Summary Description of

UFCW Local 2-D

Insurance Trust Fund

As Amended through January 1, 2017

SUMMARY DESCRIPTION
OF
Death, Dental, and Optical Benefits

Under The

UFCW Local 2-D
Insurance Trust Fund

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INTRODUCTION

The UFCW Local 2-D Insurance Trust Fund was originally established as a result of collective bargaining. Since then the Trustees have made substantial improvements in the benefits. This booklet describes your benefits as they exist on January 1, 2017 and, therefore, all of the benefits described in this booklet may not be applicable with respect to claims that were incurred prior to January 1, 2017.

The Fund is a joint labor-management trust fund, financed by contributions fixed by collective bargaining agreements, and administered by an equal number of Trustees designated by the Employers and by the Union pursuant to a Trust Agreement, which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted this Plan of benefits. Under the Trust Agreement, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question or issue of interpretation, construction, application or enforcement of the terms of the Plan, including any determination on benefit claims and appeals, is subject to the discretion of the Board of Trustees, whose determinations are final and binding. The Plan is technically known as a "welfare benefit plan" and is designed to provide death benefits and to help pay certain expenses incurred by yourself and your dependents as described herein. You are urged to read this booklet carefully and retain it with your valuable records because it describes your rights and benefits under the Plan.

This booklet is designed to explain in non-technical language the operation of the Plan. The Trustees feel extremely proud in the knowledge that our members and their dependents now have these many benefits at their disposal.

If, after reading this booklet, you still have questions, please feel free to contact the Fund Office at:

8402 18th Avenue
Brooklyn, New York 11214
(718) 331-0030

This is a valuable document. Please keep it in a safe place.

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DEFINITIONS

Any word in the male gender equally applies to the female gender unless a distinction is specified.

"Fund" means the UFCW Local 2-D Insurance Trust Fund.

"Individual" means a Member.

"Member" means a person who is a member in good standing with the UFCW Local 2-D and is actively at work with a Contributing Employer.

Terms have different meanings when applied to Death Benefits than they have with respect to Dental or Optical Benefits.

"Injury" means bodily injury caused by an accident.

"Sickness" means sickness or disease.

"Total Disability" means a Member's inability to engage in any occupation for wage or profit. The disability must be as a result of Injury or Sickness.

"Physician" means a medical practitioner licensed to provide medical services. Each such person must be licensed in the state where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such state.

"Eligible Dependents" means (1) your wife or husband except if you are legally separated or divorced, (2) your unmarried children, under age 19, and (3) your unmarried children over 19 years of age and under age 23 provided they are full-time students. Note that if your child is mentally retarded or physically handicapped when his insurance would terminate due to his age, insurance may be continued. For complete information consult the Fund Office within 90 days before your child's insurance terminates for the appropriate form to continue coverage. With respect to orthodontic coverage, your unmarried children under age 18 will be covered.

"Approved Dental Expense" means expense incurred by the individual for treatment received by him for any of the procedures listed in the Schedule of Dental Allowances for an amount equal to the lesser of (1) the actual expense, or (2) the applicable amount specified in such Schedule. An Approved Dental Expense must have been incurred while the individual is insured for this benefit. Dental expenses are deemed to be incurred on the date on which the services or supply which gives rise to the expense is rendered or obtained.

"Covered Dental Expense" means expense incurred by you or any of your family members for charges made by a dentist for any dental service provided for in the Schedule of Dental Services.

"Pretreatment Review" means the system designed to give you and your dentist a better understanding of the Covered Dental Expense payable under this plan before dental services are provided.

"Provider" means those dental or optical offices that agree to participate in the Plan by providing benefits to Plan Members.

1. DEATH BENEFITS

A. Eligibility

All employees represented by the UFCW Local 2-D are eligible provided they are employed by an Employer required to make contributions on their behalf. Employees who are classified as apprentices under the Collective Bargaining Agreement, will become eligible on the first day of the seventh month following the completion of the apprenticeship period. The Member must be actively at work on the date his insurance takes effect. If he is not, (for reasons other than health) such insurance will take effect on the day the Member resumes such work.

If a former Member is rehired within 6 months after coverage ended, coverage will take effect on the date such Member re-enters full-time employment. If the period during which the former Member is not covered is 6 months or greater, such Member will have to again complete 3 months of work as a full-time employee to be eligible for death benefit coverage. For purposes of eligibility, the UFCW Local 2-D, the UFCW Local 2-D Insurance Trust Fund and the UFCW Local 2-D Pension Fund shall be considered as Contributing Employers and may cover their employees and/or Trustees by making the appropriate monthly contributions for them.

B. Date Member's Coverage Ends

A Member's insurance will end at the earliest of:

1. The date this benefit is no longer provided by the Fund.
2. The end of the period for which the last contribution has been made for him.
3. The date his employer ceases to be a Contributing Employer.

C. Benefit Amount

$ 50,000 - Payable upon the death of a Member while eligible under the Plan.

D. To Whom Paid

Subject to due proof of claim, the above sum will be paid to the beneficiary that you designate. You may change your beneficiary at any time by filing with the Fund Office a written request on forms furnished by the Fund. The change will be effective as of the day that you sign and date the forms. If you have designated several beneficiaries to share in the death benefit, only those beneficiaries who are alive at your death will be entitled to share in the death benefit. If 2 or more beneficiaries are named and their shares are not specified, they will share the proceeds equally.

If no beneficiary is designated or your beneficiary predeceases you, the Trustees may pay it as follows: (a) to your spouse if living; (b) if your spouse is not living, to your children who survive you, divided equally; (c) if none of those survive you; to your parents, equally if both survive or solely to the survivor; or (d) to your estate.

The appropriate beneficiary designation forms are available upon request from the Fund Office.

If any beneficiary or payee is a minor or is incompetent to receive payment, then payment will be made to his guardian. If there is no living named beneficiary, then there is the option to pay part of the benefits to anyone who has incurred expenses for your last sickness or death.

II. DENTAL BENEFITS

A. Eligibility

All employees represented by the UFCW Local 2-D are eligible provided they are employed by an employer required to make contributions on their behalf. Employees who are classified as apprentices under the Collective Bargaining Agreement, will become eligible on the first day of the month following the completion of the apprenticeship period.

For purposes of eligibility, the UFCW Local 2-D, the UFCW Local 2-D Insurance Trust Fund and the UFCW Local 2-D Pension Fund shall be considered as a Contributing Employer and may cover their employees and/or Trustees by making the appropriate monthly contributions for them.

Each dependent will be insured beginning with the later of the following dates:

1. the day on which your insurance begins, or
2. the date such individual becomes an eligible dependent.

Any dependent who is confined to a hospital (except for birth) when he would normally become insured, will become insured only upon discharge from the hospital.

B. Dental Expense Benefits

If an individual incurs an Approved Dental Expense, the Fund will pay benefits up to the maximum allowance specified in a Schedule of Dental Allowances maintained out of the Fund Office.

