductible

The annual deductible is the amount of covered medical expenses that you pay before the Plan begins paying medical benefits. The amount of the annual deductible is $500 per person each calendar year.

PPO - A network of doctors and hospitals that have agreed to charge negotiated rates. Since network providers have agreed to these negotiated rates, you help control health care costs for you and the Plan when you use a network doctor or hospital. It's your decision whether or not to use a network doctor or hospital. You always have the final say about the doctors and hospitals you and your spouse use.

Emergency Room Due to Illness Co-pay

In addition to your annual deductible, you must pay a $25 co-pay each time you or your spouse use the emergency room for medical care and treatment that is not followed by a hospital admission. Effective January 1, 2008, the co-pay increases to $100 each time you or your spouse use the emergency room for medical care and treatment that is not followed by a hospital admission.

Coinsurance

Each year, once you (or your spouse) have satisfied your annual deductible of $500 per person, the Plan pays a percentage of covered expenses and you pay the rest, up to the annual out-of-pocket maximum. This is known as coinsurance.

The Plan offers benefits and care from a network of doctors and hospitals that participate in the Preferred Provider Organization (PPO).

Once you meet your annual deductible, the Plan pays:

- 80% of covered expenses when you use a network provider; or
- 60% of covered expenses when you use an out-of-network provider.

All out-of-network eligible expenses are covered at the usual and customary (U&C) rates in effect at the time of service.

When you use a network provider, you save money for yourself and the Plan because network doctors and hospitals have agreed to charge a negotiated price for their services. Here's how it works:

Example: How Using a Network Provider Can Save You Money

Let's compare what Joe pays for his hospitalization when using a network hospital versus an out-of-network hospital. Joe is eligible for benefit coverage and when Joe has surgery, his share of the costs is determined as follows, assuming Joe has not already met his annual deductible:

	*Network Hospital**	*Out-of-Network Hospital*
Expenses Charged for a 2-day Hospital Stay	*$3,200*	*$3,200*
Network Discount	*- $600*	*- $ 0*
Adjusted Charges	*$2,600*	*$3,200*
Joe's Annual Deductible	*- $500*	*- $500*
Balance of Charge	*$2,100*	*$2,700*
Plan Pays	*$1,680 (80%)*	*$1,620 (60%)*
Joe Pays	*$420 (20%)*	*$1,080 (40%)*
Joe's Total Out-of-Pocket Costs	*$920*	*$1,580*

Joe saves $660 by using a network hospital.

**This example assumes a PPO savings rate of approximately 20%. The actual savings may vary.*

To select a network provider in your area you may contact the Fund Office, which will furnish you with a list of network providers in your area.

Out-of-Pocket Maximum

Once the amount you pay toward covered medical expenses reaches your annual out-of-pocket maximum of $5,000 ($15,000 out-of-network) for the calendar year, the Retiree Medical Plan pays 100% of eligible covered medical expenses for the remainder of that year that you are eligible under the Retiree Plan, up to the lifetime maximum.

Lifetime Maximum

The Retiree Medical Plan pays up to a lifetime maximum of $250,000 per person in covered expenses.

Benefits Pre-Certification

You must contact the pre-certification organization prior to a non-emergency hospital admission, or within 48 hours of an emergency admission. When a hospital stay will exceed 48 hours (96 hours for cesarean section) for a mother or newborn child, such additional length of stay must be pre-certified.

If you fail to comply with the requirements for pre-certification, the benefits payable by the Plan will be reduced or modified as follows:

(a) reduction in the amount of $250 plus any deductibles or co-payments if the pre-certification organization is not contacted prior to a non-emergency hospital admission or within 48 hours of hospital admission;

(b) room and board charges will not be payable and all other charges will be paid the same as benefits for an outpatient treatment if the pre-certification organization was not contacted prior to admission and later determines that inpatient confinement was not warranted;

(c) no benefits will be payable for hospital days beyond those that have been pre-certified;

(d) reduction in the amount of $250 plus any deductibles or co-payments if pre-certification on non-emergency medical services is not obtained. Charges for services deemed not Medically Necessary by the pre-certification organization will not be payable.

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

Schedule of Retiree Medical Benefits

The following chart outlines the benefits payable under the Retiree Medical Plan. As a participant in the Retiree Medical Plan, you receive the benefits listed below. Benefits are paid on a calendar year basis. *All in-network eligible expenses are covered at the PPO contracted amount. All out-of-network eligible expenses are covered at the usual and customary (U&C) rates in effect at the time of service.*

Benefit	Amount Paid by Retiree Medical Plan
Annual Deductible	$500 per person per calendar year
Emergency Room - Illness	$25 co-pay per visit in addition to annual deductible if not followed by a hospital admission. Effective January 1, 2008, co-pay increases to $100 per visit in addition to annual deductible if not followed by a hospital admission.
Coinsurance Network Provider Non-Network Provider	After you pay your deductible, the Plan pays: 80% of eligible expenses 60% of eligible expenses
Annual Out-of-Pocket Maximum	Once you pay $5,000 per person per calendar year ($15,000 per person per calendar year for out-of-network expenses), the Plan pays 100% of additional expenses for the remainder of the calendar year up to your lifetime maximum.
Lifetime Maximum	$250,000 per person
Substance Abuse Inpatient - Lifetime Maximum Outpatient - Lifetime Maximum	 $25,000, 80%, in-network; 60%, out-of-network 80% (effective 1/1/08 80% in-network, 60%, out-of-network) up to lifetime maximum of $5,000

Chiropractic Care	
Maximum per visit	80% (effective 1/1/08 80% in-network, 60% out-of-network)
Annual Maximum	$1,500 per person per calendar year
X-Rays	80% (effective 1/1/08 80% in-network, 60% out-of-network) (limited to one set per calendar year)
Mental or Nervous Disorders*	
Inpatient	80%, in-network; 60% out-of-network
Outpatient	20 visits per calendar year; payable at 80% (effective 1/1/08 80% in-network, 60%, out-of-network)
Podiatry Annual Maximum	$1,500 per calendar year, payable at 80% in-network, 60% out-of-network
Prescription Drug Benefits**	Plan pays:
Network Pharmacy	80% after $500 deductible
Maximum Per Calendar Year	$2,500

* Combined inpatient maximum (in-network and out-of-network) of 45 days per calendar year.

** Prescription drug benefits are provided through the Fund's pharmacy benefit manager (PBM) and are subject to a separate annual deductible and maximum. The Plan only covers prescriptions filled at a participating network pharmacy. See page 17 for more details on prescription drug benefits.

Retiree Medical Plan Covered Expenses

Your Retiree Medical Plan covers the actual usual and customary charges for the Medically Necessary services and supplies that are listed below. Limitations on the number of treatments and the dollar amount for the treatment are listed in this section as well as contained in the Schedule of Retiree Medical Benefits above.

- **Hospital** inpatient expenses as follows:
  - Hospital room and board charges up to the standard daily rate for a semi-private room;
  - Medically Necessary services and supplies furnished by a Hospital, other than room and board.
- **Health Care Providers** include the following institutions or persons engaged in providing medical care or diagnostic treatment: Home Health Agency; Ambulatory Surgical Center or Ambulatory Care Facility; Licensed ambulance service; Birthing Center; physicians; hospitals; laboratories; skilled nursing homes; hospice; social worker with a Master's Degree working under a doctor's supervision; psychologist; limited licensed psychologist recognized by the State of Michigan and billed under the tax ID number of the supervising doctor; licensed physician's assistants; behavioral health treatment facility; certified nurse practitioner; certified registered nurse anesthetist (CRNA); licensed physiotherapist; registered nurse (RN); and, licensed practical nurse (LPN).
- **Medical and surgical benefits in connection with a mastectomy**, under federal law, must provide benefits for certain reconstructive surgeries. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the Plan's annual deductibles and coinsurance.
- **Licensed physiotherapist and graduate registered nurse**. Physical therapy (PT), occupational therapy (OT) and speech therapy (ST) are subject to the utilization review guidelines.
- **Durable medical equipment** includes items such as hospital beds, wheelchairs and crutches and is equipment that can stand repeated use, is primarily used to serve a medical purpose, is generally not

useful in the absence of illness or injury and is appropriate for use in the home when prescribed by a Doctor and within Medicare's guidelines.

The Fund Office must be contacted before you submit a claim for durable medical equipment from an out-of-network provider that exceeds $2,000. If you choose to rent or purchase equipment without prior approval from the Fund Office, a review of the charges will be made at the time the claim is submitted for payment. If the Plan determines that this equipment could have been rented or purchased at a discounted or lower cost, the Plan will pay benefits only up to the lower cost. All expenses exceeding this amount will be your responsibility. The Plan's current utilization review provider will assist the Plan in the rental or purchase of durable medical equipment at a discounted or lower cost.

- **Anesthetics** and their administration, **blood and blood plasma** and their administration, **oxygen** and the rental of equipment for the administration of oxygen.
- **X-ray and laboratory examinations** and X-ray, radium and radioactive isotope therapy.
- **Routine mammography, Pap smears, and prostate antigen (PSA) tests** once in a 12-month period.
- **Professional ambulance service**. Charges incurred for ground transportation by a local professional ambulance service to a Hospital for inpatient care are payable by the Plan. Charges incurred for professional ground or air ambulance service for emergency transportation are also covered. The transportation must be to a Hospital or for transferring from Hospital-to-Hospital. Your Doctor must certify that your condition requires specialized treatment at another Hospital and transportation by ground or air ambulance to the nearest Hospital qualified to provide such special treatment.

  In addition, when authorized in advance by the Fund Office, charges incurred for a Hospital-to-Hospital transfer by professional ground or air ambulance service are covered where you are injured or become ill a substantial distance from your residence, the Injury or Illness is a long-term condition and transportation is needed to a Hospital closer to your residence. Transportation by professional ground or air ambulance service includes transportation within the United States. When authorized in advance by the Fund Office, charges incurred for professional ambulance services for transportation from a foreign country to the United States are also covered.
- **Skilled Nursing Facility** confinement, up to the facility's most common semi-private room daily rate, if your confinement:
  - starts within seven days after a Hospital Confinement; and
  - is for the same diagnosis as the prior Hospital Confinement.
- **Birthing Center** charges, provided that such coverage will cease at the end of 48 hours (vaginal delivery) or 96 hours (cesarean delivery) following the birth of a child.
- **Hospice** care charges made by a Hospice only if:
  - you are diagnosed by a Doctor as terminally ill with a prognosis of six months or less to live; and
  - the Hospice provides a plan of care which:
    - is prescribed by a Doctor;
    - is reviewed and approved by the Doctor on a monthly basis;
    - is not for any curative treatment;
    - states the belief of the Doctor and the Hospice that the Hospice care will cost less in total than any comparable alternative to Hospice care; and
    - is covered by the Plan.

