UFCW LOCAL 1000 AND KROGER DALLAS
HEALTH AND WELFARE PLAN "MED-1000"
C/O NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.
2010 N.W. 150TH AVENUE, SUITE 100 • PEMBROKE PINES, FL 33028
Telephone (954) 266-6322 • Toll Free (800) 567-5899 • Fax (954) 266-2079

Date:	April 22, 2020
To:	All Eligible Participants
From:	Board of Trustees
Re:	Healthcare Benefits

Si usted necesita la traducción, llame por favor a la oficina del fondo en (800) 567-5899

IMPORTANT ANNOUNCEMENT ABOUT YOUR HEALTHCARE BENEFITS

This document is a "Summary of Material Modifications" (SMM). This SMM describes changes to the UFCW Local 1000 and Kroger Dallas Health and Welfare Plan. It modifies the language found in your Summary Plan Description (SPD) and Benefits Program, effective January 1, 2019.

The Board of Trustees of the UFCW Local 1000 and Kroger Dallas Health & Welfare Plan ("MED-1000") wishes to extend their best wishes for the wellbeing of you and your families during this unprecedented time.

In accordance with the Families First Coronavirus Response Act ("FFCRA"), a package of provisions aimed at providing emergency relief and support during the 2020 novel coronavirus/COVID-19 pandemic, the Board has approved certain changes to your benefit plan. The following services will be covered without any cost sharing charges (e.g. no deductible, co-payment, or co-insurance) for the Fund's eligible participants and dependents:

1. Diagnostic tests to detect the coronavirus that are approved or authorized by the FDA, including the administration of such tests and the associated office visit, urgent care visit or emergency room visit; and

2. Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, a test as described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the individual needs the test.

This provision applies to tests, items and services provided on or after March 16, 2020 through the end of the federal government's declared emergency period related to COVID-19. Medically necessary treatment of COVID-19 remains covered under the normal rules of the Plan (including cost sharing and other requirements).

Introducing Telehealth Benefits

The Board of Trustees recognizes that COVID-19 has made it more difficult to access doctors for regular care. We understand that many of you are working long hours, doctor's offices are not keeping the same hours they once were and many people are minimizing activities that may allow exposure to the virus. That's why we have partnered with Teladoc©, to provide you with easy access to the care you need, 24/7.

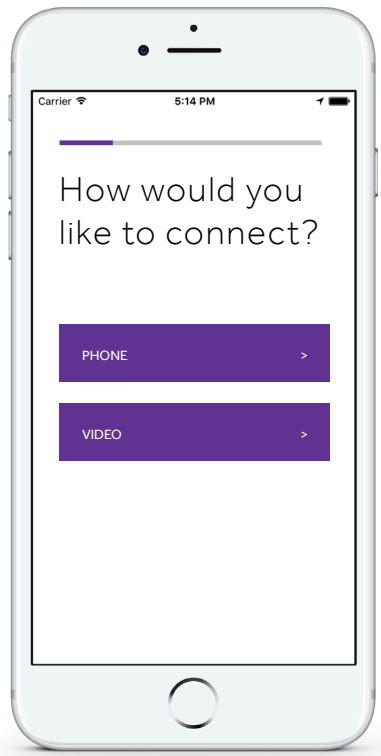
Please see the enclosed flyer for more information. **The Med-1000 plan will cover Teladoc© visits at 100%, with no participant cost sharing through June 30, 2020.**

This Summary of Material Modifications should be kept with your Summary Plan Description.

If you have any questions, please contact the Administrative Manager. The Administrative Manager can be contacted at:

National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, FL 33028
1-800-567-5899

NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.
NEBA



Introducing Teladoc!

COVID-19 has made seeing a doctor more difficult than usual, so your Care-1000 trustees have contracted with Teladoc so that you can speak with a U.S. board-certified doctor 24/7 by phone or video for many non-emergency illnesses.

Receive affordable care for:

- Sinus infection
- Flu
- Cough
- Sore throat
- Rash
- Allergy
- Upset stomach
- Nausea and more

Talk to a doctor for $0 through June 30, 2020

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MED-1000 HEALTH & WELFARE PLAN

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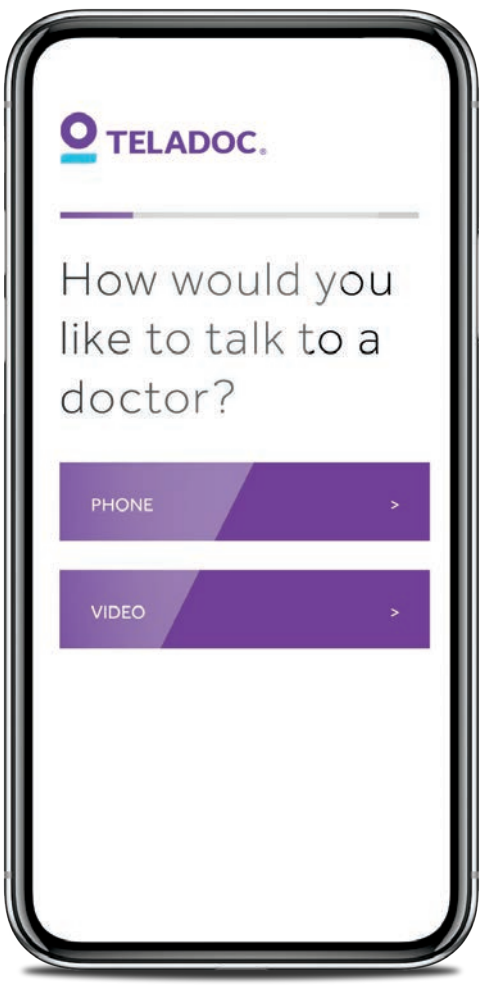
MED-1000 HEALTH & WELFARE PLAN

Set up your Teladoc account

in 4 easy steps



Download the app to talk to a doctor anytime, anywhere by phone or video.

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1 **Download the app**
Search for "Teladoc" in the App Store or on Google Play.

2 **Set up your account**
Once you've downloaded the app, select "Set up your account."

3 **Enter basic contact information**
Provide some information about yourself to confirm your eligibility. We'll confirm we found your benefits and you'll continue creating your account.

4 **Create your account**
Enter your address and phone number, create a username and password, pick security questions, and agree to terms and conditions.

Download the app to talk to a doctor for free

Download the app

Visit Teladoc.com | Call 1-800-TELADOC (835-2362)

UFCW LOCAL 1000 AND KROGER DALLAS
HEALTH AND WELFARE PLAN "MED-1000"
C/O NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.
2010 N.W. 150TH AVENUE, SUITE 100 • PEMBROKE PINES, FL 33028
Telephone (954) 266-6322 • Toll Free (800) 567-5899 • Fax (954) 266-2079

Date: June 20, 2019
To: All Participants
From: Board of Trustees
Re: Healthcare Benefits

Si usted necesita la traducción, llame por favor a la oficina del fondo en (800) 567-5899

IMPORTANT ANNOUNCEMENT ABOUT YOUR HEALTHCARE BENEFITS

This document is a "Summary of Material Modifications" (SMM). This SMM describes changes to the UFCW Local 1000 and Kroger Dallas Health and Welfare Plan. It modifies the language found in your January 1, 2019 Summary Plan Description (SPD).

As a result of collective bargaining between United Food and Commercial Workers (UFCW) Local 1000 and the Kroger Company, changes will be made to the eligibility rules for the UFCW Local 1000 and Kroger Dallas Health and Welfare Plan "Med-1000" (the Plan) **effective January 1, 2020**. This notice is intended to help you understand the changes.

