

**INTERMOUNTAIN UNITED FOOD AND COMMERCIAL  
WORKERS AND FOOD INDUSTRY HEALTH FUND**

**SUMMARY OF BENEFITS FOR ACTIVE  
AND RETIRED EMPLOYEES AND DEPENDENTS**

**October 1, 2003**

**INTERMOUNTAIN UNITED FOOD AND COMMERCIAL WORKERS  
AND FOOD INDUSTRY HEALTH FUND**

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**AMENDMENT TO THE INTERMOUNTAIN UNITED FOOD AND COMMERCIAL  
WORKERS AND FOOD INDUSTRY HEALTH FUND SUMMARY OF PLAN  
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## MESSAGE FROM THE BOARD OF TRUSTEES

To All Participants:

We are pleased to provide you with this summary of the benefits currently available to you and your eligible Dependents. The benefits explained in this booklet are effective as of January 1, 2003.

Read this booklet carefully so that you will understand the eligibility requirements and the benefits provided. We sincerely hope that you and your family will enjoy good health, but we cannot overlook the fact that injury or illness is usually unexpected and expensive. This benefit program will substantially offset these expenses.

Pay special attention to the cost containment programs (utilization review and preferred provider organization). There are financial incentives when you use these programs and penalties when you do not use them. If you follow the Utilization Management Program and use PPO providers, you will receive the highest possible reimbursement under the Plan. If you go to Non-PPO providers or fail to obtain hospital or medical review when required, you will receive a lower level of benefits. Details on how to use these programs and receive maximum benefits are explained in this booklet.

**Important Note:** You have a limited amount of time from the date Covered Charges are incurred to submit claims to the Fund Office for payment. Detailed information about these time limits as well as the claims and appeals procedures can be found on page 54.

Your eligibility for dental and vision benefits are subject to waiting periods that are described in the eligibility section for dental and vision benefits on page 16 and in the organ transplant benefit description on page 44.

If you have any questions about eligibility or the benefits after you read this booklet, please contact the Fund Office at the address or telephone number listed on the inside front cover of this booklet.

BOARD OF TRUSTEES

## IMPORTANT TELEPHONE NUMBERS

Information Needed	Contact the Following
<b>Fund Office Customer Service: Claims, Eligibility, Benefits and COBRA</b>	(801) 266-3256 or (800) 345-3248
<b>PPO Providers (Hospitals, Physicians, Laboratory and Radiology Facilities, and Ancillary Providers)</b>	Fund Office, or  <u>In Nevada and Idaho</u> Managed Care Consultants - (800) 748-6842 4160 South Pecos Road Las Vegas, Nevada 89121  <u>In Cedar City and St. George, Utah*</u> Managed Care Consultants - (800) 748-6842 4160 South Pecos Road Las Vegas, Nevada 89121  *through Coalition America  <u>In Utah (Except Cedar City and St. George)</u> CCN (formerly Premier Medical PPO) (800) 777-7572 420 E. South Temple, #300 Salt Lake City, Utah 84111
<b>Review Organization for Utilization Management</b>	Managed Care Consultants (800) 748-6842
<b>Chiropractic Network and Utilization Review</b>	Fund Office (801) 266-3256 (800) 345-3248
<b>Vision Plan</b> PPO Provider Plan Administered by: <i>Group Vision Associates, a Division of Spectera</i> 211 Rock Hill Road, Suite. 200 Bala Cynwyd, PA 19004	Fund Office (801) 266-3256 (800) 345-3248

Only the full Board of Trustees (or its authorized designee) is authorized to interpret the terms of the Plan. The Board of Trustees (or its authorized designee) has sole discretion to decide

questions involving the Plan, including questions regarding your eligibility for benefits. No individual Trustee, employer or union representative has authority to interpret this Plan on behalf of the Board (or its authorized designee). If you have questions about your benefits, you should write to the Fund Office for a written answer. As a courtesy to you, the Fund Office also may respond informally to your oral questions. However, oral information and answers are not binding upon the Board of Trustees (or its authorized designee) and cannot be relied upon in any dispute concerning your benefits.

The Board of Trustees intends to provide excellent coverage and operate the Fund in full compliance with applicable federal laws. The Plan provisions summarized in this booklet will be construed accordingly.

## PLAN A SCHEDULE OF BENEFITS

**DEATH BENEFIT** \$15,000  
EMPLOYEES ONLY

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT** \$15,000  
EMPLOYEES ONLY

**WEEKLY ACCIDENT & SICKNESS BENEFIT**  
EMPLOYEES ONLY

Reno clerks only -	\$175 per week, up to 13 weeks
Reno meatcutters only -	\$225 per week, up to 26 weeks
All other Plan A employees -	\$ 75 per week, up to 13 weeks

### PRESCRIPTION DRUG BENEFITS EMPLOYEES & DEPENDENTS:

You **must** use a participating pharmacy. (See page 30.) No benefits are payable for other pharmacies. When you obtain a generic drug or formulary brand name drug from a participating pharmacy, you pay the following copayments:

Generic drug	\$4 per prescription or refill
Formulary brand name drug	\$13 per prescription or refill

If you use a non-formulary drug or if your prescriptions for the year total more than \$1,500, you must pay for your prescription and submit a claim. The Fund will pay 80% of Covered Charges after you meet the \$75 deductible under the Comprehensive Medical Benefits.

### COMPREHENSIVE MEDICAL BENEFITS EMPLOYEES & DEPENDENTS:

Before you or your eligible Dependent are admitted to a Hospital (except in an emergency), you must receive certification from the Review Organization. If you do not receive certification prior to being admitted to the hospital, Hospital benefits may be reduced.

<i>Comprehensive Medical</i>	PPO	Out-of-Area	Non PPO
Calendar year deductible	\$75 per person, \$150 per family	\$75 per person, \$150 per family	\$250 per person, \$500 per family
Lifetime maximum	\$750,000 per person		
Coinsurance limit	The coinsurance percentage applies to the first \$30,000 of Covered Expenses each calendar year (after the deductible). After \$30,000, the coinsurance percentage is 100%.		
Office visit	\$13 copayment, 100%	85% of UCR	60% of UCR

<i>Comprehensive Medical</i>	PPO	Out-of-Area	Non PPO
Chiropractic Treatment	100% after \$13 copayment per office visit and manipulation Other Covered Charges, 85% of negotiated fee. Limited to 30 visits per calendar year. Services must be provided by a panel chiropractor, unless one is not available in your area. Preauthorization by Golden Healthcare Services, Inc. may be required. See page 37.		
Hospital inpatient	95% of contract rate	95% of UCR	60% of UCR
Mental health	80% of UCR  Physician charges limited to 1 treatment per day while hospitalized and 1 treatment in any consecutive 7 days while not hospitalized.		
Emergency room	\$25 copayment, then 95%  If the injury or illness for which services are received is determined to be a non-Emergency, benefits will be subject to the deductible and coinsurance.		
Pap smear (once per year)	85% of contract rate	85% of UCR	60% of UCR
Mammography (for age 35 and over)	85% of contract rate	85% of UCR	60% of UCR
All other expenses (surgery, anesthesia, laboratory, x-rays, physical therapy, outpatient hospital services, acupuncture, medical equipment, orthopedic appliances, prosthetics, etc.)	85% of contract rate	85% of UCR	60% of UCR
Accident Expense Benefit	\$750 for each accident for charges within 90 days		

**ORGAN OR TISSUE TRANSPLANT BENEFIT  
EMPLOYEES & DEPENDENTS:**

See page 44.

**DENTAL EXPENSE BENEFIT  
EMPLOYEES & DEPENDENTS:**

Percentage Payable:

Basic Dental Services:

Diagnostic, Preventive, Restorative, Oral Surgery, Endodontics, Periodontics	70% of UCR in the first year, 80% in the second year and 85% thereafter, provided you see the dentist yearly
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Major Dental Services:

Prosthodontics	55%
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Calendar Year Maximum	\$1,300
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**ORTHODONTIC EXPENSE BENEFIT  
EMPLOYEES & DEPENDENTS:**

Percentage Payable	70%
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Lifetime Maximum	\$1,800
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**VISION EXPENSE BENEFIT  
EMPLOYEES & DEPENDENTS:**

PPO provider program through Group Vision Associates (GVA).

<i>Vision</i>	GVA Panel	Non-GVA Panel
Calendar year benefit maximum	Up to \$112.50 for all vision care combined	
Vision exam	\$10 copayment, once each year.	Up to \$37, once every year.
Lenses		
single vision	Once each year.	Up to \$48, once each year.
bifocal vision	Once each year.	Up to \$70, once each year.
Frames	Once every two years.	Up to \$41, once every two years.

<i>Vision</i>	<b>GVA Panel</b>	<b>Non-GVA Panel</b>
Contact lenses (in lieu of all other benefits)		
Necessary	Once each year.	\$112.50 benefit, once every two years, less other vision benefits received in that year.
Elective	Once each year.	

## PLAN B SCHEDULE OF BENEFITS

### PRESCRIPTION DRUG BENEFITS

#### EMPLOYEES & DEPENDENTS:

You ***must*** use a participating pharmacy. (See page 30.) No benefits are payable for other pharmacies. When you obtain a generic drug or formulary brand name drug from a participating pharmacy, you pay the following copayments:

Generic drug	\$5 per prescription or refill
Formulary brand name drug	\$15 per prescription or refill

If you use a non-formulary drug or if your prescriptions for the year total more than \$1,500, you must pay for your prescription and submit a claim. The Fund will pay 80% of Covered Charges after you meet the \$75 deductible under the Comprehensive Medical Benefits.

### COMPREHENSIVE MEDICAL BENEFITS

#### EMPLOYEES & DEPENDENTS:

Before you or your eligible Dependent are admitted to a Hospital (except in an emergency), you must receive certification from the Review Organization. If you do not receive certification prior to being admitted to the hospital, Hospital benefits may be reduced.

<i>Comprehensive Medical</i>	<b>PPO</b>	<b>Out-of-Area</b>	<b>Non PPO</b>
Calendar year deductible	\$75 per person, \$150 per family	\$75 per person, \$150 per family	\$250 per person, \$500 per family
Lifetime maximum	\$750,000 per person		
Coinsurance limit	The coinsurance percentage applies to the first \$30,000 of Covered Expenses each calendar year (after the deductible). After \$30,000, the coinsurance percentage is 100%.		
Office visit	\$15 copayment, 100%	75% of UCR	55% of UCR
Chiropractic Treatment	100% after \$13 copayment per office visit and manipulation Other Covered Charges, 85% of negotiated fee. Limited to 30 visits per calendar year. Services must be provided by a panel chiropractor, unless one is not available in your area. Preauthorization by Golden Healthcare Services, Inc. may be required. See page 37.		
Hospital inpatient	85% of contract rate	85% of UCR	55% of UCR

<b><i>Comprehensive Medical</i></b>	<b>PPO</b>	<b>Out-of-Area</b>	<b>Non PPO</b>
Mental health		80% of UCR	
		Physician charges limited to 1 treatment per day while hospitalized and 1 treatment in any consecutive 7 days while not hospitalized.	
Emergency room		\$25 copayment, then 85%	
		If the injury or illness for which services are received is determined to be a non-Emergency, benefits will be subject to the deductible and coinsurance.	
Pap smear (once per year)	75% of contract rate	75% of UCR	55% of UCR
Mammography (for age 35 and over)	75% of contract rate	75% of UCR	55% of UCR
All other expenses (surgery, anesthesia, laboratory, x-rays, physical therapy, outpatient hospital services, acupuncture, medical equipment, orthopedic appliances, prosthetics, etc.)	75% of contract rate	75% of UCR	55% of UCR
Accident Expense Benefit		\$750 for each accident for charges within 90 days	

**ORGAN OR TISSUE TRANSPLANT BENEFIT**  
**EMPLOYEES & DEPENDENTS:**

See page 44.

**DENTAL EXPENSE BENEFIT**  
**EMPLOYEES & DEPENDENTS:**

Percentage Payable:

Basic Dental Services:

Preventive and Diagnostic Procedures 75%

Restorative, Oral Surgery, Endodontics, Periodontics 50%

Major Dental Services:

Prosthodontics 50%

Calendar Year Maximum \$1,300

**VISION EXPENSE BENEFIT**  
**EMPLOYEES & DEPENDENTS:**

PPO provider program through Group Vision Associates (GVA).

<i>Vision</i>	<b>GVA Panel</b>	<b>Non-GVA Panel</b>
Calendar year benefit maximum	Up to \$100 for all vision care combined	
Vision exam	\$10 copayment, once each year.	Up to \$37, once every year.
Lenses		
single vision	Once each year.	Up to \$48, once each year.
bifocal vision	Once each year.	Up to \$70, once each year.
Frames	Once every two years.	Up to \$41, once every two years.
Contact lenses (in lieu of all other benefits)		
Necessary	Once each year.	\$100 benefit, once every two years, less other vision benefits received in that year.
Elective	Once each year.	

Plan B does NOT include:

**DEATH BENEFIT**  
**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**  
**WEEKLY ACCIDENT & SICKNESS BENEFIT**  
**ORTHODONTIC EXPENSE BENEFIT**

## RETIREE SCHEDULE OF BENEFITS

**DEATH BENEFIT** \$15,000  
RETIREES ONLY

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT** \$15,000  
RETIREES ONLY

### **PRESCRIPTION DRUG BENEFITS** RETIREES & DEPENDENTS:

You **must** use a participating pharmacy. (See page 30.) No benefits are payable for other pharmacies. When you obtain a generic drug or formulary brand name drug from a participating pharmacy, you pay the following copayments:

Generic drug	\$4 per prescription or refill
Formulary brand name drug	\$13 per prescription or refill

If you use a non-formulary drug or if your prescriptions for the year total more than \$1,500, you must pay for your prescription and submit a claim. The Fund will pay 80% of Covered Charges after you meet the \$75 deductible under the Comprehensive Medical Benefits.

### **COMPREHENSIVE MEDICAL BENEFITS** RETIREES & DEPENDENTS:

Before you or your eligible Dependent are admitted to a Hospital (except in an emergency), you must receive certification from the Review Organization. If you do not receive certification prior to being admitted to the hospital, Hospital benefits may be reduced.

<i>Comprehensive Medical</i>	PPO	Out-of-Area	Non PPO
Calendar year deductible	\$75 per person, \$150 per family	\$75 per person, \$150 per family	\$250 per person, \$500 per family
Lifetime maximum	\$750,000 per person		
Coinsurance limit	The coinsurance percentage applies to the first \$30,000 of Covered Expenses each calendar year (after the deductible). After \$30,000, the coinsurance percentage is 100%.		
Office visit	\$13 copayment, 100%	85% of UCR	60% of UCR
Chiropractic Treatment	100% after \$13 copayment per office visit and manipulation Other Covered Charges, 85% of negotiated fee. Limited to 30 visits per calendar year. Services must be provided by a panel chiropractor, unless one is not available in your area. Preauthorization by Golden Healthcare Services, Inc. may be required. See page 37		

Hospital inpatient	95% of contract rate	95% of UCR	60% of UCR
Mental health		80% of UCR	
	Physician charges limited to 1 treatment per day while hospitalized and 1 treatment in any consecutive 7 days while not hospitalized.		
Emergency room		\$25 copayment, then 95%	
	If the injury or illness for which services are received is determined to be a non-Emergency, benefits will be subject to the deductible and coinsurance.		
Pap smear (once per year)	85% of contract rate	85% of UCR	60% of UCR
Mammography (for age 35 and over)	85% of contract rate	85% of UCR	60% of UCR
All other expenses (surgery, anesthesia, laboratory, x-rays, physical therapy, outpatient hospital services, acupuncture, medical equipment, orthopedic appliances, prosthetics, etc.)	85% of contract rate	85% of UCR	60% of UCR
Accident Expense Benefit		\$750 for each accident for charges within 90 days	

**ORGAN OR TISSUE TRANSPLANT BENEFIT  
RETIREES & DEPENDENTS:**

See page 44.