  Hospice care may be provided:
  - in the patient's home by a Home Health Care Agency or Hospice agency; or

- in a Hospice inpatient facility. Charges in a Hospice inpatient facility that exceed 100% of the average Hospital semi-private room daily rate in the geographical area in which the Hospice inpatient facility is located will not be paid. Hospice care includes palliative and supportive medical and nursing services. The Plan's requirement that expenses will be covered only when incurred for diagnosis or treatment of an Illness will not apply to Hospice Care.

■ **Home Health Care** charges made by a Home Health Care Agency, provided that the plan of care by the Home Health Care Agency:
- is prescribed by a Doctor;
- is reviewed and approved by a Doctor every two weeks;
- contains a statement expressing the belief of a Doctor and Home Health Care Agency that:
  - the number of days of Home Health Care does not exceed the number of days of confinement in a Hospital or Skilled Nursing Home which would have been required;
  - the Home Health Care will probably cost less per day than the daily rate for confinement in a Hospital or Skilled Nursing Home; and
  - confinement in a Hospital or Skilled Nursing Home would otherwise be required. A copy of this plan of care must be provided by the agency for utilization review.

Home Health Care includes:
- skilled nursing care and home health aide services; and
- any other services and supplies provided in lieu of the services, which would have been covered under the Plan, if you were confined in a Hospital or Skilled Nursing Home. Home Health Care does not include housekeeping or custodial care.

■ **Artificial limbs or eyes**, and other non-dental Prosthetic devices.

■ **Substance Abuse treatment** as shown in the Schedule of Benefits.

■ **In-network human-to-human organ or tissue transplants** where you or your spouse are the recipient of the transplant, including harvesting of the donor organ and immunosuppressive drugs, subject to the following provisions, limitations and maximums:
- Network levels of benefits when a network provider is used, up to the lifetime maximum in the Schedule of Benefits;
- Out-of-Network services are not covered.
- $10,000 transportation and lodging maximum for in-network transplants only for spouses, or one other individual who would provide support to the covered individual who is receiving the transplant.

Expenses associated with searching for a donor are excluded.

■ **Mental and Nervous Disorder** treatment as shown in the Schedule of Benefits. A mental and nervous disorder is a mental illness or functional or organic nervous disorder as defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders and/or defined by the Plan's Utilization Review Organization;

■ **Day care treatment of Mental and Nervous Disorders and Substance Abuse**. For day care treatment, two days of day care will be counted as one day of hospitalization toward the respective Calendar Year or Lifetime maximums shown in the Schedule of Benefits.

■ **Accidental injuries to oral/facial structures** including, but not limited to, jaw and facial bone fractures and sound natural teeth.

■ **Diabetic educational training** in accordance with the Utilization Review Group guidelines.

Retiree Medical Plan Exclusions and Limitations

Only expenses related to non-occupational injuries and sickness are covered.

Expenses that are *not* covered as medical expense benefits under the Retiree Medical Plan include, but are not limited to, the following:

> **Exclusions**. Not all of your medical expenses are covered by the Plan. Read these items carefully to see what is excluded from or limited in coverage.

- Any bodily Injury or Illness for which the Participant for whom claim is made is not under the regular care of a Doctor.
- Any Injury, Illness or dental treatment for which you or your spouse has received or is entitled to receive benefits under a Workers' Compensation or Occupational Disease law or which arise out of or in the course of any occupation or employment.
- Any supplies or services:
  - for which no charge is made;
  - for which the individual is not required to pay.
- Expense incurred as a direct result of an Injury or Illness due to any act of war either declared or undeclared.
- Any treatments, surgeries, services, supplies or medications provided in or by a Hospital, institution or other facility owned or operated by the United States, or any agency, or instrumentality (including, without limitation, the Veteran's Administration). If charges are made by a Veteran's Administration ("VA") hospital for care of non-service-connected disability, those charges shall be considered for reimbursement by the Plan to the extent required by law and to the extent the Plan would have considered such charges as eligible expenses had the VA not been involved.
- Co-Pay amounts.
- Expense for treatment of infertility.
- Expense for Experimental, Investigational or Unproven Services.
- Expense for the services provided by a person who normally resides in your household or who is your or your spouse's parent, spouse, child, brother or sister.
- Expense incurred for donation or transplant of an organ or tissue in cases where the recipient is not you or your spouse.
- Expense incurred while coverage is not in force.
- Expense for the purchase of exercise equipment.
- Physical examinations or medical certificates required for employment.
- Smoking cessation programs.
- Expense for any of the services listed below unless specific provisions dealing with such services are included in the Plan.

  (a) Charges to the Medical Plan for services that are deemed dental services, including but not limited to: dental X-rays, treatment to teeth whether done for medical or dental reasons; treatment of the gums; treatment of oral-facial structures mainly involved in the treatment or replacement of teeth; replacement of teeth lost due to accidental Injury.

  (b) Institution based (inpatient or outpatient Hospital or surgicenter, etc.) treatment of oral structures unless Medically Necessary.

(c) Electrographic and sonographic procedures for the diagnosis of temporomandibular and craniofacial pain disorders.

(d) All other procedures for the diagnosis and treatment of temporomandibular and craniofacial pain disorders, unless prior approval is obtained for such services from the Fund, and:

  (i) severe rheumatoid arthritis or other auto-immune disease results in significant pathology to multiple body joints, or;

  (ii) traumatic injuries have resulted in disc rupture, and/or ligament perforation, or;

  (iii) removal of prosthetic device(s) is Medically Necessary.

(e) Alveolar ridge augmentation or implant procedures whether of natural or artificial materials to stabilize or otherwise alter natural or artificial teeth.

(f) Surgical procedures to modify jaw relationships, including, but not limited to, LeFort type operations, osteoplasty and cenioplasty procedures, unless pre-approved by the Trustees to correct extreme handicapping malocclusion. Such extreme handicapping malocclusions include, but are not limited to:

  (i) Occlusion of only the most posterior molars of a full complement of teeth;

  (ii) Significant unilateral growth discrepancy of the condiles of the mandible.

(g) Charges which are dental in nature must be reviewed as Medical/Dental Crossovers.

(h) Expense for hearing aids, eye refractions, or eyeglasses other than for a contact lens used in the treatment of keratoconus or to replace a lens removed because of a cataract.

(i) Expense for radial keratotomies or other procedures for surgical correction of myopia and/or other refractive errors.

(j) Expense for immunizations, routine examinations (including X-rays and laboratory tests for this purpose) or check-ups and other preventive care, except for routine mammographies, Pap smears, and prostate antigen (PSA) tests once in a 12-month period.

(k) Expense for custodial care, except when provided by a Hospice.

(l) Expense for any service not listed as a Covered Expense.

- Expenses for services that are not Medically Necessary.
- Blood storage charges except for use for an anticipated covered medical condition for a period not to exceed six Months.
- Expense for the treatment of obesity, including but not limited to prescription or non-prescription diet pills.
- Expenses for the treatment of Mental or Nervous Disorders or Substance Abuse, unless they are received in the state in which the Participant resides or such services or treatments are rendered by an In-Network provider.

- Gastric bypass or similar surgery unless treatment is pre-authorized by the Fund's Utilization Review Service and is rendered In-Network.
- Amounts in excess of Usual, Customary and Reasonable.
- Any amounts in excess of stated benefit limitations (e.g., chiropractic maximum per Calendar Year of $1,500 and podiatry maximum per Calendar Year of $1,500).
- Expenses for cosmetic surgery unless performed to repair:

  (a) a birth defect; or

  (b) damage due to an accident.

  Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.
- Private duty nursing charges.
- Expenses incurred by you or your spouse for injuries resulting from your or your spouse's commission, or attempted commission, of a felony. Determination that this exclusion applies is not affected by any subsequent official action or determination with respect to you or your spouse's prosecution (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.

Retiree Plan Prescription Drug Benefits

The Michigan UFCW Unions and Employers Health and Welfare Fund has an agreement with a network of pharmacies to provide prescription drug coverage at a substantial discount for participants and the Fund. To receive coverage under this Plan for your eligible prescription drug expenses, you must purchase your prescription drugs at a participating pharmacy, and ***you must show your prescription drug identification card to the pharmacist***. There are many pharmacies participating in the network.

To find a network pharmacy contact the Fund Office at:

248-585-9610 , or
800-322-8190

Prescription drugs are treated separately from other medical expenses under the Retiree Medical Plan. The prescription drug benefit has a separate $500 per person per year deductible and the Plan pays 80% of your prescription drug cost if you use a participating pharmacy, up to a $2,500 calendar year maximum. In Michigan, you must use one of the pharmacies listed on your prescription drug card. For retirees living outside of Michigan, you may have your prescriptions filled at any participating pharmacy.

Remember: You must follow the appropriate process, whether you live in or outside of Michigan in order to receive the benefits available from the Plan. Contact the Fund Office if you have questions.

Prescription Drug Card

To receive the negotiated rates with participating network pharmacies and to have your prescription drug expenses apply to your annual deductible, you must show your prescription drug ID card at the time you fill your prescription.

If you do not show your identification card when your prescription is filled and/or you do not use a participating pharmacy, you are responsible for 100% of the cost of your prescription medication. So, always be sure you use a participating pharmacy and have your ID card handy to present to your pharmacy when you have a prescription filled.

It's Smart to Use Generics

You can make your prescription drug benefit go a long way and help save the Plan money by asking your doctor or pharmacist if there is a generic drug available whenever possible. The Food and Drug Administration tests the most commonly prescribed generic drugs to ensure their quality. So, the next time you or someone in your family needs a prescription drug, ask your doctor if there is a less expensive generic drug available.

Covered Prescription Drugs

The Plan covers the following:

- Legend drugs that are lawfully obtainable only from an individual licensed to dispense drugs upon the prescription of a Doctor.
- Injectable insulin.
- Diabetic supplies such as syringes, strips, lancets and glucose monitors.