Eligibility will continue to be based on employee status, seniority and hours worked, although **the hours required for eligibility have changed**. The new eligibility requirements are as follows:

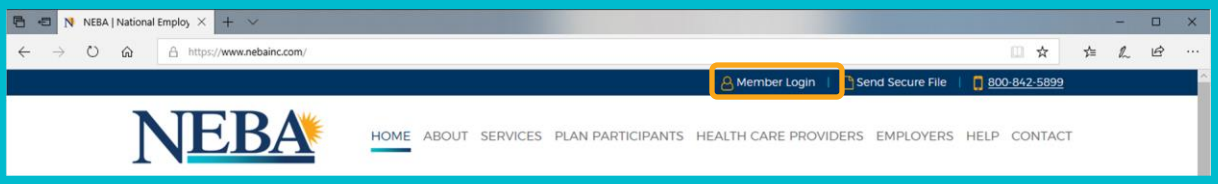
Coverage Type	Previous Requirement	NEW Requirement
Employee Only	Average of 24 hours per week	Average of 27 hours per week (1,404 hours per year)
Employee and Children	Average of 28 hours per week	Average of 30 hours per week (1,560 hours per year)
Employee and Spouse	Average of 28 hours per week	Average of 36 hours per week (1,872 hours per year)
Family	Average of 28 hours per week	Average of 36 hours per week (1,872 hours per year)

The standard 12-month measurement and stability periods will continue to be used**. Your hours worked between November 1, 2018 and October 31, 2019** will be used to determine your eligibility for coverage effective January 1, 2020 **based on the new requirements.**

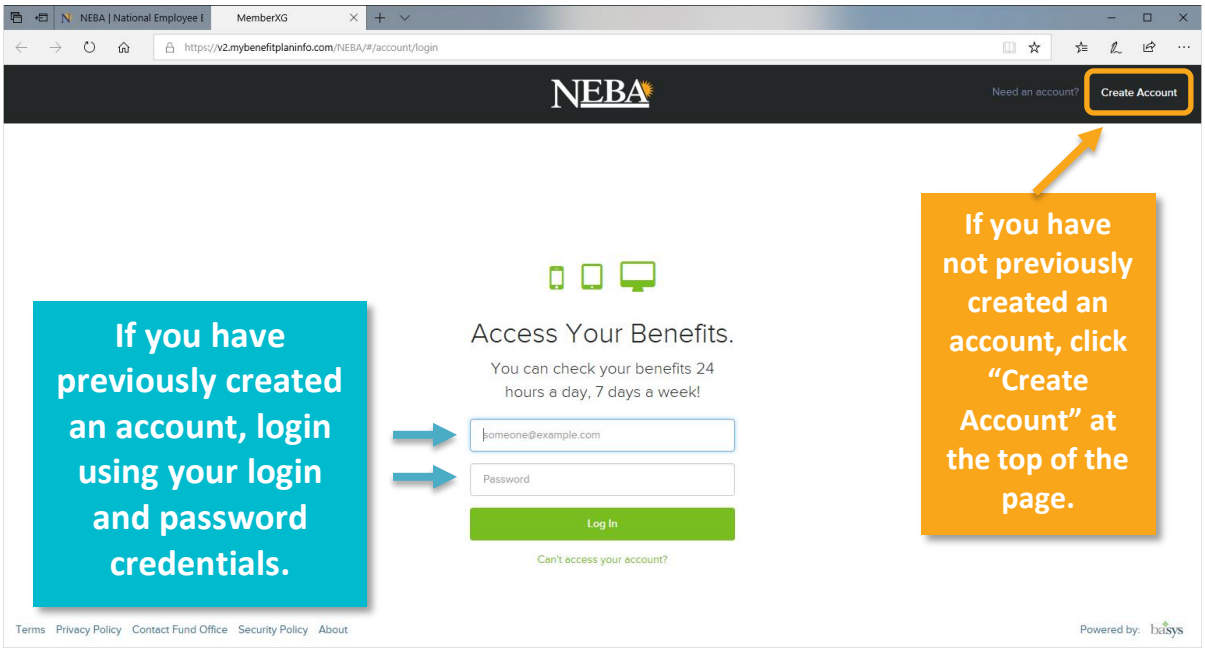
You can monitor your hours at any time by visiting www.nebainc.com and logging in to your member portal. Please see the reverse side of this page for further instructions about accessing your member portal.

MEMBER PORTAL INSTRUCTIONS

Visit www.nebainc.com and click on the "Member Login" link at the top of the page.



This will direct you to your member portal.



This Summary of Material Modifications should be kept with your Summary Plan Description.

If you have any questions, please contact the Administrative Manager. The Administrative Manager can be contacted at:

National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100 | Pembroke Pines, FL 33028
1-800-567-5899

United Food & Commercial Workers
Local 1000 & Kroger Dallas
Health & Welfare Fund
"MED-1000"

Summary Plan Description

RESTATED EFFECTIVE: January 1, 2019

HEALTH CARE INFORMATION FOR

UFCW LOCAL 1OOO & KROGER DALLAS

HEALTH & WELFARE FUND

"MED-1000"

PARTICIPANTS

Comprehensive and affordable benefits are important to all of us. The United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Fund Trust Agreement ("the Trust") provides the Trustees the authority to establish and maintain a Plan for health and welfare benefits for eligible Employees and beneficiaries.

This booklet constitutes Your Summary Plan Description (SPD) for the United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan ("MED-1000" or "the Plan"). We hope You will take the time to carefully review this SPD, which includes the governing rules and regulations for the Plan.

This Plan does not have a separate Plan Document. This SPD serves as the Plan Document. We have made every effort to ensure this Summary Plan Description (SPD) is accurate. In the event of any inconsistency between this SPD and any benefits or open enrollment materials, the terms of the official documents, as interpreted by the Plan Administrative Manager, will govern.

The Trustees may consider it necessary to revise the benefits described in this SPD from time to time. Changes are typically described in communications called "Summary of Material Modifications" (SMM) or "Summary of Benefits and Coverage" (SBC). You should keep Your SMMs and SBCs with this SPD for easy reference.

The terms of the collective bargaining agreement between Your Employer and Your local Union detail the monthly contributions Your employer is obligated to make to the Health and Welfare Plan for Your coverage.

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(800) 567-5899

Fund Auditor
LaPadula, Carlson and Co. Certified Public Accountants

Fund Consultant
Horizon Actuarial Services, LLC

Fund Counsel
Deborah Godwin
Godwin, Morris, Laurenzi, Bloomfield

ARTICLE I – ELIGIBILITY

The Trust offers two health care Plans: the Premium Plan and the Value Plan. Your eligibility for participation is based on Your employment status – whether You are a "Variable Hour" or "Known Full-Time" Employee (very few Employees are known full-time Employees).

Eligibility Rules Definitions:

- A "Variable Hour" Employee is someone who is not expected to work a minimum of 30 hours per week when hired. ***Most Employees hired are considered Variable Hour Employees.***
- A "Known Full-Time" Employee is someone who is expected to work a minimum of 30 hours per week when hired. ***Few Employees hired are considered Known Full-Time Employees.***
- The "Initial Measurement Period" is a rolling 12-month work period beginning with Your month of hire, during which hours worked are counted for initial eligibility purposes.
- The "Standard Measurement Period" is the 12-month work period from November 1– October 31 of the following year, during which hours worked are counted for continuing eligibility purposes.
- The "Initial Stability Period" is the 12-month period of time for which initial coverage under the Value Plan or the Premium Plan is earned; it begins on the first day of the month following a one-month Administrative Period after the initial measurement period ends.
- The "Standard Stability Period" is January 1 – December 31 of each calendar year.

Initial Eligibility

Initial Eligibility is determined based on your employment status as either a Variable Hour employee or a Known Full-Time employee.

The Trust offers coverage in two separate Plans – the Value Plan and the Premium Plan. Eligibility is based on Employee status, seniority, and hours worked. Initial eligibility is determined by measuring rolling 12 month periods beginning with the month in which the employee was hired.

Initial eligibility rules for both Variable Hour employees and Known Full-Time employees are summarized in tables on the following pages.

Initial Eligibility for Variable Hour Employees *Most employees hired are considered Variable Hour employees.*				
Plan	**Minimum Hours Required**	**Initial Measurement Period**	**Initial Eligibility Effective Date**	**Initial Stability Period (Coverage Period)**
Value Plan *Employee Only Coverage*	1,248 hours in 12 consecutive months (average of 24 hours per week).	Rolling 12 months beginning with the month in which the employee was hired.	1st day of the month following satisfaction of the minimum hours requirement. Earliest effective date is the 1st day of the 13th month of employment.	12 months beginning with initial eligibility month.
Value Plan *Employee, Children and Spouse Coverage*	1,440 Hours in 12 consecutive months (average of 28 hours per week).	Rolling 12 months beginning with the month in which the employee was hired.	1st day of the month following satisfaction of the minimum hours requirement. Earliest effective date is the 1st day of the 13th month of employment.	12 months beginning with initial eligibility month.
Premium Plan *Employee Only Coverage*	1,248 hours in 12 consecutive months (average of 24 hours per week).	Rolling 12 months beginning with the 12th month of employment for those hired prior to 11/15/17; or, beginning with the 24th month of employment for those hired on or after 11/15/17.	1st day of the month following satisfaction of the minimum hours requirement. Earliest effective date is the 1st day of the 25th month of employment for those hired prior to 11/15/17; or, 1st day of the 37th month of employment for those hired on or after 11/15/17.	12 months beginning with initial eligibility month.
Premium Plan *Employee, Children and Spouse Coverage*	1,440 Hours in 12 consecutive months (average of 28 hours per week).	Rolling 12 months beginning with the 12th month of employment for those hired prior to 11/15/17; or, beginning with the 24th month of employment for those hired on or after 11/15/17.	1st day of the month following satisfaction of the minimum hours requirement. Earliest effective date is the 1st day of the 25th month of employment for those hired prior to 11/15/17; or, 1st day of the 37th month of employment for those hired on or after 11/15/17.	12 months beginning with initial eligibility month.

