The United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan "MED-1000" Trust Agreement invests upon the Board of Trustees of United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan MED-1000 the authority to establish and maintain a plan for the provision of health and welfare benefits for eligible Covered Employees and beneficiaries of the Plan.

This booklet, together with the Benefits Program Brochure, constitute your Plan Document Summary Plan Description (SPD) for the United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan, "MED-1000". The SPD sets forth the governing rules and regulations, and provides that the Fund shall be maintained for the exclusive benefit of the Covered Employees and beneficiaries. The Board of Trustees may deem it necessary to revise the benefits described herein from time to time. The terms of the Collective Bargaining Agreement between your Employer and your Local Union detail the basis by which your Employer is obligated to make monthly contributions to the Health and Welfare Plan for your coverage.
The Affordable Health Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by U.F.C.W. Local 1000 and Kroger Dallas Health and Welfare Plan "MED-1000", does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of:

- $200,000 Plan AA;
- $100,000 Plan A;
- $50,000 Plan B;
- $30,000 Plan C;
- $60,000 Plan D; and
- $500 on Durable Medical Equipment

In order to apply the lower limits described above, your health plan requested a waiver of the requirements that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U. S. Department of Health and Human Services based on your health plan's representation that supplying $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to www.HealthCare.gov.

If you have any questions or concerns about this notice, contact: National Employee Benefits Administrators, Inc. at (800) 842-5899.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SCHEDULES OF BENEFITS and ELIGIBILITY</th>
<th>Benefit Highlights Brochure</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOARD OF TRUSTEES</td>
<td>iv</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>1</td>
</tr>
<tr>
<td>LIFE BENEFITS</td>
<td>5</td>
</tr>
<tr>
<td>ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS</td>
<td>6</td>
</tr>
<tr>
<td>WEEKLY ACCIDENT AND SICKNESS BENEFITS</td>
<td>7</td>
</tr>
<tr>
<td>DENTAL</td>
<td>8</td>
</tr>
<tr>
<td>VISION</td>
<td>8</td>
</tr>
<tr>
<td>COMPREHENSIVE MEDICAL BENEFITS</td>
<td>9</td>
</tr>
<tr>
<td>PRESCRIPTION BENEFITS</td>
<td>11</td>
</tr>
<tr>
<td>ELIGIBILITY RULES</td>
<td>12</td>
</tr>
<tr>
<td>GENERAL LIMITATIONS</td>
<td>23</td>
</tr>
<tr>
<td>COORDINATION OF BENEFITS</td>
<td>25</td>
</tr>
<tr>
<td>GENERAL INFORMATION</td>
<td>28</td>
</tr>
<tr>
<td>HOW TO FILE A CLAIM</td>
<td>28</td>
</tr>
<tr>
<td>CLAIMS REVIEW AND APPEAL PROCEDURES</td>
<td>30</td>
</tr>
<tr>
<td>SUBROGATION</td>
<td>38</td>
</tr>
<tr>
<td>COBRA CONTINUATION</td>
<td>40</td>
</tr>
<tr>
<td>UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT</td>
<td>44</td>
</tr>
<tr>
<td>NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT OF 1996</td>
<td>44</td>
</tr>
<tr>
<td>QUALIFIED MEDICAL CHILD SUPPORT ORDERS</td>
<td>45</td>
</tr>
<tr>
<td>INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)</td>
<td>47</td>
</tr>
<tr>
<td>STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)</td>
<td>49</td>
</tr>
</tbody>
</table>
United Food and Commercial Workers Local 1000
and Kroger Dallas Health and Welfare Plan
MED-1000

BOARD OF TRUSTEES

UNION TRUSTEES

Ricky Burris
UFCW Local 1000
967 Wall Street
Grapevine, TX 76051

Bryan Wynn
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Fund Auditor
LaPadula, Carlson and Co.
Certified Public Accountants

Plan Consultant
Crump Consulting, Inc.

Plan Counsel
Deborah Godwin
Godwin, Morris, Laurenzi, Bloomfield P.C.
DEFINITIONS

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

**Additional Buy Up Benefit** means the optional Life Insurance and AD & D Insurance that is available if you are eligible for Plan AA, Plan A, Plan B, Plan C or Plan D; and Accident and Sickness Benefit that is available if you are eligible for Plan AA or Plan A. The cost of the Additional Buy Up Benefit is paid by the Employee on a payroll deduction basis.

**Ambulatory Surgical Center** means an institution or facility, either free standing or as a part of a hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures, to which a patient is admitted and discharged within a twenty-four (24) period. An office maintained by a Physician for the practice of medicine or dentistry shall not be considered an ambulatory surgical center.

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

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

**Section 1.01 Complication of Pregnancy** means any or all of the following:

1. Separate conditions made worse or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed or spontaneous abortions, other medical problems of similar severity and pre-eclampsia; or

2. Certain conditions which occur during pregnancy such as, hyperemesis gravidarum, ectopic pregnancy that is ended, non-elective Cesarean section and miscarriages.

Complications of Pregnancy does not include: false labor, occasional spotting, rest prescribed by a Physician, morning sickness, or similar conditions that are associated with a difficult pregnancy but not classified as a distinct Complication of Pregnancy.

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

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

**Covered Expense** means the amount allowed by the Plan for a particular service or supply based on all Plan provisions.
Definitions (continued)

**Dependent** means:

1. Your lawful spouse. The term “spouse” will only include the person to whom the employee is married, and whose marriage has been solemnized and registered in accordance with the statutory law of jurisdiction in which the marriage occurred. The term will also include a common-law spouse if the employee resides in a state that legally recognizes common-law spouses.

2. Your children under age 26 including legally adopted children, stepchildren, or children placed for adoption, and/or other children for whom the Employee is designated by a court of competent jurisdiction to be legal guardian. Dependent children are not eligible for this Plan if they are eligible for other employer coverage.

3. Children who are incapable of self-sustaining employment because of a physical handicap or mental impairment, who are dependent on you for support and maintenance, provided his/her incapacity started prior to attaining the age at which his eligibility would otherwise terminate. However, the Dependent Life Insurance benefits do not apply to children above the age of 19 described in this provision.

The term dependent will not include:

1. any person who is in full-time military, naval or air service; or
2. any child whose non-custodial parent, if other than an eligible employee, is required to contribute to his/her support by order of any court and is providing medical care protection for such child unless the child is named in a QMCSO. In that case, the child will be eligible for benefits in accordance with the order.

**Durable Medical Equipment** means medical equipment designed for repeated use and which under the Plan is Medically Necessary for the treatment of a Sickness or Injury, or to improve or prevent further deterioration of your medical condition and no value to the patient or the patient’s family in the absence of the bodily injury or sickness. The Plan will pay up to $500 per calendar year for Durable Medical Equipment.