Prescription Drug Exclusions and Limitations

Charges for the following drugs and medications are not covered by the Plan:

- investigational or experimental drugs;
- research drugs;
- over-the-counter drugs;
- drugs delivered to the Participant while institutionalized;
- birth control pills (unless prior authorization is received for treating endometriosis) or devices;
- non-prescription vitamins;
- prescription or non-prescription diet pills;
- fertility drugs;
- smoking cessation drugs; and
- prescriptions filled at Out-of-Network pharmacies.

Claim and Appeal Information

Benefits Pre-Certification

You must contact the pre-certification organization prior to a non-emergency hospital admission, or within 48 hours of an emergency admission. When a hospital stay will exceed 48 hours (96 hours for cesarean section) for a mother or newborn child, such additional length of stay must be pre-certified.

If you fail to comply with the requirements for pre-certification, the benefits payable by the Plan will be reduced or modified as follows:

(a) reduction in the amount of $250 plus any deductibles or Co-Payments if the pre-certification organization is not contacted prior to a non-emergency hospital admission or with 48 hours of hospital admission;

(b) room and board charges will not be payable and all other charges will be paid the same as benefits for an outpatient treatment if the pre-certification organization was not contacted prior to admission and later determines that inpatient confinement was not warranted;

(c) no benefits will be payable for hospital days beyond those that have been pre-certified;

(d) reduction in the amount of $250 plus any deductibles or co-payments if pre-certification on non-emergency medical services is not obtained. Charges for services deemed not Medically Necessary by the pre-certification organization will not be payable.

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

Filing Claim Forms

For prompt processing of your claims, please follow the steps described in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed (see page 23).

When you need to file a claim, contact the Fund Office as soon as possible at:

Michigan UFCW Unions & Employers Retiree Health Plan
876 Horace Brown Drive
PO Box 71400
Madison Heights, MI 48071
(248) 585-9610 or (800) 322-8190

The Fund Office will provide you with all the necessary forms for filing your claim. The Plan requires proof of loss, usually in the form of written certification of the occurrence, character and extent of loss incurred. The Fund Office will provide you with information as to what you need to submit.

Timeframe for Filing Claims

> Most Health Care Providers will file claims for you. Be sure to show your ID card so your provider knows where to submit your claim. If your provider does not submit claims on your behalf, follow the steps listed in this section.

You should file your initial claim for Plan benefits **within 90 days** after the date you received services. If this is not possible, you must file your claim no later than 15 months after the date the service was incurred. No claims filed beyond 15 months after the date the service was incurred will be paid.

Steps for Filing Claims: In General

To assist the Fund Office in processing claims as quickly as possible, please follow the steps listed below.

Step 1: Obtain the appropriate claim form from the Fund Office. Whenever possible, request a claim form from the Fund Office in advance of receiving services.

Step 2: Complete the form by filling in all information requested. To assist in processing claims as quickly as possible, be sure to include all information requested on the claim form.

If you or your spouse have coverage under more than one plan, be sure to include the name of the other plan(s).

Be sure to include your Social Security number or ID number and sign your form. If the claim is for your spouse, provide your spouse's name.

Step 3: When necessary, have your Doctor complete the appropriate portion of the claim form, including the diagnosis.

> If you or your spouse has coverage under more than one health care plan, benefits are coordinated (see page 28).

Step 4: Attach any bills or receipts relating to the service provided. Make sure each bill clearly identifies the diagnosis, the service or supply, the fee, the patient's name and the date of service.

If your claim is for health care where coverage by Medicare is primary, attach a copy of the itemized bill relating to the health service provided and a copy of Medicare's explanation of benefits. Both the bill and Medicare's explanation of benefits should be submitted.

Step 5: Forward the completed form and all related attachments to:

Michigan UFCW Unions and Employers Retiree Health Plan
Claims Department
876 Horace Brown Drive
P.O. Box 71400
Madison Heights, MI 48071-0400

Filing Health Care Claims

Many Health Care Providers will submit claims for you. Health care claims include Medical and Prescription Drug Benefits. Be sure to show your ID card so your Provider knows where to submit your claim. If your Provider does not submit your claim for you, it is then your responsibility to do so.

If you or your spouse has coverage under two or more health plans, be sure to include the name of the other health plan(s) on your claim form. In addition, if you are also covered by Medicare and/or another plan, attach a copy of the itemized bill relating to the health service provided and a copy of any explanation of benefits. Both the bill and explanation of benefits must be submitted.

If the claim is the result of an Accident, be sure to complete the accident portion of the benefit claim form. If your claim is filed by a Provider, you may need to furnish additional information if requested by the Fund Office.

Types of Health Care Claims

There are four basic types of health care claims:

1. **Urgent Care**. An urgent care claim is a claim for medical care or treatment that:
   - Would seriously jeopardize your life or health; or
   - Would subject you to severe pain that cannot be adequately managed without care or treatment, in the opinion of a Doctor with knowledge of your condition.
2. **Pre-Service**. A pre-service claim is a claim for benefits where precertification is required. See page 19, Benefits Pre-Certification, for services where precertification is required.
3. **Post-service**. A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim.
4. **Concurrent Care**. A concurrent care claim is any request to extend the duration or number of treatments previously approved through a pre-service claim (such as recertification of the number of days of a Hospital stay).

Health Care Claim Decisions and Benefit Payments.

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. In some situations, the Fund has the right to request a physical exam by a Doctor of its choice (at the Fund's expense).

Generally, all health care benefits will be paid as soon as administratively possible. The Plan will notify you of its initial decision within certain timeframes (described below). If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Plan will give you written notice of its decision about your claim.

The deadlines differ for the different types of claims as shown in the following information:

1. **Urgent Care Claims**. An initial determination will be made within 72 hours from receipt of your claim. If, during the review, additional information is needed from you to process your claim, you will be notified within 24 hours. You will then have 48 hours to respond. You will be notified of the decision within 48 hours of when the additional information is submitted. Due to the nature of an urgent care claim, you may be notified of a decision by telephone. This will be followed by a written notice of the same information.
2. **Pre-Service Claims**. An initial determination will be made within 15 days from receipt of your claim. If additional time is necessary, you will receive notice within that initial 15-day period explaining why there will be a delay in the decision. You will also be given a date, no later than 15 days after the initial 15-day period, when you will receive a decision.

If, during the review, additional information is needed to process your claim, you will be notified within the time period explained above. You will have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination.

3. **Post-Service Claims**. The Plan will inform you of its decision on a post-service claim within 30 days of when you file the claim. If there will be a delay in making a decision on your claim, within that 30-day period, you will receive a notice giving a date – no later than 15 days after the ending of the initial 30-day period by which you can expect a decision.

   If, during the review, additional information is required, you will be notified within the required time period explained above. You will have 45 days to provide the additional information. After you submit the additional information or at the end of the 45-day period, you will receive notice of the Plan's determination.

4. **Concurrent Claims**. You will receive notification on a concurrent claim involving urgent care within 24 hours after receiving the claim, if the claim was received by the Plan at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. Otherwise, the Plan will respond based on whether it is an urgent, pre-service or post-service claim.

Generally, when in-network providers submit the claims, payment is made directly to the provider. In-Network providers handle all the paperwork for you. However, if you submit the claim, payments are generally made directly to you, unless you assign benefits to the Provider.

Authorized Representatives

You may appoint an authorized representative to complete a claim form when you are unable to complete the form for yourself. You can get a form from the Fund Office to designate an authorized representative. A Participant may authorize a representative to act on his behalf, provided the authorization is in writing and follows any procedures adopted by the Trustees. The Plan may request additional information to verify that this person 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 (defined below) without your having to complete the special authorization form.

If A Claim Is Denied

If all or part of your claim is denied, the Plan will notify you in writing, providing:

- The specific reason(s) for the decision;
- Reference to the specific Plan provision(s) on which the decision was based;
- A description of any additional material or information necessary to process your claim and an explanation of the reason it is needed;
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a civil lawsuit under ERISA if you decide to appeal and the appeal is denied;
- A copy, or statement that a copy is available to you at no cost upon request, of any internal rule, guideline, protocol or similar criteria that was relied on in making the decision;

- An explanation of the scientific or clinical judgment related to your condition, or a statement that a copy is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental or Investigational treatment, or other similar exclusion or limit;
- A statement explaining that the Plan will identify any medical or vocational expert that the Plan received the advice of with respect to your claim upon your request; and
- A notice, including a description of the expedited review process, if your appeal is due to the denial of an urgent care claim.

Appealing a Denied Claim

Health Care Benefits Appeal Procedures

The Fund and Board of Trustees, in making decisions on claims and appeals, will apply the terms of the Plan and any applicable guidelines, rules and schedules. Additionally, the Fund and Trustees will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similar claims. The Fund and Trustees will take into account all information you submit in making decisions on claims and appeals.

You may name a representative to act on your behalf. You must notify the Fund Office in writing of your representative's name, address, and telephone number. For urgent care claims, a Health Care Provider that has knowledge of your medical condition may act as your authorized representative.

If your claim in not an urgent care claim and is denied, you (or your authorized representative) may, within 180 days after receiving the denial, appeal the denial by sending a written request for review to the Board of Trustees at:

Board of Trustees
Michigan UFCW Unions and Employers Retiree Health Plan
876 Horace Brown Drive
P.O. Box 71400
Madison Heights, MI 48071-0400

Your written appeal (or oral appeal for urgent care claim denial) should state the reason for your appeal. You (or your authorized representative) may receive, upon request and free of charge, reasonable access to and copies of any documents relevant to your claim and may submit issues and comments in writing. A document is considered relevant if it was relied on in making the decision, was submitted, considered or generated (regardless if relied on) or demonstrates compliance with claim processing requirements.

The Board of Trustees or its authorized committee will determine all requests for review for claims that were denied based on the Fund's eligibility rules.

Appeal Timeframes

If the Board of Trustees reviews your appeal, the amount of time the Trustees have to issue a decision after receiving your appeal will depend on the type of claim.

1. **Urgent care claims**. Appeals of urgent care claims will be decided within 72 hours after the Board of Trustees or its authorized committee receive the appeal. You may appeal denials of urgent care claims either orally by calling the Fund Office at (800) 322-8190 or (248) 585-9610 in writing to the

Board of Trustees. All information necessary to decide the appeal may be transmitted via telephone, facsimile or other available method.