In most instances there will be no out-of-pocket expenses for services performed in an approved participating dental facility. In the event that you do not use a participating dental facility, you will receive a reimbursement from the Fund's dental administrator and a separate reimbursement directly from the Fund in accordance with the Schedule of Dental Allowances applicable to non participating dental facilities. The benefit for any specific procedure shall be independent of the number of dentists engaged or consulted in the planning or execution of the procedure. In addition, those procedures not listed in the Schedule of Dental Allowances shall be considered to be Approved Dental Expenses to the extent that they are not included in the Exclusions listed below.

Upon request, the Fund Office will provide you with the applicable names of all participating dentists as well as the Schedule of Dental Allowances (including limitations to Approved Dental Expenses and items not considered Covered Dental Expenses).

If the dental service is performed by or under the direction of a dentist and is essential for the necessary care of the teeth and begins while you or any of your family members are insured for dental expense benefits, it is considered a Covered Dental Expense. If the dental service is performed on a date other than the date the service was recommended or considered necessary, the dental service will be considered to begin on the date the actual performance of the service begins.

C. Pretreatment Review

When charges for a proposed dental service or a series of dental services are expected to exceed $200, your dentist should submit a claim form to the Insurance Trust Fund showing the treatment plan and fees. The Fund will then use the Pretreatment Review to determine the benefits which will be payable for each dental service according to the terms of the dental plan and notify your dentist, accordingly. When the treatment plan is finished, your dentist will resubmit the claim form for payment showing the date each service was performed.

If the Pretreatment Review process is not followed, payment will be determined taking into account alternate procedures or services which may result in the payment of a lesser amount, based on acceptable standards of dental practice.

D. Coordination of Benefits

If you or an eligible dependent is entitled to dental benefits for services covered under our dental program through any other group program, the benefits described in this booklet may be reduced so that the total benefits received through all sources will not exceed 100% of the actual charges incurred for covered dental services.

E. Termination of Dental Coverage

Dental insurance benefits will terminate on the first day of the month following the date on which you are no longer employed by a Contributing Employer. Your dependent insurance will terminate when your insurance terminates or when such individual is no longer an eligible dependent, whichever happens first.

F. Exclusions

The following charges are not covered Dental Charges, and no dental benefits will be paid with respect to them:

1. Those which do not meet the standards of dental practice accepted by the American Dental Association.
2. Those due to an injury or sickness which results from war, declared or undeclared, including armed aggression resisted by the forces of any country or combination of countries, or any act incident to war, while a covered person.
3. Those which the covered person is not legally obligated to pay, or which are for dental care furnished without charge, paid for or reimbursable by or through the government of a nation, state, province, county, municipality, or other political subdivision, or instrumentality or agency of such government.
4. Those made by a Veterans Administration Hospital, or by a dentist employed by such hospital, unless due to dental care of an emergency nature which the covered person is not entitled to without charge.
5. Those made by any person, hospital, or entity that normally does not make any charge for dental care, regardless of the patient's financial ability if the patient does not have insurance for such care.

The following items will not be considered Covered Dental Expenses under the plan:

1. Charges incurred for an extended bridge or denture to an already existing one.
2. Charges for a fixed bridge unless a natural tooth was extracted while you were insured under the Plan.
3. Charges incurred for more than one visit per month for any orthodontic case. Also, all charges incurred for the installation of any orthodontic appliance prior to date your coverage began, including any related charges for follow-up care.
4. Charges incurred for replacement of any prosthetic appliance (including **but not** limited to crowns, bridges, full and partial dentures) more than once every five years.
5. Charges for repair of all prosthetic appliances will be limited to $100.00 per calendar year.
6. Covered charges for periodontal treatment, other than a routine scaling will be covered only if the services rendered are by a Board Certified or Board Eligible periodontist.
7. Charges incurred for all fractures will be treated as a secondary coverage by the Plan to all other medical plans.
8. Expenses for sealants or splinting.
9. Athletic mouthguards.

10. Expenses incurred for oral hygiene programs (including dietary or plaque control programs or other educational programs).

Note: All allowances for fillings, gold inlay restorations, root canal work, extractions, crowns, prosthetics and periodontal include all pre and post operative care as well as x-rays and other diagnostic services.

G. Limitations

Approved Dental Expense shall not include expense incurred:

1. For any dental procedure for cosmetic reasons, or with respect to congenital malformation.
2. For dental supplies or services for which benefits are provided under any other group insurance policy, Workmen's Compensation, any other hospital, surgical or medical benefit service plan, union welfare plan or employee benefit plan for which any employer directly or indirectly makes contributions or payroll deductions.
3. For services not performed by a licensed dentist.
4. For periodontic treatment when rendered with any other services other than examination and x-rays on the same day.
5. For replacement of a lost or stolen appliance.
6. For pulp capping when performed on the same day as the final restoration.
7. For double abutments.
8. For general anesthesia if not in connection with oral surgery and not administered by the oral surgeon.
9. For any emergency treatment rendered by a dentist performing any other service on that date.
10. For a consultation if not performed by a specialist and/or when the specialist renders treatment.
11. For prophylaxis when performed on the same day as a periodontal scaling.
12. For an examination rendered by an oral surgeon performing an extraction on the same day.
13. For more than four (4) quadrants of periodontal scaling per year.

H. How to File a Dental Claim

Contact the Fund Office in order to obtain the necessary dental claim form. Take a dental claim form with you when you or one of your insured dependents first visit the dentist and when a new course of treatment may be started for any insured person. A separate claim form is necessary for each Member and each Dependent.

When charges for a proposed dental service or series of dental services are expected to exceed $200, your dentist should first submit a claim form to the Fund Office showing the treatment plan and fees. The Pretreatment Review will be used to determine the benefits which will be payable for each dental service according to the terms of the dental plan and notify your dentist accordingly. You and your dentist will then understand exactly how much of his charges will be covered under the Plan. (When submitting a claim for Pretreatment Review, you should submit

two claim forms to the Fund Office. One form for any dental work which has been completed and one form for any dental work which is to be authorized.)

Upon completion of treatment, have the dentist complete his portion of the claim form. The Member should then complete the patient's part of the claim form and mail it to the Insurance Trust Fund Office. If prolonged dental treatment is required, the Member should periodically submit claim forms to the Fund Office for that portion of the treatment which has been completed.

Payment of the claim will be made directly to you unless you have assigned the payment of a participating dentist only by completing the assignment section of the claim form. **Claims must be filed within 90 days after termination of services.**

III. OPTICAL BENEFITS

A. Eligibility

All employees represented by the UFCW Local 2-D are eligible provided they are employed by an employer required to make contributions on their behalf. Employees who are classified as apprentices under the Collective Bargaining Agreement, will become eligible on the first day of the month following the completion of the apprenticeship period.

For purposes of eligibility, the UFCW Local 2-D, the UFCW Local 2-D Insurance Trust Fund and the UFCW Local 2-D Pension Fund shall be considered as a Contributing Employer and may cover their employees and/or Trustees by making the appropriate monthly contributions for them.

