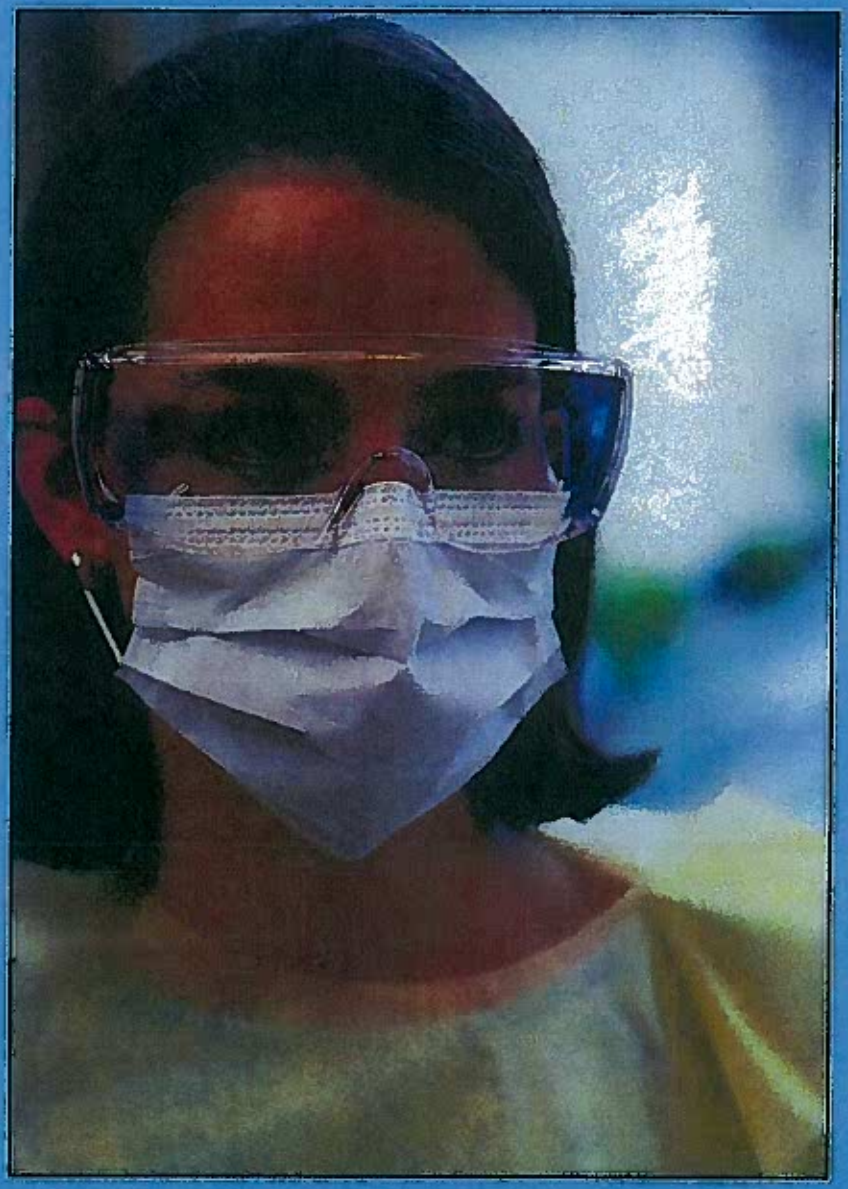


MEDICAL PLAN

IMPORTANT UPDATES TO YOUR BENEFITS

PLEASE READ THE FOLLOWING PARAGRAPH WHICH EXPLAINS WHAT "SUMMARY OF MATERIAL MODIFICATIONS" (SMMs) ARE AND HOW THEY MAY AFFECT YOUR COVERAGE.

Summary of Material Modifications – or SMMs – are letters, notices and other information distributed to Local 1262 members as required by law.

The SMMs contain information regarding changes and/or updates regarding coverage, eligibility and other items that occurred after the printing of the original Summary Plan Description (the large book with the blue and white cover).

These changes typically occur after contract negotiations and/or as a result of changes in health care laws.

It is important to note that the language in the SMMs supersedes the language included in the SPD.

For example, if the original SPD stated that full-time members were eligible for $20,000 in Life Insurance Benefits, but the SMM states that full-time members are eligible for $30,000 in Life Insurance Benefits the amount members are eligible for is $30,000 – the amount indicated in the SMM issued after the SPD was printed.