2. **Pre-service claims**. Appeals of pre-service claims will be decided within 30 days after the Board of Trustees or its authorized committee receives the appeal.

3. **Post-service claims.** Appeals of post-service claims will be decided at the next quarterly meeting of the Board of Trustees or its authorized committee immediately after receiving your appeal, unless the Trustees received your appeal within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees, you will receive a decision no later than the third quarterly meeting, and you will be notified in writing of the need for the extension, why the extension is needed, and when a decision is expected. The Trustees will send you a notice of this decision within five days of the decision.

4. **Concurrent Care Claims**. Appeals of concurrent care claims are governed by the provisions above for urgent care, pre-service, or post-service claims, whichever applies to the particular claim.

Notice of Appeal Denial

If all or part of your claim is denied on appeal, you will receive a written explanation that describes:

- The specific reason for the denial:
- The specific provisions of the Plan document on which the decision was based;
- Anny additional information necessary to reconsider your claim (and why that information is necessary);
- Notice that you may receive, upon request, access to and free copies of documents and records relevant to your claim; and
- A statement of your right to bring a lawsuit under ERISA.

If an internal rule, guideline or protocol was relied on in making the decision, you will receive either a copy of the rule, guideline or protocol, or a statement that it was relied upon and is available upon request and free of charge. If the decision on a medical claim is based on Medical Necessity, experimental treatment or a similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available, free of charge, upon request. If the initial decision on a medical claim was based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination (but not a subordinate of such person). In reviewing a denied medical claim, the Trustees will not automatically presume that the Fund's initial decision was correct. Rather, the medical claim will be reviewed independently based on all information you provided to the Trustees, including any new information that you provide that was not reviewed during the Fund's initial decision.

Sole Authority on Determination of Plan Benefits

Under the documents creating the Fund (and the terms of the Plan), the Board of Trustees have sole authority to make final determinations regarding any application for benefits, the interpretation of the

Plan and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Trustees or persons to whom such decision making authority has been delegated by the Trustees, in their sole discretion, decide the Participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan.

Legal action in Court

You may, at your own expense, have legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement or the Plan, is determined to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

Incompetence

In the event it is determined that a claimant is unable to care for his affairs because of illness, accident or incapacity, either mental or physical, any payment due may, unless claim has been made therefore by a duly appointed guardian, committee or other legal representative, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant or such person having the claimant's power of attorney, as the Board of Trustees will determine in its sole discretion.

Cooperation

Every claimant will furnish to the Board of Trustees all such information in writing as may be reasonably requested for the purpose of establishing, maintaining and administering the Fund. Failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payment of benefits. The Board of Trustees will be the sole judge of the standard of proof required in any case, and may from time to time adopt such formula, methods and procedures as the Board considers advisable.

Mailing Address

In the event that a claimant fails to inform the Board of Trustees of a change of address and the Board is therefore unable to communicate with the claimant at the address last recorded and a letter sent by first class mail to such claimant is returned, payments due the claimant will be held without interest until payment is successfully made.

Recovery of Overpayment

If you are overpaid or otherwise paid in error for a claim, you must return the overpayment. The Board of Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted, as well as any benefit payments made in error. Amounts recovered may include interest and costs. The Trustees may also take action to terminate future coverage for you and your eligible dependents.

In the event you are overpaid, the Fund Office will request a refund or the overpayment will be deducted from future benefits. Likewise, if payment is made on the eligible Plan participant's behalf to a hospital, doctor or other provider of health care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider. If the refund is not received, the amount of the overpayment can be withheld or deducted from future benefits for the Eligible Retiree or current or former Eligible Dependents, or a lawsuit may be initiated to recover the overpayment.

Discretionary Authority

The Trustees have full discretionary authority to:

- Determine your eligibility for benefits under the Plans;
- Interpret the Plans; and
- Interpret all of the documents, rules, procedures, and terms of the Plans.

The Trustees' decisions and interpretations are binding on you and will be honored by the courts, unless the Trustees acted arbitrarily.

Self-Audit Program

The Self-Audit Program provides you with a cash reward when you discover and arrange for the recovery of overcharges made on your health care bills.

The program pays 25% of the actual amount of the overcharge that is recovered, up to $500 in any one Calendar Year. If the total amount of the overcharge that is recovered is less than $25, the amount is not eligible under this program.

Program Guidelines

Under this program, only expenses covered under the Plan (not telephone bills, television rental, newspapers, etc.) will be considered in determining the amount payable. You must notify the Fund Office within 45 days of any dispute over a bill.

To receive the reimbursement under the Self-Audit Program, you must submit proof to the Fund Office in the form of a copy of the initial itemized bill with the overcharges circled and a copy of the adjusted bill showing that the Provider adjusted these charges. Within 30 days after the Fund Office receives this proof, the Fund will issue a check to you for 25% of the amount of the overcharge (limited to $500 in one Calendar Year).

The Trustees and administrative staff of the Fund will not get involved in any differences between you and the Provider with respect to disputed charges. You are solely responsible for handling such disputes.

Suggestions For Reviewing Your Itemized Bills

Always request an itemized bill to review the services rendered.

1. Before leaving the Hospital, make sure the Hospital provides or arranges to send an itemized bill.
2. Either during your admission or immediately after discharge, list the events of your stay.
3. Match this list against your actual bills to detect any overcharges.
4. Check your bill carefully for charges that represent any treatments, services or supplies that were not received. Follow this or a similar checklist.
   - Determine if you were billed for the correct number of days and for the correct type of room occupied (private, semi-private, ward).
   - If intensive care was required, determine if you were billed for the correct number of days.
   - Determine if you were charged for the day that you were discharged even though you left before the day's charges began.
   - Determine if you were charged only for the tests or X-rays that you actually received.

- Determine if you were charged for medication, injections, dressings, supplies, etc. that you did not receive or for quantities in excess of what you remember.
- Determine if medication ordered by your Doctor for a specified period was billed to you for your entire Hospital stay.
- If you received therapy, determine if you were charged for the correct type of treatment and for the correct number of hours.
- If you received a blood transfusion, determine if you were charged for blood that a donor, blood bank or a Red Cross family or community assurance program replaced.
- If admitted to the maternity wing, determine if you were billed for a labor room that may not have been used due to swift delivery.
- Ask for an explanation of specific terms used in your bill – for example, miscellaneous charges.

When An Overcharge Is Discovered

1. Circle any overcharges on your bill.
2. Report the overcharges to the Provider's billing department and request a corrected bill. If errors are properly identified on the bill, the Provider must drop these charges, unless there is evidence in the file to the contrary.
3. A copy of the adjusted bill is considered proof that the Provider acknowledged and dropped the charges.

Any Self-Audit Program payments may be considered as income to you and may need to be reported to the Internal Revenue Service.

Coordination of Benefits

The Plan has been designed to help you meet the cost of medical and prescription drug expenses. It is not intended, however, to allow you to receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will take into account any coverage you or a covered dependent has under other plans. Benefits under this Plan will be coordinated with the benefits you or your dependent receive from other plans so that no more than 100% of your covered expenses will be paid by the combination of plans.

Specifically, in a calendar year, this Plan will always pay to you either:

- Its regular benefits in full; or
- A reduced amount that if added to the amount received from another plan, will be equal to the total that the Plan would have paid if you were not covered by the other plan.

If you or your spouse are covered under another plan, you must report that health coverage when you make a Claim.

"Another plan" means any:

- Group, blanket or franchise insurance coverage;
- Group BlueCross or group BlueShield coverage and other prepayment coverage;
- Any coverage under a labor-management trusteed plan, union welfare plan or employer or employee benefit organization plan;

Medicaid

If you are entitled to Medicaid, the Retiree Plan will be primary payer.

- Any coverage under a federal, state or other governmental plan or program that is largely tax-supported or provided through an act of government; or
- Any no-fault automobile insurance coverage.

"Another plan" does not mean:

- The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or
- Medicaid.

The expenses that are coordinated are any necessary, Usual and Customary Charges or expenses, at least part of which are covered under one of the plans covering you or your spouse. If a plan provides benefits in the form of services or supplies instead of cash, such as those provided by an HMO, the reasonable cash value of the service rendered and supplies furnished will be considered when benefits are coordinated.

Order of Payment

If you and/or your spouse are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits do not exceed 100% of the allowable expense incurred.

Generally, a Plan that does not have Coordination of Benefits rules or a Plan that covers you as a cardholder pays first.

The following rules determine the order of payment:

- A plan that does not have a coordination of benefits rule is primary and will pay first..
- An automobile insurance policy is primary if the claim is the result of a motor vehicle accident.

A plan that covers you or your spouse as active employees pays benefits before a plan covering you or your spouse as retired or laid off employees.

If none of the above rules apply, the plan covering the patient the longest period of time will be primary.

Coordination of Benefits with Medicare

Your Retiree Health Plan coverage generally pays secondary to Medicare. If you or your spouse are eligible for insurance under Medicare Part A and Part B, but not enrolled in Part A and Part B and Medicare would otherwise have primary responsibility for expenses incurred, the benefits provided under this Plan will be paid as if you have enrolled in Medicare Parts A and B. However, effective January 1, 2006, if Medicare Part D coverage is primary to this Plan, prescription drug benefits will be applied only when you have enrolled in a Medicare Part D plan.

Medicare is a multi-part program:

- ***Medicare Part A:*** Officially called "Hospital Insurance Benefits for the Aged and Disabled," Medicare Part A primarily covers Hospital benefits, although it also provides other benefits.
- ***Medicare Part B:*** Officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," Medicare Part B primarily covers Physician's services, although it too covers a number of other items and services.
- ***Medicare Part C*:** Called Medicare Advantage, Medicare Part C is the managed care portion of Medicare; specific choices depend on where you live.

- ***Medicare Part D*:** Called "Medicare Prescription Drug Coverage," Medicare Part D is prescription drug coverage that is offered through private Prescription Drug Plans (PDP) to all Medicare-eligible individuals.