Initial Eligibility for Known Full Time Employees *Few employees hired are considered Known Full-Time employees.*				
Plan	**Minimum Hours Required**	**Initial Measurement Period**	**Initial Eligibility Effective Date**	**Initial Stability Period (Coverage Period)**
Value Plan *Employee & Children Coverage*	No minimum hours required.	N/A	1st day of the 3rd month of employment.	12 months beginning with initial eligibility month.
Value Plan *Employee, Children and Spouse Coverage*	1,440 Hours in 12 consecutive months (average of 28 hours per week).	Rolling 12 months beginning with the month in which the employee was hired.	1st day of the month following satisfaction of the minimum hours requirement. Earliest effective date is the 1st day of the 13th month of employment.	12 months beginning with initial eligibility month.
Premium Plan *Employee & Children Coverage*	No minimum hours required.	N/A	1st day of the 25th month of employment for those hired prior to 11/15/17; or, 1st day of the 37th month of employment for those hired on or after 11/15/17.	12 months beginning with initial eligibility month.
Premium Plan *Employee, Children and Spouse Coverage*	1,440 Hours in 12 consecutive months (average of 28 hours per week).	Rolling 12 months beginning with the 12th month of employment for those hired prior to 11/15/17; or, beginning with the 24th month of employment for those hired on or after 11/15/17.	1st day of the month following satisfaction of the minimum hours requirement. Earliest effective date is the 1st day of the 25th month of employment for those hired prior to 11/15/17; or, 1st day of the 37th month of employment for those hired on or after 11/15/17. 12 months beginning with initial eligibility month	12 months beginning with initial eligibility month.

Continuing Eligibility

Continuing eligibility for this Plan is based on Standard Measurement Periods.

After You initially become eligible, You can maintain coverage by working a minimum of 1,248 hours for single and 1,440 hours for dependent coverage during the next applicable 12-month standard measurement period (November 1st through October 31st of the following year) and then each 12-month standard measurement period after that.

Your continued eligibility is reviewed on an annual basis. Work performed between November 1st and October 31st of the following year will be used to determine eligibility for January through December of the next year.

The Plan for which You are eligible is based on seniority requirements. The seniority requirement for Value Plan coverage is 12 months of employment. For the Premium Plan, the seniority requirement is based on Your hire date:

- 24 months of employment if You were hired before November 15, 2017 or
- 36 months of employment if You were hired on or after November 15, 2017

Once You gain eligibility for the Premium Plan, You will have the choice to remain in the Value Plan or enroll in the Premium Plan. As long as You have reached the Premium Plan seniority requirements and remain eligible for coverage, You may change Your Plan selection each year during open enrollment.

Standard eligibility measurement and stability periods are summarized as follows:

Standard Measurement Periods	Standard Administrative Periods	Standard Stability Period
November 1 through October 31 (following year)	November 1 through December 31	January 1 through December 31

Continuing eligibility rules for both Variable Hour employees and Known Full-Time employees are summarized in tables on the following page.

Continuing Eligibility for Variable Hour Employees *Most employees hired are considered Variable Hour employees.*			
Plan	**Minimum Hours Required**	**Standard Measurement Period**	**Standard Stability Period (Coverage Period)**
Value Plan *Employee Only Coverage*	1,248 hours (average of 24 hours per week).	November 1st – October 31st of the following year	January 1st – December 31st (beginning with the January 1st following the October 31st end of the Standard Measurement Period)
Value Plan *Employee & Dependent(s) Coverage*	1,440 hours (average of 28 hours per week).	November 1st – October 31st of the following year	January 1st – December 31st (beginning with the January 1st following the October 31st end of the Standard Measurement Period)
Premium Plan *Employee Only Coverage*	1,248 hours (average of 24 hours per week).	November 1st – October 31st of the following year	January 1st – December 31st (beginning with the January 1st following the October 31st end of the Standard Measurement Period)
Premium Plan *Employee & Dependent(s) Coverage*	1,440 hours (average of 28 hours per week).	November 1st – October 31st of the following year	January 1st – December 31st (beginning with the January 1st following the October 31st end of the Standard Measurement Period)

Continuing Eligibility for Known Full Time Employees *Few employees hired are considered Known Full-Time employees.*			
Plan	**Minimum Hours Required**	**Standard Measurement Period**	**Standard Stability Period (Coverage Period)**
Value Plan *Employee Only Coverage*	No Minimum Hours	November 1st – October 31st of the following year	January 1st – December 31st (beginning with the January 1st following the October 31st end of the Standard Measurement Period)
Value Plan *Employee & Dependent(s) Coverage*	1,440 hours (average of 28 hours per week).	November 1st – October 31st of the following year	January 1st – December 31st (beginning with the January 1st following the October 31st end of the Standard Measurement Period)
Premium Plan *Employee Only Coverage*	No Minimum Hours	November 1st – October 31st of the following year	January 1st – December 31st (beginning with the January 1st following the October 31st end of the Standard Measurement Period)
Premium Plan *Employee & Dependent(s) Coverage*	1,440 hours (average of 28 hours per week).	November 1st – October 31st of the following year	January 1st – December 31st (beginning with the January 1st following the October 31st end of the Standard Measurement Period)

Initial Eligibility for Dependents

Your Dependents' eligibility for Premium or Value Plan benefits is determined by:

- Your eligibility for Premium or Value Plan benefits; and
- You having worked a minimum of 1,440 hours in the corresponding initial or standard measurement period required to access Dependent coverage (as opposed to the 1,248 hours required to access Employee Only coverage). The 1,440 hours per annual measurement period is approximately 28 hours per week.
- Your written election of optional Dependent Medical, and Dental coverage on the forms provided; and
- Your contribution, in an amount determined by the Trustees, through payroll deduction. When You cannot make a payroll deduction, such as when illness keeps You from working, any amount owed by You will be deducted in arrears when You return to work or You may make a direct payment of the contribution amount directly to the Plan Administrative Manager.

Employee and Dependent Contributions

Contributions are required to access coverage. These contributions are pre-tax dollars which are collected by Your Employer via payroll deductions and remitted to the Plan on a monthly basis. Your employer submits these contributions directly to the Fund Office along with their required contributions for Your hours worked during the same work month. Payment of these contributions is a contingency of coverage. Effective January 1, 2019, the Employee and Dependent Contribution Rates are as follows.

Weekly Contribution Amounts		
Coverage Tier	Value Plan	Premium Plan
Employee Only	$6.00	$12.00
Employee & Spouse	$11.25	$22.50
Employee & Child(ren)	$7.50	$15.00
Family	$15.00	$30.00

These contribution rates are determined by the Trustees and are subject to change.

Continuing Eligibility During Disability

After You become eligible, if You are unable to work because of a certified disability, You may be eligible to earn credits in order to assist in maintaining Your future eligibility. Please refer to the Disability section of this document to obtain additional information on the Short-Term Disability benefits available to You. A certified disability is one for which You are being paid Weekly Accident and Sickness benefits through the Plan or submit evidence of receiving workers' compensation benefits as the result of a disability incurred while performing work while eligible and enrolled in coverage and during which contributions were paid to the Plan.

When Coverage Ends

Your eligibility for benefits will end on the earliest of:

- The date Your employment with Your participating employer terminates; or
- The last day of a Standard Stability Period if You do not work enough hours in the preceding Standard Measurement Period to qualify.
    - For example, assume that You have Value Plan coverage for the Stability Period of January 1, 2019 through December 31, 2019 because You worked 1,248 hours in the Measurement Period from November 1, 2017 through October 31, 2018. If You do not work a minimum of 1,248 hours in the next Measurement Period of November 1, 2018 through October 31, 2019, Your Value Plan coverage would end on December 31, 2019; or
- The date You enter the armed forces of the United States on full-time active duty; or
- The date You elect in writing on the forms provided by the Plan Administrative Manager to decline or refuse all coverages provided by the Plan because You are eligible for Medicare.
    - In order to waive coverage for any reason other than being eligible for Medicare, a waiver form is required to be filled out and signed to go before and be approved by the Trustees.