It is important that you read the SMM updates as they are subject to change as new health care reforms are enacted as part of the Federal Patient Protection and Affordable Care Act.

To view a complete copy of all SMMs (56 pages total), please click on the link located on the Benefits Summary page.

As always, if you have questions regarding your coverage or eligibility, contact the Health & Welfare Fund Office at 1-800-522-4161 between 9:00 a.m. and 5:00 p.m., Monday through Friday.

MEDICAL PLAN

To ensure that you have protection against the catastrophic cost of medical care, the UFCW Local 1262 and Employers' Funds provide the Medical Plan. The Plan's benefits are important to keeping you healthy.

ELIGIBILITY

Category 1

Part-time participants — not including part-time porters and both full-time and part-time service clerks — are eligible for coverage under the Medical Plan on the first day of the month after working for a contributing employer continuously for two years and 1,000 hours in the last review year (the period from October 1 through September 30 that determines your eligibility for the next calendar year). This means generally if you work 20 hours a week, you have complete coverage. However, you must continue to work 1,000 hours each review year to qualify for coverage — leaves of absence for longer than three months or more than one leave during a 12-month period may affect your eligibility. If you worked for a contributing employer less than 1,000 hours but *more than* 750 hours and averaged 20 hours a week for each week that your were *actively* at work, you will also have complete coverage. Spouses and dependents are not eligible for coverage.

Category 2

Part-time participants — not including part-time porters and both full-time and part-time service clerks — who work *less than* 1,000 hours a year for two continuous years and who don't meet the 750-hour requirement described above are eligible for benefits under the Medical Plan on the first day of the month after working for a contributing employer for two years. However, the Medical Plan only covers hospital expenses **after 120 days of hospitalization.** Spouses and dependents are not eligible for coverage.

Delay in Eligibility

If you are absent from work on the day your eligibility would otherwise begin or benefits would increase, you will not become initially eligible or eligible for any benefit changes, as the case may be until the day you actually return to work with your contributing employer.

Eligibility Exclusions

Part-time porters and both full-time and part-time service clerks are not eligible to participate in the Medical Plan. Also, certain part-time participants who are not covered by the "Major Food Industry" contract and are employed by an independent contributing employer *may not* be covered by this Medical Plan. If you work as a part-time employee for an independent contributing employer, review your specific collective bargaining agreement and contact the UFCW Local 1262 and Employers' Fund Office at 1-800-522-4161 to determine your eligibility.

MEDICAL PLAN

Please Note

Under the Medical Plan, if a part-time participant is also an eligible dependent of a full-time participant covered under the UFCW Local 1262 and Employers' full-time participant Medical Plan, the part-time participant receives benefits as a dependent of the full-time participant.

The *only* exception to this is services in connection with maternity benefits. This means the part-time participant is only eligible for the maternity benefits through the Part-time Medical Plan.

COST

If you are covered by the Medical Plan, under the terms of the collective bargaining agreement between UFCW Local 1262 and your employer, your employer is required to contribute to the UFCW Local 1262 and Employers' Funds the cost of coverage for you under the Plans.

PLAN OVERVIEW

The Medical Plan includes the following features:

- You have a choice of visiting any qualified physician or medical facility for comprehensive health care — including covered hospital (if eligible), surgical and related charges. The Plan will pay 80% of the cost of covered reasonable and customary (R&C) charges and you pay the remaining 20% after you meet an annual deductible. See page 14 for an explanation of R&C.
- The Plan's out-of-pocket limit protects you from the catastrophic expenses associated with a serious illness or injury. See page 7 for a detailed explanation on how the out-of-pocket limit is applied.
- The Plan covers you in case of a medical emergency or an accident.
- The Plan pays 80% of expenses associated with mental health and substance abuse treatment with Value Options, a national network of mental health and substance abuse counselors, facilities and agencies.

Introducing Horizon Blue Cross/Blue Shield of New Jersey

Horizon Blue Cross/Blue Shield of New Jersey has been retained by the Fund to administer the Medical Plan.

While you have the freedom to choose any physician/hospital for your medical care, we ask you to consider the financial and other advantages of using the Preferred Provider Organization (PPO) offered by Horizon Blue Cross/Blue Shield of New Jersey.

A PPO is a network of hospitals, physicians and other health care providers who offer medical and hospital services at special negotiated rates. Providers who participate in the network have agreed to reduce fees — saving both you and the Fund money.