> ***Enroll in Medicare Part B prior to the month in which you are eligible for coverage***. You should enroll in Part B (or, alternatively, Part C) in the three-month period prior to the month in which your initial eligibility date occurs to avoid paying for expenses that Medicare Part B would have otherwise covered.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, dependent widow or have chronic End-stage Renal Disease (ESRD). If you are eligible for Medicare based solely on permanent kidney failure (or ESRD), Medicare coverage will not start until the fourth month of dialysis. Therefore, the Plan is generally your only coverage for the first three months of dialysis. When you obtain Medicare because of ESRD, there is a period of time when the Plan is primary and will pay health care bills first. This is called the 30-Month Coordination Period. The 30-Month Coordination Period starts the first of the month you are able to get Medicare because of ESRD, even if you have not enrolled in Medicare yet.

Order Of Payment With Medicare

Plan benefits otherwise payable will be reduced so that benefits payable by this Plan do not exceed the amount of Allowable Expenses reduced by the amount paid or payable by Medicare. The Plan will pay its benefits on a secondary basis to Medicare. For purposes of this provision, Allowable Expenses means the lesser of the reasonable charges for medical care or treatment as determined by Medicare or as determined by the Plan's PPO.

Medicare claims for reimbursement from the Plan are subject to the benefit claim procedures of the Plan. However, the time limit for filing and processing benefit claims incurred after August 5, 1997 is three years. Please note the following:

> This Plan will have primary responsibility the first 30 months for the claim of a Participant who is eligible for Medicare because of End-stage Renal Disease (ESRD) where Medicare has secondary responsibility.

Subrogation and Reimbursement

> **Subrogation**
>
> If another person or entity is responsible for your medical expenses, you must help the Plan recover from that person or entity the benefits that the Plan has paid to you or on your behalf.

The Plan will be subrogated to all rights of recovery of a Participant, his or her parent(s) and Eligible Dependents or a representative or guardian of the Participant, his or her parent(s) and Dependents (collectively, the Claimant), relating to any claim paid or obliged to be paid by the Plan. The subrogation right applies on a priority, first dollar basis to any recovery received by or payable to or on behalf of the Claimant by suit, settlement, or otherwise. This right applies to any recovery, regardless of whether it is a partial or full recovery, whether the recovery is designated for medical claims or whether the Claimant is made whole, from any source making a payment for the Injury, Illness, or conditions relating to the claim. It further applies regardless of whether the source admits it is liable. Possible sources include, but are not limited to a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal Injury protection, financial responsibility, uninsured or underinsured insurance coverage, the employer under the provisions of a Workers' Compensation or Occupational Disease law, as well as medical reimbursement coverage purchased by the claimant or any responsible party.

In addition to its subrogation rights, the Plan is granted a right of reimbursement from any recovery from any source whether by suit, settlement or otherwise, including a partial or full recovery, and regardless of whether the Claimant is made whole. The Plan also has the right to intervene in any lawsuit or to initiate its own lawsuit. Consistent with the Plan's right of reimbursement, the Claimant will first reimburse the Plan on a priority basis for the full amount of all payments the Plan made or may be obliged to make for the claim. This means, for example, that if you have medical claims as a result of an accident for which

the Plan pays or would pay benefits, the Plan is entitled to be reimbursed in full first from any recovery you make from any source relating to the accident. The Claimant will keep any amount greater than the total amount the Plan paid or may be obliged to pay for the claim and the costs, expenses and attorneys' fees incurred to enforce the Plan's rights.

The Plan will not be responsible for a Claimant's attorneys' fees or costs unless the Plan has agreed in writing to pay such fees or costs.

A Claimant must complete a Subrogation and Repayment Agreement and Assignment form before payment of any benefits by the Plan. In accepting benefits from the Plan, the Claimant agrees that any and all amounts recovered will be applied first to reimburse the Plan. In addition, if requested in writing by the Trustees or the Plan's representatives, the Claimant or the Claimant's authorized representative will take action as necessary or appropriate to recover, as damages, payments the Plan made or is obliged to make. If the Claimant does not, the Plan will be entitled to do so in the Claimant's name.

The Claimant will do nothing to impair, release or reduce the Plan's subrogation and reimbursement rights. The Claimant will assist and cooperate with the Plan's representatives and will do everything needed to allow the Plan to enforce these rights.

The Claimant must provide the Plan with a copy of any judgment, settlement agreement, or other document obtained in connection with the recovery. A claim that is incurred after a recovery is the Claimant's responsibility and is paid by the Claimant and not the Plan to the extent of the Claimant's net recovery. If the Plan inadvertently provides benefits for such a claim, the Claimant is obligated to repay the Plan to the extent of the Claimant's net recovery.

If the Claimant receives a recovery from a source but does not reimburse the Plan for benefits the Plan paid or is obliged to pay on the related claim, the Plan has the right to reduce future benefits to the Participant and the Participant's Eligible Dependents associated with the Claimant until the Plan has recovered the full amount under the subrogation and reimbursement provision. The Plan has the right to recover such amounts through appropriate legal or equitable remedies, including a state or federal lawsuit, the imposition of a constructive trust or filing a claim for equitable restitution or lien against any recipient of any monies recovered.

The Board of Trustees of the Plan may waive the above right to subrogation and reimbursement if they determine that doing so is in the best interest of the Plan and its Participants.

Privacy Policy

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Michigan United Food and Commercial Workers Unions and Employers Retiree Health Plan protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice, which was distributed to you when you first became eligible and is available from the Fund Office. This section of the SPD does not represent the Plan's Privacy Notice.

For a copy of the Notice, please contact the Fund's Privacy Officer at the Fund Office. If you have questions about the privacy of your health information, please contact the Fund Office. If you wish to file a complaint about the privacy issue, please contact the Fund's Privacy Officer at the Fund Office.

Administrative Plan Information

Plan Name

This Plan is called the Michigan United Food and Commercial Workers Unions and Employers Retiree Health Plan.

Plan or benefit plan means a program of benefits described in this booklet and any other written documents that the Plan Trustees designate to be part of the program of benefits under the terms of the Trust Agreement.

Summary Plan Description

This booklet provides you with summaries of retiree benefits. This booklet replaces and supersedes any prior Summary Plan Description.

Plan Sponsor and Fund Administrator

A Board of Trustees is responsible for the operation of these Plans. Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrator. The Administrator and the Fund staff, under the Administrator's supervision, maintain eligibility records, account for Employer contributions, answer Participant inquiries, process Claims and benefit payments and handle other routine administrative functions. The Fund's Certified Public Accountant prepares required government reports.

Administrative Managers

The Board of Trustees has delegated administrative responsibilities to the Fund Office. The Administrative Managers are the Chief Executive Officer and the Chief Operating Officer of the Michigan UFCW Unions & Employers Administrator, LLC.

The Fund Office:

- Maintains eligibility records and accounts for employer contributions;
- Answers Participant inquiries; and
- Is responsible for the administration of claims.

Trustees

A Trustee is an individual or the individual's successor, who is appointed and designated according to the terms of the Trust Agreement to administer the Fund. Trustees designated by the Employers are Employer Trustees. Trustees designated by the Union are Union Trustees.

> Benefits under the Retiree Plan will only be paid when the Trustees or person delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits in accordance with terms of the Retiree Plan.

Board of Trustees

The Board of Trustees consists of Employer and Union Trustees selected by the

Employers and Unions that have entered into collective bargaining agreements related to the Michigan United Food and Commercial Workers Unions and Employers Retiree Health Plan. You may contact the Board of Trustees by using the following address and phone number below:

Michigan UFCW Unions and Employers Retiree Health Plan
876 Horace Brown Drive
P.O. Box 71400
Madison Heights, MI 48071-0400
Telephone: 248-585-9610 or 800-322-8190

As of the date of this booklet, the Trustees of this Plan are:

Union Trustees

Roger Robinson
UFCW Local 876
876 Horace Brown Drive
Madison Heights, Michigan 48071

Rick Blocker
UFCW Local 876
876 Horace Brown Drive
Madison Heights, Michigan 48071

Marv Russow
UFCW Local 951
3270 Evergreen Drive NE
Grand Rapids, Michigan 49525

Employer Trustees

Stephen A. Wood
The Kroger Company
2620 Elm Hill Pike
Nashville, TN 37214

Kimberly Welch-Harlan
Hollywood Supermarkets
P.O. Box 1286
Troy, Michigan 48084

Alternate Union Trustees

George Misko
UFCW Local 876
876 Horace Brown Drive
Madison Heights, Michigan 48071

Mark Charrette
UFCW Local 876
876 Horace Brown Drive
Madison Heights, Michigan 48071

Dave Way
UFCW 951
3270 Evergreen Drive, NE
Grand Rapids, Michigan 49525

Alternate Employer Trustees

Kathleen Wagenknecht
The Kroger Company
4111 Executive Parkway
Westerville, Ohio 43081

Victor Iagnemma
Hillers, Inc.
24359 Northwestern Hwy, Suite 150
Southfield, Michigan 48075

Plan Interpretation and Continuation

Only the Board of Trustees is authorized and has the full discretion to:

- Interpret the Plan's rules and procedures;
- Decide all questions about the Plan, including questions about your eligibility for benefits and the amount of benefits payable to you;
- Determine the facts of any claim you make for Plan benefits; and
- Change the eligibility rules and other Plan terms to amend, increase, decrease or eliminate benefits or terminate the Plan, partially or totally.

The Trustees intend to continue the Retiree Plan indefinitely for your benefit and the benefit of all participants. However, the Trustees have been given the power to amend or terminate the Plan, as they deem necessary. The Plan may be amended or terminated by majority vote of the Board of Trustees at a meeting of the Trustees. If this occurs, the Fund Office will send you a written notice explaining the change. Please be sure to read all Fund and Plan communications and keep them with this summary booklet.

The Trustees also decide any factual question related to eligibility for and the type and amount of benefits. The decision of the Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion. If a decision of the Trustees is challenged in court, the decision will be upheld unless the court finds that it is arbitrary and capricious. Individual Trustees, Employers, or Union representatives do not have the authority to interpret the Plan on behalf of the Board of Trustees or to act as agents of the Board with respect to interpretation of the Plan. You may only rely on information regarding the Plan that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Administrator.

> ***Collective Bargaining Agreement*** means the negotiated Labor Agreement between the United Food and Commercial Workers Union Local 876 and Employers that are required to contribute to the Fund.

You are not vested in the benefits described this booklet. The Trustees reserve the right to amend, modify, or terminate the Plan or any of its benefits at any time.