B. Benefit Amount

The plan will provide to each employee and his dependents, once in each 12-month period, the following benefits under a $200 fee allocation to the Provider:

1. Complete eye examination, including glaucoma testing ($40 allowance).
2. Single vision lenses, glass or plastic, kryptok, flat-top executive, including oversize and fashion tinting, plus frames ($160 allowance).
3. Bifocal (or trifocal) lenses, glass or plastic, kryptok, flat-top executive, including oversize and fashion tinting, plus frames ($160 allowance).
4. Designer frames and lenses - Available to patient at out-of-pocket expense of retail price less $160.
5. Contact lenses:

   Standard daily or extended wear - Available to patient at out-of-pocket expense of retail price less $160.

   Additional types - Available to patient at maximum out-of-pocket expense of 90% of retail price less $160.

The maximum surcharges allowable are:

1)	Photosensitive lenses - single vision	$ 15.00
2)	Photosensitive lenses - bifocal	$ 30.00
3)	Invisible bifocal lenses	$100.00

In any situation where a Member does not receive a complete eye examination, the $40 examination allowance may be applied towards the allowances otherwise provided for lenses, frames or other related services.

Additional discounts:

A provider may allow additional discounts (of up to 30%) on any additional pairs of eyeglasses or parts (i.e., replacement lenses) ordered by a Member or Dependent at any time. You should ask the Provider what additional discount he offers.

In order to receive optical benefits, you must contact the Fund Office for optical authorizations, at which time a listing of participating Providers will be furnished to you. The benefits listed above are only reimbursable when you utilize a participating Provider.

IV. GENERAL PROVISIONS

A. Coordination with Other Benefits

If you or your eligible dependents are entitled to benefits under any other plan which will pay part or all of the expenses incurred, 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 expense incurred. However, 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. For this purpose the word "plan" means any plan providing benefits or services provided by:

1. Group insurance or similar group coverage, whether insured or self-funded;
2. Group contracts other than individual insurance issued on a franchise basis;
3. Coverage under a governmental plan;
4. Coverage required or provided by law; and
5. Medical benefits coverage in group, and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" contracts.

The word “plan” does not include:

1. A state plan under Medicaid;
2. Benefits under a law or plan when, by law, its benefits are excess to those of any private insurance plan;
3. Medicare with respect to any actively employed Covered Person age 65 and over or to any spouse age 65 and over of an actively employed Covered Person; or

4. School accident type coverages. These cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

The words "Primary Plan"/"Secondary Plan" are defined as follows. When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

"Allowable Expense" means a necessary, reasonable, and customary item of expense, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services rather than cash Payments, the reasonable cash value of such service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which a Covered Person has no coverage under this Plan.

Which Plan Pays First?

A. In general, when there is a basis for a claim under this Plan and another plan, this Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its benefits with those of this Plan; and
2. Both those rules and this Plan's rules, in subparagraph B below, require that this Plan's benefits be determined before those of the other plan.

B. This Plan determines its order of benefits using the first of the following rules which applies;

1. The benefits of the plan under which the person is a Covered Person (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.
2. When this Plan and another plan cover the same child as a dependent under both parents' plans (except as provided in subparagraph 3 below);

    a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    b. If both parents have the same birthday, the benefits of the plan which

covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in a. and b. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in this Plan will determine the order of benefits.

3. If the parents of a dependent child are divorced or separated benefits for the child are determined in this order.
    a. First, the plan of the parent with custody of the child;
    b. Then, the plan of the spouse of the parent with custody of the child, and
    c. Finally, the plan of the parent not having custody of the child.

    However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. The benefits of a plan which covers a person as an Employee who is neither laid-off nor retired (or as that Employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired Employee (or as that Employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule, 4, is ignored.

5. If none of the above rules determines the order of benefits, the benefits of the plan which covered the person longer are determined before those of the plan which covered that person for the shorter time.

Effects on the Benefits of This Plan

In accordance with the rules regarding which plan pays first, as described above, if this Plan is a Secondary Plan, then the benefits of this Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this Coordination of Benefits provision; and
2. The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of a Coordination of Benefits provision;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the **benefits** of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right To Receive And Release Needed Information

Certain facts are needed to apply these Coordination of Benefits rules. The Fund has the right to decide which facts are needed. The Fund may get needed facts from or give them to any other organization or person. The Fund need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Fund any facts needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Fund may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Fund will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Fund is more than should have been paid under this Coordination of Benefits provision, the Fund may recover the excess from one or more of:

1. The persons paid or for whom paid;
2. Insurance companies; or
3. Other organizations.

The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

B. Third Party Actions

Notwithstanding any state statute to the contrary, in the event you or your eligible dependents are entitled to benefits under this Plan on account of an injury for which any third party may be legally responsible, this Plan shall be subrogated to the proceeds of any settlement or judgment that may result from the exercise of any legal rights of recovery which the injured person or anyone receiving such benefits may have against any such third party, including the proceeds of any settlement or judgment in a workers’ compensation proceeding. As a condition of receiving benefits from the Plan under such circumstances, you will be required to give your written consent to the Plan's right of subrogation.

C. Grievance Procedure-Contested Claims

The benefits provided under this Plan are in accordance with the provisions outlined in this booklet and promulgated by the Trustees.

In the event that any claim for benefits submitted by any eligible employee for himself or an eligible dependent is denied in whole or in part for any reason, such eligible employee will be advised in writing of the action taken and the reasons therefore.

Should any employee be dissatisfied with the determination of a claim, he has a right to present his contentions to the Trustees at the Fund Office, in writing, within four weeks after such notice of determination is sent to him.

The employee will then be given a reasonable opportunity for a full and fair review by the Trustees of the Plan and notified in writing of their final decision.

D. Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act, more commonly known as COBRA, generally requires that group health plans offer Employees and their Dependent(s) the opportunity to temporarily continue their health coverage at group rates when coverage under the Plan would otherwise end. This extended coverage is called "COBRA coverage". COBRA coverage will include all benefits that a person was entitled to before the Qualifying Event (defined below) except Life Insurance, Accidental Death and Dismemberment Benefits and Disability Income Benefits. If you, your spouse and/or Dependent child(ren) are covered under the Plan, you and/or your spouse or child(ren) can continue coverage for a time if coverage ends for one of the several reasons (called "Qualifying Events"), even if you or they are already covered by another group health plan or Medicare.

Qualifying Events

If any of the following events result in a loss of Plan coverage, the Covered Person can elect to continue coverage under the Plan:

1. Your termination of Employment (for reasons other than gross misconduct) or retirement.
2. Reduction in your hours of Employment
3. Your entitlement to Medicare.
4. Your death.
5. Your divorce or legal separation.
6. A Dependent child ceasing to satisfy the Plan's definition of an eligible Dependent.