The Benefits to utilizing the Horizon PPO network are:

- Participants need not file medical claim forms when using a provider in the network,
- You will not be balance-billed above the reasonable and customary (R&C) and your share of coinsurance will be based on a discounted amount.
- Horizon providers will handle any Utilization Management requirements on the participant's behalf.

To obtain a listing of the participating PPO providers you may call the member Services number on your ID card or the provider look-line at 1-800-810 BLUE (2583).

Under the Medical Plan, you receive comprehensive medical coverage. This means you are protected against the potentially catastrophic costs of being seriously ill or injured — including hospital (if eligible), surgical and related charges — after you pay a deductible. The Plan pays the major portion of covered expenses and you pay the remainder, as described next.

Deductible and Coinsurance — After you meet the $300 annual deductible, the Plan pays a percentage of the cost of the covered medical services. For example, the Plan will pay 80% of R&C charges for covered services. You pay the remaining 20% as coinsurance. Specifically, coinsurance is the percentage of the covered expenses you pay after you meet the deductible. (See the box on page 14 for an explanation of R&C charges.)

Keep in Mind

The choice of specific doctors and an evaluation of their advice and recommendations is your decision and responsibility under the Medical Plan. While the UFCW Local 1262 and Employers' funds provide these benefits to help meet your medical care needs, neither the Union nor your employer is responsible for the coinsurance, deductibles or any amounts not reimbursed under this plan or the quality or appropriateness of the treatment your receive.

Plan Benefit	Deductible	Reimbursement After Deductible
Individual	$300	80% of reasonable and customary charges

Out-of Pocket Limits — To protect you from the potentially catastrophic expense of a serious illness or injury, the Medical Plan has an annual out-of-pocket limit. An out-of-pocket limit is a way of capping the amount you pay toward covered medical expenses in any calendar year. If your expenses — including deductible and coinsurance — reach a specified out-of-pocket limit during the course of a year, then the Plan will pay 100% of R&C charges for the remainder of the year (up to the Plan's maximum lifetime limits).

Plan Benefit	Out-of Pocket Deductible	Reimbursement After Out-of-Pocket Limit
Individual	$1,500	100% of reasonable and customary charges

MEDICAL PLAN

Maximum Lifetime Benefits — The Medical Plan has a **$300,000** lifetime maximum. This lifetime maximum includes a **$5,000** limit for medically recognized methods of artificial insemination and in-vitro fertilization.

The Plan will also cover charges for the storage of the covered participants sperm or egg, as applicable, up to $500 per year for a period not to exceed five years provided the participant has a medical condition covered by the Plan that would affect the participants ability to reproduce. Such coverage will be provided in the most cost-effective manner, as determined by the Trustees.

Effective January 1, 1998, there is an annual maximum of 50 visits for outpatient mental health and substance abuse treatment. The Plan will pay 80% of the R&C rate for inpatient care, up to a lifetime maximum of 120 days of coverage. Covered expenses for mental health and substance abuse are subject to the satisfaction of any deductible and coinsurance provisions. See page 20 for more information on mental health and substance abuse treatment.

Prior to January 1, 1998 you have a $50,000 non-renewable lifetime maximum (included in the **$300,000** lifetime maximum) for mental health and substance abuse treatment combined. This maximum applies regardless of whether you receive services on an inpatient (if eligible) or outpatient basis. In addition, the *annual* maximum benefit for outpatient care for mental health and substance abuse treatment combined is **$5,000** (included in the $50,000 non-renewable lifetime maximum for mental health and substance abuse treatment).

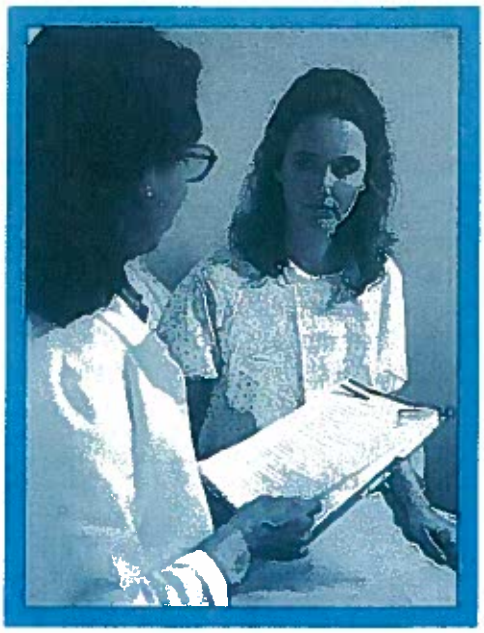
It is important to note that if you, as an eligible participant, move from full-time to part-time status — or vice versa — your accrued lifetime benefits carry forward. For example, if as a full-time participant, you use $125,000 in covered medical expenses and then change to part-time status, you only have $175,000 of coverage remaining as a part-time participant. Conversely, if as a part-time participant you use $125,000 in covered medical expenses and then change to full-time status, you will have $875,000 of coverage remaining as a full-time participant.