In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a dissolution plan adopted by the Trustees, to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any Contributing Employer, association, or labor organization.

Collective Bargaining Agreements

You and your dependents may obtain, upon written request to the Fund Office, information as to the address of a particular Employer and whether that Employer is required to pay contributions to the Plan.

Identification Numbers

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 502. The identification number assigned to the Board of Trustees by the Internal Revenue Service is 38-2427401.

Contributions

Employer and retiree contributions finance the benefits described in this booklet. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the United Food and Commercial Workers Union Local 876 and Employers.

The collective bargaining agreements specify the amount of contributions, due date of Employer contributions, type of work for which contributions are payable, and the geographic area covered by these agreements. The amount of monthly premium payments due for your coverage is determined by the Trustees.

Trust Fund

The Board of Trustees holds all assets in trust pursuant to the Trust Agreement. Benefits and administrative expenses are paid from the Fund's assets. The Trust Agreement consists of all the documents, including all amendments that establish the Trust Fund and its rules of operation.

Plan Year

The accounting records of the Plan are kept on a plan year basis beginning each April 1 and ending March 31.

The Plan Year Is April 1 Through The Following March 31.

Purpose

This Retiree Plan is an employee welfare benefits plan maintained to provide medical and prescription drug benefits for you and your spouse who meet the eligibility requirements described in this booklet.

Plan Inspection

If you wish to inspect or receive copies of additional documents relating to this Plan, contact the Administrator at the address or telephone number listed on page 35. You will be charged a reasonable fee to cover the cost of copying any document you request.

Agent for Service of Legal Process

If legal disputes involving the Plan arise, legal documents should be served upon the Administrative Managers at the Fund Office. Documents may also be served upon the Board of Trustees at the address of the Michigan United Food and Commercial Workers Unions and Employers Retiree Health Plan, or to the address listed for any individual Trustee.

Service of any legal process may also be made on any individual Trustee at the Fund Office address.

Your ERISA Rights

As a participant in the Michigan United Food and Commercial Workers Unions and Employers Retiree Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to the following rights.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Your spouse also has the right to:

- Continue health care coverage if there is a loss of coverage under the Plan as a result of a Qualifying Event. Your spouse will have to pay for such coverage. The Fund Office will provide your spouse with the rules governing your COBRA Continuation Coverage rights.
- Receive a Certificate of Creditable Coverage, free of charge, from the Plan when:
    - You lose coverage under the Plan;
    - You become entitled to elect COBRA Continuation Coverage; or
    - Your COBRA Continuation Coverage ceases.

  You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to any pre-existing condition exclusions under a new group health plan for 12 months (18 months for late enrollees) after your enrollment in that new coverage. The Fund Office will send you the certificate by first class mail within 45 days it receives your request.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a Claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's Claim and Appeal procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

National Office
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
866-444-3272

Nearest Regional Office
Employee Benefits Security Administration
Detroit District Office
211 West Fort Street, Suite 1310
Detroit, MI 48226-3211
313-226-7450

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their website at www.dol.gov/ebsa.

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AMENDMENT NO. 1 TO THE MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND EMPLOYERS RETIREE HEALTH AND WELFARE PLAN DOCUMENT

1. Effective October 1, 2009, Article 9 shall be amended to add new section 25 to read as follows:

> Section 25. Expenses incurred by a Medicare eligible Participant which the Centers for Medicare and Medicaid Services ("CMS") deny payment to a hospital because of CMS' "never events" policy, as amended from time to time, and for whom Medicare would pay primary to the Plan under the Plan's coordination of benefits order.

2. Effective October 1, 2009, a new section 7 to Article 12, Medicare "Never Events," shall be added to read as follows:

> Section 7. Medicare "Never Events." If a Participant for whom Medicare pays primary to the Plan is denied payment for expenses by a hospital because of CMS' "never events" policy, as amended from time to time, the Plan shall exclude coverage as provided for under Article 9, section 25. However, in the event the affected Participant can be held responsible to the provider for payment of expenses in connection with the Medicare "never event," the Plan shall extend coverage for such expenses.

3. Effective April 1, 2009, section 11, Claim Appeal Process, of Article 4 shall be amended to add a new paragraph (E) under section 11(d)(ii) to read as follows:

> (E) Prescription Drug Benefits. Appeals of denials of Prescription Drug Benefits are reviewed pursuant to the terms of the agreement between the Plan and the Plan's pharmacy benefit manager.

AMENDMENT NO. 2 TO THE
MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND
EMPLOYERS RETIREE HEALTH AND WELFARE PLAN DOCUMENT

Effective January 1, 2012, Article 5 of the Retiree Health and Welfare Plan document shall be amended and restated as attached hereto in the following respects to reflect changes adopted effective January 1, 2012:

1. Article 5, Schedule of Benefits, shall be amended by restating in its entirety as attached hereto as Exhibit 1.

2. The first paragraph of Article 6, Section 2, Benefits Payable, shall be restated to read as follows:

> Benefits that are subject to the deductible are not payable under the Calendar Year deductible has been satisfied, and then benefits are payable at the percentage specified in the applicable Schedule of Benefits for Covered Expenses.

3. A new Section 8, Wellness Benefits, is added to Article 6, to read as follows:
Section 8. Wellness Benefit.

(a) The Plan provides a Wellness benefit that covers preventive care services as indicated in the applicable Schedule of Benefits. For and may include annual physicals, age- and gender-specific screenings, , and immunizations, when these preventive care services are performed according to age- and gender-specific guidelines.

(b) When performed by an In-Network provider, wellness services are covered as indicated on the applicable Schedule of Benefits and are not subject to the deductible. If services are determined to be Medically Necessary based on diagnosis, they will be covered under Section 7, Covered Expenses, of this Article. After the Plan pays the amount listed in the applicable Schedule of Benefits for Wellness benefits, any additional covered costs are subject to Plan deductibles and coinsurance. All Out-of-Network preventive care services that meet the wellness services guidelines are subject to the Plan deductibles and coinsurance. indicated in the applicable Schedule of Benefits.

(c) The Plan pays the amount listed in the applicable Schedule of Benefits for preventive care services that meet the guidelines below. These are listed on the applicable Schedule of Benefits and may include:

(i) Annual physicals: general guidelines recommend physicals every one to two years for ages 40 to 59; and, every year for age 60+.

(ii) Colon and rectal cancer screenings: men and women beginning at age 50, with follow-up tests every five years;

(iii) Prostate cancer screening: prostate-specific antigen (PSA) test recommended annually for men age 50 and older; men in "high-risk categories (i.e., African-Americans and men with a family history of fathers/brothers diagnosed before age 65) should begin at age 45;

(iv) Breast cancer and cervical cancer:

(A) Yearly mammograms are recommended for women beginning at age 40 (earlier if there's a family history);

(B) For cervical cancer, women should first begin receiving Pap tests by age 21 (earlier if they are sexually active); Pap tests are generally recommended every one to three years.

(v) Immunizations, including flu shots for adults;

(d) Any screenings or testing that is not age-appropriate will *not* be covered under this Wellness benefit. Services listed in the Wellness Benefit that are not routine, but that are Medically Necessary will be covered as medical benefits as indicated in the applicable Schedule of Benefits.

Michigan United Food and Commercial Workers (UFCW)
Unions and Employers Retiree Health and Welfare Plan

ARTICLE 5

SCHEDULE OF BENEFITS—FOR ELIGIBLE RETIREE AND SPOUSE *EFFECTIVE JANUARY 1, 2012*

In-Network services, percentage refers to percentage of Preferred Provider Organization's contracted amount. Out-of-Network percentage refers to percentage of Usual, Customary and Reasonable charges.

Medical Benefits		
Lifetime Maximum For Medical Benefits	$250,000 per Individual	
Calendar Year Deductible	$500 per individual	
	In-Network Provider	***Out-of-Network Provider***
Calendar Year Out-of-Pocket Maximum *Individual*	$5,000 (includes deductible)	$15,000 (includes deductible)
Medical Benefits	Plan pays 80% after deductible	Plan pays 60% after deductible
Age Appropriate Preventive/Routine/Wellness	100% of covered expense, no deductible	60% after deductible
Office Visits	Covered 100% after $20 Co-pay	60% after deductible
Specialist Office Visit	Covered 100% after $30 Co-pay	60% after deductible
Urgent Care Facility (free-standing only)	100% after $40 Co-pay	60% after deductible
Emergency Room Treatment Due To Illness	$100 Co-pay if not admitted to the Hospital, then 80% after deductible	$100 Co-pay if not admitted to the Hospital, then 60% after deductible
Surgical Benefits *Allowable Amounts:* *All Covered Surgical Procedures* *1st Procedure* *2nd Procedure*	Plan pays 80% of allowable amount after deductible 100% 50%	Plan pays 60% of allowable amount after deductible 100% 50%
Chiropractic Benefits Office Visit	Covered 100% after $30 Co-pay Other covered expenses payable at 80%; (after deductible) Xrays limited to one set per calendar year	Plan pays 60% (after deductible) Xrays limited to one set per calendar year
Annual Maximum	$1,500	$1,500

	In-Network Provider	*Out-of-Network Provider*
Podiatry Benefit	Plan pays: 80% after deductible	Plan Pays: 60% after deductible
Calendar Year Maximum	$1,500	$1,500
Substance Abuse Benefits *Inpatient & Outpatient*	Plan pays: 80% after deductible	Plan pays: 60% after deductible
Lifetime Maximum	$25,000 Inpatient Expense (combined in-network and out-of-network providers) $5,000 Outpatient Expense(combined in-network and out-of-network providers)	$25,000 Inpatient Expense (combined in-network and out-of-network providers) $5,000 Outpatient Expense (combined in-network and out-of-network providers)
Mental/Nervous Disorder Benefits	Plan pays:	Plan pays:
Inpatient	80% after deductible up to 45 days* per Calendar Year *(combined maximum of in-network and out-of –network)	60% after deductible up to 45 days* per Calendar Year *(combined maximum of in-network and out-of –network)
Outpatient	80% for up to 20 visits per Calendar Year after deductible	60% for up to 20 visits per Calendar Year after deductible
Prescription Drug Benefits -- In-Network Only		
Calendar Year Deductible	$100 per individual	N/A
Calendar Year Maximum Benefit	$5,000 per individual	N/A
Participant Co-Payment Percentage (After Prescription Drug Deductible)	20% up to $50 maximum out-of-pocket expense per drug per fill or refill	N/A

AMENDMENT NO. 3 TO THE
MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND
EMPLOYERS RETIREE HEALTH AND WELFARE PLAN DOCUMENT

1. Effective April 1, 2012, Article 5, Schedule of Benefits, shall be amended and restated, in part, to reflect changes to conform to the provisions of the Mental Health Parity and Addiction Equity Act as set forth below.