Important-If you and/or your Dependent(s) do not elect COBRA coverage, you and/or your Dependent(s)'s group health coverage will end if one of these Qualifying Events occur.

Reporting Requirements

Your Employer must notify the Fund Office if Qualifying Events (1) through (4) occur. This notification must be in writing and must be provided within 30 days of the Qualifying Event. Failure to provide such timely notification may subject the Employer to federal excise taxes.

The Participant or the affected Dependent(s) must notify the Fund Office within 60 days of Qualifying Events (5) and (6). The Participant or the affected Dependent(s) is responsible for this notice. If you or your Dependent(s) fail to give written notice to the Fund Office within the required 60 days, the affected person will lose the right to COBRA coverage.

Notices should be mailed or hand delivered to the Fund Office, Attention: COBRA Department, at the following address: UFCW Local 2-D Insurance Trust Fund, 8402 18th Avenue, Brooklyn, New York 11214. Written notice of a Qualifying Event must include the following information: name and address of affected Participant and/or beneficiary, Participant's Social Security number, and date of occurrence of the qualifying event. In addition, you must enclose evidence of the occurrence of the qualifying event (for example, a copy of the divorce decree, separation agreement, death certificate, dependent's birth certificate). Once the Fund receives timely notification that a qualifying event has occurred, COBRA coverage will be offered to Participants and Dependents, as applicable.

It is most important that Employees and Dependents keep the Fund informed of their current addresses. If you or a covered family member experience a change of address, immediately inform the Fund Office. Participants should also keep a copy, for their records, of any notices they send to the Fund Office.

Financial responsibility for Failure to Give Notice

If a Covered Person fails to give written notice within 60 days of the date of the Qualifying Event, or an Employer within 30 days of the Qualifying Event, and as a result, the Plan pays a claim for a Covered Person whose coverage terminated due to a Qualifying Event and who does not elect COBRA coverage under this provision, then the Covered Person or the Employer, as appropriate, must reimburse the Plan for all paid claims that should not have been paid. If the Covered Person or Employer does not reimburse the Fund, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the Covered Person was his or her Dependent(s).

In addition, you or your eligible Dependent must notify the Fund Office immediately if you or they become covered by any other plan of group health benefits whether through your employment or your spouse's employment or otherwise. You must repay the Fund for any claims paid in error as a result of your failure to notify the Fund Office of any other health coverage.

Notice and Election Form

COBRA coverage requires timely election of the coverage. The Fund Office will, after receiving notice of the Qualifying Event, send to the affected Covered Person a COBRA Notice and

Election Form. This form will describe the cost of coverage and the conditions under which the COBRA coverage will terminate. In order to obtain COBRA coverage, the election form must be completed and returned to the Fund Office within 60 days after receipt.

Coverage may be continued for any eligible Dependent who is properly enrolled on the day before the event resulting in loss of eligibility (listed above). Each eligible Dependent has the independent right to elect or reject COBRA continuation coverage. The Participant may elect coverage on behalf of his or her spouse and family members. An election on behalf of a Dependent child can be made by the child's parent or legal guardian.

Details of Continuation Coverage

If you choose COBRA coverage, the coverage provided is identical to the coverage provided under the Plan to similarly situated Covered Persons, except Death Benefits are not provided. If the coverage provided under the Plan is modified after you elect COBRA Coverage, your coverage also will be modified.

Children born to or placed with you for adoption during the COBRA period also may receive coverage for the duration of your COBRA coverage period, provided you enroll the child in accordance with the fund's rules. Coverage for the newborn or adopted child will continue for the same time as coverage for dependent children who were properly enrolled in the Fund on the day before the qualifying event. Newborn or adopted children added to your COBRA coverage also become qualified beneficiaries.

Payment Provisions

COBRA coverage requires that you make timely monthly payments. The payment due date is the first day of the month in which COBRA coverage is sought. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of COBRA coverage must include payment for the period of time dating back to the date that coverage terminated. If you fail to pay the full payment by each due date (or within the thirty day grace period for payments other than your initial payment) you will lose all COBRA coverage. There is an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected.

The monthly cost of COBRA Coverage is based on 102% of the full monthly cost of the coverage under the Plan. The monthly cost of COBRA coverage is set by the Board of Trustees each year. If any individual or family coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits (described below), the cost of COBRA coverage is based on 150% of the full monthly cost of COBRA coverage during the 11-month extension of COBRA coverage. The Fund Office will tell you the cost of COBRA coverage at the time you receive your notice of entitlement to COBRA coverage. There is then a grace period of 30 days to pay any subsequent amounts due. If payment of the amounts due is not received by the end of the applicable grace period, the COBRA coverage will terminate.

Once a timely election of COBRA coverage has been made, it is the responsibility of the Covered Person seeking COBRA coverage to make timely payment of all required payments. The Fund will NOT send notice that a payment is due or that it is late, or that COBRA coverage is about to be or has been terminated due to the untimely payment of a required payment. The Fund's failure to provide a notice will not serve to extend the time that COBRA payments are due.

The Trustees will determine the monthly cost for the COBRA continued coverage. The monthly cost will not necessarily be the same as the amount of the monthly contribution that an Employer makes on behalf of a covered employee. The monthly cost will be fixed, in advance, for a 12-month period. The COBRA monthly cost will be calculated at the same time every year for all COBRA beneficiaries, therefore, the monthly cost may change every year for an individual beneficiary before he or she has received 12 months of COBRA coverage.

If you become entitled to Medicare, and within 18 months of becoming entitled to Medicare, you become entitled to COBRA due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for your dependents may be continued for up to 36 months from the date you became entitled to Medicare.

Maximum Periods of COBRA Coverage for Each Qualifying Event

COBRA coverage continues subject to a maximum time period as set forth in the chart below:

	Participant	Spouse	Dependent Children
Participant terminated (or retires) (for other than gross misconduct)	18 months	18 months	18 months
Participant dies	N/A	36 months	36 months
Participant becomes divorced or legally separated	N/A	36 months	36 months
Participant becomes entitled to Medicare	N/A	36 months	36 months
Dependent child ceases to have Dependent status	N/A	N/A	36 months

If your Dependent(s)'s coverage is continued for 18 months as a result of a Qualifying Event listed above and, during the COBRA period, a second Qualifying Event occurs that entitles the Dependent(s) to continue coverage, your Dependent(s) may elect to continue coverage up to a combined maximum of 36 months. For example, if you retire and you and your Dependent(s) elect COBRA coverage from May 1, 2005 and you then become entitled to Medicare on November 1, 2005, your Dependent(s) can elect to continue coverage for the balance of 36 months, measured from May 1, 2005.