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

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

**Hospice Care** means care given to a terminally ill (6 months or less to live) person by a Hospice Care Agency. The care must be part of a Hospice Care Program.
Definitions (continued)

Hospital means a place which is licensed as a hospital, which is operated for the care and treatment of resident in-patients and which has a laboratory, registered graduate nurses always on duty and an operating room where major surgical operations are performed by legally licensed Physicians. In no event will the term “Hospital” include an institution which is used principally as a clinic, convalescent home, nursing home or home for the aged, drug addicts or alcoholics. The term "Hospital" does apply to institutions accredited by the Joint Commission of Accreditation of Hospitals, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

Hour Bank is a record maintained by the Fund Administrative Manager of hours worked in excess of the minimum required to maintain eligibility in either Plan AA, Plan A or Plan D. Each Plan has a maximum number of Hours that may be accumulated. The accumulated Hours could be withdrawn to help the Participant maintain eligibility if he or she works less than the required amount in a month.

Injury means a bodily injury sustained accidentally by external means.

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

Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Network refers to medical, dental and vision service providers having an agreement in force with a Preferred Provider Organization, Dental Care Service Organization or Vision Care Service Organization that has been retained by the Plan.

Panel Doctors or Panel Provider means medical, dental or vision service providers having an agreement in force with a Preferred Provider Organization or Vision Care Service Organization that has been retained by the Plan.

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

Plan means this Welfare Plan of United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan, also referred to as “MED-1000.”
Definitions (continued)

Pre-existing Condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 month period immediately prior to the first day of the eligibility waiting period prior to enrollment for medical coverage. Medical benefits are not payable for covered expenses incurred for a pre-existing condition until the date the participant has been covered for benefits under this Plan for 12 consecutive months, including the eligibility waiting period requirements. Credit will be given for earlier coverage under a previous employer’s plan, a health insurance policy, Medicare, Medicaid or other government-sponsored health programs. However, no crediting of previous coverage will be applied if a participant has gone for 63 days without any health care coverage. The eligibility waiting period requirements do not count towards the 63 day break in coverage. Pregnancy is not included in the definition of a pre-existing condition. Children under the age of 19 are not subject to the pre-existing condition.

Preferred Provider Organization (PPO) is a network or panel of medical service providers who agree to furnish medical services and be paid on a negotiated fee schedule. Services provided by non-PPO network are not covered by the Plan, except in the case of an emergency. The name of the PPO organization will be provided by the Plan Administrator or its claims administrator. The Board of Trustees has the authority and ability to change and choose PPO networks as it deems appropriate and necessary for the Plan. It is the Plan participant’s responsibility to make sure the identity of the PPO is known and whether or not a specific medical provider is in the PPO network.

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

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

Total Disability or Totally Disabled means an Injury or Sickness that wholly and continuously keeps an Employee from performing the material duties of his occupation or keeps a dependent from performing the normal activities of a person of the same age and sex. The Trustees reserve the right to require you to be examined by a Physician selected by the Trustees to determine whether you are or continue to be disabled. The Trustees reserve the right to discontinue benefits under this Plan that are available by virtue of a Total Disability if, in the Trustees’ discretion, you are no longer Totally Disabled.
**LIFE BENEFITS**

**Life Benefits** are provided on a self-insured basis for Plan B and Plan C participants and for Dependent Life Benefits. Life Insurance Benefits for Plans AA, A and D are provided through an insured group life policy. A copy of the insured Life Insurance policy is available upon request. Please refer to that policy for more information about the insured Life Benefits.

**Additional Life Insurance or Additional Buy Up Benefit** means the optional Life Insurance and AD & D Insurance that is available if you are eligible for Plan AA, Plan A, Plan B, Plan C or Plan D. The cost of the Additional Buy Up Benefit is paid by the Employee on a payroll deduction basis.

If you die while eligible for benefits under this provision, the Plan will pay the amount of Life Benefit shown in the Schedule of Benefits. Benefits will be paid to:

1. the beneficiary you name; or if no named beneficiary is surviving at the death of the insured person, payment will be made to the first surviving class in the following order of preference;
2. the surviving spouse;
3. your children, in equal shares;
4. your brothers and sisters, in equal shares;
5. the executors or administrators of your estate; or
6. for Dependent Life Benefits, the employee.

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

**Mode of Payment** - the Plan will pay benefits:

1. in a lump sum; or
2. in other than a lump sum if:
   a. another mode of payment is requested as described herein; and
   b. the Board of Trustees agrees to it in writing.

**Change of Beneficiary or Mode of Payment**
The Beneficiary and mode of payment may be changed from time to time. To make a change, written request should be sent to the Administrative Manager. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken by the Plan before the request was acknowledged.
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS  
(Employees Only)

Accidental Death and Dismemberment Benefits (AD & D) are provided on a self-insured basis for Plan B and Plan C participants. AD & D for Plans AA, A and D are provided through an insurance policy. A copy of the insurance policy is available upon request.

Benefits
If, while eligible for benefits under this provision, you suffer an Injury and sustain a loss, you will be paid the following Accidental Death and Dismemberment (AD & D) benefit shown in the table below and in the Schedule of Benefits. If you do not survive the Injury, the benefit will be paid to your beneficiary or to your estate if you do not name a beneficiary or no beneficiary survives you.

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life, both hands, both feet or both eyes</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>One hand and one eye</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>One foot and one eye</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>One hand or one foot or one eye</td>
<td>One-Half Principal Sum</td>
</tr>
</tbody>
</table>

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

Exceptions – AD & D benefits are not payable for any loss caused by, contributed to by, or resulting from, either directly or indirectly;
1. bodily or mental illness;
2. medical or surgical treatment of an illness or disease;
3. participation in, or the result of participation in, the commission of an assault, or a felony, or a riot or insurrection;
4. war or any act of war, declared or undeclared, or any act related to war or insurrection;
5. ptomaine or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound;
6. intake of any drug, medication or sedative, unless taken as prescribed by a physician, or the intake of any alcohol in combination with any drug, medication or sedative;
7. suicide or attempted suicide while sane or insane;
8. intentional self-inflicted injury;
9. competing or practicing for competition in a car, motorcycle, moped or speed boat or other vehicular race;
10. travel or flight in or descent from any kind of aircraft as a passenger, pilot, crew member or participant in training that is owned, operated, or leased by or on behalf of your employer or the armed forces;
11. parachuting, skydiving, bungee cord jumping, flying, ballooning, hang-gliding, skydiving, parasailing, or any other aeronautic activities except as a fare paying passenger on a commercial aircraft;
12. travel or flight as pilot or crew member in any kind of aircraft including, but not limited to a glider, a seaplane, or a hang kite;
13. use of alcohol, non-prescriptive drugs such as PCP (also known as “angel dust”), LSD or any other hallucinogens, cocaine, heroin or any other narcotics, amphetamines or other stimulants.
WEEKLY ACCIDENT AND SICKNESS
(Employee Only)

Benefits
If you are an employee covered for Weekly Accident and Sickness Benefits and are Totally Disabled as certified by a Physician, the Plan will pay up to the Weekly Benefit shown in the Schedule of Benefits.