## DEFINITIONS

**“Board”** means the Board of Trustees established by the Trust Agreement.

**“Contributing Employer or Employer”** means any Employer who is required to contribute to this Fund under the terms of a collective bargaining agreement or any other agreement in effect between the Employer and the Union. The term “Contributing Employer” or “Employer” also means the Local Union organizations, based on acceptance by the Board of Trustees.

**“Covered Charge(s)”** means only those charges that are Usual, Customary and Reasonable and which are made for the Medically Necessary care and treatment of a non-occupational Illness or Injury. It shall also mean only those charges incurred by a Covered Person while eligible for benefits expressly provided under this Plan. Covered Charges are limited to the lesser of:

- the Usual, Customary and Reasonable Charges billed by a health care provider or
- the contract rate for such expense under a PPO agreement and this Plan or between a health care provider and the plan with which this Plan is coordinating benefits.

**“Covered Person”** means each Active or Retired Employee and each eligible Dependent, including any Employee or Retired Employee and Dependent who is continuing coverage under the COBRA Continuation Coverage provisions.

**“Custodial Care”** means treatment, services or confinement which could be rendered safely and reasonably by a person not medically skilled, and which are designed mainly to help the patient with daily living activities. Custodial Care includes personal care, homemaking, moving the patient, acting as companion or sitter, or supervising medication that can usually be self-administered.

**“Dependent”** means:

1. The Employee’s lawful spouse and unmarried natural, legally adopted, step or foster children from birth to 19 years of age. An adopted child is considered a Dependent from the date the child is placed for adoption with the Employee.

The Fund requires that working spouses enroll in benefit plans offered by their employers, even if the spouse must pay a share of the cost of coverage. If your working spouse does not enroll in his/her employer’s plan, the benefits otherwise payable for your spouse’s health claims will be reduced to 40%. To avoid this reduction, your spouse should sign up for his or her employer’s plan as soon as possible. Your spouse is only required to enroll for single coverage and is not required to enroll you or any other Dependents.

2. The Employee’s unmarried children age 19, but less than age 24, who are financially dependent upon the Employee for support, attending a state-accredited institution of higher learning on a full-time basis and who are not covered under the Fund as an Employee. A full-time student means one who is taking 12 hours of credit per quarter or semester (10 hours in post-graduate studies). Generally, most universities, colleges, trade schools, etc., will qualify as an accredited educational institution; however, the Board of Trustees makes the final determination.

3. An Employee's unmarried children age 19 years or older who are on a full-time Church mission, provided satisfactory proof is submitted to the Fund.
4. A Dependent child who is mentally or physically incapable of engaging in any occupation or employment for wage or profit on the date such Dependent child's coverage would otherwise terminate due to attainment of the termination age for dependent children. Due proof that such incapacity commenced prior to such Dependent child's 19th birthday must be submitted to the Fund Office within 31 days of such date. The coverage will be continued for so long as the Employee remains covered and such incapacity continues.
5. A Dependent child when coverage is required by a Qualified Medical Child Support Order (QMCSO). The procedures regarding a QMCSO may be obtained from the Fund Office.

**“Drugs”** means any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Physician licensed by law to prescribe it.

**“Emergency”** means an unforeseen Injury or acute Illness for which medical attention cannot be delayed without serious risk to the Covered Person's health.

**“Eligible Employee”** or **“Eligible Retired Employee”** means each person who meets the eligibility rules of the Plan.

**“Federal Medicare”** means the benefits provided under Title XVIII of the Social Security Act Amendments of 1965.

**“Fund”** means the Intermountain United Food and Commercial Workers and Food Industry Health Fund.

**“Fund Office”** means the Administrative Office of the Intermountain United Food and Commercial Workers and Food Industry Health Fund located at 4885 South 900 East, #202, Salt Lake City, Utah 84117.

**“Home Health Agency”** means a home health care provider which is licensed according to state or local laws to provide skilled nursing and other services on a visiting basis in the Covered Person's home, and is recognized as a provider under Federal Medicare.

**“Hospital”** means an institution which:

1. provides diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of the injured and sick by or under the supervision of a staff of doctors;
2. continuously provides twenty-four hour a day service by a registered nurse;
3. is not, other than incidentally, a place for rest or for the aged, for drug addiction treatment, for alcoholic treatment, for psychiatric treatment or mental care, or a nursing home; and
4. has permanent full-time facilities for bed care of resident patients.

For purposes of this Plan, the term “Hospital” shall also include a Skilled Nursing Facility, as defined herein.

“**Hospital Review**” means the process whereby the Review Organization under contract to the Fund determines the Medical Necessity of a Covered Person’s non-emergency confinement to a Hospital, and if Medically Necessary, the number of pre-authorized days eligible for unreduced benefit coverage according to the terms of the Plan. Review must be made prior to such elective Hospital confinement actually occurring. For emergency confinements, such review must be obtained retrospectively.

“**Illness**” means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes.

“**Injury**” means physical harm sustained as the direct result of an accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

“**Medically Necessary**” with respect to services and supplies received for treatment of an Illness or Injury, means those services or supplies determined to be:

1. appropriate and necessary for the symptoms, diagnosis or treatment of the Illness or Injury; and
2. provided for the diagnosis or direct care and treatment of the Illness or Injury; and
3. within standards of good medical practice within the organized medical community; and
4. not primarily for the convenience of the patient, the patient’s Physician or another provider; and
5. the most appropriate supply or level of service that can safely be provided. For Hospital stays, this means that acute care as a bed patient is needed due to the kind of services the patient is receiving or the severity of the patient’s condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

“**Mental Illness**” means any condition, disorder or disease as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual which includes, but is not limited to, autism, depression, schizophrenia, neurotic disorders and personality disorders. For purposes of this Plan, the term “Mental Illness” does not include substance abuse. Substance abuse treatment is specifically excluded from the Comprehensive Medical Benefits.

“**PPO Hospital**” and “**PPO provider**” means a Hospital, facility, Physician or other health care provider that has a contract with the PPO Organization.

“**PPO Organization**” means an entity under contract to the Fund which contracts with Hospitals, facilities, Physicians and other health care providers to render services to Covered Persons at negotiated rates.

**“PPO Service Area”** means the geographic area in which Covered Persons have reasonable access to a PPO Hospital and PPO Physicians. Only Covered Persons outside of the PPO Service Areas are subject to the reimbursement levels of the Out-of-Area portion of the Medical Benefits. In general, the PPO Service Area will be determined by the zip codes within 30 miles of a PPO provider.

**“Non-PPO Hospital” and “Non-PPO provider”** means a Hospital, facility, Physician or other health care provider that does not have a contract with the PPO Organization.

**“Patient”** means that Covered Person who is receiving medical treatment, services, or supplies.

**“Physician”** means any of the following persons, duly licensed by the state in which they practice, who render a Covered Charge as follows:

- Medical Benefits - Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O.); Surgeon (M.D.); Podiatrist (D.P.M.); Chiropractor (D.C.); Psychiatrist (M.D.); Psychologist (Ph.D.); Social Worker (L.C.S.W.); Marriage and Family Therapist (M.F.C.C.). A Registered Nurse First Assistant (R.N.F.A.) and Certified Registered Nurse Anesthetist (C.R.N.A.) for services performed under a Physician’s supervision.
- Dental Care Benefits - Dentist (D.D.S. or D.M.D.); Denturists.
- Vision Care Benefits - Ophthalmologist (M.D.); Optometrist (O.D.) or Optician.

**“Plan”** means the Rules and Regulations of the Intermountain United Food and Commercial Workers and Food Industry Health Fund and any amendments thereto.

**“Plan Year”** means May 1 of any year to April 30 of the succeeding year.

**“Relative”** means the Covered Person’s spouse, parents, children, siblings, or anyone residing in the same household as the Covered Person.

**“Review Organization”** means an organization working under an agreement with the Fund to administer Utilization Management services, which is responsible for determining Medical Necessity and appropriateness of health care services.

**“Skilled Nursing Facility”** means a lawfully operated institution, other than a Hospital, which meets all of the following requirements:

1. It maintains permanent and full-time facilities for care of at least ten resident patients; and
2. It provides twenty-four hour nursing service by licensed nurses and is under the full-time supervision of a legally qualified Physician or a Registered Nurse (R.N.); and
3. It is primarily engaged in providing skilled nursing care for sick or injured persons during the convalescent stage of their illnesses or injuries and is not a rest home, a Custodial Care home or an institution engaged, other than incidentally, in the care and treatment of drug or alcohol addiction.

**“Total Disability” or “Totally Disabled”** means the following:

- With respect to an Employee, the Employee is prevented from working at any occupation for wage or profit due to a non-occupational Illness or Injury.
- With respect to a Dependent or a Retired Employee, the Dependent or retiree is prevented from engaging in all the normal activities of a person of like age and sex in good health due to a non-occupational bodily Injury or Illness.

**“Trust Agreement”** means the Trust Agreement establishing the Intermountain United Food and Commercial Workers and Food Industry Health Fund and any modification, amendment, extension or renewal thereof.

**“Usual, Customary and Reasonable Charge(s)”** is a charge which falls within the common range of fees billed by a majority of health care providers for a procedure in a given geographic region, or which is justified based on the complexity or the severity of treatment for a specific case, as determined from time to time by the Board.

**“Utilization Management”** means the process of obtaining an advance opinion from the Review Organization as to the Medical Necessity of anticipated medical services prior to the time the Covered Person incurs Hospital confinement or medical procedure expenses.

## ELIGIBILITY

### ***ENROLLMENT***

As soon as you begin work, complete an enrollment card. You may obtain one from your Local Union Office or from the Fund Office. Send the completed form to the Fund Office.

You should notify the Fund Office whenever:

- ⇒ you change your home address,
- ⇒ you wish to change your beneficiary, or
- ⇒ there is any change in your family status; *EXAMPLES*: if you marry, divorce or legally separate from your spouse, or if you have a baby or adopt a child.

If you have not returned a completed enrollment card to the Fund Office, one is included as a tear-out on the inside front cover of this booklet or you can obtain one from your Local Union Office or the Fund Office. Please complete and return it to the Fund Office **as soon as possible**. Fund Office must have your enrollment card to process your claims.

**If You Need Assistance:** If at any time you have questions concerning eligibility, contact the Fund Office or your Local Union Office.

### ***ELIGIBILITY REQUIREMENTS FOR ACTIVE EMPLOYEES***

#### ***HOW YOU BECOME ELIGIBLE – NEW HIRES***

You must work the required hours for a Contributing Employer for three consecutive months. (If you were hired before June 1, 2002, you must have worked the required hours for two consecutive months for a Contributing Employer.) Then, there is a lag month. You will become eligible on the first day of the following month.

*EXAMPLE:* If you first work the required work hours in January, February and March, you will become eligible on May 1. (If you were hired before June 1, 2002, you would have become eligible April 1 after working required hours in January and February.)

#### ***WORK HOURS REQUIRED FOR ELIGIBILITY***

The number of hours you must work each month in order to become eligible for benefits, and to maintain your eligibility, depends on the terms of the collective bargaining agreement in effect between your Employer and your Union. For most employees, the requirement is 87 hours per month.

If you have questions concerning your eligibility, call the Fund Office at (801) 266-3256 or (800) 345-3248.

CONTINUING ELIGIBILITY

You will continue to be eligible for benefits if you work the required hours for a Contributing Employer during a calendar month. In order that there will be enough time for Employer reports to be received and processed by the Fund Office, a reporting or “lag” month is used to determine your monthly eligibility. The lag month is the month between the month in which the hours are worked and the month of eligibility provided by those hours. If you work the required hours in a month, those hours are reported to the Fund in the following month and are used to provide coverage for the third month.

<u>EXAMPLES:</u>	If you work the required hours in the month of:	You will have coverage for the month of:
	February	April
	March	May
	April	June
	May	July

**Exception:** These eligibility provisions do NOT apply to certain benefits that require an additional waiting period. (See eligibility for Dental and Vision benefits.)

PLAN A and PLAN B COVERAGE

You will have coverage under Plan B benefits for 24 months from your initial date of hire. Plan A coverage will commence on the first day of the month following the second anniversary of your date of hire. If you have a break in employment of six months or more, you will again become covered under Plan B benefits for 24 months from the date you again start work for a Contributing Employer.

EFFECTIVE DATE OF COVERAGE FOR ALL BENEFITS EXCEPT DENTAL AND VISION

Effective Date of Coverage for Employees - You will become covered for all benefits except dental, vision and organ transplant benefits on the day you become eligible, subject to the exceptions explained below.

Effective Date of Coverage for Dependents – Coverage for your Dependents will begin at the same time as yours. If you acquire a Dependent after your Effective Date of Coverage, the Dependent will be covered as of the date the Dependent qualified as an eligible Dependent (e.g., date of marriage or date of birth).

EFFECTIVE DATE OF COVERAGE FOR DENTAL AND VISION EXPENSE BENEFITS

EFFECTIVE DATE OF COVERAGE FOR EMPLOYEES NOT PREVIOUSLY COVERED

To be eligible for Dental and Vision Care Benefits, **you must be continuously employed for one year with the same Contributing Employer and** you must work the required hours for your Employer in each of the 9th, 10th and 11th months of the first year of your employment. If you satisfy these requirements, your Effective Date for Dental and Vision benefits will be the first day of the 13th month of your employment.

If you do not work the required hours per month in the 9th, 10th and 11th months of your first year of employment, your coverage will be delayed until you have worked the required hours for three consecutive months. Then, there will then be a one lag month and your Effective Date of Coverage will be the first of the following month.

EXAMPLES: You were employed by your current Employer in January and remained continuously employed by that Employer for one year. If you work the required hours in September, October and November, you will become covered for Dental and Vision benefits on January 1st of the following year.

If you did not work the required hours in September, October and November, your Effective Date of Coverage would be delayed until the first day of the second calendar month following a three consecutive month period in which you do work the required hours each month. (If you work the required hours in October, November and December, your Effective Date of Coverage will be February 1).

Special Effective Date Of Coverage For Employees Who Terminate Employment And Then Return To Work For The Same Employer If you terminate employment with your Employer after meeting the one-year continuous employment requirement explained above and if you return to work for the same Employer and reestablish your coverage for “All Benefits Except Dental and Vision” within six (6) months of your termination date, you will become covered for the Dental and Vision Expense Benefit at the same time you become covered for all other benefits.

Special Effective Date Of Coverage For Employees Who Change Employers If you have attained eligibility for Dental and Vision Benefits and subsequently change Employers, the Dental and Vision coverage will terminate at the end of two calendar months following the last month you work the required hours. From the date your coverage terminates, there will be a six-month wait for the Dental and Vision Expense Benefit under your second Employer’s contribution.

CONTINUING ELIGIBILITY Following your Effective Date of Coverage, you and your eligible Dependents will remain covered as long as you work the required hours each month for a Contributing Employer.

### ***ELIGIBLE DEPENDENTS***

Your Eligible Dependents are your legal spouse and all unmarried natural or adopted children under 19 years of age (stepchildren, foster children who live with and are solely supported by you and children who are placed with you for adoption are also included). Coverage for unmarried children over age 19 will be continued if the child qualifies as an Eligible Dependent as defined on page 10.

The Fund requires that working spouses enroll in benefit plans offered by their employers even if the spouse must share in the cost of coverage. Your spouse is only required to enroll for single coverage and is not required to enroll you or any other Dependents. If your working spouse does not enroll in his/her employer’s plan, the benefits otherwise payable for your spouse’s health

claims will be reduced to 40%. To avoid this reduction, your spouse should sign up for his or her employer's plan as soon as possible.