Your Dependents' eligibility for benefits will end on the earliest of:

- The date Your eligibility for benefits (Death benefits, Dental, and Medical benefits) ends; or
- The date You elect in writing on the forms provided by the Plan Administrative Manager to decline or refuse all coverages provided by the Plan because You are eligible for Medicare; or

- The first day of the month following the month in which required Employee contributions are not paid to the Plan Administrative Manager; or
- The date that Your Dependent(s) fails to qualify as a Dependent(s) under the Plan.

Continuation of Coverage

When Your coverage for Medical and Dental benefits ends, You and Your enrolled Dependents may be eligible to continue coverage at Your own expense.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), You and Your enrolled Dependents may continue medical and dental coverage when coverage would otherwise end. See the section COBRA Continuation of Medical and Dental Coverage in this SPD for more information.

ARTICLE II – DESCRIPTION OF BENEFITS

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

Medical Benefits

The Trust offers comprehensive medical benefits that provide broad and extensive coverage to help You pay the costs of most types of medical care. The medical benefits under either the Premium Plan or Value Plan may not pay 100% of the medical Expenses that You may incur.

Deductible Amount
Medical benefits become payable after You have satisfied the Deductible of eligible Expenses each Calendar Year as set forth in the SBC. The annual Deductible applies only once in any Calendar Year to each individual. You or Your healthcare providers must submit Your eligible Expenses to the Plan for Your Deductible to be satisfied.

If You have family members on the Plan, each family member must meet their own individual Deductible until the total amount of the Deductible Expenses paid by all family members meets the overall family Deductible.

Also note that there is an additional and separate Deductible for failure to pre-certify a hospital inpatient stay as well as for an Emergency Room visit.

Lifetime and Annual Maximum Benefit
There is no limit on annual or lifetime benefits.

Medical Plan Out-of-Network
This Plan does not cover Out-of-Network medical Expenses.

Comparison of Medical Plan In-Network
The chart on the following page compares In-Network benefits under the Premium and Value Plans. Please refer to the Medical Benefits section of Article III – Description of Benefits for detailed information on covered Expenses as well as preventive health services.

Deductible and Maximums		Value Plan In-Network Benefits Only	Premium Plan In-Network Benefits Only
Calendar Year Deductible per Covered Person *Does not apply to In-Network preventive care or office visits*		$1,100 Single $3,300 Family	$900 Single $2,700 Family
Calendar Year Out-of-Pocket Maximum per Covered Person		$6,850 Single $13,700 Family	$6,850 Single $13,700 Family
Employee Coinsurance		40%	30%
Services		**In-Network**	**In-Network**
Preventive Care		No Charge	No Charge
Primary Care Visit		$35 Copay	$35 Copay
Specialist Visit		$60 Copay	$60 Copay
Urgent Care		$25 Copay	$25 Copay
Hospital Inpatient[1]	**Facility Fee**[2]	Deductible & 40% Coinsurance	Deductible & 30% Coinsurance
	Physician Fee	Deductible & 40% Coinsurance	Deductible & 30% Coinsurance
Hospital Outpatient[3]	**Facility Fee**	Deductible & 40% Coinsurance	Deductible & 30% Coinsurance
	Physician Fee	Deductible & 40% Coinsurance	Deductible & 30% Coinsurance
Emergency Room and ER Professional[4]		$500 Deductible per Visit & 40% Coinsurance[4]	$500 Deductible per Visit & 30% Coinsurance[4]
Other Services		Deductible & 40% Coinsurance	Deductible & 30% Coinsurance

1. Includes mental/behavioral health inpatient services.
2. $300 Deductible applies for failure to pre-certify.
3. Includes mental/behavioral health outpatient services.
4. $500 per visit Deductible waived if admitted.
Emergency benefits available Out of Network.
5. These benefits are for In-Network service only.
The Plan does not cover Claims that are Out-of-Network.

Medical Expenses Covered

Medical Expenses covered by the Plan for Medically Necessary care and services ordered by a Physician for a non-occupational Injury or illness include:

- Hospital care - room and board and miscellaneous charges during a Hospital confinement, and outpatient charges if outpatient treatment is provided as an alternative to a Hospital confinement
- Physician care - treatment by a Physician, whether in or out of a Hospital, for an Injury or illness, including diagnosis, x-ray and laboratory services, in-Hospital visits or office visits
- Surgical care - Physician Expenses incurred in connection with a surgical procedure, including anesthetist's charges
- Nursing services – treatment or nursing services of a registered nurse or licensed practical nurse
- Ambulance service to a Hospital or transfer between Hospitals, if Medically Necessary
- Anesthesia, oxygen and their administration
- X-ray and laboratory tests
- Radium, radioactive isotope or similar therapy
- Blood or blood plasma and their administration
- The rental of Durable Medical Equipment such as a Hospital bed, wheelchair, crutches or breast pumps – this covers the rental of original equipment only, up to the purchase price of such equipment, not replacement of the equipment
- Durable Medical Equipment including equipment or devices designed for repeated use and is Medically Necessary for the treatment of an illness or Injury, or to improve or prevent further deterioration of a medical condition and is of no value to the You or Your family in the absence of the Injury or illness (the device must not be unproven, Experimental or Investigational)
- Orthopedic braces, casts or splints
- Dental treatment will be covered only for: (a) charges incurred for treatment of an accidental injury or illness to sound natural teeth; or (b) charges for Hospital expenses incurred while Hospital confined for dental care and treatment.
- Chiropractic services not to exceed 27 visits per year.
- Outpatient surgery benefits for covered surgeries and all related charges, if the surgery is performed in a Physician's office, or as an outpatient in a Hospital or ambulatory surgical facility
- Pregnancy-related Expenses
- Initial prosthetic devices for a loss or Injury, not for replacement of these devices
- Charges made by an alternative birthing center for medical care and treatment received in connection with a birth
- Charges for certified nurse-midwives and licensed midwives – no benefit will be paid for the same services furnished by a Physician

- Expenses incurred for necessary home health care services recommended by a Physician will be payable for the following services and supplies furnished in Your home, not to exceed 30 days in a Calendar Year:
    - Part-time or intermittent home nursing care from or supervised by a registered nurse
    - Part-time or intermittent home health aide services
    - Physical therapy, occupational therapy and speech therapy
    - Physician and laboratory services by or on behalf of a Hospital to the extent such items would have been covered if the person was confined in a Hospital or a skilled nursing facility
    - Room and board and miscellaneous services for an eligible stay in an extended care facility up to a total of 30 days in each Calendar Year; a stay in an extended care facility is covered only if:
        i. The stay begins within 7 days after a Hospital stay
        ii. The stay is due to the same or related causes as the Hospital stay and
        iii. A Hospital stay would otherwise be needed
- Charges for breast cancer screening and mammograms, as set forth in the SBC
- Charges made by a Hospice Care facility or agency
- Charges for Hospital emergency room care for treatment of an Injury or illness, subject to the Deductible set forth in the SBC
- Hospital outpatient care for an illness
- Pre-admission tests or exams - exams made before You enter a Hospital for inpatient surgery, when:
    - The tests or exams pertain to the planned surgery and are ordered by a Physician
    - The Physician requests Hospital admission for surgery and the Hospital confirms the request.
- In compliance with the Women's Health and Cancer Rights Act of 1998, medical and surgical benefits in connection with a mastectomy for certain reconstructive surgery; if You or a covered Dependent undergoes a mastectomy and elects breast reconstruction, coverage in a manner determined in consultation with the attending Physician and patient will be provided for:
    - Reconstruction of the breast on which the mastectomy was performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance and
    - Prostheses, mastectomy bras and treatment of physical complications at all stages of the mastectomy, including lymphedema – coverage is subject to the Plan's annual Deductibles, coinsurance provisions and annual maximums
- Charges incurred for care provided to a newborn infant while still in the Hospital. Under federal law, the Plan may not restrict benefits for any Hospital stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of

the above periods; however, a mother and her Physician may agree to discharge the mother (and infant) after a shorter Hospital stay than those described above

- Mental health care such as neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind
- Clinical trials - the Plan will not prohibit individuals from participating in a clinical trial or limit coverage for routine patient cost related to a clinical trial
- Preventive care - the Plan covers preventive services in accordance with applicable legal requirements without a Copayment or Deductible, but only when the services are delivered by a Network provider.
    a. For a list of all services classified as preventive care, as the list is subject to change over time, please refer to the following URL:
        i. https://www.healthcare.gov/coverage/preventive-care-benefits/

Ways You Can Save $$$

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

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

   KATE:

   a. Kate's doctor normally bills $3,200 for the procedure. The allowed amount is $2,600 and, because the doctor is In-Network, Kate is not responsible for the difference.
   b. Kate is required to pay the $1,100 individual Deductible.
   c. Kate also pays 40% of the remaining $1,500 in charges ($2,600 - $1,100 Deductible), or $600.
   d. **Kate's total payments to the doctor = $1,700** ($1,100 Deductible + $600 in Coinsurance)

JACK:

a. Jack's doctor also bills $3,200 for the procedure. Because the doctor is out of the Network, for which this Plan does offer Coverage, Jack is responsible for paying the entire amount.
b. **Jack's total payments to the doctor = $3,200**

Kate's total cost of $1,700 for using an In-Network provider represents a savings of $1,500 compared to Jack's total cost of $3,200 for using an Out-of-Network provider.