Before benefits begin, you must be continuously and Totally Disabled during the Waiting Period. Benefits will then begin on the first day after the Waiting Period. Weekly Accident and Sickness benefit payments will continue until the earlier of: (1) the date you are no longer Totally Disabled, or (2) when you have received benefits for the Maximum Benefit Period set forth in the Schedule of Benefits.

Weekly Accident and Sickness Benefits are computed on a weekly basis. If payment is to be made for a period of less than a full week, then you will receive a proportional benefit. The amount for each day of the disability will be one-seventh of the Weekly Benefit.

The maximum benefit amount is the lesser of the maximum amount specified for your Level (1 through 5) and Plan (AA, A or D), or 75% of your hourly pay rate multiplied by your average number of hours worked for the eight weeks previous to your disability.

Period of Disability
Successive or different periods of disability, separated by less than two weeks of continuous active work at your regular occupation, will be considered as one period of disability, unless the subsequent disability is due to an Injury or Sickness entirely unrelated to the causes of the previous disability and commences after your return to active work for at least one (1) day.

Limitations and Exclusions
No benefits are payable if:
1. you are not under the direct care of a physician;
2. the injury or sickness was caused by a war or any act of war, whether declared or undeclared;
3. the disability is due to any Injury or Sickness arising out of or in the course of any employment or occupation for compensation or profit, or any Injury or Sickness compensable under any Workers’ Compensation Law or similar law;
4. your disability begins after your employment has terminated, even if you are still eligible for other coverage under the Plan;
5. for any period while you are on paid vacation; or
6. your disability results from a suicide attempt or from any intentionally self-inflicted injury.
DENTAL BENEFITS
Plan AA, Plan A and Plan D (Employee and Eligible Dependents)
   Plan B (Employee Only)

The Plan has contracted with United HealthCare Dental to establish and maintain a Dental Benefits Program. You will become eligible for this benefit based on the eligibility rules for Plan AA, A, B and D.

See the Benefits Program brochure for more information about your Dental Benefits.

VISION CARE BENEFITS
Plan AA, Plan A and Plan D (Employees and Eligible Dependents)
   Plan B and Plan C (Employees Only)

The Plan has contracted with United HealthCare Vision to provide you and your Dependents when eligible, with various vision care services. Benefits are subject to the provisions of the contract between the Plan and United HealthCare Vision.

See the Benefits Program brochure for more information about your Vision Benefits.
COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Expense Benefits provide broad and extensive coverage to help you pay the costs of most types of medical care. The Medical Expense Benefits will not pay 100% of the medical expenses that you may incur. You will be required to pay a portion of all medical expenses.

DEDUCTIBLE AMOUNT

Comprehensive Medical Benefits become payable after you have satisfied the cash deductible of eligible expenses each calendar year as set forth in the Schedule of Benefits. The deductible applies only once in any calendar year to each individual even though you may have different disabilities. Eligible expenses must be submitted to the Plan in order for your deductible to be satisfied.

ANNUAL MAXIMUM BENEFIT

The amount payable with respect to all Injuries or Sicknesses during a calendar year will be determined in part by the maximum annual benefit set forth in the Benefits Program Brochure. If a participant moves from one MED 1000 Plan to another MED 1000 Plan in a calendar year (for example, moves from Plan B to Plan A), his or her Annual Maximum Benefit for the remainder of the calendar year will be determined by subtracting eligible expenses paid under the previous MED 1000 Plan from the Annual Maximum Benefit of the current Plan of coverage.

DESCRIPTION OF BENEFITS

The Plan pays you the applicable percentage of covered medical expenses, as shown in the Schedule of Benefits, in excess of the deductible and copayment, if required.

MEDICAL EXPENSES COVERED

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

1. Hospital Care - the Room and Board charges and miscellaneous charges during a Hospital confinement, and outpatient charges if outpatient treatment is provided as an alternative to a Hospital confinement;
2. Physician Care - treatment by a Physician, whether in or out of a Hospital, for an Injury or Sickness, including diagnosis, x-ray and laboratory services, in-hospital visits or Physician’s office visits;
3. Surgical Care - Physician expenses incurred in connection with a surgical procedure, including anesthetist’s charges;
4. Nursing Services - Private duty nursing services of a registered graduate nurse (RN) or licensed practical nurse (LPN) or treatment by a licensed physical therapist;
5. Ambulance service to the Hospital or transfer between hospitals, if Medically Necessary;
6. Anesthesia, oxygen and their administration;
7. X-ray and laboratory tests;
8. Radium, radioactive isotope or similar therapy;
9. Blood or blood plasma and their administration;
10. The rental of durable medical equipment such as a hospital bed, wheelchair or crutches. This covers the rental of original equipment only, up to the purchase price of such equipment, and not replacement of such equipment. The Plan will pay a maximum of $500 per calendar year for Durable Medical Equipment for all sickness and accidents;

11. Braces, casts or splints;

12. Dental treatment for the repair or replacement within one year of injury or damage of sound natural teeth that were harmed while you were eligible, removal of tumors or cysts or extraction of impacted teeth;

13. Physician’s services provided in connection with spinal treatment, not to exceed the maximum shown in the Schedule of Benefits;

14. Outpatient surgery benefits are payable for covered surgeries and all related charges, if the surgery is performed in a Physician’s office, or as an outpatient in a Hospital or Ambulatory Surgical Facility;

15. Pregnancy related expenses, other than for elective abortions unless the mother’s life would be endangered if the fetus were carried to term;

16. Initial prosthetic devices for a loss or Injury while you are covered, and not for replacement of these devices;

17. Charges made by an Alternative Birthing Center for medical care and treatment received in connection with a birth;

18. Charges for Certified Nurse-Midwives and licensed Midwives. No benefit will be paid for the same services furnished by a Physician;

19. If you receive necessary Home Health Care Services upon the recommendation of a Physician, expenses incurred will be payable for the following services and supplies furnished in your home, not to exceed 30 days in a calendar year for
   a. part-time or intermittent home nursing care from or supervised by, a registered nurse;
   b. part-time or intermittent home health aid services;
   c. physical therapy, occupational therapy, and speech therapy; and
   d. Physician and laboratory services by or on behalf of a Hospital to the extent such items would have been covered under the Plan if the individual was confined in the Hospital or in a skilled nursing facility;

20. Room and board and miscellaneous services for an eligible stay in an Extended Care Facility but only up to a total of 30 days in each calendar year. A stay in an Extended Care Facility is covered only if
   a. the stay begins within 7 days after a Hospital stay;
   b. the stay is due to the same or related causes as the Hospital stay;
   c. a Hospital stay would otherwise be needed;

21. Charges for breast cancer screening and mammograms, as set forth in the Schedule of Benefits;

22. Charges made by a Hospice Care Facility or Hospice Care Agency;

23. Charges for hospital emergency room care for treatment of an Injury or Sickness within 24 hours, subject to the co-payment set forth in the Schedule of Benefits;

24. Hospital outpatient care for a Sickness;

25. Pre-admission Tests or Exams - Exams made before you enter the Hospital for inpatient surgery, when
COMPREHENSIVE MEDICAL BENEFITS (continued)

a. the tests or exams pertain to the planned surgery and are ordered by a Physician;
b. the Physician requests Hospital admission for surgery and the Hospital confirms the request; and
c. the Hospital admits the covered individual within 7 days after the test or exam results are known. The 7-day rule will be waived if
   i. the planned Hospital stay is canceled; or
   ii. a change in the person’s condition precludes the need for surgery;

26. In compliance with the Women’s Health and Cancer Rights Act of 1998, this Plan provides medical and surgical benefits in connection with a mastectomy for certain reconstructive surgery. If, while covered under this Plan, a participant or beneficiary undergoes a mastectomy and elects breast reconstruction, coverage in a manner determined in consultation with the attending physician and patient will be provided for
   a. reconstruction of the breast on which the mastectomy was performed;
   b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. prosthesis and treatment of physical complications at all states of the mastectomy, including lymphedema.