There are some exceptions to the enrollment requirements:

1. This rule does not apply if your spouse is not employed. This rule will apply if your spouse becomes employed in the future.
2. This rule does not apply if your spouse's employer does not offer any benefits or your spouse is not eligible for benefits (*EXAMPLE*: if your spouse is a new or part-time employee). This rule will apply when your spouse's employer offers benefits or your spouse becomes eligible for benefits.
3. Your spouse is only required to enroll for coverage for himself or herself. Your spouse is not required to cover you or your children. However, your spouse must enroll for all available medical, dental and vision benefits.

Please call the Trust Fund Office if you have any questions regarding coordination of benefits (COB) or other rules.

The Effective Date of Coverage for your eligible Dependents is the same as yours. If you acquire a Dependent after your Effective Date of Coverage, the Dependent will be covered as of the date the Dependent qualifies as an eligible Dependent (e.g., date of marriage or date of birth).

#### Qualified Medical Child Support Orders

Under the Omnibus Budget Reconciliation Act of 1993, the Fund must recognize any Qualified Medical Child Support Order (QMCSO) and enroll as directed by the Order any child of a Fund participant specified by the Order. The Fund has written procedures for approval of a Qualified Medical Child Support Order which are on file at the Fund Office.

No eligible participant's child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's Federal income tax return or does not reside with the parent.

#### **TERMINATION OF COVERAGE**

Once eligibility for benefits has been established, coverage for you and your eligible Dependents will automatically terminate at the earliest of the following:

1. If you are no longer employed by a Contributing Employer and you have not demonstrated continuing attachment to the Food Industry, your eligibility will terminate at the end of the month in which you quit or are discharged.
2. Otherwise your coverage will terminate at the end of the second calendar month following the last month in which you work the required hours for your Employer. (*EXAMPLE*: If you last work the required hours in January, your coverage will terminate March 31.)
3. Coverage for your Dependents will terminate on the date your Dependents cease to qualify as an eligible Dependent as defined or the date your coverage terminates, whichever is earlier.

***CONTINUATION OF ELIGIBILITY IF YOU BECOME TOTALLY DISABLED  
(Eligible Employees Only)***

If you, the Employee, become Totally Disabled (as defined in the Definitions Section of this booklet) while covered under the Fund and your coverage terminates as explained under “Termination of Coverage,” eligibility will be continued as follows:

1. You and your eligible Dependents will remain eligible for the benefits to which you were entitled while covered as an Eligible Employee for the period of your disability, until the earlier of: (a) the date your disability terminates; or (b) the last day of the twelfth (12th) calendar month following the date your coverage would have terminated under “Termination of Coverage.”
2. If your Dependent ceases to qualify as an eligible Dependent during this period, coverage for that Dependent will terminate at the end of the month in which he or she no longer qualifies as an eligible Dependent.

***FAMILY AND MEDICAL LEAVE***

If your Employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you and your eligible Dependents will continue to be covered under this Fund provided you were eligible when the leave began and your Employer makes the required contributions during your leave. Coverage will be continued while you are absent from work on an FMLA leave as if there were no interruption of active employment and as if you were continuing to work the number of hours required for coverage. Coverage will continue until the earlier of the expiration of the FMLA leave or the date you give notice to your Employer that you do not intend to return to work at the end of the leave. If you do not return to work after the end of the FMLA leave, your Employer may require reimbursement for the contributions made on your behalf after your leave ended, subject to legal requirements.

The Fund does not determine whether or not an Employee is entitled to FMLA leave with medical coverage. Any disputes regarding entitlement to FMLA leave with continuing medical benefits must be resolved with the Employer.

***MILITARY LEAVE OF ABSENCE***

If you enter the uniformed military service of the United States for a period of less than 31 days, your eligibility will be continued with no self-payment required based on the “lag month” termination provision of the Plan, provided you were eligible under the Fund when your military leave began. If your military service will last longer than 31 days, you may continue eligibility for up to 18 months. You may be required to make self-payments for the continued eligibility. Upon release from military service, your eligibility may be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994.

***RETIREE ELIGIBILITY***

An Employee who retires prior to age 65 and who has ten (10) years of service in the Intermountain Retail Food Industry Pension Trust Fund or the Intermountain Retail Store

Employees Pension Trust may continue to participate in the Fund by making self-payments at a rate to be determined by the Board of Trustees. Only the Death, Accidental Death and Dismemberment and Medical/Drug benefits are provided under this provision; Dental, Vision and Weekly Accident and Sickness benefits are not included. (However, if the Retiree was eligible for Dental and Vision benefits as an Eligible Employee, the Retiree and Dependents may continue these benefits on a self-pay basis for up to 18 months under the COBRA Continuation of Coverage provision described on page 21).

The Retiree must make the required monthly payment as determined by the Board of Trustees and the payments must be made by the fifteenth (15th) day of the month prior to the month of coverage. Eligibility will terminate on the first day of the month for which a timely payment was not received.

The coverage is provided to both the Retiree and the eligible Dependents. If coverage terminates due to non-payment of premium, the Retiree must re-apply for approval to participate under these provisions.

All benefits provided under this self-pay provision will terminate for the Retiree and the Dependents on the Retiree's 65th birthday.

Health care benefits are not vested rights. The Trustees have the authority to modify, limit or terminate health care benefits at any time as they deem appropriate. Benefits for Retirees and their eligible Dependents are provided only so long as the funds negotiated by the collective bargaining parties are sufficient to pay for the benefits.

#### SPECIAL LATE ENROLLMENT RULES

If a Retiree chooses not to enroll on the date he or she first became eligible because the Retiree or a Dependent had other health coverage under another health insurance policy or program (including any COBRA Continuation Coverage, individual insurance or a public program such as Medicaid), and the Retiree or a Dependent cease to be covered by that other coverage, they may enroll in this Fund within 31 days after termination of the other coverage if the other coverage terminated due to any of the following reasons:

1. The loss of eligibility for the other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation;
2. The termination of employer contributions toward the other coverage; or
3. If the other coverage was COBRA coverage, the exhaustion of that coverage. COBRA coverage is "exhausted" if it ceases for any reason other than failure to pay premiums on a timely basis.

If a Retiree, after declining coverage, acquires a new Dependent spouse, the Retiree may enroll himself and the newly acquired Dependent spouse within 31 days after the date the new Dependent spouse is acquired.

## **CONTINUATION OF COVERAGE UNDER FEDERAL LAW (COBRA)**

If one of the following events (known as a Qualifying Event) occurs, you and your eligible Dependents have the right to continue health coverage that was in effect at the time of the Qualifying Event under a federal law known as “COBRA”. The following are Qualifying Events:

1. The Employee’s loss of eligibility due to insufficient hours or termination of employment, whether involuntary, voluntary or due to retirement;
2. The Employee’s or Retiree’s divorce;
3. Death of the Employee or Retiree; and
4. The loss of status as a dependent child.

If you, the Employee, lose eligibility because of a reduction in hours or termination of employment (Item 1), you and your Dependents are entitled to **18 months** of coverage from the date of the Qualifying Event. Each of the other above listed items (Items 2 through 4) entitles your Dependents to **36 months** of coverage from the date of the Qualifying Event.

If a second Qualifying Event occurs within an 18-month continuation coverage period or if you become entitled to Medicare during that period, your Dependents may extend their period of COBRA coverage up to a total of 36 months from the date of the first Qualifying Event.

If you, an Employee already entitled to Medicare, have a Qualifying Event because insufficient hours are reported to the Fund Office for the month, your Dependents will be allowed to continue their coverage until the later of:

1. 18 months from the date you did not work the required minimum work hours; or
2. 36 months from the date you became entitled to Medicare, less any months of coverage you earned benefits under the regular Plan. *EXAMPLE:* If you turn 65 and become eligible for Medicare and then lose regular Plan coverage 12 months later due to retirement, your dependents will be entitled to 24 months of COBRA continuation coverage.

### ***COST OF CONTINUATION COVERAGE - BENEFITS THAT MAY BE CONTINUED***

COBRA coverage is available only at your own expense. If COBRA coverage is elected, the full cost, plus a 2% administrative charge, will be charged. You may elect to continue medical coverage only (Core coverage); or medical, dental, and vision coverage (Core Plus coverage). Dental and vision coverages do not have to be continued; however, you may not continue one of these benefits without the other. You can only elect and be covered by the same plans of benefits under which you were covered the day prior to the Qualifying Event. *EXAMPLE:* If you were not eligible for dental or vision benefits before the Qualifying Event, you may not elect dental and vision benefits under COBRA Coverage.

COBRA Core Plus will cost more than Core coverage since more benefits are provided. The benefits under each plan are the same as for all other eligible participants, and deductibles and copayments will apply as if there has been no gap in regular plan coverage. The COBRA rates are adjusted once each year and may be obtained from the Fund Office.

### ***HOW TO OBTAIN COBRA COVERAGE***

Under COBRA, you or your family members have the responsibility to inform the Fund Office within 60 days of one of these events:

- a divorce; or
- a child losing dependent status.

COBRA rights will be forfeited if you do not notify the Fund Office within 60 days of the Qualifying Event.

Your Employer has the responsibility to notify the Fund Office within 30 days of the date coverage would otherwise be lost for one of the following reasons:

- your death;
- termination of employment or a month for which your Employer reports less than the minimum required work hours to the Fund Office on your behalf.

However, you or your Dependents should also advise the Fund Office of these events as well.

The Fund Office will send a letter to qualified beneficiaries explaining their option to continue coverage within 14 days following receipt of notification of a Qualifying Event. This notice will tell you when your eligibility will run out and ask you to complete and return the form if you want self-pay COBRA continuation coverage beyond the termination of your eligibility. The letter will be addressed to the Employee and Dependents at the address of record on file at the Fund Office. It is the responsibility of all participants to keep the Fund Office informed of their current mailing address.

You must sign and return the form electing COBRA coverage to the Fund Office within 60 days of the Qualifying Event or 60 days from the date the Fund Office notified you of your right to COBRA continuation coverage, whichever is later. You do not have to show that you are insurable to choose COBRA coverage. COBRA rights will be forfeited if you or your eligible Dependents do not return the COBRA election forms to the Fund Office within this 60-day election period.

The Fund Office will notify you of the cost of COBRA coverage when it notifies you of your right to this coverage. You will have a maximum of 45 days from the date you mail your election form to the Fund Office in which to submit your first payment. The first payment must include all premium costs retroactive to the date your coverage would have otherwise terminated. After the initial payment is made, you must make monthly payments to continue coverage. You will not receive a monthly bill; instead you should automatically send your check or money order

to the Fund Office before the first of each month. Failure to make a monthly payment within 30 days of the beginning of the coverage month will result in termination of your COBRA coverage as of the end of the last month for which payment was made.

If you do not choose continuation coverage, your health coverage will end. However, your spouse and/or your eligible dependent children may elect the continuation coverage, independent of your rejection.

COBRA coverage is not available to anyone who was not covered before the COBRA Qualifying Event; however you may add newly acquired Dependents while covered under COBRA by notifying the Fund Office within 30 days of acquiring the new Dependent and paying the premium.

### ***EXTENDED COBRA CONTINUATION COVERAGE FOR DISABLED INDIVIDUALS***

If you or your Dependent are determined by Social Security to have been totally disabled at the time of the Qualifying Event, or within 60 days after that date, coverage may be extended for the disabled person and his or her family beyond the original 18 months up to 29 months. To qualify for these additional 11 months, the disabled person must report the Social Security determination to the Fund Office before the original 18 month period expires and within 60 days after the date of the determination. Further, the Fund Office must be notified within 30 days of the final determination that the qualified beneficiary is no longer totally disabled. Please note, the premium for the additional 11 months will be approximately 50% higher than the initial 18 month COBRA premium.

### ***TERMINATION OF COBRA CONTINUATION COVERAGE***

Eligibility for COBRA continuation coverage will terminate on the first day of the month following the occurrence of any one of the events listed below:

1. Failure to remit the required premium payments in full and on time;
2. You or your Dependent become covered, as an employee or as a dependent, under any other group medical plan; however, if the other group health plan will not cover, or limits coverage for, a pre-existing health problem, COBRA continuation coverage will not be terminated;
3. You or your Dependent become entitled to Medicare benefits;
4. Your Employer no longer provides group health coverage to any of its Employees; or
5. You or your Dependent have continued coverage for additional months due to a disability and there has been a final determination by Social Security that you or your Dependent are no longer disabled.

Should federal legislation alter the provisions of COBRA in existence at the time this Summary Plan Description is printed, participants will be advised of any such modification as required.

If you have changed marital status, or you or your spouse have changed addresses, please contact the Fund Office. Please let the Fund Office know of any Qualifying Event even if your Employer is otherwise required to give notice to the Fund Office.

***COBRA CONTINUATION COVERAGE QUICK REFERENCE CHART***

<b>Qualifying Event</b>	<b>Qualified Beneficiary</b>	<b>Maximum Continuation Period</b>
(1) Reduction in your work hours	You, your spouse and Dependent children	18 months after date of qualifying event*
(2) Termination of your employment, or retirement	You, your spouse and Dependent children	18 months after date of qualifying event*
(3) Your death	Your spouse and Dependent children	36 months after date of qualifying event
(4) Your divorce or legal separation	Your spouse	36 months after date of qualifying event
(5) Your Dependent child's loss of that status under Plan	Affected Dependent child if covered under Plan	36 months after date of qualifying event
(6) Your entitlement to Medicare <u>after</u> a qualifying event described in (1) or (2).	Your spouse and Dependent children	36 months after date of initial qualifying event
(7) Your entitlement to Medicare <u>before</u> a qualifying event described in (1) or (2).	Your spouse and Dependent children	Later of 18 months from the qualifying event or 36 months from the date of the Employee's Medicare entitlement

\* If you or one of your eligible Dependents are disabled at the time of the Qualifying Event, or within 60 days after that date, COBRA coverage may continue for the disabled person and family for up to 29 months. Proof of eligibility for Social Security disability benefits is required within 60 days after the date of the Social Security determination and prior to the expiration of the initial 18 months of COBRA coverage, to qualify for continuation of the additional 11 months of coverage. A higher premium will be charged for the additional 11 months of coverage.

If a second qualifying event occurs within the first 18-month period, COBRA coverage may be extended for up to a maximum of 36 months from the date of the first qualifying event.

## **CERTIFICATE OF CREDITABLE COVERAGE WHEN COVERAGE ENDS**

When your medical coverage ends, the Fund Office will provide you and/or your covered Dependents with a Certificate of Creditable Coverage that indicates the period of time you and/or they were covered under the Fund. If, within 62 days after your coverage under the Fund ends, you and/or your covered Dependents become eligible for coverage under another group health plan or if you buy (for yourself and/or your covered Dependents) a health insurance policy, this certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply to you and/or your covered Dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under the Fund, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under the Fund ends. If you (or any of your covered Dependents) elect COBRA Continuation Coverage, another certificate will be sent to you (or if COBRA Continuation Coverage is provided only to your covered Dependent(s), to the Dependent(s)) by first class mail shortly after the COBRA Continuation Coverage ends for any reason.

In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a request for such a certificate if that request is received by the Fund Office within two years after the later of the date your coverage under the Fund ended or the date COBRA Continuation Coverage ended.

**DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT  
BENEFIT**

(Plan A Eligible Employees and Retirees)

***DEATH BENEFIT***

If you die while eligible for the Death Benefit, the Fund will pay a death benefit of \$15,000 to your designated beneficiary.

***ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT***

If you suffer one of the losses listed below solely as a result of an accidental bodily Injury, the Fund will pay you or your beneficiary the applicable benefit amount. The Injury must be sustained while you are eligible and the loss must occur within 90 days of the accident. The benefit will be paid regardless of any other benefits you may receive.