Entitlement to Social Security Disability Income Benefits

If you and/or an eligible Dependent(s) is/are determined by the Social Security Administration to be disabled at the time of the Qualifying Event or within 60 days after the Qualifying Event, coverage may be continued for all family members for up to an additional 11 months, for a maximum of 29 months from the date of the Qualifying Event. The Social Security Administration must make the determination of disability before the end of the 18 month coverage period and you must notify the Fund Office before the end of the 18 months and within 60 days of the date of the determination in order to be eligible for the extended coverage. If you do not notify the Fund Office within these time limits, you will not be eligible for the 29 month extended coverage. This extended coverage will stop earlier if the Social Security Administration determines that the individual is no longer disabled. The disabled person must notify the Fund Office if the person is no longer disabled within 30 days of a final determination of the Social Security Administration that the person is no longer disabled.

Termination of COBRA Coverage

If you and /or your Dependent(s) elect COBRA coverage, the COBRA coverage will cease on the first of the following dates:

1. The date the Plan terminates or the Plan no longer provides coverage to similarly situated Participants or Dependent(s).

2. The date a required payment is due and unpaid. Coverage may be reinstated if payment is made during the applicable grace period.

3. The date you and/or your Dependent(s) first become covered under another group health plan as long as it is after the Qualifying Event. This may not apply if you and/or your Dependents(s) have a pre-existing condition that is not covered under the new plan. Contact the Fund Office for additional information when you and/or your Dependent(s) become covered under another group plan.

4. The date you or your Dependent(s) first become eligible for Medicare, as long as it is after the Qualifying Event.

5. The date the applicable period of COBRA coverage ends.

6. The first month that begins more than 30 days after the date of the Social Security

7. Administration’s determination that you or your Dependent(s) is/are no longer disabled in situations where coverage was being extended for eleven months, so long as the period of continuation coverage does not exceed 29 months.

8. If your Employer ceases to maintain any group health plan for its Employees through the Fund, the date your Employer makes health coverage available to a class of Employees formerly covered under the Plan.

Trade Act Right

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TD/TTY callers may call toll-free 1-866-626-4282. More information about the Trade Act is also available at http:/www.doleta.gov/tradeact/benefits.cfm. This program is offered by the federal government and the Fund Office has no role in its administration.

E. Medical Child Support

Purpose

The Fund has adopted the following procedures to determine the qualified status of Medical Child Support Orders and to administer pay-meets under such orders. These procedures are intended to comply with the requirements of Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Fund may, from time to time, alter, amend or terminate these procedures and substitute other procedures satisfying legal requirements.

Definitions

As used herein, the following terms shall have the meanings referred to below:

(a) Alternate Recipient - Alternate Recipient shall mean any child of an Eligible Employee who is recognized by a Medical Child Support Order as having a right to enrollment under the Plan with respect to such Eligible Employee.

(b) Medical Child Support Order - Medical Child Support Order shall mean any judgment, decree, or order (including approval of a property settlement agreement) which (i) relates to the provision of child support to a child of an Eligible Employee, and (ii) is made pursuant to a State domestic relations law (including a community property law).

(c) Qualified Medical Child Support Order - (also QMCSO) - Qualified Medical Child Support Order shall mean an order which the Trustees have determined meets the requirements of Section 6.3 of these QMCSO Procedures.

(d) QMCSO Procedures - QMCSO Procedures shall mean the provisions of this **instrument,** including all supplements or amendments in effect from time to time.

Qualified Medical Child Support Order

(a) A Qualified Medical Child Support Order (hereinafter referred to as 'QMCSO") is a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient's right to enrollment under the Plan, and which the Trustees have determined meets the requirements of subsections (b) and (c) of this Section 3.

(b) A Medical Child Support Order meets the requirements of a QMCSO only if the order clearly specifies
   (i) the name and the last known mailing address of the Participant and the name and last known mailing address of each Alternate Recipient covered by the order; and
   (ii) a reasonable description of the type of coverage to be provided by the plan to each such Alternative Recipient, or the manner in which such type of coverage is to be determined; and
   (iii) each period to which such order applies; and
   (iv) each plan to which such order applies.

(c) A Medical Child Support Order meets the requirements of a QMCSO only if the order does not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act.

Procedures

Upon receipt of a MCSO, the Fund shall take, or cause to be taken, the following actions:

(a) The Fund shall promptly notify the Participant, each Alternate Recipient covered by the order and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and procedures for determining whether such order is a QMCSO.

(b) Within a reasonable period after receipt of a Medical Child Support Order, the Trustees shall determine whether it is a QMCSO and shall notify the parties indicated in subsection (a) of such determination.

(c) If the MCSO is determined to be a QMCSO, then the Alternate Recipient shall be treated by the plan as a Beneficiary for the purposes of reporting and disclosure under ERISA; and

(d) The Fund shall distribute to the Alternate Recipient a copy of the Summary Plan Description and any subsequent Summary of Material Modifications generated by a Plan amendment.

F. Fund's Right to Subrogation, Assignment to Rights and Reimbursement

Where the Fund has or may provide benefits to you or your dependent(s) in connection with or arising from an accident or other occurrence for which some other party or parties may be responsible ("Claims"), the Fund has the right, under the Plan, to subrogation, assignment and reimbursement to all Claims, rights, causes of action or other interests that you or your dependent(s) has/have, or which may accrue against any party or parties (including your own or your dependent(s) insurance company) arising out of said accident or occurrence to the extent of any benefits paid by the Fund to you and/or your dependent(s) arising from said accident or occurrence.

You and/or your dependent(s) are required to notify the Fund, in writing, within ten (10) days of any accident or occurrence resulting in an injury for which some other party or parties may be responsible. The Fund has the right to intervene, at any time, in any procedure, proceeding and/or lawsuit arising from said accident or other occurrence.

You and/or your dependent(s) are required to notify the fund, in writing, within ten (10) days of making such Claims as well as within two (2) days of a judgment relating to such Claims. You and/or your dependent(s) must obtain the Fund's written consent prior to settling or compromising any such Claims. Should you and /or your dependent(s) choose not to pursue the Claims against the party or parties that may be responsible for the injury or injuries sustained, you and/or your dependent(s) must, upon request by the Fund, authorize and empower the Fund to litigate, compromise or settle said Claims against such party or parties that may be responsible for the accident or other occurrence to the extent of the benefits paid by the Fund.

The Fund shall have an equitable lien on any amount received from any Claims from some other party or parties, to the extent of any benefits paid by the Fund to you and/or your dependent(s), arising from said accident or other occurrence, and such amount received, by you and/or your dependent(s), or your respective representative(s) (including attorneys) shall be held in constructive trust for the sole benefit of the Fund until paid to the Fund. The Fund's rights to assignment, reimbursement and subrogation are for the full amount of all related benefit payments; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by you and/or your dependent(s) in obtaining a recovery on the Claims.

Consistent with the Fund's rights as set forth above, if you or your dependent(s) receive any benefit payments from the Fund as a result of an accident or other occurrence that may give rise to any Claim, you and/or your dependent(s) will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement ("Agreement") affirming the Fund's rights of assignment, reimbursement and subrogation. This Agreement must be executed by you and/or your dependent(s) that seek to have benefits paid by the Fund in connection with said accident or other occurrence. Benefit payments from the Fund will not be paid until the Agreement if fully executed by you, your dependent(s) and your respective attorney(s), if applicable.