Key Terms

The deductible is the amount you pay each calendar year before the plan reimburses you for a portion of your covered expenses.

Coinsurance is the percentage of your covered expenses you pay after you meet the deductible. For example, if the plan has 20% coinsurance, you pay 20% of covered expenses beyond the deductible and the plan pays 80%.

The out-of-pocket limit is the maximum you can pay in any calendar year for covered expenses. It includes your deductible and coinsurance.



Lifetime Maximum

$300,000 which includes:

- up to a $5,000 maximum for medically recognized methods of artificial insemination and in-vitro fertilization.
- up to $500 per year, not to exceed five years for the storage of the participant's sperm or egg, as applicable, provided the participant has a medical condition covered by the Plan that affects their ability to reproduce.
- 120 days lifetime maximum for inpatient mental health and substance abuse treatment.

Horizon Centers of Excellence

A Center of Excellence is a facility designated by Horizon as a preferred facility specifically contracted with to handle selected services of a highly specialized nature, such as organ transplants. Under the Plan, benefits are available for medically necessary services received in a Center of Excellence, provided the services are not otherwise excluded from coverage because they constitute experimental or investigative procedures.

While you are encouraged to utilize these centers, you are not required to do so. You may obtain these specialized services from any facility licensed to provide them. You must still follow standard procedures in order to secure coverage. When using a Center of Excellence facility that is more than 50 miles from the patient's home, benefits for certain travel and lodging expenses may be available. These include:

- **Transportation costs for the patient and a traveling companion (for a participant whose age, medical condition or incapacity so warrant an accompanying immediate family member) for one round trip to and from the center's location. For airline travel, the coach fare will be reimbursed. For travel by private automobile, mileage will be reimbursed at the then current mileage reimbursement rate as set by the IRS.**
- **Reasonable lodging and meal expenses for a traveling companion (for a participant whose age, medical condition or incapacity so warrant an accompanying immediate family member). Lodging must be preapproved by Horizon in order for these benefits to be available.**

Utilization Management Features

Utilization management services — including pre-admission reviews, second surgical opinions and case management — are important features of your health care coverage. These services are provided through Horizon Blue Cross/Blue Shield of New Jersey's Utilization Review program, Horizon Utilization Management. Horizon Utilization Management helps you avoid extended periods of hospitalization and unnecessary surgery. If a doctors recommends surgery or hospitalization (if eligible) for you, you **must immediately** call Horizon Utilization Management Review at **1-877-649-3130.**

In these situations, Horizon Utilization Management Review helps you determine if hospitalization is really required or whether you can be safely and effectively treated:

- on an outpatient basis,
- in a specialized treatment center, or
- in a doctor's office.

Remember, you **must** call Horizon Utilization Management Review at **1-877-649-3130** if a doctor recommends hospitalization (if eligible) or surgery. **If you do not call Horizon Utilization Management Review before hospitalization or surgery, your reimbursement from the Plan may be reduced or eliminated.**

The following are details of the utilization management services.

Hospital Pre-Admission Review — If your doctor recommends hospitalization you must call Horizon Utilization Management Review at **1-877-649-3130** and provide:

- your name, address, Social Security number and phone number,
- the physician's name, address and phone number, and
- the name and location of the hospital where treatment will occur.

A nurse will review the reason for hospitalization, the proposed length of stay, the proposed treatment and the physician's' diagnosis. Horizon Utilization Management Review will then either approve or disapprove your hospitalization and length of stay. Once in the hospital, you, a family member or a doctor can request an extension of your stay by contacting Horizon Utilization Management Review before the expiration of your originally approved number of days. A nurse will then let you know whether an extension has been approved.