Loss of life	\$15,000
Loss of two limbs or sight of both eyes	\$15,000
Loss of one limb <u>and</u> sight of one eye	\$15,000
Loss of one limb <u>or</u> sight of one eye	\$7,500

The maximum amount payable for all losses resulting from any one accident is \$15,000. Payment for all benefits, except loss of life, are paid directly to you. In case of loss of life, payment is made to your beneficiary.

The loss of limb means the loss of its use due to severance of the hand or foot at or above the wrist or ankle joint and the loss of sight means the total and irrevocable loss of sight.

No Accidental Death And Dismemberment Benefit is payable for any loss caused or contributed to by:

1. Disease or Mental Illness, or any medical or surgical treatment thereof;
2. Suicide or self-inflicted injury, while sane or insane;
3. Declared or undeclared war, or any act or incidence of war;
4. Bacterial infections, except pyogenic infections of and through a visible wound sustained through an accidental Injury;
5. Ptomaines.

## ***BENEFICIARY***

Your designated beneficiary is the individual(s) you name on your “Beneficiary Designation Form.” If you designate more than one beneficiary and you do not specify the portion to be paid to each, the beneficiaries will share equally.

If a beneficiary is not living on the date the benefit becomes payable, then payment will be made equally to your remaining beneficiaries, unless you had made written request to the contrary. If no designated beneficiary is living on the date the benefit becomes payable, or no beneficiary was named, payment will be made in the following order:

1. To your spouse.
2. Equal portions to your children.
3. Equal portions to your father and mother, if both are living. If only one parent is living, to that parent.
4. To your estate.

You may change your designated beneficiary at any time. To do so, request a “Beneficiary Designation Form” from the Fund Office or your Local Union Office. Complete the form and return it to the Fund Office. The beneficiary change will become effective upon receipt of the completed form by the Fund Office.

**WEEKLY ACCIDENT AND SICKNESS BENEFIT**  
**(Plan A Eligible Employees)**

***ELIGIBILITY***

The Fund will pay the weekly benefit amount stated in the Schedule of Benefits if you are unable to work as a result of a non-occupational Illness or Injury that occurs while you are eligible, provided you meet the following requirements:

1. You must be Totally Disabled as defined in the Definitions section of this booklet.
2. You must be under the care of a legally qualified Physician.
3. You must remain in the jurisdiction of the collective bargaining agreement.
4. Your Physician must verify in writing that he or she attended you during your period of Total Disability and he or she must also verify the date your disability commenced and the date the disability ends.

***COMMENCEMENT OF BENEFIT***

If you are unable to work because of an accidental Injury, benefits are payable starting with the first (1st) day of the disability.

If you are unable to work because of an Illness, benefits are payable starting with the fourth (4th) day of Illness.

***DURATION OF PAYMENTS***

The weekly amount listed and the number of weeks listed in the Schedule of Benefits is the maximum permitted by the Plan for any one disability. Your disability ends when you no longer meet the requirements explained above or when you return to work for the contributing Employer, whichever is earlier.

If you return to work and become Totally Disabled again, it will be considered a new period of disability. All disabilities, whether they are due to the same condition, a related condition or an unrelated condition, will be considered one period of disability if you have not returned to work.

If you receive the maximum benefits for a disability before you return to work and you are again disabled due to a covered accident or Illness totally unrelated to the previous disability for which you received benefits, it will be considered a new disability.

## ***LIMITATIONS***

No benefits are payable under this provision for any of the following:

1. Any disability directly related to treatment for the use of alcohol, barbiturates, hypnotics, narcotics, or any other illegal drug or any type of addiction (not induced by a Medical Doctor).
2. Any disability resulting from participation in, or consequence of, a riot or the commission of a felony or misdemeanor or activity otherwise “outside the law” (this does not include traffic violations).

**PRESCRIPTION DRUG BENEFITS**  
**(Active and Retired Employees and Their Dependents)**

You must obtain your prescription at one of the “participating pharmacies”:

In Northern Nevada:      Smiths, Safeway, Scolari’s, Albertson’s  
In Utah:                      Smiths, Albertson’s

If you use another pharmacy, no benefits are payable and you will be responsible for the full cost of your prescription. If you are outside of the service area of the participating pharmacies, you should pay for your prescription and submit a claim for reimbursement. If the prescription is for an emergency and it is after the service hours of the participating pharmacies, you should also pay for your prescription and submit a claim for reimbursement.

When you obtain a generic drug or a formulary brand name drug prescription at the participating pharmacies, you are only required to pay a small copayment to the pharmacy. You do not need to file a claim. This “point of sale” convenience is available for the first \$1,500 of prescription drug expenses per calendar year.

If you use a non-formulary brand name drug, you will have to pay the full cost of your prescription to the pharmacy and then submit a claim to the Fund Office for reimbursement.

***COPAYMENTS***

For participating pharmacies the Fund pays the cost of the prescription drug, less the copayments shown in the Schedule of Benefits.

The copayments apply until your benefits for prescription drugs reach \$1,500 during a calendar year. When your prescription drug expenses exceed \$1,500, you will be required to pay for your prescription at the pharmacy and submit a claim for reimbursement under the Medical Expense Benefits for the remainder of that calendar year.

***FORMULARY DRUGS***

You are not required to use formulary drugs but you will find it convenient to do so. If you use a non-formulary drug, you must pay for your prescription and submit a claim for reimbursement.

The formulary, is intended to serve as a guide in selecting clinically and therapeutically appropriate medications in a cost-effective manner. The formulary list is available at the NPA website, [www.npa.com](http://www.npa.com). Your doctor can call NPA at (800) 467-2006 for assistance.

The formulary is not intended to set a standard of care nor is it intended to take the place of a physician's or pharmacist's judgment with regard to their patients' pharmaceutical care. It was developed to complement aspects of the patients' prescription benefit program. Each practitioner must rely on his/her own best medical judgment in selecting the appropriate pharmaceutical agent.

## ***HOW TO FILE A CLAIM FOR PRESCRIPTION DRUG BENEFITS***

You must use a participating pharmacy. Show your ID card at the Participating Pharmacy to obtain your prescription. Or give the pharmacist the employee's name, social security number and "Express Scripts Group #YZF."

- For a generic or formulary brand name drug, you pay the copayment when you pick up your prescription. You are not required to pay the full cost of the prescription and there are no claim forms to file.
- If you use a non-formulary drug, you will be required to pay the full cost of your prescription. You may then submit a claim to the Fund Office for reimbursement.
- If your prescription drug expenses exceed \$1,500 in a calendar year, you will be required to pay the full cost of your prescription. You may then submit a claim to the Fund Office for reimbursement.

There are no benefits for non-participating pharmacies.

## **MEDICAL EXPENSE BENEFITS**

### **(Active and Retired Employees and Their Dependents)**

The medical plan has financial incentives for you and your eligible Dependents to use PPO providers. In addition, you must comply with the Utilization Management program in order to obtain maximum plan benefits.

#### ***UTILIZATION MANAGEMENT PROGRAM***

The Fund contracts with a Review Organization, a panel of healthcare professionals, to administer the Utilization Management program. (See page vii for the name and telephone number of the Review Organization.) The Utilization Management is intended to identify:

1. Services that are not Medically Necessary;
2. Hospital confinements for care which could be given on an outpatient basis;
3. Hospital confinement for a period of time longer than necessary; and
4. Hospital charges for services that are inappropriate or services or supplies which were not provided.

#### ***HOW UTILIZATION MANAGEMENT WORKS***

Whenever your doctor recommends:

- a non-emergency Hospital admission,
- any outpatient surgical procedure, or
- any diagnostic tests costing more than \$300,

you must inform him or her that the Review Organization must approve your Hospital admission or procedure before you enter the Hospital or undergo the surgical procedure or tests. You or your Physician must then contact the Review Organization to obtain the necessary approval. If possible, the Review Organization should be contacted three days prior to the admission, surgical procedure or tests.

The Review Organization will review the medical reasons for the admission, surgery or tests. Then you, your doctor and/or the hospital are notified whether or not the hospitalization or procedure has been authorized. If the treatment is not authorized, your doctor may contact the Review Organization and request a second review. Your doctor will be asked to submit additional medical evidence supporting the treatment plan. The Review Organization will make its final determination based on this evidence.

At designated intervals, the Review Organization will review the pertinent medical information. If Medically Necessary, the Review Organization will approve the additional days required. In most cases, the patient does not need to be involved in the Concurrent Review process.

If you do not agree with the final decision made by the Review Organization, you may file an appeal with the Board of Trustees by following the procedures on page 62.

**It is your responsibility to notify your doctor of this Utilization Management requirement. You should also confirm with the Hospital at the time of admission that Review has been obtained.**

### HOW UTILIZATION MANAGEMENT AFFECTS YOUR BENEFITS

FAILURE TO COMPLY WITH THE UTILIZATION MANAGEMENT PROGRAM WILL RESULT IN A REDUCTION IN BENEFITS. Benefits otherwise payable will be reduced by 20% for hospitalization, outpatient surgery or diagnostic tests when authorization by the Review Organization is required but not obtained. No benefits will be provided for any days of confinement or services or supplies determined to be not Medically Necessary.

There are no benefit reductions in these cases:

1. Emergency Admissions. Prior authorization is not required for emergency Hospital admissions. However, the Review Organization must be contacted on the first business day after you are admitted or you will be subject to the reduced benefits described above.
2. This Fund is the secondary payor.
3. Medicare is the primary payor (Medicare has its own review program).
4. Hospitalization is in connection with childbirth for the mother or newborn child for up to 48 hours following a normal delivery, or up to 96 hours following a cesarean section. If the confinement will be longer than 48 hours (96 hours after a cesarean section), the Review Organization must be contacted.

**Important:** Utilization Management only certifies the Medical Necessity of proposed treatment; **it does not guarantee that you will be eligible when services are received.** If you have any questions regarding your eligibility, call the Fund Office. Also, even though the Review Organization approves the medical necessity for the Hospital admission, you must use a PPO Hospital (see page 34) in order to receive the maximum Plan benefits.

### CASE MANAGEMENT

The Review Organization provides case management to assess alternatives to hospitalization for patients with long term disabling conditions or frequent hospitalizations. Case management is used to ensure that care is being provided in the most appropriate setting. In some instances, a patient's needs may be met as well or better by offering an alternative treatment to hospitalization. Such alternatives, which may not normally be covered services under the Plan,

could include home, hospice or Skilled Nursing Facility care. Working with the patient's Physician and family, the Review Organization determines whether alternative care is suitable for the patient, arranges the care and oversees that the health care services are delivered in a manner that provides continuity of care.

There is no charge to the patient for the services of the case manager. Expenses incurred for alternative treatment that has been arranged and approved by the Review Organization will be reimbursed in full by the Fund. If you do not choose to follow the alternative treatment plan approved by the case management program, normal Plan benefits and exclusions will apply.

**Benefits are not provided for alternative treatment which has not been arranged and pre-approved by the Review Organization, or which are not in lieu of acute care Hospital confinement.**

### ***PPO PROGRAM***

The Fund has entered into contracts with preferred provider organizations. These organizations contract with many of the finest Hospitals, facilities and doctors to provide medical care to you and your Dependents at negotiated rates. The provider must also meet the organization's credentialing standards.

Refer to the PPO Directory applicable to your area for a listing of PPO providers. The names and telephone numbers of the PPOs used by the Fund are shown on page vii.

The list of PPO Hospitals and other providers is updated periodically, so it is important that you contact the PPO provider or the Fund Office before receiving services to make sure the Hospital or provider you select is a PPO provider.

There is only one Review Organization for Utilization Review regardless of your PPO.

### **PPO HOSPITALS**

You may use any licensed Hospital of your choice but if you live in the PPO Service Area and use a Non-PPO Hospital for a non-emergency admission, the benefits are lower and you will have more out of pocket expenses.

There are two situations when you may use a Non-PPO Hospital within the PPO Service Area and still receive the same benefits that are payable for a PPO Hospital. These are:

- **Emergencies:** PPO Hospital benefits will be payable for a Non-PPO Hospital admission in a severe or life-threatening emergency. However, if continued hospitalization is necessary, the Fund may require that you be transferred to a PPO Hospital as soon as it is medically safe to be transported. If you decline to be transferred to a PPO Hospital after the acute emergency period, your benefits will be paid at the reduced level for Non-PPO Hospitals.

If the injury or illness for which services are received is determined to be a non-Emergency, benefits will be subject to the deductible and coinsurance.

- **Specialized Services that are not Available in a PPO Hospital:** In rare cases, there may be certain procedures or treatment that require special facilities that are not available at a PPO Hospital. In such cases your doctor must contact the Review Organization for pre-authorization of admission to the Non-PPO Hospital in order to receive PPO Hospital benefits.

NOTE: Refer to the Schedule of Benefits for the “Out-of-Area” benefits that apply if you live outside of the PPO Service Area.

Remember, the Review Organization must be contacted for all Hospital admissions, not just those at a PPO Hospital.

### **Other PPO Facilities**

The PPO Directory also includes other providers, such as urgent care facilities, outpatient surgical centers, and laboratory and radiology facilities which have also agreed to charge special rates. Your doctor should refer you to a PPO facility for any x-rays or lab tests. If you use a Non-PPO facility for x-rays or laboratory tests, your benefits will be paid at a reduced percentage. Services received at a Non-PPO outpatient surgical facility will also be paid at a reduced percentage in non-emergency situations.

### **PPO Physicians**

By using a PPO Physician, you will receive a better benefit. You will have to pay only your copayment for each office visit to a PPO Physician and the rest of the negotiated fee is paid in full. Other covered services of a PPO Physician will be paid at a higher percentage. PPO Physicians will not balance bill you beyond the Plan’s required copayments. If hospitalization is required, they will also admit you to a PPO hospital whenever possible.

All you have to do is go to one of the Physicians listed in the PPO Directory. Bring your Plan Identification Card with you. Be sure to tell the Physician that you are an eligible participant in the Intermountain UFCW and Food Industry Health Fund.

The Fund Office will automatically adjust the Physician’s bill to the contract rate. The Fund Office will then send you an Explanation of Benefits showing exactly how much the Fund paid and how much you owe the Physician.

If a Covered Person uses a PPO Physician and Hospital but receives in-patient services from non-PPO providers selected or assigned by the PPO Physician or Hospital, the reimbursement percentage made to the non-PPO provider will be at the higher PPO reimbursement percentage.

### **Chiropractic Network**

Chiropractic benefits are provided through a “closed panel” of chiropractors under Golden Healthcare Services, Inc. You must use a member of the Golden Healthcare Services, Inc. Network in order to utilize your chiropractic benefits, unless there is no panel chiropractor in your area. You can obtain a listing of member chiropractors from the Fund Office or from your

Local Union Office. Call the Fund Office at (801) 266-3256 or (800) 345-3248 for information. (If there is no panel chiropractor in your area, call Golden Health Care Services, Inc. at 702-897-1483.)

## **COMPREHENSIVE MEDICAL BENEFITS**

The Comprehensive Medical Benefits provide coverage treatment of a non-occupational Illness or Injury.

To be considered Covered Charges, the expenses must also be:

1. for Medically Necessary services, supplies, care or treatment; and
2. prescribed, performed, or ordered by a Physician; and
3. the charges may not exceed Usual, Customary and Reasonable charges; and
4. incurred while you and your dependents are eligible.

### ***PHYSICIAN OFFICE VISIT BENEFIT***

For PPO office visits, the Fund will pay 100% of the contract rate after you pay a copayment for the visit. PPO Physicians will not bill you for any amount other than your copayment. The office visit benefit will also cover one routine gynecologic examination per calendar year.