Because benefit payments are not payable unless you sign the Agreement, <u>you or your dependent's Claims will not be considered filed and will not be paid until the fully signed Agreement is received by the Fund.</u> This means that, if you file a Claim and your Agreement is

not received promptly, the Claim will be untimely and will not be paid if the period for filing Claims passes before your fully-executed Agreement is received by the Fund.

The Plan excludes coverage for any charges for any medical or other treatment, service of supply to the extent that the cost thereof may be recoverable by, or on behalf of you or your dependent(s) in any action at law, any judgment, compromise or settlement of any Claims against any party, or any other payment you, your dependent(s), or your attorney(s) may receive as a result of the accident or other occurrence, no matter how these amounts are characterized or who pays them.

You and/or your dependent(s) are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of assignment, reimbursement and/or subrogation, including notifying the Fund of the status of any Claims or legal action asserted against any party or insurance carrier and of you or your dependent(s) receipt of any recovery. You or your dependent(s) also must do nothing to impair or prejudice the Fund's rights. For example, if you or your dependent(s) choose not to pursue the liability of a third party, you or your dependent(s) may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. Where you or your dependent(s) choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your Claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent(s) (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident or other occurrence.

You or your dependent(s) must also notify the Fund before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced to you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your dependent(s) waive any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's assignment, reimbursement and subrogation rights.

G. The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), and the regulations thereunder, require that the Plan provide the right to elect continuous health coverage for up to 18 months, beginning on the date in which the Participant's absence from employment begins, to Participants and their Dependent(s) who are absent from Employment due to military service, including Reserve and National Guard duty, as described below.

If you are absent from Employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your Dependent(s) under the provisions of USERRA. This coverage will include the same health benefits offered under COBRA coverage. Your coverage also will include any other benefits that you would be entitled to if you were on leave of absence. The period of coverage for the Participant and Dependent(s) ends on the earlier of:

1. the end of the 18 month period beginning on the date on which your absence begins;

or

2. the day after the date on which you are required to but fail to apply for or return to a position of Employment. For example, for periods of service over 180 days, generally you must reapply for Employment within 90 days of discharge.

You may be required to pay a portion of the cost of your benefits. If your military service is less than 31 days, there is no charge for this coverage beyond the Co-Pays you would pay if you were employed. If you military service extends 31 days or more, you must pay the cost of the coverage. The cost that you must pay to continue benefits will be determined in the same manner as the premium for coverage under COBRA.

You must notify your Employer and the Fund Office that you will be absent from Employment due to military service unless you cannot give notice because of military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. You also must notify the Fund Office if you wish to elect continuation coverage for yourself or your eligible Dependent(s) under the provisions of (USERRA). If you satisfy the Plan's eligibility requirements at the time you entered the uniformed services and you qualify for coverage under USERRA, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service.

H. HIPAA Certificate of Creditable Coverage

When your coverage ends, you and/or your Dependent(s) are entitled by law to a Certificate of Creditable Coverage that indicates the period of time you and/or they were covered under the Plan. This Certificate will be provided to you shortly after the Fund knows or has reason to know that coverage for you and/or your Dependent(s) has ended. In addition, this certificate will be provided on receipt of a request for a Certificate by the Fund within two years after the date coverage has ended. If you need a Certificate of Coverage, write to the Fund at the address shown below. The Fund will send you a Certificate at any time while you are still covered and up to two years after you lose coverage.

If, within 63 days after your coverage under this Plan ends, you and/or your Dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your Dependent(s) a health insurance policy, this Certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply to you and/or your Dependent(s) in that group health plan or health insurance policy.

The Certificate will indicate the period of time you and /or they were covered under this Plan, and certain additional information that is required by law. The Certificate will be sent to you or to any of your Dependent(s) by first class mail within a reasonable time after your or their coverage under this Plan ends. If you or any of your Dependent(s) elect COBRA coverage, another Certificate will be sent to you (or them if COBRA coverage is provided only to them) by first class mail shortly after the COBRA coverage ends for any reason.

I. Notice of Privacy Practices

This section describes how medical information about you may be used and disclosed under the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Further, this section tells you how you can get access to your Personal Health Information (PHI). We suggest you read this section carefully.

The Privacy Rules of HIPAA limit the access and use of your PHI solely for purposes of making or obtaining payment for your health care and conducting the necessary health care operations of your Plan. Your Board of Trustees has established a policy to guard against unnecessary disclosure of your PHI. The following is a summary of the circumstances under which your PHI may be used and disclosed:

To Make or Obtain Payment

The Plan may use or disclose your PHI to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations

The Plan may use or disclose PHI for its own operations to facilitate the administration of your Plan and as necessary to provide coverage and services to the Plan's participants. Health care operations include such activities as:

Quality assessment and improvement activities

Activities designed to improve health or reduce health care costs.

Clinical guideline and protocol development, case management and care coordination.

Contacting health care providers and participants with information about treatment alternatives and other related functions.

Health care professional competence or qualifications review and performance evaluation.

Accreditation, certification, licensing or credentialing activities.

Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.

Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.

Business planning and development including cost management and planning related analyses and formulary development.

Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

For Treatment Alternatives

The Plan may use and disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be applicable to you.

For Distribution of Health-Related Benefits and Services

The Plan may use or disclose your PHI to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor

Your Plan may disclose your PHI to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of your Plan. In addition, the Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. Your Plan also may disclose to the plan sponsor PHI on whether you are participating in the health plan.

When Legally Required

Your Plan will disclose your PHI when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities

The Plan may disclose your PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings

As permitted or required by state law, the Plan may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your PHI.

For Law Enforcement Purposes

As permitted or required by state law, the Plan may disclose your PHI to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety

The Plan may, consistent with applicable law and ethical standards of conduct, disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions

In certain circumstances, federal regulations require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation

The Plan may release your PHI to the extent necessary to comply with laws related to worker's compensation or similar programs.

Authorization to Use or Disclose Health Information

Other than as stated above, the Plan will not disclose your PHI without your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Health Information

You have the following rights regarding your PHI that the Plan maintains:

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your PHI. You have the right to request a limit on the Plan's disclosure of your PHI to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the UFCW Local 2-D Insurance Trust Fund, 8402 18th Avenue, Brooklyn, NY 11214, 718-331-0030.

Right to Receive Confidential Communications

You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your PHI could endanger you. For example, you may ask that the Plan only

communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Official at UFCW Local 2-D Insurance Trust Fund, 8402 18th Avenue, Brooklyn, NY 11214, 718-331-0030. The Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy your Health Information

You have the right to inspect and copy your PHI. A request to inspect and copy records containing your PHI must be made in writing to the Privacy Official at the address and phone number shown above. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information

If you believe that your PHI records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing to the Privacy Official at the address and phone number shown above. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your PHI records were not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, if the PHI you wish to amend falls within an exception to the PHI you are permitted to inspect and copy, or if the Plan determines the records containing your PHI are accurate and complete.