The coverage provided by the Plan is subject to the Plan’s annual deductibles, coinsurance provisions and annual maximums;

27. Charges incurred for care provided to a newborn infant while still in the Hospital. Under Federal law, the Plan may not restrict benefits for any Hospital stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. However, a mother and her physician may agree to discharge the mother (and infant) after a shorter Hospital stay than those described above;

28. Preventive Care, when services are obtained by a PPO provider. Covered preventive care charges are:
   a. Well baby care;
   b. Childhood immunizations;
   c. Mammogram, once every five (5) years for women under age 40 and once every year for women over age 40;
   d. Annual pap tests;
   e. Adult physical exam;
   f. Prostate screening;
   g. Annual cholesterol screening;
   h. Colonoscopy;

29. Prescription drugs when:
   a. such medication is necessary for the treatment of an acute medical condition; and
   b. the participant or eligible dependent is not able to obtain the medication from a Kroger Pharmacy through the Kroger discount drug program.
ELIGIBILITY RULES
Plan AA

How to Become Eligible
1. You will become eligible for Plan AA benefits if:
2. You have at least 36 consecutive calendar months of employment with your employer; and
3. You work the minimum number of hours in a calendar month(s). See the following sections on Initial Eligibility and Continuing Eligibility and Hour Bank for rules concerning hours worked;
4. You are actively at work the day you become eligible for Plan AA benefits;
5. You must have met Plan AA eligibility requirements prior to March 1, 1998.

Initial Eligibility
If you are not currently eligible for Plan AA coverage, you can become eligible by completing 36 consecutive months of employment and, in the 34th and 35th months work at least 276 hours. Your coverage under Plan AA will commence on the first day of the second month following that two month period, but not before the first day of the 37th month.

You must have met the eligibility requirements for Plan AA before March 1, 1998 to be eligible for Plan AA. You must meet the Initial Eligibility requirements for Plan AA to reenter Plan AA.

Initial Eligibility for Dependents
Your dependents’ eligibility for Plan AA Life benefits, Medical benefits, Dental benefits and Vision Care benefits is determined by your eligibility for Plan AA benefits.

Continuing Eligibility and Hour Bank
After you become eligible for Plan AA, all Hours worked and reported in excess of 138 per month shall be credited to an Hour Bank account established and maintained on your behalf. You will continue to be eligible for Plan AA coverage during any month in which the Hours reported for the corresponding eligibility month, including any Hours withdrawn from your Hour Bank, equal at least 138. If you work less than the required minimum number of hours to maintain Plan AA eligibility, including hours withdrawn from your Hour Bank, if available in your Bank, you may be eligible for Plan A or Plan B benefits if you meet the minimum number of hours required for Plan A or Plan B medical benefits. You must meet the Initial Eligibility requirements for Plan AA in order to reenter Plan AA.

Continuing Eligibility During Disability
After you become eligible, if you are unable to work because of a certified disability, the Plan will continue your eligibility for benefits without charging your Hour Bank for up to the Accident and Sickness Maximum Benefit Period during periods of time lost due to Illness or Injury (on or off the job). A certified disability is one for which the Participant is
ELIGIBILITY RULES (continued)

Plan AA

being paid Weekly Accident and Sickness benefits through the Plan or submits evidence of receiving Workers’ Compensation benefits as the result of a disability incurred while performing work for which Contributions were paid to the Plan. **In no case will benefits continue beyond your Plan’s maximum period shown in your Schedule of Benefits unless COBRA Continuation of Medical Coverage is elected.**

Skip Month Eligibility
For purposes of determining eligibility, hours worked for a month shall be used to determine your eligibility status two months after the work month. For example, the 138 Hours reported for November will provide eligibility for January.

Hour Bank Maximum
The maximum number of hours that will be allowed to accumulate in any individual’s Plan AA Hour Bank will be 137.

Termination of Eligibility
Your eligibility for plan AA benefits will terminate on:
1. The date your employment with your participating employer terminates;
2. The date you enter the Armed Forces of the United States on full-time active duty;
3. The date you become eligible for Plan A or Plan B benefits; or
4. The date you elect in writing on the forms provided by the Plan Administrative Manager to decline or refuse all coverages provided by the Plan.

Your dependents’ eligibility for benefits will terminate on:
1. The date your eligibility for benefits as a Participant terminates (Death benefits, Dental, Vision Care and Medical benefits); or
2. The date you elect in writing on the forms provided by the Plan Administrative Manager to decline or refuse all coverages provided by the Plan.
ELIGIBILITY RULES (continued)

Plan A

How to Become Eligible For Employees hired before October 1, 2000
You will become eligible for Plan A benefits if:
1. You have at least six (6) consecutive calendar months of employment with your participating employer; and
2. You work the minimum number of hours in a calendar month(s). See the following sections on Initial Eligibility and Continuing Eligibility and Hour Bank for rules concerning hours worked;
3. You are actively at work on the day you become eligible for Plan A benefits.

How to Become Eligible For Employees hired after October 1, 2000 and before May 19, 2002
You will become eligible for Plan A benefits if:
You have at least twelve (12) consecutive calendar months of employment with a participating employer; and
1. You work the minimum number of hours in a calendar month(s). See the following sections on Initial Eligibility and Continuing Eligibility and Hour Bank for rules concerning hours worked;
2. You are actively at work on the day you become eligible for Plan A benefits.

How to Become Eligible For Employees hired on or after May 19, 2002
You will become eligible for Plan A benefits if:
You have at least twenty-four (24) consecutive calendar months of employment with a participating employer; and
1. You work the minimum number of hours in a calendar month(s). See the following sections on Initial Eligibility and Continuing Eligibility and Hour Bank for rules concerning hours worked;
2. You are actively at work on the day you become eligible for Plan A benefits.