Second Surgical Opinions — If surgery is involved in your hospital stay, Horizon Utilization Management Review may arrange for you to have a second surgical opinion. A board-certified specialist near your home will provide this examination and the Plan will cover all costs. If the second opinion does not confirm the need for surgery, you may request a third opinion.

Mandatory Second Surgical Opinion

You or your physician must contact Horizon's Utilization Management department before having any of the following services performed:

- back surgery
- cataract removal
- coronary bypass
- hysterectomy
- prostatectomy
- tonsillectomy
- mastectomy and other breast surgery
- bone surgery of the foot
- cholecystectomy (gall bladder removal)
- endarterectomy (removal of an inner layer of an artery)
- knee surgery
- reconstruction of the hip
- submucous resection (deviated septum)

It Pays to Call Ahead

You have the right to enter the hospital or undergo surgery regardless of the decision of Horizon Utilization Management Review. However, if you don't call Horizon Utilization Management Review at 1-877-649-3130 as required *prior* to hospitalization or surgery — or in an emergency, within 48 hours (or the next business day, if the emergency occurs on a weekend or holiday) of hospitalization — you will have to pay up to 50% of the bill (after the applicable deductible and coinsurance) or $300, whichever is less. If you fail to comply again, you will have to pay the lesser of 50% of the bill (after the deductible and coinsurance) or $1,500. For any subsequent failure to comply, you will have to pay 50% of the bill (after the deductible and coinsurance).

The Medical Plan will not reimburse you for any hospitalization, treatment or surgery that Horizon Utilization Management Review considers medically unnecessary, i.e., diagnosis or treatment of an occupational injury or if you stay in the hospital beyond the approved number of days.

Horizon will determine whether you must have the second opinion based on the medical information you or your physician provides. In all cases, you may always voluntarily seek a second opinion.

Case Management — Horizon Utilization Management Review provides case management services for catastrophic illnesses and injuries or any problem that can result in significant medical expenses. In such a situation, a professional from Horizon Utilization Management Review will act as your dedicated case manager. He or she is your health care advocate and will work with you, your doctor and the hospital to develop an appropriate plan for your care. Horizon Utilization Management Review provides case management services to you at no cost and participation is voluntary.

What's Covered

The Medical Plan pays 80% of the R&C charges of covered medical treatments and services. (See the box on page 14 for an explanation of R&C charges.)

The following services are covered under the Plan:

- semi-private hospital room and board and miscellaneous charges (subject to the utilization management procedures described beginning on page 9) for up to 365 days each calendar year for stays in a hospital (if eligible) or other covered facility, including intensive care unit services.
- charges for emergency room visits for a non-occupational injury or illness.
- doctors' services for treating a non-occupational injury or illness in a hospital, (if eligible), office or outpatient facility.

- private duty registered or licensed nursing by someone who is not a close relative. A close relative means you or your spouse, your child, sister, brother or parent of you or your spouse. There is an annual maximum of $7,000 and coverage is subject to a medical necessity review by Horizon.
- charges for services or supplies considered medically necessary.

  Medically necessary means those services or supplies needed and appropriately provided in connection with a non-occupational illness, non-occupational injury or pregnancy. Medically necessary services or supplies will be appropriately provided if the Claim Administrator determines that each of the following requirements has been met:

  — your doctor has ordered the service or supply for the diagnosis or the treatment of a non-occupational illness, non-occupational injury or pregnancy (routine care in not covered);
  — the prevailing opinion in the U.S. medical profession is that the service or supply is safe and effective for its intended use, and that its omission would adversely affect your medical condition;
  — a provider with appropriate training, experience, staff and facilities delivers the service or supply; and
  — you receive the service or supply during a period of treatment that does not exceed the appropriate length of care determined by the Claim Administrator. (Non-availability of other facilities is not a valid reason for receiving a higher level of care than medically necessary.)

  The Claim Administrator will determine whether the requirements have been met based on:

  1) published reports in authoritative medical literature.
  2) regulations, reports, publications or evaluations issued by government agencies.
  3) listings in the following drug publications: *The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information.*

  4) other authoritative medical sources.