Office visits to Non-PPO Physicians are subject to the deductible and coinsurance percentage.

### ***CHIROPRACTIC TREATMENT***

Covered treatment from a Golden Healthcare Services, Inc. Network Provider will be covered at 100% after you pay a \$13 copayment for the visit. If you have other Covered Charges (EXAMPLE: x-rays or other treatment modalities like hot or cold packs or ultrasound), the Fund will pay 85% of the negotiated fee. Benefits are limited to one treatment per day. Supports and appliances are not covered.

Preauthorization is not required for the first 12 visits for a particular condition in a calendar year. Any further treatment for that condition must be preauthorized. The maximum is 30 visits per calendar for all treatment combined.

### ***ACCIDENT EXPENSE BENEFIT***

If you or your Dependent sustain an Injury due to an accident, up to \$750 per accident will be paid for Covered Charges. There are no deductible or coinsurance requirements. Treatment must be received within 90 days of the date of the accident. Treatment after 90 days and treatment in excess of \$750 will be subject to the deductible, coinsurance percentage and other provisions of the Comprehensive Medical Benefits.

### ***DEDUCTIBLE***

Before Comprehensive Medical Benefits are payable, you and your Dependents must each satisfy the deductible. The deductible is the amount of out-of-pocket Covered Charges that you must pay each calendar year.

The deductible is \$75 per person for PPO services, with a maximum of \$150 per family. For non-PPO services, the deductible is \$250 per person, with a maximum of \$500 per family. The deductible applies only once in any calendar year, even though you may have several different Illnesses or Injuries. So that you will not have to satisfy a deductible late in one calendar year and soon again in the following year, any expenses incurred and applied against the deductible in the last three months of a calendar year are also applied against the deductible for the next calendar year.

### ***COINSURANCE PERCENTAGE***

Once the deductible is satisfied in a calendar year, the Fund will pay a percentage of Covered Charges up to the Maximum Benefit. The coinsurance percentage depends on the type of expense and whether or not PPO providers are used and Utilization Management requirements are followed. The percentages payable for each type of Covered Charge are listed in the SCHEDULE OF BENEFITS.

The percentages apply to the first \$30,000 in Covered Charges in excess of the deductible in each calendar year. After a Covered Person has incurred \$30,000 in Covered Charges, the coinsurance percentage will be 100% for the remainder of the calendar year.

### ***MAXIMUM BENEFIT***

The maximum amount payable for Comprehensive Medical Benefits for each individual is \$750,000, regardless of whether there has been an interruption in eligibility.

The maximum will automatically be restored by up to \$1,000 on each January 1st without evidence of insurability. This means that each January 1st, up to \$1,000 will be added to the maximum benefit available for each person who has used Comprehensive Medical Benefits. In no event can the total benefit, including the amount restored, exceed the \$750,000 maximum.

### ***COVERED CHARGES***

Covered Charges include:

1. Inpatient charges made by a PPO or non-PPO Hospital for room and board, including intensive care unit (ICU) or coronary care unit (CCU), and all necessary services and supplies. Such expenses may include operating room, general nursing care, newborn routine nursery care, anesthesia and its administration, drugs, oxygen and its administration, bandages and dressings, diagnostic services and therapy. Charges for personal items, such as guest trays, are not included. Special nursing care is not included.
2. Outpatient facility charges, including outpatient services provided by a Hospital, such as emergency room, ambulatory surgical facility, urgent care facility or birthing center. Utilization Review is required prior to an outpatient surgical procedure at an ambulatory surgical facility or Hospital.

3. Services rendered by a Physician, including an assistant surgeon, physician's assistant, nurse-practitioner or allied health provider. Benefits for services of an assistant surgeon are reimbursed up to 20% of the maximum benefit payable for the primary surgeon.

Physician charges for outpatient treatment of Mental Illness are limited to one treatment per day while hospitalized and one treatment in any seven consecutive days while not hospitalized.

As required by the Women's Health and Cancer Rights Act of 1998, benefits are provided for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

4. Outpatient diagnostic radiology and laboratory services, including a routine annual pap smear and mammography screening. Routine (screening) mammography is subject to the following frequency guidelines:

For women age 35 through 39: one baseline mammogram

For women age 40 through 49: one mammogram once every two years, or more frequently if recommended by a Physician as Medically Necessary

For women age 50 and over: one mammogram every year

Any x-ray or laboratory procedure costing more than \$300 requires pre-authorization by the Review Organization. If pre-authorization is not obtained, benefits otherwise payable are reduced by 20%.

5. Charges for administration of anesthesia in connection with a covered surgical procedure.
6. Radiation therapy, chemotherapy, dialysis.
7. Physical therapy by a registered physical therapist (RPT), provided the therapist is not a Relative.
8. Services of a Registered Nurse (RN) rendered in or out of a Hospital, up to a maximum benefit payable of \$20 in any period of 24 consecutive hours. The attending Physician must authorize the services. The RN may not be a Relative. Nursing services provided during Hospital confinement when the RN is on staff at the Hospital and nursing services are included in the Hospital's charges are not considered to be Separate Covered Charges under this section.
9. Charges by a licensed professional ambulance service for transportation of a Covered Person to or from a Hospital, or both.
10. Charges for transportation of the Covered Person within the United States and Canada by a railroad or by regularly scheduled flight of a commercial aircraft from the place where the Covered Person becomes disabled to (but not back from) a Hospital equipped to provide treatment of the Illness or Injury.

11. Charges for Drugs and medicines requiring the written prescription of a Physician.
12. Blood transfusions, including blood processing and the cost of unreplaced blood plasma or whole blood.
13. Dental Services as follows:
  - dental services for removal of impacted wisdom teeth or other unerupted teeth if such charges are not covered under the Fund's dental plan;
  - Hospital confinements in connection with a procedure covered under the Fund's dental plan; and
  - treatment of Injuries to natural teeth sustained in an accident, provided treatment is received within six months following the accident and such treatment is not otherwise covered under the dental plan.

Damage to natural teeth due to chewing or biting is not covered.

14. Rental or purchase of prosthetic devices, orthopedic appliances, durable medical equipment and supplies. Covered Charges are:
  - Prosthetic devices (including prothetic limbs or eyes, surgically implanted devices and corrective appliances), excluding replacements or repairs.
  - Orthopedic appliances (including casts, trusses, braces or splints) for the purpose of improving function of a body part. Excluded are arch supports and custom shoe inserts, or orthopedic shoes not attached to a brace.
  - Equipment and those supplies that are:
    - ordered by a Physician, and
    - usable only by the patient, and
    - of no further use when medical need ends, and
    - not primarily for the comfort or hygiene of the patient, and
    - not for environmental control, and
    - not for exercise, and
    - manufactured specifically for medical use, and
    - approved as Medically Necessary treatment, as determined by the Fund, and
    - not for prevention purposes.

Rental or purchase of items such as wheelchairs, hospital beds and crutches are included.

- Ostomy supplies for removal of bodily secretions or waste through an artificial opening.
- Oxygen and oxygen equipment for home use.

Rental charges for durable medical equipment are limited to the purchase price of that equipment. A device used specifically as a safety item or to affect performance primarily in

sports-related activities is not a Covered Charge. Non-durable medical supplies including (but not limited to) elastic stockings, ace bandages, gauze and like products are not Covered Charges.

15. Home health care or home IV therapy rendered by a Home Health Agency.

16. Acupuncture services rendered by a Physician.

### ***EXCLUSIONS***

No prescription drug or medical benefits are payable for any of the following:

1. Expenses for which benefits are payable under any other programs provided by the Fund.
2. Services or supplies furnished prior to the Patient's effective date of coverage. An expense is considered incurred on the date the person receives the service for which the charge is made.
3. Any expense incurred after eligibility terminates except as provided by the Extension of Benefits due to Total Disability provision and COBRA continuation coverage.
4. Any medical care, services or supplies for which no charge is made or for which the Covered Person is not, in the absence of this Plan, legally obligated to pay.
5. To the extent permitted by Federal law, services rendered while a Covered Person is confined in a Hospital or facility operated by the United States Government or an agency of the United States Government or by a doctor employed by such a Hospital or facility, unless (a) the treatment is of an emergency nature, or (b) the patient is not entitled to such treatment without charge by reason of status as a veteran. However, the Fund, to the extent required by law, will reimburse a VA Hospital for care of a non-service-related disability if the Plan would normally cover such care if the VA were not involved.
6. To the extent permitted by Federal law, any services or supplies paid for or provided by any governmental program - national, state, county or municipal - including any group insurance policy approved under such a program.
7. Work-related conditions regardless of whether covered by any Workers' Compensation, occupational disease or similar laws.
8. Conditions arising out of an act of war (declared or undeclared), armed invasion or aggression.
9. Intentionally self-inflicted Injury; or Injury or Illness resulting from participation in, or in consequence of having participated in, the commission of an assault or felony.
10. Care in a rest home or institution of a similar character; any Custodial Care.

11. Eye refractions, eye glasses or contact lenses, or the fitting of eye glasses and contact lenses except as provided under the Vision Expense Benefit (see page 51); radial keratotomy or other refractive procedures.
12. Hearing aids, the fitting of hearing aids or routine hearing examinations.
13. Cosmetic surgery, except for (a) treatment of Injury sustained in an accident and received within 6 months of the date of the accident; (b) treatment for correction of an abnormal congenital condition in a child; and (c) reconstruction of a breast or both breasts following a mastectomy.
14. Expenses incurred for treatment of alcoholism, drug addiction or drug overdose, or expenses incurred due to being under the influence of illegal drugs or alcohol.
15. Pregnancy related expenses of a Dependent child.
16. Dental treatment on or to the teeth or gums (except for tumors), including repair, removal or replacement of teeth; except that removal of impacted and other unerupted teeth, Medically Necessary Hospital confinements and Injury to natural teeth resulting from an accident may be covered. Treatment of Temporomandibular Joint Syndrome (TMJ), except for jaw repositioning and treatment performed by a Medical Doctor (M.D.)
17. Speech therapy.
18. Services primarily for weight loss, educational services, nutritional counseling or food supplements.
19. Any expenses related to treatment of infertility, elective sterilization, reversal of a sterilization procedure, or any treatment, services or supplies related to transsexual (sex change) procedures.
20. Services received from a registered nurse or physical therapist who is a Relative as defined by the Plan.
21. Any amounts in excess of Usual, Customary and Reasonable Charges.
22. Treatment, services or supplies not considered Medically Necessary.
23. Any services and supplies in connection with Experimental or Investigational procedures. For purposes of this exclusion, the term Experimental or Investigational procedures means a drug, device, medical treatment or procedure if:
  - a) the drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing hasn't been given at the time the drug or device is furnished; or
  - b) the drug, device, medical treatment or procedure, or the patient informed consent document was reviewed and approved by the treating facility's Institutional Review

Board or other body serving a similar function, or if federal law requires such review or approval; or

- c) *Reliable Evidence* shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- d) *Reliable Evidence* shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this exclusion, “*Reliable Evidence*” shall mean only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

- 24. Expenses incurred in connection with any organ or tissue transplant procedure. (See separate “Organ or Tissue Transplant Benefits” in the following section.)

#### ***EXTENSION OF BENEFITS PROVISION***

If you or your eligible Dependent are Totally Disabled (as defined in the Definitions section) on the date coverage terminates, benefits for the disabled person will be extended while that person remains Totally Disabled. Only Covered Charges relating to the Injury or Illness causing the Total Disability will be payable. This extension will be continued until the earliest of the following:

- 1. 12 months following the termination of coverage; or
- 2. a period equal to the time the disabled person was covered under the Fund; or
- 3. the date the disabled person is no longer Totally Disabled; or
- 4. the date the disabled person becomes covered under any other plan of benefits which provides coverage for the disability.

**Important Note:** Benefits are not extended under this provision for any person other than the person with the Total Disability and benefits are payable only for treatment of the Illness or Injury causing the Total Disability.

This extension begins at the end of the “*Continuation of Eligibility If You Become Totally Disabled*” period described on page 19 of this booklet, provided the Covered Person remains Totally Disabled.

## ORGAN OR TISSUE TRANSPLANT BENEFITS

### ***ELIGIBILITY***

Allowable Expenses incurred for a Covered Transplant Procedure during a Covered Person's Transplant Benefit Period will be payable provided the Recipient: 1) is eligible at the time the Allowable Expense is incurred; and 2) was eligible under the Medical Plan for 12 consecutive months immediately prior to commencement of benefits provided for herein.

The Allowable Expense must be incurred due to an accidental Injury or Illness that is covered by the Plan.

Organ or Tissue Transplant benefits are limited to those expressly set forth herein and no other benefits are payable.

The Fund will pay Allowable Expenses provided the following conditions are met:

1. The Recipient receives at least two medical opinions in writing confirming the need for transplant surgery from board certified Physicians. The specialists must certify that alternative procedures, services, or courses of treatment would not be effective in the treatment of the patient's condition.
2. The Recipient does not suffer from a terminal Illness and is reasonably expected to live at least one or more years beyond the transplant date.

### ***DEFINITIONS***

The following definitions apply to Allowable Expenses for Organ or Tissue Transplant benefits:

1. ***“Covered Transplant Procedure”*** - Shall mean any one of the following human to human organ or tissue transplants performed during a Transplant Benefit Period: (a) bone marrow; (b) heart; (c) heart/lung; (d) liver; (e) lung; (f) pancreas; (g) kidney. An Employee and/or Dependent is entitled to one Covered Transplant Procedure per lifetime, regardless of whether there has been an interruption of coverage under the Fund.
2. ***“Transplant Benefit Period”*** - Shall mean the period that begins the later of: (a) the date of the Employee or Dependent's effective date of coverage under the Medical plan, or (b) the date of the onset of the covered Illness or Injury requiring the transplant; and ends eighteen months after the date the Covered Transplant Procedure is performed.
3. ***“Recipient”*** - Shall mean an Employee or Dependent covered by this Fund who is to receive a transplanted organ or tissue and who meets the eligibility requirements set forth above.
4. ***“Allowable Expenses”*** - Shall mean those expressly set forth herein that are directly related to the Covered Transplant Procedure and the benefit amounts provided therefor, except that amounts payable by the Fund shall not, in any event, exceed the Usual, Customary and Reasonable charge determined by the Board of Trustees in its sole discretion.

***ALLOWABLE EXPENSES***

The Fund will reimburse the following Allowable Expenses incurred as the result of a Covered Transplant Procedure during an Employee or Dependent’s Transplant Benefit Period:

1. Transportation of the Recipient and a companion to and from the site of the transplant. If the Recipient is a minor, transportation of two persons who travel with the minor is included. Reasonable and necessary lodging and meal costs incurred in the interim by such companions are included, except that there is a daily limit of \$200 for all lodging and meal costs. The total payment for all transportation, lodging and meal costs for all Covered Persons for the Covered Transplant Procedure shall not exceed \$5,000.
2. Hospital room and board and other Hospital expenses.
3. Diagnosis, treatment and surgery by a Physician.
4. Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.). Total payment for all private nursing care shall not exceed \$10,000.
5. The rental of wheel chairs, Hospital-type beds and other mechanical equipment required for treating respiratory impairment.
6. Local ambulance service, medications, x-rays and other diagnostic services, laboratory tests and oxygen.
7. Rehabilitation therapy consisting of: speech therapy (not for voice training or a lisp); audio therapy, visual therapy; occupational therapy; and physiotherapy.
8. Surgical dressing and supplies.
9. If the Covered Transplant Procedure is not performed as scheduled due to the intended Recipient’s medical condition or death, benefits will be limited to Allowable Expenses incurred for #1 and #2 above.
10. The maximum lifetime benefit payable by the Fund for all Allowable Expenses related to a Covered Transplant Procedure during the Transplant Benefit Period will not exceed:

Bone Marrow	\$150,000
Heart	\$110,000
Heart/Lung	\$130,000
Liver	\$240,000
Lung	\$150,000
Pancreas	\$ 50,000
Kidney	\$ 39,000

***EXCLUSIONS***

No benefits will be payable by the Fund for any of the following:

1. Animal and/or mechanical organs, except pumps and valves.

2. Any service or supply not ordered by a Physician.
3. Any expense incurred for which the eligible person would not legally have to pay if there were no insurance.
4. Custodial Care.
5. If an Employee or Dependent has established a Transplant Benefit Period (that is, a Covered Transplant Procedure has commenced) and subsequently loses coverage under the Plan, all benefit payments by the Plan will cease at the time coverage terminates, regardless of whether the Transplant Benefit Period has been completed.
6. Any organ or tissue transplant due to an accidental Injury or Illness that is not covered under the Plan.
7. Donor expenses.