Initial Eligibility
If you are not currently eligible for Plan A coverage, you can become eligible by completing the required number of consecutive months of employment, 6 months if hired before October 1, 2000, 12 months if hired after October 1, 2000 or 24 months if hired after May 19, 2002 and, in the 4th and 5th months work at least 240 hours if hired before October 1, 2000 or, if hired after October 1, 2000 work at least 240 hours in the 10th and 11th months, or if hired after May 19, 2002 work at least 240 hours in the 22nd and 23rd months. Your coverage under Plan A will commence on the first day of the second month following that two month period, but not before the first day of the 7th month if hired before October 1, 2000 or the 13th month if hired after October 1, 2000, or the 25th month if hired after May 19, 2002.

Initial Eligibility for Dependents
Your dependents’ eligibility for Plan A Life benefits, Medical benefits, Dental benefits and Vision Care benefits is determined by your eligibility for Plan A benefits.
ELIGIBILITY RULES (continued)

Plan A

Continuing Eligibility and Hour Bank
After you become eligible for Plan A, all Hours worked and reported in excess of 120 per month shall be credited to an Hour Bank account established and maintained on your behalf. You will continue to be eligible for Plan A coverage during any month in which the Hours reported for the corresponding eligibility month, including any Hours withdrawn from your Hour Bank, equal at least 120. If you work less than the required minimum number of hours to maintain Plan A eligibility, you may be eligible for Plan B benefits if you meet the initial eligibility requirements for Plan A in order to reenter Plan A.

Continuing Eligibility During Disability
After you become eligible, if you are unable to work because of a certified disability, the Plan will continue your eligibility for benefits without charging your Hour Bank for up to the Accident and Sickness Maximum Benefit Period during periods of time lost due to Illness or Injury (on or off the job). A certified disability is one for which the Participant is being paid Weekly Accident and Sickness benefits through the Plan or submits evidence of receiving Workers’ Compensation benefits as the result of a disability incurred while performing work for which Contributions were paid to the Plan. In no case will benefits continue beyond you Plan’s maximum period shown in your Schedule of Benefits unless COBRA Continuation of Medical Coverage is elected.

Skip Month Eligibility
For purposes of determining eligibility, hours worked for a month shall be used to determine your eligibility status two months after the work month. For example, the 120 Hours reported for November will provide eligibility for January.

Hour Bank Maximum
The maximum number of hours that will be allowed to accumulate in any individual’s Plan A Hour Bank will be 119.

Termination of Eligibility
Your eligibility for benefits will terminate on:
1. The date your employment with your participating employer terminates;
2. The date you enter the Armed Forces of the United States on full-time active duty;
3. The date you become eligible for Plan AA or Plan B benefits; or
4. The date you elect in writing on the forms provided by the Plan Administrative Manager to decline or refuse all coverages provided by the Plan.

Your dependents’ eligibility for benefits will terminate on:
1. The date your eligibility for benefits as a Participant terminates (Death benefits, Dental, Vision Care and Medical benefits); or
2. The date you elect in writing on the forms provided by the Plan Administrative Manager to decline or refuse all coverages provided by the Plan.
ELIGIBILITY RULES (continued)
Plan B

How to Become Eligible For Employees hired before May 19, 2002
You will become eligible for Plan B Life benefits on the first day of your first month of employment.

You will become eligible for Plan B Life and Medical and benefits if:
1. You have at least 3 consecutive calendar months of employment with your participating employer; and
2. You work the minimum number of hours in a calendar month(s). See the following sections on Initial Eligibility and Continuing Eligibility for rules concerning hours worked;
3. You are actively at work on the day you become eligible for Plan B benefits.

How to Become Eligible For Employees hired on or after May 19, 2002
You will become eligible for Plan B benefits if:
You have at least twenty-four (24) consecutive calendar months of employment with a participating employer; and
1. You work the minimum number of hours in a calendar month(s). See the following sections on Initial Eligibility and Continuing Eligibility for rules concerning hours worked;
2. You are actively at work on the day you become eligible for Plan B benefits.

Initial Eligibility
If you are not currently eligible for Plan AA or Plan A coverage, you can become eligible for the Life benefits on the first day of employment. There is no minimum hours required.

If you worked a total of at least 64 hours in two consecutive months and have completed three (3) consecutive months of employment, you can become eligible for additional benefits on the first day of the second month following that two month period, but not before the first day of the fourth month.

Continuing Eligibility During Disability
After you become eligible, if you are unable to work because of a certified disability, the Plan will continue your eligibility for benefits without charging your Hour Bank for up to one month of time lost due to Illness or Injury (on or off the job). A certified disability is one for which the Participant submits evidence of a disability that does not allow him or her to work or evidence of receiving Workers’ Compensation benefits as the result of a disability incurred while performing work for which Contributions were paid to the Plan. In no case will benefits continue beyond one month unless COBRA Continuation of Medical Coverage is elected.
ELIGIBILITY RULES (continued)
Plan B

Skip Month Eligibility
For purposes of determining eligibility, hours worked for a month shall be used to determine your eligibility status two months after the work month. For example, the 32 Hours reported for November will provide eligibility for January.

Termination of Eligibility
Your eligibility for benefits will terminate on:
1. The date your employment with your participating employer terminates;
2. The date you enter the Armed Forces of the United States on full-time active duty;
3. The date you become eligible for Plan AA or Plan A benefits; or
4. The date you elect in writing to waive all benefits on forms provided by the Trustees.
How to Become Eligible
You will become eligible for Plan C Life benefits on the first day of employment.

You will become eligible for Plan C, Medical benefits if:
1. You have at least 3 consecutive calendar months of employment with a participating employer; and
2. You work the minimum number of hours in a calendar month(s). See the following sections on Initial Eligibility and Continuing Eligibility or rules concerning hours worked;
3. You are actively at work on the day you become eligible for Plan C benefits.

Initial Eligibility
If you are hired on or after May 19, 2002, you can become eligible for the Life Insurance benefits on the first day of employment. You must work a minimum of 60 hours each month to maintain the Life Insurance benefits.

If you worked a total of at least 120 hours in the last two consecutive months and have completed three (3) consecutive months of employment, you can become eligible for additional benefits on the first day of the second month following that two month period.

If you continue to work a minimum of 60 hours per month, and work 12 consecutive months, you become eligible for Vision Care benefits on the first day of your thirteenth month of employment.

Continuing Eligibility and Hour Bank
Plan C does not have an Hour Bank provision. You will continue to be eligible for Plan C coverage during any month in which the Hours reported for the corresponding eligibility month equal at least 60. If you do not meet the Continuing Eligibility rules for Plan C, you must again meet the Initial Eligibility requirements for Plan C medical coverage in order to reenter Plan C medical coverage.

Continuing Eligibility During Disability
After you become eligible, if you are unable to work because of a certified disability, the Plan will continue your eligibility for benefits for up to one month of time lost due to Illness or Injury (on or off the job). A certified disability is one for which the Participant submits evidence of a disability that does not allow him or her to work or evidence of receiving Workers’ Compensation benefits as the result of a disability incurred while performing work for which Contributions were paid to the Plan. In no case will benefits continue beyond one month unless COBRA Continuation of Medical Coverage is elected.