2. *Emergency room vs urgent care facility visit*:
In the example below, both Jay and Bob are enrolled in Premium Coverage and have mild allergic reactions. Jay visits an In-Network urgent care facility while Bob goes to the closest In-Network emergency room.

JAY:

a. Jay visits an In-Network urgent care facility. The visit yields $400 in allowable charges, of which Jay is only responsible for paying a **$25 Copayment**.

BOB:

b. Bob visits an In-Network Emergency Room. The visit yields $2,000 in allowable charges. Bob pays the following for the visit:
    i. $900 Deductible
    ii. + $500 Sickness Emergency Room Copayment
    iii. + $180 = 30% Coinsurance on the remaining $600
    iv. = **$1,580 total**.

Jay's total cost of $25 for going to the In-Network urgent care facility represents a savings of $1,555 compared to Bob's total cost of $1,580 for going to the Emergency Room.

3. Pre-Certification of Inpatient Hospital Stay
In the example below, both Tom and Heather are enrolled in the Value Plan and go to an In-Network Hospital for a surgery that requires an inpatient stay. Tom's provider pre-certifies his procedure, while Heather's provider does not and therefore must pay the additional $300 Deductible for failure to Pre-Certify

TOM:

a. Before scheduling his surgery and going to the Hospital, Tom's provider Pre-Certifies the procedure and is approved.
b. Tom gets the surgery and is billed $18,000 for the procedure. The allowed amount is $12,000. Because the Hospital is In-Network, Tom is not responsible for the difference.
c. Tom pays the following for the visit:
    i. $1,100 Deductible
    ii. + $4,360 = 40% Coinsurance on the remaining $10,900
    iii. **= $5,460 total**

HEATHER:

d. Heather schedules her surgery and goes to the same Hospital and her provider does not Pre-Certify beforehand.
e. Heather receives the surgery and is billed $18,000 for the procedure. The allowed amount is $12,000. Because the Hospital is In-Network, Heather is not responsible for the difference.
f. Heather pays the following for the visit:
    i. $1,100 Deductible
    ii. + $300 additional Deductible for failure to Pre-Certify the stay
    iii. + $4,240 = 40% Coinsurance on the remaining $10,600
    iv. **= $5,640 total**

Tom's total cost of $5,460 for Pre-Certifying his inpatient Hospital stay represents a savings of $180 compared to Heather's total cost of $5,640 for failing to do the same.

Dental Benefits

Depending on Your eligibility for the Value or Premium Plan, You and Your Dependents may be eligible for dental benefits.

The Plan has contracted with United HealthCare to establish and maintain a dental benefits program. You will become eligible for this benefit based on the eligibility rules for the Value and Premium Plans.

Dental benefits, subject to copayments and limitations, include routine exams twice every 12 months, X-rays, preventive and restorative services, crowns and inlays, periodontics, endodontics, orthodontics, dentures and bridges. Please refer to the UHC Schedule of Dental Benefits for additional detailed information about Your dental benefits.

Emergency Services

1. Availability - If a Participant is not able to reasonably get services from a Participating Dentist in an Emergency, United HealthCare Dental will pay for Emergency Care from a non-participating Dentist. The Participant must give United HealthCare Dental a copy of the bill for Emergency Care no later than 60 days after the care or as soon as reasonably possible. United HealthCare Dental will pay any amount which United HealthCare Dental determines that it owes within 60 days of receiving the Claim.

2. Determination of Coverage - United HealthCare Dental will decide if the Claim is based on an Emergency and if services were reasonably available from a Participating Dentist. If a Participant asks United HealthCare Dental to authorize Emergency services, United HealthCare Dental will grant or deny the request in no more than one hour. The Participant may ask the Texas Department of Insurance to review any denial. A Participant cannot reasonably get services from a Participating Dentist if he or she is more than 30 miles from the service area or if timely care is not available from a Participating Dentist. United HealthCare Dental will pay for Claims based on a real Emergency only if United HealthCare Dental would have paid for the service if the service had been provided by a Participating Dentist.

3. Amount of Coverage - If there is coverage, United HealthCare Dental may try to get a reduced charge from the non-participating Dentist. If a reduced charge is obtained, United HealthCare Dental will pay that charge. If no reduced charge is obtained, United HealthCare Dental will pay the Usual and Customary fee for the services rendered. The Participant must pay any additional amounts due.

Out-of-Area Services and Benefits

United HealthCare Dental does not provide out-of-area services and benefits, except Emergency Care.

Dental Limitations and Exclusions

- Any non-emergency services provided by a non-participating Dentist.
- Emergency care provided within the service area.

- Temporomandibular Joint Procedures (TMJ) and related treatments.
- Oral Surgery to set a fracture or dislocation.
- Fees for time spent in a Hospital for a dental procedure.
- An illness or Injury that arose out of or in the course of Your employment.
- Implants related prosthetics.
- Dental treatment which is required due to an Injury which the Participant gave, and intended to give, to himself, a war or engaging in a riot or insurrection.
- Experimental procedures.
- Medications.

Weekly Accident and Sickness

If You are an Employee covered for Weekly Accident and Sickness Benefits and are Totally Disabled as certified by a Physician, the Plan will pay a weekly benefit up to the maximum benefit amount shown below, depending on whether You are participating in the Value Plan or Premium Plan.

Loss of Time Benefits

Benefit Provisions	Value Plan	Premium Plan
Waiting Period	4 days *(waived for accident or inpatient illness when Optional Coverage elected)*	4 days *(waived for accident or inpatient illness when Optional Coverage elected)*
Maximum Benefit Period	26 weeks	26 weeks
Maximum Weekly Benefit Amount	$150[1]	$300[2]

1. Not to exceed 50% of earnings
2. Not to exceed 75% of earnings

Before benefits begin, You must be continuously and Totally Disabled during the four-day waiting period described above. Benefits will then begin on the first day after the waiting period. Weekly Accident and Sickness benefit payments will continue until the earlier of the date You are no longer Totally Disabled or when You have received benefits for the maximum benefit period shown above.

Weekly Accident and Sickness Benefits are computed on a weekly basis. Payment for a period of less than a full week will be proportional. The amount for each day of the disability will be one-seventh of the weekly benefit.

If You are participating in the Value Plan, the maximum benefit amount is the lesser of the maximum benefit amount shown above or 50% of Your hourly pay rate multiplied by Your average number of hours worked for the eight weeks previous to Your disability.

If You are participating in the Premium Plan, the maximum benefit amount is the lesser of the maximum benefit amount shown above or 75% of Your hourly pay rate multiplied by Your average number of hours worked for the eight weeks previous to Your disability.

Period of Disability

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

Limitations and Exclusions

No benefits are payable if:

- You are not under the direct care of a Physician
- The Injury or illness was caused by a war or any act of war, whether declared or undeclared
- The disability is due to any Injury or illness arising from or in the course of any employment or occupation for compensation or profit, or any Injury or illness covered under any workers' compensation law or similar law
- Your disability begins after Your employment has terminated, even if You are still eligible for other coverage under the Plan
- For any period while You are on paid vacation
- Your disability results from a suicide attempt or from any intentionally self-inflicted Injury

Life and AD&D Insurance

Life and accidental death & dismemberment (AD&D) insurance benefits are available for all employees with amounts varying based on seniority and hours worked. Employee life benefits are available from the first day of employment while Dependent life benefits require additional seniority and hours worked. A copy of the policy is available upon request. Please refer to that policy for more information about the life and AD&D benefits.