## **DENTAL BENEFITS**

### **(Active Employees and Their Dependents)**

The eligibility requirements for dental benefits are not the same as for medical expense benefits. Refer to EFFECTIVE DATE OF COVERAGE FOR DENTAL AND VISION EXPENSE BENEFITS on page 16 for more information. Verify your eligibility with the Fund Office before you make an appointment.

The Fund emphasizes preventive dentistry and has many other advantages - you may select the qualified Dentist of your choice, pre-existing conditions are covered and oral examinations and teeth cleanings are payable even if no other work is done.

### ***HOW TO USE THE DENTAL PLAN***

First, verify your eligibility for benefits and then visit your Dentist. At the first appointment, tell your Dentist that you participate in the Intermountain UFCW and Food Industry Health Fund.

Before the treatment plan begins, discuss with your Dentist the total fees and the portion you will be required to pay. If everything is agreeable, leave a completed claim form with the Dentist. The Dentist should complete the claim form and mail it to the Fund Office for processing.

### ***COVERED CHARGES***

Payment will be made for the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Covered Charges are limited to the Usual, Customary and Reasonable charges for the Basic and Major Dental Services and supplies as described below.

***BASIC DENTAL SERVICES*** – Basic Dental Services include the following:

*Diagnostic* - procedures to assist the Dentist in evaluating the conditions existing and the dental care required. Oral examinations and x-rays are covered subject to the following limitations:

Oral examinations - covered once in six months.

Full-mouth x-rays - covered once in three years unless special need is shown.

Bitewing x-rays - covered once in six months.

*Preventive* - procedures or techniques to prevent the occurrence of dental abnormalities or disease. A prophylaxis (teeth cleaning) is covered once in six months.

*Restorative* - procedures to restore the teeth. Gold restorations, crowns and jackets are covered when teeth cannot be restored with other materials. If a tooth can be restored with amalgam, silicate or plastic, the Fund will only recognize the cost of that procedure toward the cost of any other type of restoration; any balance remains the responsibility of the patient.

*Oral Surgery* - extractions and other oral surgery, including pre-and post-operative care.

*Endodontics* - pulpal and root-canal therapy.

*Periodontics* - treatment of the tissues that support the teeth.

MAJOR DENTAL SERVICES – Major Dental Services include the following:

*Prosthodontics* – construction, placement or repair of fixed bridges, partial and complete dentures, subject to the following:

1. Replacement of an existing denture will be covered only if it is unsatisfactory. Services which are necessary to make such appliances satisfactory will be considered a Covered Charge. Replacement of prosthodontic appliances will be considered only after five years have elapsed following placement of the appliance under this or any other program.
2. Partial Dentures - If a cast chrome or acrylic partial denture will restore the case, the Fund will only allow the applicable percentage of the Covered Charge for such procedure toward a more elaborate or precision appliance that the patient and Dentist may choose to use.
3. Complete Dentures - If, in the construction of a denture, the patient and Dentist decide on personalized restorations or specialized techniques are employed as opposed to standard procedures, the Fund will only cover the Allowable Charge for a standard denture toward such treatment and the patient will be responsible for the balance.

### ***BENEFITS PAYABLE FOR COVERED CHARGES***

#### ***Plan A:***

BASIC DENTAL SERVICES – The percentage of Covered Charges that the Fund will pay is listed in the SCHEDULE OF BENEFITS.

If you are continuously covered and all prescribed treatment has been completed, your percentage of reimbursement will increase each year until the maximum percentage listed in the Schedule of Benefits has been reached. You will remain at the maximum reimbursement percentage each year thereafter unless a calendar year is missed between treatments. If you do not receive dental care in a calendar year, payments for the next calendar year will be based on the next lower percentage per year that treatment is missed. EXAMPLE: If you were at 85% reimbursement and you miss treatment during a year, your reimbursement will drop to 80%. If you were at 80% and miss treatment for a year, your reimbursement will drop from 80% to 70%.

MAJOR DENTAL SERVICES - The percentage of Covered Charges that the Fund will pay is listed in the SCHEDULE OF BENEFITS.

#### ***Plan B:***

BASIC DENTAL SERVICES – The percentage of Covered Charges that the Fund will pay is listed in the SCHEDULE OF BENEFITS.

MAJOR DENTAL SERVICES - The percentage of Covered Charges that the Fund will pay is listed in the SCHEDULE OF BENEFITS.

### ***MAXIMUM BENEFIT***

Regardless of the percentage, the maximum payment for all dental services combined will not exceed \$1,300 during a calendar year.

## ***EXCLUSIONS***

No benefits are payable under the Dental Expense Benefit for any of the following:

1. Services which are provided by any Federal or State or Provincial government agency, or which are provided without cost to the patient by any municipality, county or other political sub-division or community agency.
2. Services with respect to congenital or developmental malformations, jaw repositioning, cosmetic surgery or dentistry for solely cosmetic reasons.
3. Dental services started prior to the date the participant becomes eligible for such services under the Plan.
4. General anesthesia except when administered by a Dentist in connection with oral surgery.
5. Prescription Drugs.
6. Hospital services.
7. Orthodontic services except as provided for Plan A participants (see page 50).
8. Treatment of an Injury, Illness or condition resulting from any act or incident of war, whether declared or undeclared.
9. Dental care, services or supplies resulting from participation in or in consequence of having participated in the commission of an assault or a felony.
10. Dental care, services, or supplies for which benefits are payable under any other provisions of this Plan or any other group plan, but only to the extent that benefits are payable under such other provisions or policies.
11. Charges for replacement of lost, stolen or damaged dental bridges, crowns or dentures.
12. Treatment rendered for Temporomandibular Joint Syndrome (TMJ).
13. Appliances or restorations necessary to increase vertical dimension or restore or equilibrate the occlusion are considered optional and the cost will remain the responsibility of the patient. Payment will be made for only one restoration on any one surface of a tooth.

## ***EXTENSION OF BENEFITS***

If you or your eligible Dependent obtain services from a Dentist while eligible, but subsequently lose eligibility, all covered services listed on the treatment form that were approved while you were eligible will be covered, except for single procedures (e.g., filling of a tooth), which must be completed within 60 days following loss of coverage.

## **ORTHODONTIC EXPENSE BENEFIT**

### **(Active Plan A Employees and Their Dependents)**

The eligibility requirements for orthodontic benefits are not the same as for medical expense benefits. Refer to EFFECTIVE DATE OF COVERAGE FOR DENTAL AND VISION EXPENSE BENEFITS on page 16 for more information. Verify your eligibility with the Fund Office before you make an appointment.

#### ***COVERED TREATMENT***

The Fund Office must approve the treatment plan before the orthodontic treatment begins. Treatment is limited to the following:

1. Extreme bucco-lingual version of teeth (unilateral and bilateral)
2. Protrusion of maxillary anterior teeth of more than 4 mm.
3. Maxillary or mandibular arch in either protrusive or retrusive relation of at least one cusp.
4. Malalignment of teeth which unquestionably interferes with their function or creates marked facial deformity.

#### ***LIFETIME MAXIMUM BENEFIT***

For an approved treatment plan, the Fund pays 70% of Covered Charges, but not more than \$1,800 for any one individual.

#### ***LIMITATIONS***

The following limitations and exclusions apply to the Orthodontic Expense Benefit:

1. Completion of treatment for a dependent child must occur prior to the child's 19th birthday, or if a full-time student, prior to the child's 24th birthday. All periodic payments by the Fund cease when the child reaches the age limit.
2. No cases already in progress at the time eligibility is established are covered under this Benefit. A case is considered to begin on the date of banding.
3. Periodic payments by the Fund will cease in the event the Employee loses eligibility or upon termination of the treatment plan for any reason prior to completion of the case.

## **VISION EXPENSE BENEFITS**

The eligibility requirements for vision benefits are not the same as for medical expense benefits. Refer to EFFECTIVE DATE OF COVERAGE FOR DENTAL AND VISION EXPENSE BENEFITS on page 16 for more information. Verify your eligibility with the Fund Office before you make an appointment.

Vision Expense benefits are available to you and your Dependents through a service agreement with **Group Vision Associates (GVA)**, a national panel of participating optometrists, or you may obtain services from a doctor who is not a GVA panel member. Your out of pocket costs will be lower if you receive services from a GVA panel doctor.

### ***HOW TO OBTAIN VISION CARE UNDER THE GVA PROGRAM***

Before you make an appointment, contact the Fund Office for a list of GVA panel doctors in your area. Select the doctor of your choice and call for an appointment. Be sure to identify yourself as a participant in the Intermountain UFCW. Health Fund and give the doctor's office the patient's name and the covered employee's name and social security number. The doctor should call the Fund Office to verify your eligibility before you arrive for the appointment.

### ***COVERED SERVICES***

Covered Services are available as follows:

- **Vision Examination:** once every calendar year.
- **Lenses:** once every calendar year, if needed.
- **Frames:** once every two calendar years, if needed.
- **Contact Lenses:** up to the maximum plan benefit payable per benefit period.

**Plan A:** The maximum benefit payable for all vision care, including the examination, lenses and frames is \$112.50 per calendar year.

**Plan B:** The maximum benefit payable for all vision care, including the examination, lenses and frames is \$100 per calendar year.

### **GVA PANEL DOCTOR - AVAILABLE BENEFITS**

**Vision Examination:** a complete analysis of the eyes to determine the presence of vision problems or other abnormalities, including a glaucoma test. When you select a doctor from the GVA panel list, you will pay only \$10 for a complete eye examination.

**Lenses:** The Fund will cover clear glass or plastic single vision lenses, or clear glass or plastic standard bifocal or trifocal lenses, subject to the maximum benefit. You pay the additional cost for "upgrades," such as tints, coatings, photogray, blended or progressive bifocals, etc.

**Frames:** GVA offers a wide selection of frames; however, if you select a frame that costs more than the Plan allowance, there will be an additional charge to you.

**Elective Contact Lenses:** After your \$10 copayment, the Fund will pay an allowance toward the doctor's usual and customary contact lens fee (includes exam and fitting), in lieu of all other benefits for that benefit period. The maximum contact lens benefit amount is payable once every calendar year.

**Necessary Contact Lenses:** "Necessary Contact Lenses" are contact lenses that are required (a) following cataract surgery; (b) when visual acuity is not correctable to 20/70 in either eye with spectacle lenses but can be corrected to at least 20/70 with contact lenses; or c) to correct certain conditions of anisometropia or keratoconus.

#### NON-GVA DOCTOR - AVAILABLE BENEFITS

If you or your Dependents choose to receive services from a non-GVA provider, you must pay the doctor the full fee and submit a claim to the Fund Office for reimbursement. You will be reimbursed in accordance with the allowances shown in the Schedule of Benefits. The allowance for a single lens is one half of the "per pair" allowance. **There is no assurance that this schedule will cover all of the expenses.**

The allowances for contact lenses are payable in lieu of all other vision benefits; only the contact lens allowance will be paid - no separate benefit is payable for an examination or other materials. The maximum contact lens benefit amount is payable once every two calendar years.

Availability of services under the reimbursement schedule is subject to the same limits as described in "Covered Services" and are in lieu of obtaining these services from a GVA Panel doctor. To receive reimbursement, you must submit a vision claim form and the doctor's itemized bill to:

Intermountain United Food and Commercial Workers and Food Industry Health Fund  
4885 South 900 East, Suite 202  
Salt Lake City, UT 84117

#### **EXCLUSIONS**

There is no benefit for professional service or materials connected with:

1. More than one examination or pair of lenses during any calendar year.
2. More than one set of frames during any two calendar years.
3. Glasses secured when there is no prescription change.
4. Non-prescription glasses or sunglasses or the fitting thereof.
5. Expenses incurred prior to your date of eligibility or after termination of your eligibility.
6. Orthoptics or vision training, aniseikonia or reading rate and comprehension studies.

7. Medical or surgical treatment of eye disease or Injury other than a vision examination.
8. Any eye examination or corrective eyewear required by an employer as a condition of employment.
9. Charges for replacement of lost, stolen or broken lenses or frames if benefits have already been provided during the time limitations of the Plan.
10. Charges for vision care, services or supplies resulting from participation in, or in consequence of having participated in, the commission of an assault or a felony.

**Important:** If you do not identify yourself as a member of this Fund, but visit a GVA panel doctor as a private patient, the panel Doctor is not obligated to accept GVA fees as full payment for these services and may elect to charge his or her usual fees. However, the Fund will pay only the GVA fees and you will be responsible for the difference.

## CLAIMS AND APPEALS PROCEDURES

A claim for benefits is a request for Plan benefits made in accordance with the Fund's claims procedures, which are described in this section. These procedures for filing claims for benefits from the Intermountain United Food and Commercial Workers and Food Industry Health Fund (the Plan) are effective January 1, 2003. This section also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

### *WHAT IS NOT A "CLAIM"*

- Simple inquiries about the plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits.
- A request for a determination regarding the Plan's coverage of a medical treatment or service that your physician has recommended is not a "claim" under these procedures if the treatment or service has not yet been provided and the treatment or service is for non-urgent care for which the Plan does not require prior authorization. You may request a determination from the Fund Office regarding the Plan's coverage of the treatment or service. However, this will not be a guarantee of payment because such a request is not a "claim" as described in Section E, and therefore will not be subject to the requirements and timelines described in this section.
- When you present a prescription to a participating pharmacy to be filled out under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

### *HOW TO FILE A CLAIM*

Your physician will usually file the appropriate claim on your behalf. In the event that you need to file your own claim, a claim form may be obtained from your local union or the Fund Office by calling **(801) 266-3256 or (800) 345-3248**. After obtaining the claim form, fill out the top portion of the form using the proper sections as provided for Employee's claims or for Dependent's claims and sign as Employee.

The following information must be completed in order for your request for benefits to be a claim, and for the Fund Office or Review Organization to be able to decide your claim.

Participant Completes:

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant or retiree
- Date of Service
- Information on other insurance coverage, if any, including coverage that may be available to your spouse through his or her employer

Provider completes:

- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association) or HCPC code
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9<sup>th</sup> Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge (all bills must be itemized)
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Provider's billing name and address
- If treatment is due to accident, accident details

In the event of death, you or your beneficiary must obtain a claim form and submit the written claim form and a certified copy of the death certificate to the Fund Office.

**Claims involving Urgent Care** (defined below) must be submitted in one of the ways described below. All claims, except chiropractic and transplant claims, must be submitted directly to the Review Organization. Chiropractic claims must be submitted directly to the Fund Office. They are **not** to be submitted via the US Postal service.