- medically necessary home care services — subject to an annual maximum of 100 visits. (Medically necessary means your tests, treatments, services and supplies must be consistent with the symptoms, diagnosis and treatment of your illness or injury, be given to you as an inpatient only when the services cannot be safely provided as an outpatient of a hospital; not be provided solely for the convenience of your physician, hospital, other provider or you.)
- doctors' consultations while in the hospital, (if eligible).
- medical dressings, syringes, consumable medical supplies, splints, braces, casts and artificial limbs.
- blood and blood products like plasma.
- x-rays and laboratory tests for diagnostic purposes.
- surgical procedures (subject to the utilization management procedures described beginning on page 9).

- anesthesia, oxygen and their administration.
- chemo/radiation therapy.
- charges for a hospital stay (if eligible) of at least 48 hours following birth if the birth is a normal vaginal delivery and for a hospital stay of at least 96 hours following birth by cesarean section.
- care received at a licensed birthing center.
- services rendered by a licensed certified nurse-midwife.
- occupational and physical therapy up to a combined 90-day annual maximum.
- speech therapy up to a 90-day annual maximum.
- rental of durable medical equipment.
- rehabilitative convalescent care received at an extended care facility for 60 days in a calendar year.
- care for the terminally ill received as part of a hospice program certified by Medicare (up to a maximum of $7,000 per calendar year).
- surgery for the fracture of the jaw, removal of a mouth tumor or necessitated by injury to sound natural teeth, as long as the treatment is received within three months of the accident.
- medically recognized methods of artificial insemination and in-vitro fertilization (up to $5,000 in lifetime benefits per participant).
- Charges not in excess of $500 per year for the storage of the covered participants sperm or egg, as applicable, for a period not to exceed five years; provided the participant has a medical condition covered by the Plan that would affect the participants ability to reproduce. Such coverage will be provided in the most cost-effective manner, as determined by the Trustees.
- Shock therapy in a hospital, (if eligible).
- Non-experimental organ transplants.

What's Not Covered

The following are not covered under the Medical Plan:

- Charges for the first 120 days of inpatient hospital confinement for a participant who does not meet the eligibility requirements for coverage under the Medical Plan. (See page 5 for a detailed explanation of Eligibility).
- charges that are recoverable and/or compensated for under any provision of the Workers' Compensation Law, Occupational Disease Law or paid under the laws of the United States and/or a state or subdivision of the United States.
- hospitalization primarily for diagnostic studies and evaluations, x-ray examinations, laboratory examinations, electrocardiograms or physical therapy.
- any charges for services considered experimental procedures or part of a research program.

MEDICAL PLAN

Explaining *Reasonable And Customary*

Under the Medical Plan, you will be reimbursed for a percentage of the cost of *reasonable and customary* (R&C) charges. To determine what is reasonable and customary, Horizon Blue Cross/Blue Shield gathers information about surgical, medical, x-ray and lab expenses from the claims it processes through its computerized claims system. Horizon then sorts these costs by zip code area (generally a city or county) and sets an R&C fee based on what eight out of ten doctors charge.

$100 × 80% reimbursement leaves:
$120 doctor's fee – $100 R&C fee:

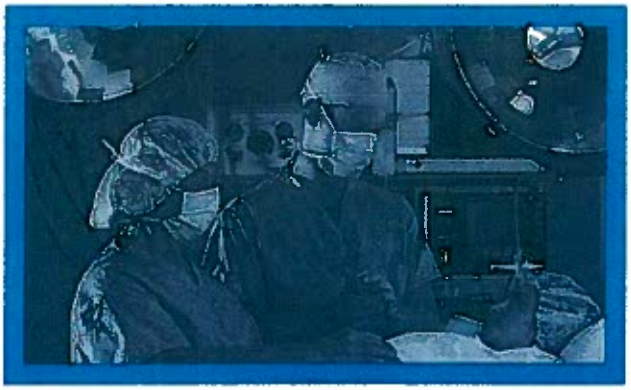
$20 coinsurance
+ $20 difference in fees
$40 = your cost for the service

The Medical Plan pays claims at the 80th percentile of R&C charges. For example, if your doctor charges $120 for a covered expense and Horizon determines $100 is the reasonable and customary charge for that service at the 80th percentile, the Plan reimburses you 80% of $100. You are responsible for the $20 coinsurance and the $20 of un-reimbursed doctor's fee.