Substance Abuse Benefits	Plan pays:	Plan pays:
Inpatient & Outpatient	80% after deductible	60% after deductible
Office Visit	100% after $20 Co-pay	60% after deductible
Mental/Nervous Disorder Benefits	Plan pays:	Plan pays:
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Office Visit	100% after $20 Co-pay	60% after deductible

2. Effective April 1, 2012, Article 6 section 7(q), shall be restated to read as follows:

(q) Day care treatment of Mental and Nervous Disorders and Substance Abuse.

3. Effective April 1, 2012, Article 9, Section 18, excluding treatment for Mental and Nervous Disorders and Substance Abuse, other than that provided in the state in which the participant resides and services, other than from an In-Network provider, is deleted in its entirety and the subsequent Sections shall be renumbered accordingly.

AMENDMENT NO. 4 TO THE MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND EMPLOYERS RETIREE HEALTH AND WELFARE PLAN DOCUMENT

1. Effective January 1, 2014, Article 3 shall be amended to add a new section 10 as follows:

   Section 10 Availability of Local Union Program. An Eligible Retiree or Eligible Dependent Spouse who is covered under the Plan and whose eligibility for Plan coverage terminates at a time when such person is age 65 and Medicare eligible may qualify for a group coverage sponsored by the UFCW Local 876 for its members and if such person is so eligible, the Plan Office may remit to the affected insurance company amounts collected from the affected person's voluntary deduction from pension payments by the United Food and Commercial Workers International Union - Industry Pension Fund for such premium payment for the UFCW Local 876 sponsored medical coverage. The Plan shall not have any responsibility for any benefits, coverage or premiums for such UFCW Local 876 sponsored medical program and the premiums for such coverage shall be the sole responsibility of the affected insured member.

AMENDMENT NO. 5 TO THE
MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND
EMPLOYERS RETIREE HEALTH AND WELFARE PLAN DOCUMENT

The Retiree Health and Welfare Plan document shall be amended as set forth below and attached hereto to incorporate the dental expense benefits and vision benefits agreed to by the Trustees for the Retiree Plan effective July 1, 2017:

1. Article 5, Schedule of Benefits, shall be amended by restating it in its entirety as attached hereto as Exhibit I.

2. A new section 7, Dental Services, is added to Article 2, Definitions, to read as follows and the current Sections 7 through 39 shall be renumbered accordingly as Sections 8 through 40:

Section 7. Dental Services.

Any service involving teeth, tooth supporting structures, tissues of the oral cavity, and services listed in the Dental Fee Schedule. Excision of malignant and non-malignant lesions are considered a medical expense.

3. A new Article 13, Dental Expense Benefit shall be added as attached hereto as Exhibit II and a new Article 14, Vision Benefit, shall be added as attached hereto as Exhibit III and current Article 13, HIPAA Privacy and Security Provisions shall be renumbered as Article 15 along with all references thereto in the Plan document.

4. Article 9, General Plan Exclusions and Limitations, Sections 14(a) and 14(g) shall be amended to clarify the exclusion for medical/dental expense benefits as follows:

(a) Charges to the Medical Plan for services that are deemed dental services of the type covered under the Dental Expense Benefit including, but not limited to: dental X-rays, treatment to teeth whether done for medical or dental reasons; treatment of the gums; treatment of oral-facial structures mainly involved in the treatment or replacement of teeth; replacement of teeth lost due to accidental Injury.

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(g) Charges which are dental in nature must be reviewed as Dental Expense Benefits and only covered to that extent.

EXHIBIT I
Michigan United Food and Commercial Workers (UFCW)
Unions and Employers Retiree Health and Welfare Plan

ARTICLE 5

SCHEDULE OF BENEFITS—FOR ELIGIBLE RETIREE AND SPOUSE *EFFECTIVE JULY 1, 2017*

In-Network services, percentage refers to percentage of Preferred Provider Organization's contracted amount. Out-of-Network percentage refers to percentage of Usual, Customary and Reasonable charges.

Medical Benefits		
Lifetime Maximum For Medical Benefits	$250,000 per Individual	
Calendar Year Deductible	$500 per individual	
	In-Network Provider	***Out-of-Network Provider***
Calendar Year Out-of-Pocket Maximum *Individual*	$5,000 (includes deductible)	$15,000 (includes deductible)
Medical Benefits	Plan pays 80% after deductible	Plan pays 60% after deductible
Age Appropriate Preventive/Routine/Wellness	100% of covered expense, no deductible	60% after deductible
Office Visits	Covered 100% after $20 Co-pay	60% after deductible
Specialist Office Visit	Covered 100% after $30 Co-pay	60% after deductible
Urgent Care Facility (free-standing only)	100% after $40 Co-pay	60% after deductible
Emergency Room Treatment Due To Illness	$100 Co-pay if not admitted to the Hospital, then 80% after deductible	$100 Co-pay if not admitted to the Hospital, then 60% after deductible
Surgical Benefits *Allowable Amounts:* *All Covered Surgical Procedures* *1st Procedure* *2nd Procedure*	Plan pays 80% of allowable amount after deductible 100% 50%	Plan pays 60% of allowable amount after deductible 100% 50%

Chiropractic Benefits Office Visit	Covered 100% after $30 Co-pay Other covered expenses payable at 80%; (after deductible) X-rays limited to one set per calendar year	Plan pays 60% (after deductible) X-rays limited to one set per calendar year
Annual Maximum	$1,500	$1,500
	In-Network Provider	***Out-of-Network Provider***
Podiatry Benefit	Plan pays: 80% after deductible	Plan Pays: 60% after deductible
Calendar Year Maximum	$1,500	$1,500
Substance Abuse Benefits *Inpatient & Outpatient*	Plan pays: 80% after deductible	Plan pays: 60% after deductible
Office Visit	100% after $20 co-pay	60% after deductible
Lifetime Maximum		
Mental/Nervous Disorder Benefits	Plan pays:	Plan pays:
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Office Visit	100% after $20 co-pay	60% after deductible
Prescription Drug Benefits — In-Network Only		
Calendar Year Deductible	$100 per individual	N/A
Calendar Year Maximum Benefit	$5,000 per individual	N/A
Participant Co-Payment Percentage (After Prescription Drug Deductible)	20% up to $50 maximum out-of-pocket expense per drug per fill or refill	N/A

Dental Benefits	For Employees and Eligible Dependent Spouse
Non-Orthodontic Benefit	Plan pays 100% of Dental Fee Schedule for preventive services and 80% of Dental Fee Schedule for all other services up to $2,000 per individual per Calendar Year
Orthodontia Benefit	Plan pays 50% of Dental Fee Schedule up to a $2,000 lifetime maximum per individual
Vision Benefits	**For Employees and Eligible Dependent Spouse**
Exam	Plan pays 100% up to $35 per person during any 12-month period
Frames/Lenses or Contact Lenses	Plan pays 100% for one pair of frames/lenses or contact lenses up to $100 per person during any 24-month period

EXHIBIT II
Michigan United Food and Commercial Workers (UFCW)
Unions and Employers Retiree Health and Welfare Plan

ARTICLE 13
DENTAL EXPENSE BENEFIT

Section 1. General.

If a Participant incurs Covered Dental Expenses for Dental Services when they are performed by a licensed Dentist or dental hygienist, payment will be made for the Covered Dental Expenses incurred, up to the maximum amounts specified in the applicable Schedule of Benefits and according to the provisions in this Article.

Section 2. Benefits Payable.

Benefits are payable for Covered Dental Expenses incurred for dental care or treatment in an amount equal to the percentage specified in the applicable Schedule of Benefits. Reimbursement for all types of expenses may not exceed the maximum payment per Calendar Year specified in the applicable Schedule of Benefits. The Dental Fee Schedule is attached as Appendix B, and is updated annually on January 1st.

Section 3. Covered Dental Expenses.

Covered Dental Expenses include only the charges for services and supplies that:

(a) are authorized by a Dentist; and

(b) are of the usual type furnished for the purpose.

Section 4. Alternate Course of Treatment.

Expenses incurred for an alternate method of treating a dental condition will be payable at the scheduled fee for the service that is:

(a) most commonly used nationwide in the treatment of that condition; and

(b) recognized by the dental profession to be appropriate in accordance with accepted nationwide standards of dental practice.

If an expense is incurred for a more expensive alternative treatment than that indicated in the foregoing guidelines, payment of benefits will be limited to no more than the amount of benefits that would have been paid had the procedures indicated in the guidelines been followed.

Section 5. Pre-Determination Requirement.

If proposed treatment will cost more than $350 or if it includes partial dentures, crowns, periodontics, or fixed bridgework, pre-determination is mandatory. Failure to obtain pre-determination may result in a 20% reduction of benefits, except to the extent waived by the Fund Office in exceptional circumstances. Pre-determination for emergency treatment is not required.