For claims involving hospital services, outpatient surgical procedures, diagnostic tests and alternative treatments, contact Managed Care Consultants (MCC) by:

- Faxing the request to (702) 932-2142 or (702) 933-6677
- Bringing claim in person to the Fund Office located at 4885 South 900 East, Suite 202, Salt Lake City, Utah 84117, and asking to speak to the Claims Supervisor

For chiropractic claims or transplants, contact the Fund Office by:

- Faxing the request to (801) 266-4383, attention: Claims Supervisor
- Bringing claims in person to the Fund Office located at 4885 South 900 East, Suite 202, Salt Lake City, Utah 84117, and asking to speak to the Claims Supervisor

### ***WHEN CLAIMS MUST BE FILED***

All other claims for medical service not requiring pre-authorization and disability, life and Accidental Death and Dismemberment (AD&D) claims must be filed within 90 days following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. In that case, the claim must be submitted as soon as reasonably possible and in no event later than one year after the date the charges were incurred.

## ***WHERE TO FILE CLAIMS***

Your claim will be considered to have been filed as soon as it is received at the appropriate organization or office as described below.

Requests for pre-authorization for hospital services, outpatient surgical procedures, diagnostic tests and alternative treatments should be filed with the Review Organization at the following address:

MCC  
4160 South Pecos Road,  
Las Vegas, Nevada 89121

Requests for preauthorization for chiropractic claims, orthodontic claims and transplants should be filed with the Fund Office at the following address:

Intermountain UFCW and Food Industry Health Fund  
4885 South 900 East #202  
Salt Lake City, Utah 84117

Claims for services that have been provided, including dental, life and AD&D claims, should be filed with the Fund Office at the following address:

Intermountain UFCW and Food Industry Health Fund  
4885 South 900 East, Suite 202  
Salt Lake City, Utah 84117

## ***AUTHORIZED REPRESENTATIVES***

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. 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 completion of the special authorization form.

## ***CLAIMS PROCEDURES***

The claims procedures for comprehensive medical benefits will vary depending on whether your claim is for a **Pre-Service Claim**, an **Urgent Care Claim**, a **Concurrent Care Claim**, a **Post-Service Claim**, **Disability, Dental and Vision Claims** and **Death and Accidental Death and Dismemberment (AD&D) Claims** also require different procedures. Read each section carefully to determine which procedure is applicable to your request for benefits:

### ***Urgent Care Claims***

An **Urgent Care Claim** is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
2. would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment that is the subject of the claim.

The Plan will determine whether your claim is an **Urgent Care Claim** by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an **Urgent Care Claim** within the meaning described above, shall be treated as an **Urgent Care Claim**.

If you improperly file an **Urgent Care Claim**, the Review Organization will notify you as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a claim. The Plan will notify you by telephone unless you have previously requested all such notification to be in writing.

Generally, the Review Organization will respond to you [and your doctor] with a determination as soon as possible, taking into account the medical exigencies, but not later than *72 hours* after receiving the claim.

However, if an **Urgent Care Claim** is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Review Organization will notify you [and your doctor] as soon as possible, but not later than *24 hours* after receipt of the claim, of the specific information necessary to complete the claim. You [and/or your doctor] must provide the requested information within a reasonable time period, taking into account the circumstances, but not later than *48 hours* after receiving the request for the information. If the information is not requested within that time, your claim will be denied.

Notice of the decision will be provided no later than *48 hours* after the earlier of: 1) the Review Organization's receipt of the specified information; or 2) the end of the period afforded to you to provide the specified additional information.

Please note that the Urgent Care Claims procedures described in this Summary Plan Description do not apply to emergency care. If you experience a medical emergency, such as acute onset of chest pain, major trauma or sudden shortness of breath, you should go to the nearest hospital emergency room. The charges for these services will be submitted as Post-Service Claims.

### Pre-Service Claims

A **Pre-Service Claim** is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) from the Plan's Review Organization before medical care is obtained in order to receive benefits. Under this Plan, prior approval of services is required for the following services:

- Hospital services (exceptions: emergencies, situations where the Plan is a secondary payor, and hospitalization for childbirth up to 48 hours following normal delivery, or 96 hours following a caesarean section)
- Chiropractic treatment (pre-authorization required from Golden Healthcare Services after the first 12 visits during a calendar year)
- Outpatient surgical procedures
- Diagnostic tests costing more than \$300
- Alternative Treatment (in lieu of inpatient hospital services)
- Covered orthodontic treatment
- Organ or tissue transplants. The Plan requires at least two medical opinions in writing that confirm the need for the transplant and that alternative procedures would not be effective.

If you improperly file a **Pre-Service Claim** the Review Organization will notify you as soon as possible of the proper procedures to be followed in filing a claim. You will receive this notice no later than *five days* after receipt of the claim by the Review Organization. You will only receive notice of an improperly filed Pre-Service Claim if the claim is submitted to the appropriate office as identified in the section entitled, *WHERE TO FILE CLAIMS*, and includes: (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim. The Plan may notify you by telephone unless you have previously requested that all such notification be given in writing.

If you improperly file an **Urgent Care Claim**, the Review Organization will notify you as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a claim. The Plan will notify you by telephone unless you have previously requested all such notification to be in writing.

For properly filed **Pre-Service Claims**, you [and your doctor] will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the Review Organization. If an extension is necessary, you will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Review Organization needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. Notice of the decision will be provided no later than 48 hours after the earlier of: 1) the Review Organization's receipt of the specified information; or 2) the end of the period afforded to you to provide the specified additional information. The initial 15-day period for making a determination on your Pre-Service Claim will be tolled from the date on

which the notice for additional information is sent until the date on which the appropriate Review Organization receives the information requested. When the Review Organization receives the requested information, it then has the remainder of the initial 15 days to make a decision and notify you of its determination.

### Concurrent Claims

A **Concurrent Claim** is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a **Concurrent Claim** that involves *the termination or reduction* of a previously-approved benefit (other than by plan amendment or termination) will be made by the review organization as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to *extend* approved Urgent Care treatment or what will amount to Urgent Care will be acted upon by the review organization as soon as possible, taking into account the medical urgency of the claim, and the review organization will notify the claimant of the determination within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

### Post-Service Claims

The following procedure applies to **Post-Service Claims**, which are all claims that are not **Urgent Care Claims, Pre-Service Claims or Concurrent Claims** as described above. An example is a claim submitted for payment after health services and treatment have been obtained. Your physician or dentist will usually submit Post-Service Claims on your behalf. Should you need to submit a Post-Service Claim yourself, follow the procedures below:

1. Obtain a claim form.
2. Complete the employee's portion of the claim form.
3. Attach all itemized Hospital bills or doctor's statements or other itemized statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim information is incomplete, delays in payment will result.

You do not have to submit an additional claim form if your bills are in conjunction with a continuing disability and you have filed a signed claim within the past calendar year period. Mail any further bills or statements for any medical, hospital, prescription drug, dental or vision services covered by the Plan to the Fund Office as soon as you receive them.

Ordinarily, you will be notified of the decision on your **Post-Service claim** within *30 days* from the Plan's receipt of the claim. The Plan may extend the period once for up to *15 days* if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from receipt of the notification; or (2) the date you respond to the request. The initial 30-day period for making a determination on your Post-Service Claim will be tolled from the date on which the notice for additional information is sent until the date on which the appropriate Review Organization receives the information requested. When the Review Organization receives the requested information, it then has the remainder of the initial 30 days to make a decision and notify you of its determination.

### Disability Claims

A **Disability Claim** is any claim that requires a finding of total disability as a condition of eligibility. EXAMPLE: Weekly accident and sickness benefits will be treated as Disability Claims.

For **Disability Claims**, the Fund Office will make a decision on the claim and notify you of the decision within *45 days* after receipt of the claim by the Fund Office. If the Fund Office requires an extension of time due to matters beyond its control, the Fund Office will notify you of the reason for the delay and the date by which it expects to render a decision. This notification will occur before the expiration of the 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

A decision will be made within *30 days* of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional *30 days*, provided the Fund Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date that the Plan expects to render a decision.

If an extension is needed because the Fund Office needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from receipt of the notification; or (2) the date you respond to the request. The initial 45-day period for making a determination on your Disability Claim will be tolled from the date on which the notice for additional information is sent until the date on which the appropriate Review Organization receives the information requested. When the Review

Organization receives the requested information, it then has the remainder of the initial 45 days to make a decision and notify you of its determination.

For Disability Claims, the Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

#### Death and Accidental Death and Dismemberment Claims

For **Death and AD&D Claims**, the Fund Office will make a decision on the claim and notify you of the decision within *90 days* of receipt of the claim by the Fund Office. If the Fund Office requires an extension of time due to matters beyond the control of the Fund Office, the Fund Office will notify you of the reason for the delay and the date by which the Fund Office expects to render a decision. This notification will occur before the expiration of the 90-day period. The period for making a decision may be delayed an additional *90 days*.

#### **NOTICE OF DECISION**

You will be provided with written notice of a denial of a claim, whether denied in whole or in part. This notice will state:

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- A description of the appeal procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, you will receive either a copy of the rule, guideline, protocol or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the determination and that such rule or guideline is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- For **Urgent Care Claims**, the notice will describe the expedited review process applicable to **Urgent Care Claims**. The required determination for **Urgent Care Claims** will be made in writing, or orally and followed with written notification within 3 days thereafter. Requests for review of an adverse benefit determination involving an Urgent Care Claim may be made orally, followed by a written request, or in writing.

For **Pre-Service** and **Urgent Care Claims**, you will receive notice of the determination even when the claim is approved.

## ***REQUEST FOR REVIEW OF DENIED CLAIM***

If your claim is denied in whole or in part or if you disagree with the decision made on a claim, you may ask for a review. Your request for review for must meet the following criteria:

- made in writing;
- state the reason(s) for disputing the denial; and
- be accompanied by any pertinent material not already furnished to the Plan.

Requests for review of **Pre-service, Urgent Care, Post-Service** and **Disability** claims must be submitted to the Fund Office within *180 days* after you receive notice of denial. Requests for review of **Death and AD&D** claims must be filed within *60 days* of receipt of the denial notice. Failure to file an appeal within the prescribed period from the initial denial of your claim will constitute a waiver of your right to a review of the denial of your claim.

Appeals involving an adverse determination of an **Urgent Care Claim** may be made in any of the following ways:

- calling the Fund Office at (801) 266-3256 or (800) 345-3248; ask for the Claims Supervisor
- faxing the request to (801) 266-4383, attention: Claims Supervisor
- bringing the appeal in person to the Fund Office at 4885 South 900 East, Suite 202, Salt Lake City, Utah 84117, and asking to speak to a Claims Supervisor.

### *Review Process*

The review process works as follows:

For appeals involving an adverse determination of an **Urgent Care Claim**, all information necessary to decide the appeal shall be transmitted to the Fund Office as shown above or by other available similarly expeditious method. **Urgent Care Claim** appeals may **not** be submitted via US postal service.

You have the right to submit comments, documents, records and other information in support of your claim for benefits. Upon request and free of charge, the Fund Office will provide you with reasonable access to and copies of all documents, records or other information relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund Office in making the decision; it was submitted, considered or generated in connection with the claim (regardless of whether it was relied upon), it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A person who did not make the original decision and who is not a subordinate of the person who denied your claim will review your claim. The reviewer will not give deference to the initial

adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you relating to the claim.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Such professional will not be an individual who was consulted in connection with the initial determination that is the subject of the appeal, or any subordinate of such individual.

#### Timing of Notice of Decision on Appeal

- **Pre-Service Claims:** You will be sent a notice of decision on review within 30 days of receipt of the appeal by the Fund Office.
- **Urgent Care Claims:** You will be sent a notice of a decision on review as soon as possible but no later than 72 hours after receipt of the appeal by the Fund Office.
- **Post-Service Claims:** Ordinarily, decisions on appeals involving **Post-Service Claims** will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. This notification of extension will contain an explanation of the special circumstances requiring the extension and the date on which the decision on appeal is expected to be made. If an extension is needed because the Trustees need additional information from you, the extension notice will specify the information needed. In that case, the period of time for the Board of Trustees to make the decision on appeal will be suspended from the date on which you are sent such notification until you respond to the request for additional information. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.
- **Disability Claims:** The decision will be made in the same manner as for **Post-Service Claims**.
- **Death and AD&D Claims:** The decision will be made in the same manner as for **Post-Service and Disability Claims**.

#### Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination
- Reference to the specific plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents, records and other information relevant to your claim, upon request and free of charge

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline, protocol or similar criterion was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity or because the treatment was experimental, investigational, or other similar exclusion, you will receive either an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your claim or a statement that it is available at no charge upon request.
- A statement regarding any voluntary alternative dispute resolution or mediation options that may be available to you if you contact the United States Department of Labor or the State insurance regulatory agency.

The denial of a claim to which the right to review has been waived, or the decision of the Board or its designated Appeals Committee with respect to a petition for review, is final and binding upon all parties, including the claimant or the petitioner, subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or any right to arbitration.

## **COORDINATION OF BENEFITS WITH OTHER PLANS**

You and your Dependents may be eligible for benefits under this Fund as well as benefits under another plan. In such cases, this Fund will coordinate its benefits with those provided by (a) any group coverage arranged through any Employer, Trust, union or Employee Benefit Association, (b) any government or tax supported benefit program, (c) Medicare.

With coordination of benefits, a combination of payments up to, but not to exceed, 100% of Covered Charges may be paid. In no event will the benefit paid by this Fund exceed the amount that would have been paid if there were no other plans involved.

### ***COORDINATION OF BENEFITS LIMITATIONS***

1. Except for copayments and deductibles which result in out-of-pocket expenses for the participant, this Fund will not pay benefits for expenses covered by a prepaid plan.
2. This Fund shall recognize all discount arrangements between other plans and Preferred Provider Organizations. Wherever a discount fee is applicable, the maximum reimbursement shall be the lesser of:
  - the contract rate a Preferred Provider Organization charges for such expense; or
  - the amount this Fund pays as a Covered Charge.
3. The Fund requires that working spouses enroll in benefit plans offered by their employers. If your working spouse does not enroll in his/her employer's plan, the benefits otherwise payable for your spouse's health claims will be reduced to 40%. To avoid this reduction, your spouse should sign up for his or her employer's plan as soon as possible.

### ***ORDER OF BENEFIT PAYMENT***

One of the two or more plans involved is the primary plan while the others are secondary plans. The primary plan pays benefits first without regard to the other plans involved. The secondary plan then makes up the difference, up to the total Covered Charges.

The following rules will determine which plan will be primary and which will be secondary:

If one plan has no coordination of benefits provision, it is automatically primary.

***Employees and Dependents*** - The plan covering the participant as an employee will be primary, and will pay benefits first. The plan which covers the participant as a dependent will be secondary, and will pay benefits last.

***Active/Retired or Laid-off Employees*** - The plan covering the person who is neither laid-off nor retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid-off or retired employee pays benefits second.

***Dependent Children of Parents NOT Separated or Divorced*** - The plan covering the parent whose birthday falls earliest in the calendar year, regardless of birth year, will be primary. If the birthdays of the parents fall on the same day, the plan that has covered the parent the longest

shall be primary and the plan covering the parent for the shorter period of time pays benefits second.

***Dependent Children of Parents Separated or Divorced*** - The following order shall apply:

1. The plan of the parent with custody pays first;
2. The plan of the spouse of the parent with custody (the stepparent) pays next; and
3. The plan of the parent without custody pays last.

However, if a divorce decree places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent shall be primary.

***Longer/Shorter Length of Coverage*** - If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering the person for shorter period of time pays second.

### ***COORDINATION WITH MEDICARE***

If a person has coverage under this Plan and is eligible for Medicare, the following special rules apply:

***Employees*** – An Employee who is age 65 or older may select either this Fund or Medicare as primary. If this Fund is primary, it will pay its regular benefits without regard to Medicare. If you select Medicare as your primary plan, Medicare will be your **only** medical coverage. This Fund will automatically provide you with primary coverage unless you notify the Fund Office in writing that you wish to select Medicare as your primary coverage.