- charges for services or supplies not considered medically necessary. (See page 12 for a definition of "medically necessary")
- care for which government legislation, regulations and/or programs reimburse benefits. However, the plan does cover services or supplies furnished in a Veteran's hospital (if eligible) for the treatment of non-military, service-related disabilities.
- expenses applied toward the satisfaction of deductibles and out-of-pocket maximums.
- charges for health screening examinations, immunizations, vaccinations, and premarital examinations. (See page 27 for specific coverage for routine physicals.)
- charges incurred for, or in connection with, treatment by a chiropractor.
- charges for care that cannot reasonably be expected to substantially improve a medical condition.
- charges for educational testing or training necessitated by a nervous, mental or emotional disorder.
- charges exceeding the R&C charge for medical services.
- charges in excess of the default deductible and the 20% coinsurance that normally are covered under any state's Personal Injury Protection (PIP) Program, if you are a resident of that state.

- charges for any services as a result of a motor vehicle accident that can be collected under terms of any federal or state law mandating indemnification regardless of fault. This exclusion applies whether or not you assert your right to obtain coverage under the applicable law.
- expenses incurred prior to an individual's eligibility under the plan or after coverage terminates.
- orthotics or diagnosis and treatment of weak, strained or flat feet, or instability or imbalance of the feet or any tarsalgia, metatarsalgia or bunion, other than an operation involving the exposure of bones, tendons or ligaments, treatment (including cutting or removal by any method) of toe nail or superficial lesions of the feet including corns, calluses and hyperkeratoses, other than removal of nail matrix or root.
- examinations, diagnostic procedures or treatment by any method of jaw joint problems, including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders and myofascial pain dysfunction or other conditions of the joint linking the jaw bone (mandible) and skull and the complex muscles, nerves and other tissues related to the joint.
- treatment of any disease contracted, injuries sustained or any medical services or supplies necessary as a result of an act of declared or undeclared war or for any person who is on active duty during military service.
- any institution or part used principally as a rest or nursing facility or a facility for the aged, chronically ill, convalescents, or a facility providing custodial, educational, rehabilitative care, rest cures or merely maintenance.
- charges for transportation service that are not medically necessary.
- organ transplant services that are considered experimental and are not consistent with standard insurance practice regarding the types of transplants that are acceptable.
- surgery, hospital charges and related services intended solely for cosmetic reasons, but not to restore a bodily function or correct a deformity resulting from disease, trauma, congenital or developmental abnormalities or previous therapeutic processes.
- charges for services or supplies that do not require a prescription.
- personal comfort items, such as telephones or televisions.
- housekeeping services (other than those that are incidental to the covered services of a home health aide).
- expenses that are reimbursed as a result of legal action.

- charges incurred for which the covered person is not — in the absence of this coverage — legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
- care for which no charge is usually made or, if made, would not usually be collected, or any charge which has already been reimbursed from any source.
- dental treatment including hospital care, unless it is for treatment of a fracture of the jaw, removal of a mouth tumor or necessitated by injury to sound natural teeth, as long as the treatment is received within three months of the accident that caused the need for treatment or with prior approval when a medical condition, handicap or age of the patient creates a life-threatening situation.
- claims submitted more than 12 months from the date of treatment or service.
- charges in connection with eye examinations or refractions, or the purchase or fitting of eyeglasses or contact lenses.
- hearing aids and related examinations.
- charges resulting from or occurring during the commission of a crime by the covered person (whether or not convicted), or during engagement in an illegal act, illegal occupation or felonious act, aggravated assault, or intentional tort, by the covered person.
- charges for services rendered by a physician, nurse or licensed therapist who is a close relative of the covered person or who resides in his or her household. A close relative means your spouse, your child, sister, brother or parent of you or your spouse.
- charges eligible under a private/personal health insurance plan whether or not you avail yourself of that benefit.
- services or supplies for any condition exceeding the medically necessary length of care, as determined by Horizon Utilization Management Review. (Non-availability of other facilities is not a valid reason for a higher level of care than medically necessary.)