Skip Month Eligibility
For purposes of determining eligibility, hours worked for a month shall be used to determine your eligibility status two months after the work month. For example, the 60 Hours reported for November will provide eligibility for January.
Termination of Eligibility
Your eligibility for benefits will terminate on:
1. The date your employment with your participating employer terminates;
2. The date you enter the Armed Forces of the United States on full-time active duty;
3. The date you become eligible for Plan AA or Plan A benefits; or
4. The date you elect in writing to waive all benefits on forms provided by the Trustees.
ELIGIBILITY RULES (continued)
Plan D
For Employees hired on or after May 19, 2002

How to Become Eligible
You will become eligible for Plan D benefits if:
1. You have at least twelve (12) consecutive calendar months of employment with a participating employer and;
2. You work the minimum number of hours in a calendar month(s). See the following sections on Initial Eligibility and Continuing Eligibility and Hour Bank for rules concerning hours worked;
3. You are actively at work on the day you become eligible for Plan D benefits.

Initial Eligibility
If you are not currently eligible for Plan D coverage, you must work a total of 240 hours in the last two (2) consecutive months to become eligible. Your coverage under Plan D will commence on the first day of the second month following that two month period. However, in no event can you become initially eligible prior to the first day of the thirteenth consecutive month of employment.

Initial Eligibility for Dependents
Your dependents’ eligibility for Plan D Life benefits, Medical benefits, Vision benefits and Dental benefits, is determined by your eligibility for Plan D benefits.

Continuing Eligibility and Hour Bank
After you become eligible for Plan D, all Hours worked and reported in excess of 120 per month shall be credited to an Hour Bank account established and maintained on your behalf. You will continue to be eligible for Plan D coverage during any month in which the Hours reported for the corresponding eligibility month, including any Hours withdrawn from your Hour Bank, equal at least 120. If you work less than the required minimum number of hours to maintain Plan D eligibility, you may be eligible for Plan C benefits if you meet the minimum number of hours required for Plan C medical benefits. You must meet the Initial Eligibility requirements for Plan D in order to reenter Plan D.

Continuing Eligibility During Disability
After you become eligible, if you are unable to work because of a certified disability, the Plan will continue your eligibility for benefits without charging your Hour Bank for up to the Accident and Sickness Maximum Benefit Period during periods of time lost due to Illness or Injury (on or off the job). A certified disability is one for which the Participant is being paid Weekly Accident and Sickness benefits through the Plan or submits evidence of receiving Workers’ Compensation benefits as the result of a disability incurred while performing work for which Contributions were paid to the Plan. In no case will benefits continue beyond your Plan’s maximum period shown in your Schedule of Benefits unless COBRA Continuation of Medical Coverage is elected.
Skip Month Eligibility
For purposes of determining eligibility, hours worked for a month shall be used to determine your eligibility status two months after the work month. For example, the 120 Hours reported for November will provide eligibility for January.

Hour Bank Maximum
The maximum number of hours that will be allowed to accumulate in any individual’s Plan D Hour Bank will be 119.

Termination of Eligibility
Your eligibility for benefits will terminate on:
1. The date your employment with your participating employer terminates; or
2. The date you enter the Armed Forces of the United States on full-time active duty; or
3. The date you become eligible for Plan AA or Plan A benefits;
4. The date you elect in writing to waive all benefits on forms provided by the Trustees.

Your dependents’ eligibility for benefits will terminate on:
1. The date your eligibility for benefits as a Participant terminates (Death benefits, Dental, Vision Care and Medical benefits); or
2. The date you elect in writing on the forms provided by the Plan Administrative Manager to decline or refuse all coverages provided by the Plan.
GENERAL ELIGIBILITY RULES

Continuing Eligibility During Family or Medical Leave
If you qualify, the Family and Medical Leave Act of 1993 (FMLA) permits you to take up to twelve weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child. The law requires employers who meet specific requirements to maintain health care coverage for their employees and eligible dependents during a qualified period. If you qualify and take a leave, your employer must contribute to this benefit program on your behalf during your approved leave. If you think this law may apply to you, please contact your employer. Any disputes over your eligibility for a FMLA leave is between you and your employer.

In the event that the Plan provides for a contribution by you for a portion of the total contributions, then you remain obligated to make payment of such co-contributions which are due during the period of qualified leave.

Reinstatement of Eligibility
If you are no longer eligible for benefits under Plan AA, Plan A or Plan D due to insufficient Hours worked, including those supplemented by your hour bank, the remaining hours in the Hour bank will be retained for up to three (3) months from the last month of your eligibility and used, along with hours actually worked, in determining eligibility. If you do not work sufficient hours, with those supplemented by your hour bank, to become eligible during this three month period of time, you will forfeit all hours in your hour bank and again be required to meet the initial eligibility requirements of the Plan.

If your status as a participant terminates because of entrance into full-time military service, upon leaving military service you shall resume being a participant in the same eligibility status and with the same hour bank credit, if any, as of the date you entered military service, provided you return to work within 90 days from date of discharge or within 90 days following recovery from a disability continuing since discharge. If you do not meet the above requirements, you shall forfeit all hours credited to your hour bank account.

1) Eligibility for Additional Coverages
Your eligibility for additional Life and Accidental Death and Dismemberment (AD&D) insurance, additional Dependent Life Insurance (does not apply to Plan B or Plan C Participants) and additional Accident and Sickness benefits (does not apply to Plan B or Plan C Participants) is determined by:

1. Your eligibility for either Plan AA, Plan A or Plan D; and
2. Your written election of the additional coverages on the forms provided when you are initially eligible; or
3. Your written election of the additional coverages during the annual open enrollment period; and
4. Your timely contribution, in an amount determined by the Trustees, through payroll deduction, or in certain circumstances when payroll deduction cannot be made, such as illness that keeps you from working, a direct payment of the contribution amount directly to the Plan Administrative Manager.

The required contribution will provide eligibility effective the first day of the second month following the month in which the contribution is payroll deducted or remitted directly to the Administrative Manager.
GENERAL LIMITATIONS

Limitations that apply only to certain services have been described in the appropriate sections. In general, no benefits are payable for charges:

1. for treatment that is not medically necessary;
2. for cosmetic surgery, unless it is performed as soon as medically feasible and is needed for:
   a. repair of an Injury received while you are covered under this plan;
   b. reconstruction that is incidental to or follows surgery resulting from an Injury or Sickness;
   c. correction of a congenital defect that results in a functional defect of an Eligible Dependent Child; or
   d. correction of a normal bodily function needing repair as a result of an Injury or Sickness.
   Treatment of an Injury must begin within 90 days of the date of the accident in order to be eligible;
3. for dental care or treatment, except as otherwise provided;
4. for hearing aids or the fitting thereof, or eye care for or in connection with:
   a. exams to determine the need or changes of eyeglasses or lenses of any type, except initial replacements for loss of the natural lens; or
   b. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring);
5. for transportation, except local ambulance service, as otherwise provided;
6. incurred prior to the effective date or subsequent to the termination date of your coverage;
7. for services or supplies in connection with a service related disability in a Service Facility or Veteran’s Administration Hospital owned or operated by the U.S. Government, unless otherwise required by law;
8. for an elective abortion unless the mother’s life would be endangered if the fetus were carried to term and excluding any complications that are the result of an elective abortion;
9. in connection with any intentional self-inflicted Injury unless the result of a medical condition (medical conditions include physical or mental conditions);
10. in connection with any Injury or Sickness arising out of or in the course of any employment or occupation for compensation or profit, or any Injury or Sickness compensable under any Workers’ Compensation Law or similar law;
11. as a result of an Injury or Sickness caused by war, or by any act of war, declared or undeclared, or by participating in a riot or as the result of participation in the commission of a felony;
12. in excess of the Reasonable and Customary Charge or Charges for unnecessary care or treatment;
13. for which no charge is made that you are required to pay;
14. for service, supplies or treatment in connection with or related to trans-sexuality or reverse sterilization or any attempt of these procedures;
15. for any treatment, surgical procedure, facility, equipment, drugs, drug usage or supplies requiring Federal or other governmental agency approval that:
   a. is not granted at the time the services are rendered; or
   b. is determined to be experimental or not accepted medical practice;
16. for a weight control program or treatment of obesity;
17. for Custodial Care, for services provided by a rest home, home for the aged, nursing home, residential care facility, or any other similar facility that is primarily for custodial care;
GENERAL LIMITATIONS (continued)

18. made by a Physician, registered nurse, licensed practical nurse or physical therapist if such person is a member of Your immediate family or resides with the person receiving treatment;
19. for any loss sustained as a result of being under the influence of a narcotic, alcohol, chemical or drug, unless prescribed by a Physician;
20. Home Health Care benefits other than services specifically included in the Home Health Care Plan. In addition, Home Health Care benefits are not payable for:
   a. any period during which you are not under the continuing care of a Physician;
   b. transportation services; or
   c. services, supplies or treatment not otherwise payable under this section;
21. in connection with any organ transplant procedures that are experimental in nature;
22. in connection with smoking cessation;
23. for personal hygiene, comfort or convenience items such as humidifiers or exercise equipment;
24. for a Pre-existing condition for which treatment was recommended or received during the 6 month period immediately prior to the first day of the eligibility waiting period prior to enrollment for medical coverage or until the date you or your dependent has been covered for benefits under this Plan for 12 consecutive months, including the eligibility waiting period requirements. Credit will be given for earlier coverage. However, no crediting of previous coverage will be applied if a participant has gone for 63 days without any health care coverage;
25. for routine foot care, flat foot conditions, supportive devices for such conditions or corrective shoes;
26. for an inpatient stay when the stay is primarily for a behavioral problem, social maladjustment or any other antisocial action;
27. in connection with sexual dysfunction, impotence or infertility treatment or procedures;
28. for any prescription medicine administered or dispensed by a physician or nurse in a physician's office;
29. for a failure to keep a scheduled visit;
30. for any loss in excess of $20,000 sustained while operating or as a passenger on a motorcycle, all terrain vehicle or cycle (3 or 4 wheels), snowmobile, any motorized vehicle that does not require a license, or jet skis;
31. to the extent that you are entitled to receive benefits under any governmentally mandated no-fault motor vehicle insurance;
32. for non-prescription medicines, oral contraceptives, vitamins, nutrients and food supplements, even if prescribed by a physician;
33. treatment of temporomandibular joint disorder or dysfunction by surgery of the temporomandibular joint or mandible, intra-oral prosthetic devices, orthodontics, dental splints or extractions, or any other means, regardless of medical necessity;
34. charges received in the Administrative Manager's office more than 1 year after they were incurred;
35. charges incurred for treatment outside of the United States or Puerto Rico;
36. for which you did not complete and file the Fund’s Medical Statement of Claim (Claim Form) when requested by the Fund; or
37. charges for prescription drugs except for those prescriptions prescribed and dispensed as part of an inpatient hospital stay; or if the participant or eligible dependent is not able to obtain the medication from a Kroger Pharmacy through the Kroger discount drug program.
COORDINATION OF BENEFITS

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

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

**Other Plan** means any policy, contract, or other arrangement to pay the cost of hospitalization, medical, surgical, prescription drug, dental, or vision care. This includes:
1. group or blanket insurance including no-fault automobile insurance, but excluding school accident insurance;
2. any Blue Cross/Blue Shield and other prepayment coverage provided on a group basis;
3. coverage under any labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, and professional association plans;
4. coverage under governmental programs, and any coverage required or provided by any statute; and
5. hospital and medical benefits under Social Security (Medicare), or any other arrangements of insured or self-insured group coverage.

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

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

**EFFECT ON BENEFITS**
The effect on benefits is that the amount of covered expense that would otherwise be payable under this Plan may be reduced if benefits are payable under any other plan for the same expenses.

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

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

2. The benefits of Plans that cover the Individual as an employee will pay its benefits before the plan that covers the person as a dependent.
3. The Plans covering the Individual as a Dependent of a parent whose birthday (excluding year of birth) falls earlier in the calendar year pays before the Plans of the parent whose birthday (excluding year of birth) falls later in the calendar year. If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

4. In situations of divorce, separation and/or divorce and remarriage, benefits for a Dependent child shall be determined as follows:
   a. when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of Other Plans that cover the child as a Dependent of the parent with custody of the child shall be determined before the benefits of Other Plans that cover the child as a Dependent of the parent without custody;
   b. when the parents are divorced and the parent with custody of the child has remarried, the benefits of Other Plans that cover the child as Dependent of the parent with custody shall be determined before the benefits of Other Plans that cover the child as a Dependent of the step-parent, and the benefits of Other Plans that cover the child as a Dependant of the step-parent shall be determined before the benefits of Other Plans that cover the child as a Dependent of the parent without custody.

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

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

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

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

Disabled Employees Under 65 - Medicare Benefits Secondary
If you are under 65, and eligible for Medicare by reason of disability, Medicare will provide Secondary coverage and the Plan will be Primary.

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

IDENTIFICATION CARD - After you become initially eligible, the Administrative Manager will issue you an Identification Card which should be kept in your possession at all times so that when hospitalization is necessary, the card can be presented at the admissions desk.

PLEASE REPORT CHANGES PROMPTLY
IT IS IMPORTANT THAT YOU NOTIFY THE ADMINISTRATIVE MANAGER WHENEVER:

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

HOW TO FILE A CLAIM - In order to assure yourself of the fastest possible service, all claims should be reported to the Administrative Manager, as soon as possible. For care received by Participating Providers, those Participating Providers will file your claims for you. The Administrative Manager will furnish you with the claim forms necessary for filing a medical claim and Accident and Sickness claims, or whenever a claim form is required.

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

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

2. Have your Physician complete the Physician’s portion of the claim form and sign his or her name.

3. Obtain itemized Hospital bills and Physician bills which set forth all of the services and treatments received.

4. Forward the completed claim form with substantiating bills to the Administrative Manager’s address listed in the front of this booklet.