If You are eligible for the Plan, You can choose to elect optional life insurance and AD&D insurance. You pay the cost of the optional life and AD&D coverage through payroll deductions.

If You or a covered Dependent dies while eligible for life insurance benefits, the Plan will pay the amount shown in the chart below. (You can also request the benefit amount from the Administrative Manager). Benefits will be paid to the beneficiary You name; if no named beneficiary is surviving at the death of the insured person, payment will be made in the following order:

1. The surviving spouse
2. Your children, in equal shares
3. Your brothers and sisters, in equal shares
4. The executors or administrators of Your estate

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

Employee and Dependent benefit amounts are as follows:

EMPLOYEE LIFE BENEFITS

Number of months of eligibility & minimum hours worked

1st day of Employment - Basic Benefit.....	$1,000
31st day of Employment - Basic Benefit.....	$1,500
61st day of Employment - Basic Benefit.....	$2,000
1st day of 4th month - Basic Benefit.....	$2,500
Additional Buy-Up Benefit.....	$2,500
1st day of the calendar year following 12 continuous months of eligibility	
Part-Time (32 hours per month).....	$3,500
Additional Buy-Up Benefit.....	$3,500
1st day of the month following 24 continuous months of eligibility	
Part-Time (32 hours per month).....	$5,000
Additional Buy-Up Benefit.....	$5,000

DEPENDENT LIFE BENEFITS

Number of months of eligibility & hours worked

1st day of 13th month - Full Time (120 hrs. per month)

Spouse	$4,000
Child(ren) (Birth to 6 months)	$400
Child(ren) (Over 6 months)	$1,000

Additional Buy-Up Benefit - Full Time (120 hrs. per month)

Spouse	$4,000
Child(ren) (Birth to 6 months)	$400
Child(ren) (Over 6 months)	$1,000

1st day of 37th month - Full Time (138 hrs. per month)

Spouse	$5,000
Child(ren) (Birth to 6 months)	$500
Child(ren) (Over 6 months)	$2,500

Additional Buy-Up Benefit - Full Time (138 hrs. per month)

Spouse	$5,000
Child(ren) (Birth to 6 months)	$500
Child(ren) (Over 6 months)	$2,500

Reduction of Insurance for all Insureds

All amounts of Life and AD&D insurances in force reduce as follows:

Attained Age	Percentage of Reductions of Amount In Effect at Age 64
65 - 69	35%
70 - 74	60%
75 - 79	70%
80 - 84	80%
85 - 89	85%
90 - 94	90%
95 and over	95%

AD&D Benefits
If You suffer an Injury and sustain a loss while eligible for benefits, the Plan will pay the AD&D benefit shown in the following table. (You can request the Principal Sum amount from the Administrative Manager). If You do not survive the Injury, the benefit will be paid to Your beneficiary or to Your estate if You do not name a beneficiary or no beneficiary survives You.

For Loss of:	Benefit
Life, both hands, both feet or both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and one eye	Principal Sum
One foot and one eye	Principal Sum
One hand or one foot or one eye	One-Half Principal Sum

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

If more than one loss occurs, the maximum amount payable is the Principle Sum. An example would the loss of one and one foot, or any such similar combination of losses.

Exceptions
See the AD&D insurance policy for exceptions to AD&D benefits. AD&D benefits are not payable for any loss caused by, contributed to by, or resulting from, either directly or indirectly:

- Suicide or attempted suicide
- Bacterial infection (except pyogenic infections resulting solely from Injury)
- Medical or surgical treatment (except medical or surgical treatment made necessary solely by Injury)
- War or any act of war
- Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger in any aircraft then licensed to carry passengers
- Committing a felony or
- Intentionally self-inflicted Injury

Mode of Payment
The Plan will pay benefits in a lump sum. You may request another mode of payment, by providing the Trustees with a written request listing the optional payment form You wish to select.

Change of Beneficiary or Mode of Payment

The beneficiary and mode of payment may be changed from time to time. To make a change, submit a written request to the Administrative Manager. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken by the Plan before the request was acknowledged.

ARTICLE III – GENERAL LIMITATIONS

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

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

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

1. treatment that is not Medically Necessary;

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

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

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

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

4. transportation, except Emergency ambulance service;

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

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

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

8. any intentionally self-induced sickness or intentionally self–inflicted injury unless such results from a medical condition (including both physical and mental health conditions) or from an act of domestic violence:

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

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

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

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

13. Any charges incurred as a result of, or in connection with, any surgical sex transformations;

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

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

15. a weight control program or treatment of obesity except as described as a preventive benefit;

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

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

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

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

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

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

21. any charges in connection with smoking cessation other than screening and/or counseling sessions performed in a doctor's office;

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

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

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

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

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

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

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

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

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

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

32. charges for Prescription drugs except for those Prescriptions prescribed and dispensed as part of an inpatient Hospital stay;

33. charges related to eye care, including, but not limited to eyeglass lenses and frames, contact lenses, and eye exams.

ARTICLE IV – MISCELLANEOUS PROVISIONS

Coordination of Benefits

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

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

Definitions

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

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

2. any health insurance company or organization or other prepayment coverage provided on a group basis;

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

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

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

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

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

Effect on Benefits

The effect on benefits is that the amount of Allowable Expense that would otherwise be payable under this Plan may be reduced if benefits are payable under any Other Plan for the same Expenses.

Order of Benefit Determination

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

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

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

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

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

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

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

Notwithstanding the above, if there is a court decree or Qualified Medical Child Support Order (QMCSO – see page 68 for definition) which would otherwise establish financial responsibility for the Hospital, medical, surgical, or other health care Expenses with respect to the child, benefits under the Plans of the natural parent with such financial responsibility shall be determined before the benefits under the Plans of the other natural parent, and the benefits under the Plans of the other natural parent shall be determined before the benefits under the Plans of the spouse of the parent with court-decreed financial responsibility. If the Other Plan with which this Plan is coordinating does not provide for the same procedures in the case of a Dependent child, the Plans which cover the Individual as a Dependent of a male participant shall be determined before the benefit of the Plans which cover such Individual as a Dependent of a female participant.

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

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

Medicare and this Plan

Active Employees - Medicare Benefits Secondary

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

Active Employees - Election of Medicare as Primary

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

Disabled Employees Under 65 - Medicare Benefits Secondary

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

Medicare Eligibility due to Kidney Disease

An Employee or Dependent becomes eligible for Medicare when afflicted by kidney failure, also called end stage renal disease (ESRD) that is treated by dialysis or transplant. Medicare coverage begins the third month after the month Your course of maintenance dialysis treatments began. It will continue until 12 months after the month You no longer require dialysis or 36 months after the month of the kidney transplant.

Benefits provided by this Plan are:

1. The same benefits as those provided to Active Employees and Dependents for the first 30 months following the date dialysis began;

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

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

Identification Card

After You become initially eligible, You will be issued an Identification Card which should be kept in Your possession at all times so that when healthcare is necessary, the card can be presented at the provider's office.

PLEASE REPORT CHANGES PROMPTLY

It is important that You notify the Administrative Manager whenever:

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

How to File a Claim

In order to assure Yourself the fastest possible service, all Claims should be reported to United HealthCare (UHC), as soon as possible. For care received by Participating Providers, those Participating Providers will file Your Claims for You. The Administrative Manager will furnish You with the Claim forms necessary for filing Accident and Sickness Claims or any additional documents that are needed.

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

1. You must complete the Employee portion of the Claim form by inserting all of the requested information and signing Your name on the line specified.

2. In the case of Accident and Sickness Claims, have Your Physician complete the Physician's portion of the Claim form and sign his or her name.

Time Limit to File a Claim

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

Claim Forms

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

Physical Examination and Autopsy

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

Assignment of Benefits

All benefits will be payable to You, unless You specifically assign them. Only medical, dental, and self-funded life insurance benefits may be assigned.

Assignment is arranged by the provider and transmitted to the Administrative Manager electronically with the claim from UHC.

The self-funded life insurance benefit assignment may be to a funeral home or financial institution so that a funeral could be performed in cases where there are no other funds available to cover funeral costs.

Facility of Payment of Benefits

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

If a participant dies while benefits for Hospital, nursing, medical or surgical services remain unpaid, the Plan may make direct payment to the individual or institution on whose charges claim is based, or to any of the following surviving relatives of the participant: wife, husband, mother, father, child or children, brothers or sister, or to the participant's executors or administrators.