Right to an Accounting

You have the right to request a list of certain disclosures of your PHI that the Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Privacy Official at the address and phone number shown above. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2004. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Official at the address and phone number shown above.

Duties of the Plan

The Plan is required by law to maintain the privacy of your PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the

terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all personal health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to UFCW Local 2-D Insurance Trust Fund, 8402 18th Avenue, Brooklyn, NY 11214, or call 718-331-0030. The Plan encourages you to express any concerns you may have regarding the privacy of your PHI. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Plan has designated a Privacy Official for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Official, at the, UFCW Local 2-D Insurance Trust Fund 8402 18th Avenue, Brooklyn, NY 11214, or call 718-331-0030, and ask to speak to the designated Privacy Official.

J. Claims and Appeals Procedures for Health Claims

A claim for health benefits must be provided to the Fund within 90 days of the date the claim was incurred. The claim must include a completed claim form (if requested by the Fund Office) and a completed and fully executed Subrogation Assignment To Rights and Reimbursement Agreement (if applicable). Each of these documents and all information necessary to process the claim must be provided within the 90-day claim filing deadline. It is your responsibility to provide the Fund with all information necessary to process each claim and to do so within the time limits

Claims Processing and Appeal Procedures for All Claims Except Dental, Death & Optical Claims

The Fund will make every effort to process your claims accurately, efficiently and as quickly as possible once the claim is received. If additional information is required to process the claim, the Fund will notify you explaining what additional information is required to complete the claim. You are responsible for submitting any such additional information within the claim filing deadline indicated above.

If such a claim is denied in whole or part, or if a claim is denied because the Plan believes it was filed on behalf of someone who is ineligible for benefits under the Plan, you will be notified in writing within 60 days and advised of the reason for the denial. You (or your authorized representative) may, within 60 days from the denial, request a review by the Fund. A decision will be made within 60 days after receipt of a request for review.

If you are still dissatisfied, you may within 60 days, request a review upon written application addressed to the Board of Trustees, UFCW Local 2-D Insurance Trust Fund at 8402 18th Avenue, Brooklyn, NY 11214. A decision will be made by the Board no later than the date of the next regularly scheduled Board meeting following the receipt of the request. However, if the request

for review is receive within 30 days prior to the meeting, then a decision may be made at the time of the second meeting following the request for review. You will then be notified, in writing, within 60 days and given specific reasons for the decision.

Legal Actions to Recover Benefits

You and your dependent(s) may not file legal action against the Fund to recover benefits prior to exhausting your rights of appeal in accordance with the appeal procedures described above. In any event, no legal action may be filed against the Fund to recover benefits under this Plan more than one year after the date of the notice to the Trustees' decision on appeal.

Naming an Authorized Representative

You may name a representative to act on your behalf during the entire claims procedure. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number and authorize the Fund to release information (which may include PHI) to your representative. The Fund may establish procedures for determining whether an individual has been authorized. Please contact the Fund's office for a form. The Fund will then send all information regarding your claim to your representative.

Where to submit Your Claim Form

The Fund Office can assist you in obtaining the proper Claim Forms. When the Claim Form has been completed and you have signed it, send it together with all itemized bills or required documents to the location shown below:

UFCW Local 2-D Insurance Trust Fund
8402 18th Avenue
Brooklyn, New York 11214
(718) 331-0030

The Limitations for Filing Your Claim

All claims must be filed within 90 days after the charges have been incurred. Claims submitted after the 90 days will be denied unless it is determined that there is a satisfactory explanation for the delay. In no event will the Fund pay a claim filed more than 90 days from the date the claim was incurred. A chart is shown below that summarizes the time requirements under these Claims and Review procedures.

Length of Time Required to Process Claims

The length of time required to process the claim depends upon the type of claim. The Plan differentiates between four types of claims, divided according to their urgency.

Urgent Care Claim

An Urgent Care claim is one that must be processed quickly to prevent serious jeopardy to you or your dependent's life or health. Additionally, Urgent Care claims include those claims that, in the opinion of your doctor, would subject you to severe pain that cannot be managed without the care or treatment requested under the claim.

Your Urgent Care claims will be processed within 72 hours after receipt (through either written or oral communication) by the Fund. If it is determined that more information is necessary to process the claim, you will have 48 hours to provide the necessary information. The Fund then has 48 hours to decide the claim after receipt of this information. An Urgent Care claim to extend Concurrent Care (described below) will be decided within 24 hours (if you make the claim at least 24 hours before treatment expires).

If your Urgent Care claim is filed improperly, then you will be notified by telephone and given a chance to correct it within 24 hours. If you do not provide the information requested, or do not properly re-file the claim, the Plan will have to decide the claim based on the information it has, and your claim may be denied. Due to the nature of an Urgent Care claim, you may be notified of a decision via telephone. This will be followed by a written notice of the same information within three days of the oral notice.

Pre-Service Claim

A Pre-Service claim is one that requires pre-approval under the terms of the plan. Your Pre-Service claims will be decided within 15 days of receipt by the Fund. If it is determined that an extension of this time is necessary, the claim will be decided within 30 days of receipt (unless the period is extended while the Fund awaits receipt of information requested from you). You will be notified of the need for an extension within 15 days of receipt of the claim and the reasons why the extension is needed.

If the Fund needs more information from you to process the claim, you will have 45 days to provide the needed information to the Fund. If your claim is filed improperly, you will be notified of the problem within 5 days of filing the claim. If you do not provide the information requested, or do not properly re-file the claim, the Fund will have to decide the claim based on the information it has, and your claim may be denied.

Post-Service Claim

A Post-Service claim is any other type of claim under the Plan, such as a payment for covered services after a doctor visit. You will be notified if your claim is denied within 30 days after receipt of the claim. If it is determined that an extension of this time is necessary to decide the claim, the claim will be decided within 45 days of receipt (unless the period is extended while the Fund awaits receipt of information requested from you). You will be notified of the need for an extension within 30 days of receipt of the claim and the reasons why the extension is needed.

If the Fund needs more information from you to process the claim, you will have 45 days to provide the needed information to the Fund. If you do not provide the information requested, the Fund will have to decide the claim on the information it has, and your claim may be denied.

Concurrent Care Claim

A Concurrent Care claim is a claim that the Fund is asked to approve, or has already approved for an ongoing course of treatment or a certain number of treatments over time. If the Fund determines that treatment is no longer necessary, you will be notified of the denial within a sufficient amount of time to allow an appeal before the Fund ceases or reduces coverage for your treatment. If you ask that Concurrent Care treatment be extended beyond the initially determined time, your claim will be decided no later than 24 hours after your claim is receive by the Fund (if you make the claim at least 24 hours before the period or number of treatments expires).