***Dependent Spouse*** - If your spouse is age 65 or older, she/he will be eligible for the same benefits as you. If you select Medicare as your primary coverage, Medicare will also provide your spouse's coverage. If you do not select Medicare as your primary coverage, this Fund will be your spouse's primary coverage.

***Totally Disabled Participants*** - If you or your Dependent becomes Totally Disabled, as determined by the Social Security Administration, and are entitled to Social Security Benefits for at least two years, you will be eligible for Medicare. This Fund, if you are still eligible, will integrate benefits with those paid by Medicare.

***Enrolling in Medicare*** - When you or your Dependent reach age 65, whether you select this Fund or Medicare as your primary coverage, you must enroll in Medicare in order to be entitled to Medicare benefits - it is not automatic. You must file an application with Social Security for both Parts A and B during the three months preceding your 65th birthday in order for coverage to be effective at the start of the month in which you reach age 65.

## **SUBROGATION AND REIMBURSEMENT**

If benefits are paid on account of Illness or Injury for which a Third Party may be liable, the Fund shall have the right to recover against any source which is or may be liable to make payments on account of the Illness or Injury or to be reimbursed by the Covered Person on whose behalf such payments are made, to the full extent of the benefit payments made by the Fund. The Covered Person must immediately notify the Fund Office of all information available concerning such Third parties, including identity and whereabouts, and about the facts concerning any claims against Third Parties.

The term “Third Party” shall include all insurers of Covered Persons, including, but not limited to, insurers providing Covered Persons with uninsured or underinsured motorist coverage.

The Trustees may sue Third Parties directly regarding any such claim, or settle such claim against Third Parties. It is the obligation of the Covered Person to cooperate with the Trustees in any such lawsuit. If claims against the Third Party exceed the amount of benefits paid by the Fund, the Trustees will not settle the claim without consent of the Covered Person.

The Covered Person also has the right to pursue Claims against the Third Party. However, before initiating a lawsuit against such Third Party, the Covered Person must notify the Fund and give the Fund an opportunity to participate in or monitor the proceedings. No claim may be compromised or settled with a Third Party without the express written consent of the Trustees

The Fund shall have an equitable lien, in an amount equal to the amount of the benefits the Fund has paid on behalf of a Covered Person, on account of Illness or Injury for which a Third Party may be liable. This equitable lien shall attach to any recovery (and the proceeds of any recovery that has been disposed of) by the Covered Person, or the Covered Person’s attorney, agent or designee (including any trust or other entity created to receive all of any part of the recovery) from the Third Party, regardless of any allocation of the recovery. The amount of the recovery (and of the proceeds of any recovery that has been disposed of) subject to the equitable lien is held in constructive trust for the benefit of the Fund, regardless of who the holder may be, and shall be subject to an equitable claim by the Fund, seeking restitution, disgorgement or other equitable remedy.

If either the Covered Person or the Trustees recover against a Third Party, the proceeds will be distributed as follows:

1. The reasonable costs and attorneys’ fees of the action will be charged proportionately against both the interests of the Fund and the Covered Person.
2. The Fund shall be reimbursed in full up to the amount of total benefit payments made on account of the Illness or Injury, less the Fund’s proportionate share of attorneys’ fees and costs.
3. The balance, if any, shall be paid to the Covered Person.

The Fund’s reimbursement rights are not dependent on the Covered Person being made whole for damages suffered as a result of the Third Party’s conduct. In the event benefits become payable under the Fund related to the Illness or Injury that was the subject of the Third Party

recovery, the Fund has the right to offset the balance of the Third Party recovery paid to the Covered Person against the benefit obligation. If the Fund must retain an attorney to enforce these rights, the Fund may collect reasonable attorneys' fees, costs and expenses incurred.

***SUBROGATION AND REIMBURSEMENT AGREEMENT***

Each Covered Person must sign a Subrogation and Reimbursement Agreement in the form required by the Trustees to confirm the terms of the Fund's Subrogation and Reimbursement provisions. You must sign the Agreement before receiving benefits from the Fund.

## **GENERAL INFORMATION**

The Intermountain United Food and Commercial Workers and Food Industry Health Fund was established and is continued pursuant to the Collective Bargaining Agreement in effect between your Union and your Employer. The Plan is self-funded and financed by negotiated Employer contributions made on behalf of eligible Employees; no Employee contributions are permitted except under special circumstances.

The Fund contracts with organizations to administer the Utilization Management and PPO provider programs; however these organizations do not insure any benefits.

### ***PLAN BENEFITS ARE NOT GUARANTEED***

All benefits are paid directly from the Fund and are not insured by any contract of insurance. There is no liability on the Board of Trustees or any individual or entity to provide payment over and above the amounts in the Trust Fund collected and available for such purposes.

### ***PLAN ADMINISTRATION***

The operation of the Fund is controlled by the Board of Trustees which provides equal representation by the Employers and the Unions. The names and addresses of the Trustees are listed on the inside front cover of this booklet. The benefits may be increased, decreased or terminated by the Trustees. No Employee, Dependent or other person has any vested right in the Trust Fund or the payments made therefrom.

The Fund is administered by the Board of Trustees which has full power to interpret the Plan and all Plan documents, agreements, rules and regulations, and to decide all questions concerning the Fund, including, but not limited to, the eligibility of any person to participate in the Fund and his or her entitlement to Plan benefits. The Board's interpretations and decisions concerning these matters are final and conclusive, so long as they are made in good faith and are not arbitrary or capricious.

### ***AMENDMENT OF THE PLAN***

The provisions of the Plan (including the increase and decrease or other modification of benefits) may be amended at any time by the vote of the Board of Trustees.

### ***RIGHT TO RECOVER OVERPAYMENTS AND DUPLICATE PAYMENTS AND RIGHT TO OFFSET***

If benefits are overpaid or paid in duplicate, or if benefits are paid when the Covered Person is not entitled to the benefits, or if the Covered Person fails to reimburse the Fund from a Third Party recovery, the Fund may bring legal action against the Covered Person or other recipient of the inappropriate payments to collect such duplicated or overpaid benefits. The Fund may also offset such overpaid amounts against future benefit payments which otherwise might be due on behalf of the Covered Person.

### ***NO FAULT INSURANCE EXCLUSION***

Any claim for medical, dental, vision or any other benefits is excluded to the extent such benefits are provided or should have been provided pursuant to state laws requiring an Employee or

Dependent to obtain no-fault insurance coverage, regardless of whether such coverage is actually obtained.

***EMPLOYMENT EXCLUSIONS***

Any claim for medical, dental, vision or any other benefits is excluded to the extent it arises from any Injury or Illness covered by workers' compensation laws, occupational disease laws, or laws of a similar character, or from any Injury or Illness arising out of or in the course of any occupation or employment for compensation, profit or gain regardless of whether covered by any worker's compensation, occupational disease or similar laws.

***UTILIZATION MANAGEMENT PROGRAM***

Failure to comply with the Utilization Management provisions may result in a reduction in benefits. Refer to page 32 for more information.

## **INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following information concerning the Fund is being provided to you in accordance with federal government regulations:

1. The name and type of administration:

Intermountain United Food and Commercial Workers and Food Industry Health Fund is administered by a joint Board of Trustees.

2. The name and address of the Plan Administrator is:

Board of Trustees  
Intermountain United Food and Commercial Workers and Food Industry and Food Industry Health Fund  
4885 South 900 East, Suite 202  
Salt Lake City, Utah 84117

Upon written request, the Plan Administrator will provide any participant or beneficiary information as to whether a particular Employer is contributing to this Fund and, if so, that Contributing Employer's address.

3. The names, titles, and business addresses of the Trustees are listed on the inside front cover of this booklet.

4. Type of Plan:

A Welfare Benefit Plan which provides Death Benefits, Accidental Death and Dismemberment, Weekly Disability Income, Medical Benefits, Dental and Orthodontic Benefits and Vision Benefits.

5. Name and address of agent for service of legal process:

In addition to the Board of Trustees, the following persons have been designated as agents for the service of legal process:

John S. Chindlund, Esq.  
Prince, Yeates & Geldzahler  
175 East 400 South, Suite 900  
Salt Lake City, Utah 84111

Steven Stemerman, Esq.  
Davis, Cowell & Bowe  
100 Van Ness Avenue, 20th Floor  
San Francisco, California 94102

6. The Employer Identification Number assigned by the Internal Revenue Service to the Plan is 87-0221322. The Plan Number assigned by the Board of Trustees is: 501.
7. For the purposes of maintaining the Trust Fund's fiscal records, the year-end date is April 30th.

## 8. Funding Medium

Benefits are provided from the Trust Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Agreement and Declaration of Trust and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

## 9. Source of Financing of the Fund

All contributions to the Trust Fund are made by Employers in accordance with Collective Bargaining Agreements between the Local Unions No. 711, and 7 of the United Food and Commercial Workers International Union, and signatory Employers.

Copies of Collective Bargaining Agreements as they relate to the Plan are available for inspection at the Plan Administrator's office during regular business hours, and will be furnished by mail upon written request. A copy of any Collective Bargaining Agreement as it relates to contributions to the Fund is available for inspection within 10 calendar days after written request at any Local Union office or any Contributing Employer to which at least 50 Plan participants report each day. The Fund may make a reasonable charge for copying documents; the Plan Administrator will state the charge for specific documents on request, so you may know the cost before ordering.

## 10. Identity of organizations through which benefits are provided. Following are the names and addresses of organizations providing administrative services to the Fund:

Managed Care Consultants (MCC)

4160 South Pecos Road

Las Vegas, Nevada 89121

*(administers utilization management program. Administers preferred provider program for Nevada, Idaho and St. George and Cedar City, Utah)*

CCN (formerly Premier Medical PPO)

420 E. South Temple, #300

Salt Lake City, UT 84111

*(administers preferred provider program in Utah, except St. George and Cedar City)*

Coalition America

*(administers preferred provider program in St. George and Cedar City, Utah)*

Group Vision Associates, a division of Spectera

211 Rock Hill Road, Ste. 200

Bala Cynwyd, PA 19004

*(administers vision care program)*

National Prescription Administrators, a division of Express Scripts

711 Ridgedale Avenue  
East Hanover, NJ 07936  
*(administers prescription drug card program)*

#### 11. Language Assistance

This booklet contains a summary in English of your Plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Fund Office.

#### 12. Future of the Plan and Fund

Plan benefits are provided to the extent that monies are currently available to pay the cost of benefits. The Board of Trustees retains full and exclusive authority to determine the extent to which monies are available and to determine the expenditures of such monies for benefits. This Plan is not a guaranteed lifetime benefit program nor are benefits guaranteed to continue indefinitely. Benefits may be terminated or modified at any time by the Board of Trustees. The Fund will terminate upon expiration of all Collective Bargaining Agreements requiring payment of contributions to the Fund. In the event of termination of the Fund, any and all monies and assets remaining in the Fund, after payment of expenses, shall be used for continuance of benefits provided by then existing benefit plans, until such monies and assets have been exhausted.

## ERISA STATEMENT OF RIGHTS

As a participant in the Intermountain United Food and Commercial Workers and Food Industry Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### ***Receive Information About Your Plan and Benefits***

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### ***Continue Group Health Plan Coverage***

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### ***Prudent Actions by Plan Fiduciaries***

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

### ***Enforce Your Rights***

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

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

### ***Assistance with Your Questions***

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

**AMENDMENT TO THE INTERMOUNTAIN UNITED FOOD AND  
COMMERCIAL WORKERS AND FOOD INDUSTRY HEALTH FUND  
SUMMARY OF PLAN BENEFITS**

THIS AMENDMENT to the Summary of Plan Benefits is hereby adopted by the Board of Trustees of the Intermountain United Food and Commercial Workers and Food Industry Health Fund effective as of April 14, 2003 in order to comply with certain provisions of the Health Insurance Portability and Accountability Act of 1996, and the Privacy Regulations promulgated thereunder;

WHEREAS, the Health Insurance Portability and Accountability Act of 1996, and the Privacy Regulations promulgated thereunder, limit the use and disclosure of the protected health information of the participants of the Intermountain United Food and Commercial Workers and Food Industry Health Fund; and

NOW THEREFORE, the Board of Trustees adopt this Amendment to the Summary of Plan Benefits, adding the following section to the end of the Summary of Plan Benefits:

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

1. The Health Fund will use and disclose Protected Health Information (“PHI”) to the extent permitted and in accordance with the Health Insurance Portability and Accountability Act of 1996, and regulations issued thereunder, including, without limitation, those regulations at 45 C.F.R. Parts 160 through 164 (“HIPAA”). Specifically, the Health Fund will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.
2. Subject to obtaining written certification as required in the subparagraph 4 below, the Health Fund may disclose PHI to the Board (the “Plan Sponsor”), provided the Plan Sponsor does not use or disclose such PHI except:
  - A. To perform administrative functions which the Plan Sponsor performs for the Health Fund;
  - B. To obtain premium bids from insurance companies, HMOs or other health plans for providing group insurance coverage under the Plan;
  - C. To modify, amend, or terminate the Plan; or
  - D. As permitted by the Plan, or as required by law.

3. In no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f). The Health Fund shall not disclose PHI to the Plan Sponsor unless the Plan Sponsor agrees to:
  - A. Not use or further disclose the PHI other than as permitted by the Plan, or as required by law.
  - B. Ensure that any agent (including a subcontractor) who receives PHI from the Health Fund, agrees in advance to the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.
  - C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
  - D. Report to the Health Fund any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.
  - E. Make available to an Eligible Employee or Dependent his or her PHI in accordance with 45 CFR §164.524.
  - F. Make available to an Eligible Employee or Dependent who requests an amendment to his or her PHI and incorporate any amendments to his or her PHI in accordance with 45 CFR §164.526.
  - G. Make available to an Eligible Employee or Dependent who requests an accounting of disclosures of his or her PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
  - H. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Fund with 45 CFR §164.504(f).
  - I. If feasible, return or destroy all PHI received from the Health Fund that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
  - J. Ensure that the adequate separation required by 45 CFR §164.504(f)(2)(iii) between the Health Fund and the Plan Sponsor exists.

4. The Health Fund shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(s)(ii), and that the Plan Sponsor agrees to the conditions of disclosure described above.
5. Notwithstanding any other provision herein, the Health Fund may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:
  - A. Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or
  - B. Modifying, amending, or terminating the Plan.
6. The Health Fund may disclose enrollment and disenrollment information and information on whether individuals are participating in the Health Fund to the Plan Sponsor, provided such enrollment and disenrollment information is only used by the Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Health Fund.
7. The Plan Sponsor shall only allow access to PHI to the Privacy Officer, the Administrator, other employees on the Administrator's benefits staff and the accounting staff with responsibility for supporting and performing administrative functions for the Health Fund, and members of the Board (including, alternates and the Industry Representative, if any). Such persons shall only have access to and use such PHI to the extent necessary to perform the appropriate supporting and administrative functions that the Plan Sponsor performs for the Health Fund. In the event that any such person does not comply with the provisions of this Section, the Plan Sponsor shall take appropriate action for resolving the non-compliance, including disciplinary action, if appropriate.
8. For purposes of complying with HIPAA, the Health Fund is a "Hybrid Entity" (as such term is defined in HIPAA) because it has both health plan and non-health plan functions. The Health Fund designates that this Section applies to its health care components that are covered by HIPAA Privacy Regulations and not other Health Fund functions or benefits.

9. For purposes of this Amendment, the following terms shall have the meaning described below unless otherwise provided by the Plan:

A. “Protected Health Information” means information that is created or received by the Health Fund and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member, and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Protected Health Information includes information of persons living or deceased.

B. “Summary Health Information” means information that may be individually identifiable health information, and (i) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and (ii) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

**FUND OFFICE**

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