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

Initial Claims Decisions and Claims Appeals Procedures

A Claim is a request for a Plan benefit made by a Claimant on a form provided by the Fund, or in the case of an urgent care Claim either orally or on such a form. A Claimant is a person who participates or Claims to participate in the Plan. For such a form to be considered, the Claimant

must mail or deliver it, completed and executed, to the Plan Administrative Manager at the following address:

United Food & Commercial Workers Local 1000 and
Kroger Dallas Health & Welfare Fund "MED-1000"
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, FL 33028

For an urgent care Claim to be considered, it must be communicated in writing as provided above, or by phone to MED-1000 Fund Office using these phone numbers:

MED-1000 – (800) 567-5899

The Plan Administrative shall decide the Claim. None of the following constitutes a Claim:

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

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

Urgent Care Claims

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

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

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

Except as provided below, whether a Claim is a "Claim involving urgent care" is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any Claim that a Physician with knowledge of the Claimant's medical condition determines is a "Claim involving urgent care,"

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

Pre-Service Claims

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

Failure to Follow Pre-Service Claim Procedures

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

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

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

Concurrent Care Decisions

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

Post-Service Claims

The term "post-service Claim" means any Claim for a benefit under the Plan that is not a pre-service Claim. In the case of a post-service Claim, the Plan Administrative Manager shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but

not later than 30 days after receipt of the Claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrative Manager both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary, due to a failure of a Claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Notification for Disability Claims

In the case of a Claim for disability benefits, the Plan Administrative Manager shall notify the Claimant of the Plan Administrative Manager's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the Claim by the Plan Administrative Manager. This period may be extended by the Plan Administrative Manager for up to 30 days, provided that the Plan Administrative Manager both determines that such an extension is necessary due to matters beyond the control of the Plan Administrative Manager, and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring an extension of time and the date by which the Plan Administrative Manager expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrative Manager determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrative Manager notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan Administrative Manager expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent the decision on the Claim, and the additional information needed to resolve those issues. The Claimant should be afforded at least 45 days within which to provide the specified information.

Calculating Time Periods for Claims

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

Notification of the Decision

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

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

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

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

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

5. in the case of an adverse benefit determination,

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

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

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

Authorized Representative

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

Consistency

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

Deciding the Appeal

A Claimant may appeal an adverse benefit determination to the Trustees by mailing or delivering to the Plan Administrative Manager a written notice of appeal. The Claimant may submit written comments, documents, records, or other information relating to the Claim for benefits to the Plan Administrative Manager. The Plan Administrative Manager shall provide to the Claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits. Whether a document, record or other information is relevant to a Claim for benefits shall be determined in accordance with standards issued by the Department of Labor. The Trustees shall decide the appeal. In cases where a Medically Necessary issue is decided by the utilization review provider, the provisions dealing with appeals shall be applied, to the extent that they are more stringent or extensive than the rules set forth, by substituting the phrase "Physicians" in place of the word "Trustees" wherever it appears. The Trustees' decision shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Trustees will not, however, consider a Claimant's appeal unless the Plan Administrative Manager receives it within 180 days following receipt by the Claimant of a notification of an adverse benefit determination. The appeal will be considered by the Trustees without deference to the original decision made by the Plan Administrative Manager. In deciding an appeal of any adverse benefit determination where the determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other

item is Experimental, investigational, or not Medically Necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Plan Administrative Manager shall, when requested to do so by a Claimant, identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Any health care professional engaged for purposes of a consultation under this subsection shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Appeal of Urgent Care Claims

In the case of a Claim involving urgent care:

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

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

Notification of the Decision on Appeal; Urgent Care Claims

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

Notification of the Decision on Appeal; Pre-Service Claims

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

Notification of the Decision on Appeal; Post-Service Claims

In the case of a post-service Claim, The Trustees will decide a Claimant's appeal no later than the first meeting following the Plan Administrative Manager's receipt of the appeal, unless the Plan Administrative Manager received the appeal within 30 days prior to that meeting, in which case

the Trustees will decide the Claimant's appeal no later than the second meeting following receipt of the request for review. If special circumstances require further extension of time for processing, the Trustees will decide the appeal no later than the third meeting following receipt by the Plan Administrative Manager of the Claimant's request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrative Manager shall notify the Claimant which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrative Manager shall notify the Claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

Content of the Notification of the Decision on Appeal

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

1. the specific reason for the adverse determination;

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

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

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

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

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

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

Calculating Time Periods on Appeal

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

Extension of Time

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

Legal Action

No action at law or in equity shall be brought against the Plan, or a representative or fiduciary of the Plan, more than one year from the later of (i) the date Your Claim is first filed, or (ii) the date the Plan renders a decision on Your Claim, or, if You timely file an appeal with the Plan, on Your appeal.

Altered or Forged Claim Forms

Any Claim form submitted by or on Your behalf that contains false or forged information, will be rejected by the Plan. The Plan reserves the right to recover claim amounts paid out as a result of fraud.

Right to Receive Information

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

Right to Recovery

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

Severability Clause

Should any provision of this Plan be determined or judged to be unlawful, such illegality shall apply only to the provision in question and shall not apply to any other provisions of the Plan unless such illegality shall make impractical or impossible the functioning of the Plan.

Construction

All questions of interpretation of the Plan provisions shall be decided exclusively by the Trustees in their sole discretion under the express authority granted to them by the Trust Agreement of the UFCW Local 1000 & Kroger Dallas Health & Welfare Fund. The Trustees shall be the sole arbiter of questions of eligibility and the amounts of benefits. This Fund is intended to comply with the terms and conditions of the Trust Agreement of the UFCW Local 1000 & Kroger Dallas Health & Welfare Fund.

Notice No Fund Liability

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

The use of the services of any Hospital, clinic, doctor, Dentist, podiatrist, optician or any other person or establishment rendering health care or services whether specifically designated by the Fund or otherwise (hereinafter referred to as “provider”) under the Plan is the VOLUNTARY ACT of the EMPLOYEE AND/OR HIS DEPENDENT. Some benefits may only be obtained from providers designated by the Plan. In such situations, the designation is not meant to be a recommendation or instruction to use such provider. An Employee and/or his Dependent should select a provider or course of treatment based on all appropriate factors, only one of which is coverage under the Plan. Said providers are independent contractors, not Employees of the Fund.

The Plan and Fund make no representation regarding the quality of service or treatment provided by any provider and ARE NOT RESPONSIBLE FOR ANY ACTS OF COMMISSION OR OMISSION OF

ANY PROVIDER in connection with the services or treatments provided herein. THE PROVIDER IS SOLELY RESPONSIBLE for the services and treatments to be rendered under this Plan.

Worker's Compensation

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

HIPAA Privacy Rule

Plan's Designation of Person/Entity to Act on its Behalf

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

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

HIPAA Security Rule

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

Qualified Medical Child Support Order

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

1. **Medical Child Support Order** means any judgment, decree or order issued by a Court of competent jurisdiction which provides for child support with respect to a child of a

Covered Employee under the Plan or provides for coverage to such child pursuant to state domestic relations law, or enforces a law relating to medical child support described in Section 1908 of the Social Security Act.

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

3. **Notice of Receipt of Claim**

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

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

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

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

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

6. **"Qualified" Medical Child Support Order**

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

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

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

ARTICLE V – SUBROGATION AND RESTITUTION

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

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

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

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

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

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

If You recover any damages from an uninsured/underinsured motorist policy or Your own homeowner's insurance policy, the proceeds of that policy are subject to the same lien and trust

as any proceeds You recovered from the third party. The first priority lien applies to the proceeds from such policy, and You also hold these proceeds in trust for the exclusive benefit of the Plan. Any recovery will be presumed to be recovery for medical Expenses, regardless of allocation or designation.