How a Decision Regarding Your Claim is Made

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

The Fund, at its own expense, has the right to have a Physician examine you or your Dependent as often as is reasonably required while a claim is pending. The Fund also has the right to have an autopsy performed at its own expense, where not prohibited by law.

If the Fund has all of the information needed to process the claim, it will be processed. If you claim was for Urgent Care or a Pre-Service claim, you will receive notice regarding payment of your claim.

Notice if Claim is Denied

If your claim is denied, you will receive a written explanation that describes the specific reason for the denial, the specific provisions of the Plan document on which the decision was based, any additional information necessary in order for the Fund to reconsider your claim (and the reasons why that information is necessary), and the Fund's appeal procedures and the time limits for use of those procedures. The explanation will also advise you of your right to bring an action under ERISA § 502(a) if you decide to appeal and that appeal is denied. If your claim concerned Urgent care and was denied, you may receive timely oral notification, however, you will also receive written notification within three (3) days after the oral notification. Your notice will also include a description of the expedited review process.

If the Fund relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, guideline or protocol or a statement that it was relied upon and is available upon request and free of charge. Additionally, if the Fund based its decision on medical necessity, experimental treatment or a similar exclusion or limit, you will receive either an

explanation of the judgment related to your condition or a statement that such an explanation is available upon request and free of charge.

How to Appeal A Decision to Deny Benefits

If your benefits are denied, in whole or in part, and you wish to appeal the Fund's decision, you (or your representative) should request that the Board of Trustees review your benefit denial by submitting a written appeal to the Trustees. If you are appealing an Urgent Care claim denial, you may do so orally or in writing. The Trustees or a designated committee of the Trustees will review your appeal.

Your written appeal should state the reason for your appeal. You may submit written comments, documents, records, and other information relating to the claim. If you choose to appeal, upon request you can receive, free of charge, access to and copies of all documents, records and other information relevant to your claim.

Your appeal should be sent to:

UFCW Local 2-D Insurance Trust Fund
8402 18th Avenue
Brooklyn, New York 11214

Time Limitations for Submitting an Appeal

You have 180 days from the day you receive notice of the initial determination to appeal that decision.

Length of Time to Issue a Decision Regarding Your Appeal

Once your appeal is received by the Trustees, the time to issue a decision will depend on the type of claim.

Urgent Care Claims

Appeals of Urgent Care claims will be decided within 72 hours after the Trustees receive the appeal. You may appeal denials of Urgent Care claims either orally or in writing. All information necessary to decide the appeal may be transmitted via telephone, facsimile or other available method.

Pre-Service Claims

Appeals of Pre-Service claims will be decided within 30 days after the Trustees receive the appeal.

Post-Service Claims

If the Board of Trustees is holding regularly scheduled meetings at least quarterly, appeals of Post-Service claims will be decided at the next quarterly meetings of the Trustees (or a designated committee of Trustees) immediately following the receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review by the Trustees, you will receive a decision no later than the third quarterly meeting, and you will be notified in writing of the need for the extension, why the extension is needed, and when a decision is expected. The Trustees will send you a notice of this decision within 5 days of the decision.

If the Board of Trustees is holding regularly scheduled meetings less often than quarterly, appeals of post-service claims will be decided within a reasonable time but in no event will you be notified of the determination later than 60 days after receipt of the appeal.

Concurrent Care Claims

Appeals of Concurrent Care claims are governed by the provisions above for Urgent Care, Pre-Service or Post-Service claims, whichever applies to the particular claim.

Notice of Denial of Appeal

If your claim is denied on appeal, you will receive a written explanation that describes the specific reasons for the denial, the specific provisions of the plan document on which the decision was based, any additional information necessary to reconsider your claim (and why that information is necessary), notice that you may receive on request access to and free copies of documents and records relevant to your claim, and a statement of your right to bring a lawsuit under ERISA.

If the Trustees relied on an internal rule, guideline or protocol in making the decision, you will receive either a copy of the rule, guideline, or protocol or a statement that it was relied upon and is available upon request and free of charge. If the Trustees based their decision on medical necessity, experimental treatment or a similar exclusion or limitation, you will receive either an explanation of the scientific or clinical judgment related to your condition or a statement that such an explanation is available upon request and free of charge. If the Fund received the advice of any medical or vocational expert with respect to your claim, the Fund will identify the expert upon your request.

If the initial decision on a medical claim was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination or a subordinate of such person. In reviewing a denied medical claim, the Trustees will not automatically presume that the initial decision was correct.

Rather, the medical claim will be reviewed with no reliance on the record used in making the initial benefit determination, and, by a named fiduciary of the plan who did not make the determination you are appealing and who is not a subordinate of any individual who made the determination that you now appeal.

If you have any questions on how to file a claim or how to appeal a claim decision, please contact the Fund office at UFCW Local 2-D Insurance Trust Fund, 8402 18th Avenue, Brooklyn, NY 11214 or by calling 718-331-0030.

Amendment/Termination of the Plan

This Fund is a joint labor-management trust fund, financed by contributions fixed by collective bargaining agreements, and administered by an equal number of Trustees designated by the employers and by the Union pursuant to a Trust Agreement, which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted this Plan of benefits. Under the Trust Agreement, and under this Summary Plan Description, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Also, under the Trust Agreement and this Summary Plan Description, any question or issue of interpretation, construction, application or enforcement of the terms of the Plan, including any determination on benefit claims and appeals, is subject to the discretion of the Board of Trustees, whose determinations are final and binding. In the event that the Plan terminates, any remaining Trust assets will be used for the exclusive benefit of the members.

K. Rights and Protections

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

(a) Examine, without charge, at the plan administrator's office, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

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

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

(d) Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and

the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request ERISA described materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide said materials, and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that the 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.

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory (the New York Regional Office is located at 1633 Broadway, Rm. 226 New York, N.Y. 10019, (212) 399-5191) or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

This section is required by the United States Department of Labor. Its inclusion in this Summary Plan Description should not be construed as offering legal advice.

APPENDIX

GENERAL INFORMATION

NAME OF PLAN:

UFCW Local 2-D Insurance Trust Fund

TYPE OF PLAN:

Welfare Plan administered by the Board of Trustees. The Plan is financed by the contributing employers who make a fixed monthly contribution per member.

NAME OF PARTICIPATING EMPLOYERS AND RELEVANT COLLECTIVE BARGAINING PROVISIONS:

You may, at the Fund Office, inspect a list of Contributing Employers and review the applicable collective bargaining provisions at your request during normal business hours.

PLAN ADMINISTRATOR:

Board of Trustees
UFCW Local 2-D Insurance Trust Fund
8402 18th Avenue
Brooklyn, New York 11214

PLAN IDENTIFICATION NUMBERS:

EIN: 13-6118802 Plan #: 501

AGENT FOR SERVICE OF LEGAL PROCESS:

Board of Trustees
UFCW Local 2-D Insurance Trust Fund
8402 18th Avenue
Brooklyn, New York 11214

PLAN YEAR:

January 1 - December 31.