Section 6. **Exclusions and Limitations.**

No benefits will be payable under this Article for the following:

(a) any procedure, including orthodontics, which began before the date the Participant's dental coverage starts. X-rays and prophylaxis will not be deemed to start a dental procedure;

(b) any procedure, except full dentures, whose main purpose is to change vertical dimension;

(c) the replacement of a prosthesis within five years after it was first placed, except for:

  (i) a permanent prosthesis that replaces an interim complete or partial denture or other temporary prosthesis on anterior teeth only;

  (ii) replacement of a prosthesis which, while in the mouth, has been damaged beyond repair as a result of an accident;

(d) replacement of a lost or stolen appliance;

(e) a prosthesis or lab processed restoration on which work starts during the first six months of dental coverage. This exclusion will not apply if the treatment results from an accident. X-rays and prophylaxis will not be deemed to start a dental procedure;

(f) any expense covered under the Medical Benefit;

(g) more than four cleanings, two periodic oral exams, ne topical fluoride varnish on adults per Calendar Year;

(h) charges for ridge augmentation procedures except for stabilization of removable prosthesis on severely atrophic ridges, where full denture prosthesis has failed;

(i) construction of duplicate dentures;

(j) lab processed or nonabutment cast crowns unless the tooth cannot be restored with amalgam or composite materials;

(k) treatment for congenital malformations except dental care that would otherwise be covered (*e.g.*, replacement of a congenitally missing tooth);

(l) non-emergency services for temporomandibular disorders, craniofacial pain disorders and orthognathic surgery that have not been predetermined;

(m) charges for procedures that are experimental in nature, or are not generally recognized by the dental profession for the condition being treated;

(n) customization of dental prosthesis, including personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, unless the prosthesis cannot be made to function without the specialized technique;

(o) procedures or surgeries that are undertaken for primarily cosmetic reasons;

(p) fixed prosthesis or provisional splinting on periodontally compromised teeth with significant bone loss, unless it is certified by an independent periodontist, retained for this purpose by the Trustees, that needed therapy is complete and that the prognosis for the affected tooth (teeth) is good;

(q) fixed prosthesis on endodontically compromised teeth unless it is certified by an independent endodontist, retained for this purpose by the Trustees, that needed therapy is complete and that prognosis is good;

(r) all malignant and non-malignant lesions (which are provided under the Plan's medical benefits). Related services will be prorated for redundant parts of those services;

(s) prosthetics (including crowns) within the first six months of consecutive coverage;

(t) periodontal maintenance without history of periodontal therapy is payable as a regular prophylaxis;

(u) procedures that are not in accordance with the processing guidelines of the current dental consultant;

(v) any Covered Dental Expense incurred after the date coverage terminates, except that claims incurred for a course of dental treatment that began before coverage terminated would be covered provided the service is completed within 30 days of the termination of coverage; or

(w) any Covered Dental Expense that exceeds the maximum amount set forth on applicable Schedule of Benefits.

Section 7. Extended Benefits.

Except as provided in section 6(v), no benefits will be paid for Covered Dental Expenses incurred after coverage terminates, except if, on the date the coverage terminates, a Participant is totally disabled as a result of an accident/Injury, benefits will be paid for dental expenses incurred for repair of damage to natural teeth due to such accident/Injury. However, the expense must be incurred within *three months* after the date of such accident or Injury.

<u>EXHIBIT III</u>

Michigan United Food and Commercial Workers (UFCW) Unions and Employers Retiree Health and Welfare Plan

ARTICLE 14
VISION BENEFIT

<u>Section 1.</u> **<u>General.</u>**

If a Participant incurs Covered Expenses for vision care benefits, payment will be made for the Covered Expenses incurred, up to the maximum amounts specified in the applicable Schedule of Benefits and according to the provisions of this Article.

<u>Section 2.</u> **<u>Benefits Payable.</u>**

Benefits are payable for Covered Expenses for vision care incurred, but not to exceed the maximums specified in the applicable Schedule of Benefits. Covered Expenses for vision care include charges for:

(a) complete eye examination including dilation of pupil and/or relaxing of focusing muscles by drops and refraction for vision by a legally qualified ophthalmologist or optometrist; and

(b) new or replacement frames and/or lenses (including contact lenses) prescribed by an ophthalmologist, optometrist, or optician, including fitting.

All expenses are deemed to be incurred on the date on which the service that gave rise to the expense is rendered. No Covered Expense for vision care incurred for a service or supply listed in this Article or in the applicable Schedule of Benefits will be payable under the Major Medical Benefits.

<u>Section 3.</u> **<u>Exclusions and Limitations.</u>**

No benefits will be payable under this Article for:

(a) any expense for an eye exam that exceeds the specified amount set forth in the Schedule of Benefits;

(b) any expense for one pair of glasses, or one set of contact lenses, which exceeds the specified amount during any 24-month period;

(c) any material furnished as the result of an examination that began before the date the person became eligible for vision care; or

(d) radial keratotomies or other procedures for surgical correction of myopia and/or refractive errors.

AMENDMENT NO. 6 TO THE
MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND EMPLOYERS RETIREE HEALTH AND WELFARE PLAN DOCUMENT

The Retiree Health and Welfare Plan document Schedule of Benefits shall be amended as set forth below to reflect the availability of prescription drug benefits under a mail order program effective January 1, 2019:

	In- Network	**Out-of-Network**
Prescription Drug Benefits — In-Network Only		
Calendar Year Deductible	$100 per individual	N/A
Calendar Year Maximum Benefit	$5,000 per individual	N/A
Participant Co-Payment Percentage (After Prescription Drug Deductible)	20% up to $50 maximum out-of-pocket expense per drug per fill or refill when filled at a participating pharmacy	N/A
	20% up to $125 maximum out-of-pocket expense per drug per 90 day fill or refill when filled under Mail Order Program	N/A

AMENDMENT NO. 7 TO THE MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND EMPLOYERS RETIREE HEALTH AND WELFARE PLAN DOCUMENT

The Retiree Health and Welfare Plan document shall be amended as set forth below and attached hereto to amend and restate the eligibility rules for the Retiree Plan set forth in Article 3 effective January 1, 2018:

Section 1. General Retiree Eligibility - Excluding Disability Retirees

To be eligible to participate in the retiree Plan, an individual must meet all of the following conditions to become an Eligible Retiree:

(a) he must have attained age 55 but not age 65; and

(b) he must have participated as an active full-time employee in the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Fund for at least 15 years; provided if an individual participated in the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan but, without leaving active employment with his or her Employer, transferred participation to the Heartland Fund as a result of his or her Employer's negotiating a transfer of participation into the Heartland Fund, any such years of service may be counted for purposes of satisfying the 15-year requirement; and

(c) he must have retired directly from active employment with a Contributing Employer and be eligible to receive a pension benefit from the United Food And Commercial Workers International Union - Industry Pension Fund, or a predecessor pension fund. (For purposes of this provision, active employment shall include, after a Contributing Employer ceases to make contributions on behalf of the individual, the individual's continuation on the Contributing Employer's seniority list with recall rights, but not in excess of twelve (12) Months following the Participating Employer's discontinuance of contributions on behalf of the individual, and subject to the individual applying for and being entitled to receive a pension effective no later than the expiration of such twelve (12)-Month period); and

(d) throughout the period of five years immediately preceding retirement, he must have been employed by one or more of the Contributing Employers in a position covered by the collective bargaining agreement (regardless of whether contributions were made to this Plan with regard to his service for the entire five-year period); and

(e) for at least three of the five years immediately preceding retirement, he must have worked as a full-time employee for whom employer contributions were made to the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan and/or the Heartland Fund, except that where the Plan has existed for less than three years or a Contributing Employer has participated in this Plan for less than three years, this requirement shall be applied by substituting such lesser period.

(f) In order to enroll in the Plan, an Eligible Retiree must file an application for coverage with the Fund Office. An Eligible Retiree will not be covered under the Plan for any period before an application for enrollment is filed.

Section 2. Retiree Specific Entry Dates.

An individual who qualifies as an Eligible Retiree under Section 1 of this Article will become eligible to participate in the retiree Plan effective on the first day of the month following the Fund Office's receiving the individual's completed enrollment application. Except as described in paragraphs (d) and (e) of Section 2, coverage under the retiree Plan must be uninterrupted with coverage under the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan, including COBRA continuation coverage under the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan as follows:

(a) Retirement at Age 55 and Before Age 57. An Eligible Retiree who retires at or after age 55 and before age 57, must elect COBRA continuation coverage under the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan and maintain such coverage for the full 18-month period or until attainment of age 57. Such Eligible Retiree may then apply and elect, immediately upon the expiration of such coverage, to participate in the retiree Plan, provided the election is made within 60 days. If such Eligible Retiree attains age 57 before expiration of the 18-month COBRA continuation period, the Eligible Retiree may elect, immediately upon attainment of age 57, to participate in the retiree Plan, provided the election is made within 60 days.

(b) Retirement at or After Age 57 and Before Age 60. An Eligible Retiree who retires at or after age 57 and before age 60 may elect immediately upon retirement to participate in the retiree Plan. Or, upon retirement, such Retiree may elect COBRA continuation coverage under the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan immediately upon retirement, and upon the expiration of the full 18-month period of such COBRA continuation coverage elect to participate in the retiree Plan, provided the election is made within 60 days. If such Eligible Retiree attains age 60 before expiration of the COBRA continuation period, the Retiree may elect upon attainment of age 60 to participate in the retiree Plan, provided the election is made within 60 days. If such election is not made upon attaining age 60, the Retiree may not elect to participate in the retiree Plan until the full 18-month period of COBRA continuation coverage has expired from the date he first commenced his COBRA continuation coverage.

(c) Retirement at or After Age 60 and Before Age 65. An Eligible Retiree who retires at or after age 60 or before age 65 may elect immediately upon retirement to participate in the retiree Plan. If the Eligible Retiree elects to participate and completes his or her enrollment application in advance of attaining age 60, his or her coverage will be effective the first day of the first full Month following the Month in which the Eligible Retiree attains age 60.

An Eligible Retiree who retires at or at any time after age 60 as described in section 1, may elect, to participate in the retiree Plan. If he or she elects coverage at age 60, his coverage will be effective as described in this paragraph (c). However, if such Eligible Retiree elects COBRA continuation coverage under the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan upon retirement, he may not participate in the retiree Plan until the full 18-Month period has expired from the date he first commenced his COBRA continuation coverage.

(d) Exception for Other Group Health Plan Coverage. If, upon retirement at or after age 57 and before age 65, the Retiree is covered by a group health plan as an active employee or as the dependent of his or her spouse, such Retiree may defer to elect to participate

in this retiree Plan and may apply and enroll in the retiree Plan upon the loss of such other coverage. Written proof of uninterrupted coverage from the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan retirement date to the date of the enrollment request must be substantiated by a COBRA notice or other written evidence from either his or her employer or his or her spouse's employer.

(e) Heartland Plan Rule. Effective January 1, 2018, an individual who transferred from the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan coverage on account of transfer of his Contributing Employer's participation to the Heartland Fund effective January 1, 2018 may treat this period as continuous uninterrupted service under the Michigan United Food and Commercial Workers Unions and Employers Health and Welfare Plan coverage in determining eligibility and effective date of coverage under the retiree Plan.