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

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

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

ARTICLE VI – COBRA CONTINUATION OF MEDICAL COVERAGE

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

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

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

Qualifying Event

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

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

2. a reduction in hours worked by the Employee;

3. death of a Covered Employee;

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

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

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

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

COBRA Notice Requirements

1. **Notice from Contributing Employers**
   Your employer must notify the Administrative Manager in writing within 30 days after the date of the following Qualifying Events:

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

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

2. **Notice from You and Your Dependents**
   You or Your Dependent, as applicable, must notify the Administrative Manager in writing no later than 60 days after the following Qualifying Events:

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

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

Qualified Beneficiary

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

Election Requirements

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

Maximum Period Allowed Under Continuation Coverage

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

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

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

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

Multiple Qualifying Events

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

Self-Payment

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

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

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

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

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

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

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

Termination of COBRA Coverage (All Individuals)

COBRA continuation coverage will terminate on the earliest of the:

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

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

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

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

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

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

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

Benefits Provided

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

ARTICLE VII – CONTINUATION AND REINSTATEMENT OF COVERAGE ON ACCOUNT OF QUALIFIED UNIFORMED SERVICE

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

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

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

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

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

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

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

ARTICLE IX – WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

3. prosthesis; and

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

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

ARTICLE X – IMPORTANT PLAN INFORMATION

Fund Name

United Food and Commercial Workers (UFCW) Local 1000 and Kroger Dallas Health and Welfare Fund ("MED-1000")

Board of Trustees

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

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

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

Fund Administrative Manager

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

National Employee Benefits Administrators, Inc.
2010 N. W. 150th Avenue, Suite 100
Pembroke Pines, FL 33028
(800) 567-5899

Plan Sponsor

The Kroger Company is the sole Employer and sponsor of this Plan. Kroger's corporate address is listed below.

The Kroger Co.
1014 Vine Street
Cincinnati, OH 45202

Identification Number

The Fund's Employer Identification Number is 31-1586967. The three-digit Plan Number is 501.

Fund's Fiscal Year End

The date of the end of the Fund year is December 31.

Source of Contributions

The amount of contributions from a Contributing Employer is determined by the provisions of its collective bargaining agreement with Employee representatives. Employee payroll deductions are also a source of contributions. You may review the Agreements at the Local Union Office or You may request a copy by writing to the Plan Administrative Manager.

Agent for Service of Legal Process

The Fund's agent for service of legal process is:

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

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

Funding Medium

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

Fund Assets

All assets and reserves are maintained by the Board of Trustees in the form of cash or investments kept at the bank or other financial institution.

Fund Termination

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

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

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

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

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

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

6. upon a termination of the Plan.

Filing Claims

Refer to the section entitled "How to File a Claim" under Article V - Miscellaneous Provisions for information on filing Claims.

Appeal of Denied Claims

Refer to the section entitled "Initial Claims Decisions and Claims Appeals Procedures" under Article V - Miscellaneous Provisions for information on appealing denied Claims.

Type of Plan

This Plan is maintained for the purpose of providing death benefits, accidental death and dismemberment benefits, weekly accident and Sickness (also called loss of time) income, medical benefits, and dental benefits. A detailed written description of the Plan benefits appears in this Booklet.

Plan and Fiscal Year

The fiscal records of the Plan are kept on a Calendar Year basis.

ARTICLE XI – STATEMENT OF ERISA RIGHTS

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

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

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

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

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

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

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 will 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrative Manager . If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrative Manager, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and

responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

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

(800) 567-5899

United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Fund

"MED-1000"

2010 N.W. 150th Avenue, Suite 100

Pembroke Pines, Florida 33028

ARTICLE XII – DEFINITIONS

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

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

Administrative Period is a two-month period between the Eligibility Measurement Period and the Stability Period. The Plan Office uses this time to determine eligibility, send enrollment materials and process applications. For initial eligibility, there is no administrative period.

Allowable Expense means the dollar amount upon which benefits will be determined.

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

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

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

Claim means any Claim for benefits (including medical care, dental care, Weekly Accident and Sickness Benefits or death benefits) which follows the Plan's procedures for filing a Claim, including the procedures of filing Pre-Service and Post-Service Claims, submitted on a Claim form that has been approved by the Board of Trustees of the Plan.

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

Coinsurance is a percentage of medical or dental Claim cost that the participant pays after the Deductible is exceeded.

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

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

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

Deductible means the amount that a covered person must pay each Calendar Year before the Plan pays any benefits for Covered Expenses.

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

Dependent means:

1. Your lawful spouse. The term "spouse" will only include the person to whom the Employee is married, and whose marriage has been solemnized and registered in accordance with the statutory law of jurisdiction in which the marriage occurred. The term will also include a common-law spouse if the Employee resides in a state that legally recognizes common-law spouses. Proof of such status satisfactory to the Trustees may be required.

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

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

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

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

The term Dependent will not include:

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

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

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

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

Eligibility Measurement Period is the period of time that the Plan looks at to determine if the Employee worked the minimum number of hours to earn eligibility. The Eligibility Measurement Period for both the Standard Plan and Premium Plan is 12 months. Until the Employee has earned eligibility, the Plan measures hours worked on a rolling 12-month basis. Once an Employee becomes eligible, the Plan measures hours worked each standard Eligibility Measurement Period to determine continued eligibility. Standard Eligibility Measurement Periods are November 1 through October 31 (following year).

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

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

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

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

Known Full-Time Employee is someone who a Contributing Employer hires with the expectation that they will work a minimum of 30 hours per week.

Fund or Trust means the entire trust estate of the UFCW Local 1000 & Kroger Dallas Health & Welfare Fund, also referred to as MED-1000, as it may from time to time be amended.

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

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

Hospital means a place which is licensed as a Hospital, which is operated for the care and treatment of resident in-patients and which has a laboratory, registered graduate nurses always on duty and an operating room where major surgical operations are performed by legally licensed

Physicians. In no event will the term "Hospital" include an institution which is used principally as a clinic, convalescent home, nursing home or home for the aged, drug addicts or alcoholics. The term "Hospital" does apply to institutions accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities

Injury means a bodily injury sustained accidentally by external means.

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

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

Network refers to medical and dental service providers having an agreement in force with a medical care service organization or a dental care service organization that has been retained by the Plan. The name of the medical and dental care organization Networks will be provided by the Plan Administrative Manager or its Claims administrator. The Board of Trustees has the authority and ability to change and choose medical and dental care organization Networks as it deems appropriate and necessary for the Plan. It is the Plan Participant's responsibility to make sure the identity of the Network is known and whether or not a specific care provider is in the Network.

Non-Participating Provider - Doctors who provide medical or dental care services and materials to You but who do not have an agreement in force with a medical care service organization or a dental care service organization that has been retained by the Plan.

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

Participating Provider - Doctors who provide medical or dental services and materials and have an agreement in force with a medical care service organization or a dental care service organization that has been retained by the Plan.

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

Plan means this Welfare Plan of UFCW Local 1000 & Kroger Dallas Health & Welfare Fund, also referred to as MED-1000.

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

Pre-Certification of a Hospital Admission is the process of reviewing Hospital services. All inpatient hospitalizations are subject to Pre-Certification. You or Your provider should contact the Toll Free Pre-Certification number which You will find located on Your ID card. Failure to obtain Pre-Certification will result in a $300 penalty Deductible. This Deductible is in addition to the annual Deductible and does not count towards Your out of pocket maximum. Pre-Certification is not required for a Hospital stay in connection with childbirth for the mother or newborn child of up to 48 hours following a normal vaginal delivery, or up to 96 hours following a cesarean section.

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

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

Reasonable and Customary Expenses means the usual, Reasonable and Customary fee or charge, as determined by the Board of Trustees, for the services rendered and the supplies furnished, in the particular area where such services are rendered and such supplies are furnished, provided such services and supplies are recommended and rendered by a provider.

Restatement Date is the date this revised Summary Plan Description is effective, or January 1, 2018.

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

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

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

Stability Period is the period of time following the Administrative Period during which coverage is effective if the eligibility rules have been met. The Stability Period for both the Standard Plan and Premium Plan is 12 months. The Standard Stability Period is from January 1 through December 31 of each year.

Summary of Material Modifications (SMM) means a formal document that changes a provision of this Plan.

Total Disability or Totally Disabled means an Injury or Sickness that wholly and continuously keeps an Employee from performing the material duties of his occupation. The Trustees reserve the right to require You to be examined by a Physician selected by the Trustees to determine whether You are or continue to be disabled. The Trustees reserve the right to discontinue

benefits under this Plan that are available by virtue of a Total Disability if, in the Trustees' discretion, You are no longer Totally Disabled.

Trust Agreement means the Trust Agreement establishing the UFCW Local 1000 & Kroger Dallas Health & Welfare Fund, also referred to as MED-1000.

Union refers to the United Food and Commercial Workers (UFCW) Local 1000 union.

Variable-Hour Employee is someone a Contributing Employer does not reasonably expect to work a minimum of 30 hours per week when they are hired.

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

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

(800) 567-5899

United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Fund

"MED-1000"

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