- services related to sex transformations or sexual dysfunction or inadequacies.
- charges for weight control programs and nutritional counseling or any other type of service, except for surgical procedures, for weight control, whether or not it relates to an illness.
- mental health and/or substance abuse care rendered by a non-Value Options network professional, facility or hospital unless prior approval is obtained from Value Options.
- charges that result from a failure to follow the provisions applicable to another medical plan under which you may be covered, including but not limited to penalties for not complying with pre-admission review or second surgical opinion provisions.
- in the event a Health Maintenance Organization (HMO) would be the primary carrier for a claim submitted under this Medical Plan, any expense for services or supplies which are covered or would have been covered by the HMO had you used the services of an HMO participating provider.
- any and all prescription drugs or medicines that are covered under the UFCW Local 1262 and Employers' Prescription Drug Plan.
- charges related to utilization management service penalties and mental health and substance abuse limitations.
- charges for contraceptives, contraceptive materials or devices.
- charges for services or supplies that are educational or furnished in connection with a service or supply that is educational. For this purpose, a service or supply shall be determined by the Claim Administrator to be educational if:
  - — the primary purpose of the service or supply is to provide you with any of the following: training in the activities of daily living (other than training directly related to treatment of a non-occupational illness or non-occupational injury that results in a loss of a previously demonstrated ability to perform those activities); instruction in scholastic skills such as reading or writing; preparation for an occupation; or treatment for learning disabilities; or
  - — the service or supply is being provided to promote development beyond any level of function previously demonstrated.
- In the case of a hospital stay (if eligible), the length of stay and hospital services and supplies are not covered to the extent that they are determined to be allocable to the scholastic education or vocational training of the patient.

MEDICAL PLAN

If you have any questions about what is or is not covered under the Medical Plan, call Horizon Blue Cross/Blue Shield of New Jersey at **1-800-545-9891** or the UFCW Local 1262 and Employers' Fund Office at **1-800-522-4161.**

Claiming Benefits

The Medical Plan will reimburse you for covered medical expenses after you submit a completed claim form. A claim for benefits must include the following information:

- doctors' bills must indicate your name, diagnosis, treatment and charge for each treatment.
- nurses' bills must show the date, place, hours of duty, name of patient, charges for each date, nurses' signatures and license number.

Don't Miss the Deadline for Reimbursement of Out-of-Network Claims

Under the Medical Plan, there is a *12-month* deadline for submitting claims for reimbursement to Horizon. This means you must submit all claim forms to Horizon within *12 months* from the date of treatment or service.

Although the UFCW Local 1262 and Employers' Funds provide this Medical Plan as part of your total benefits program, you are responsible for filing any necessary claims for reimbursement.

Your Member ID Card and Member Services

You will receive a Medical Plan identification card that lists your name and Social Security number, and plan identification number. Your identification card contains all of the information that you need to have your benefits paid. If you are admitted to the hospital, the hospital can use your card to verify your eligibility and coverage. Remember, you must call Horizon Utilization Management Review at 1-877-649-3130 *prior* to a pre-planned hospitalization and within 48 hours of an emergency hospitalization (or the next business day, if the emergency occurs on a weekend or holiday).

- all other bills — including hospital bills — must indicate the patient's name, nature of services, date and charges.
- if you are submitting a claim in connection with the coordination of benefits feature of the Medical Plan described beginning on page 24 you must include the Explanation of Benefits (EOB) from the primary medical plan.

Health care providers must indicate their federal tax identification or Social Security numbers on the invoice or claim form. Horizon Blue Cross/Blue Shield of New Jersey will not accept canceled checks, balance due statements or paid receipts in place of the actual bill or itemized statement as part of your claim for benefits. (See page 82 for information on appealing a claim.)

Claim forms for reimbursement are available by calling the UFCW Local 1262 and Employers' Fund Office at **1-800-522-4161.** It is important that you complete the claim form as directed. Otherwise, the form will be returned to you causing a delay in processing and reimbursement.

You should submit your completed claim form and itemized bills in the envelope provided to:

Horizon Blue Cross/Blue Shield of New Jersey
PO Box 127
Newark, NJ 07101-0127

Directory of Important Medical Plan Phone Numbers

UFCW Local 1262 and Employers' Fund Office
1-800-522-4161
Call for information on:

- ✔ Eligibility
- ✔ COBRA coverage
- ✔ Claim forms/claim status
- ✔ Questions about/concerns with Claims Administrators
- ✔ Marital status or address change
- ✔ Disability leave or return from leave

Horizon Healthcare Administrators
1-800-545-9891
Call for information on:

- ✔ Eligibility
- ✔ Deductibles/out-of-pocket limits
- ✔ Covered expenses/exclusions
- ✔ Maximum benefits
- ✔ Coordination of benefits
- ✔ Claim forms/claims status

Horizon Utilization Management Review
1-877-649-3130
Call for information on (or to report):

- ✔ Emergency hospitalizations
- ✔ Hospital pre-admission reviews
- ✔ Second surgical opinions
- ✔ Case management services