NOTICE OF CLAIM
Written Notice of Claim, including necessary information as requested by the Administrative Manager, must be given to the Administrative Manager within 12 months after a loss. Failure to give written notice, including additional information as requested by the Administrative Manager, within the time specified above will invalidate the claim.

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

PROOF OF LOSS - Written proof of loss must be furnished to the Administrative Manager within 90 days following the date of the loss for which claim is made. Late proof may be accepted only if, under the particular circumstances, it was furnished as soon as was reasonably possible. In no event, except in the absence of an Employee’s legal capacity, will proof be accepted after one year from the time of the date of loss.
GENERAL INFORMATION (continued)

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

ASSIGNMENT OF BENEFITS - All benefits will be payable to you, unless you specifically assign them. Only medical and dental benefits may be assigned.

In the event that you wish to assign your medical benefits, the check will be sent directly to the Hospital or Physician instead of to you. To assign benefits, complete the assignment section of the claim form or special forms Your Physician or Hospital may provide.

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

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

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

(ii) DECIDING THE CLAIM A claim is a request for a plan benefit made by a claimant on a form provided by the Plan, or in the case of an urgent care claim either orally or on such a form. A claimant is a person who participates or claims to participate in the Plan. For such a form to be considered, the claimant must mail or deliver it, completed and executed, to the Plan Administrator at the following address:

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

For an urgent care claim to be considered, it must be communicated in writing as provided above, or by phone to the Plan Administrator or Administrative Manager using this phone number:

1-800-842-5899
The Plan Administrator shall decide the claim. None of the following constitutes a claim:

1. The presentation of a prescription to a pharmacy to be filled at a cost to the participant determined by reference to a formula or schedule established in accordance with the terms of the Plan and with respect to which the pharmacy exercises no discretion on behalf of the plan;
2. A request for prior approval of a benefit or service when the prior approval is not required under the terms of the Plan; or
3. Interactions between participants and PPO providers under arrangements by which the providers provide services or products at a predetermined cost to participants and with respect to which the providers exercise no discretion on behalf of the Plan.

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

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

Except as provided below, whether a claim is a “claim involving urgent care” is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care,” shall be treated as a “claim involving urgent care.” The nature of a claim or a request for review of an adverse benefit determination shall be judged as of the time the claim or review is being processed. If requested services have already been provided between the time the claim was denied and the request for review was filed, the claim no longer involves urgent care. The Plan Administrator may request specific information from the claimant regarding whether and what medical circumstances exist that may give rise to a need for expedited processing of the claim. A post-service claim never constitutes a claim involving urgent care. In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan’s benefit determination (whether adverse of not) as soon as possible, taking into account the medical requirements, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator shall notify the claimant of the Plan’s benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan’s receipt of the specified information, or the end of the period afforded the claimant to provide the specified additional information.
GENERAL INFORMATION (continued)

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

Failure to Follow Pre-Service Claim Procedures. In the case of a failure by a claimant to follow the Plan’s procedures for filing a pre-service claim, the claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant. This subsection shall apply only in the case of a failure that:

1. Is a communication by a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and
2. Is a communication that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Plan of such course of treatment (other than by an amendment of the Plan or its termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator shall notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination before the benefit is reduced or terminated. Moreover, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical circumstances, and the Plan Administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in compliance with the provisions relating to the Notification of the Decision section, which follows, and the appeal shall be governed by the Notification of the Decision on Appeal sections, which follow, as appropriate.
Post-Service Claims. The term “post-service claim” means any claim for a benefit under the Plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator shall notify the claimant of the Plan’s adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary, due to a failure of a claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

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

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

Notification of the Decision. The Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by regulation issued by the Department of Labor under ERISA. The notification shall set forth in a manner calculated to be understood by the claimant:
1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan provisions on which the determination is based;
GENERAL INFORMATION (continued)

3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

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

5. In the case of an adverse benefit determination,
   a. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or
   b. If the adverse benefit determination is based on a medical necessity or experimental treatment of similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

6. In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims. In the case of an adverse benefit determination concerning a claim involving urgent care, the information in this subsection may be provided to the claimant orally within the timeframe prescribed in preceding Urgent Care Claims subsection, provided that a written or electronic notification in accordance with this subsection is furnished to the claimant not later than three days after the oral notification.

Authorized Representative. An authorized representative of the claimant may act on his or her behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan Administrator may require, as a prerequisite to dealing with a representative, that the claimant verify in writing authority of the representative to act on behalf of the claimant.

In the case of a claim involving urgent care, a physician or other health care professional licenses, accredited or certified to perform specified health services consistent with State law, with knowledge of the claimant’s medical condition, may act as the authorized representative of the claimant. An assignment of benefits by a claimant to a health care provider does not constitute the designation of an authorized representative.

Consistency. The Trustees, the Plan Administrator, or both, shall conduct or have conducted on their behalf periodic reviews to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the Plan’s provisions have been applied consistently with respect to similarly-situated claimants.

Deciding the Appeal. A claimant may appeal an adverse benefit determination to the Trustees by mailing or delivering to the Plan Administrator a written notice of appeal. The claimant may submit written comments, documents, records, or other information relating to the claim for benefits to the Plan Administrator. The Plan Administrator shall provide to the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits.
Whether a document, record or other information is relevant to a claim for benefits shall be determined in accordance with standards issued by the Department of Labor. The Trustees shall decide the appeal. In cases where an issue of medical necessity is decided by the utilization review provider, the provisions dealing with appeals shall be applied, to the extent that they are more stringent or extensive than the rules set forth, by substituting the phrase “physicians” in place of the word “Trustees” wherever it appears. The Trustees’ decision shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Trustees will not, however, consider a claimant’s appeal unless the Plan Administrator receives it within 180 days following receipt by the claimant of a notification of an adverse benefit determination. The appeal will be considered by the Trustees without deference to the original decision made by the Plan Administrator.

In deciding an appeal of any adverse benefit determination where the determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Plan Administrator shall, when requested to do so by a claimant, identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Any health care professional engaged for purposes of a consultation under this subsection shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

**Appeal of Urgent Care Claims.** In the case of a claim involving urgent care:

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

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

**Notification of the Decision on Appeal; Urgent Care Claims.** In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan’s benefit determination on review as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claimant’s request for review of an adverse benefit determination by the Plan.

**Notification of the Decision on Appeal; Pre-Service Claims.** In the case of a pre-service claim that is not a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan’s benefit determination review within a reasonable period of time appropriate to the medical circumstances. That notification shall be provided not later than 30 days after receipt by the Plan of the claimant’s request for review of an adverse benefit determination.
Notification of the Decision on Appeal; Post-Service Claims. In the case of a post-service claim, The Trustees will decide a claimant’s appeal no later than the first meeting following the Plan Administrator’s receipt of the appeal, unless the Plan Administrator received the appeal within 30 days prior to that meeting, in which case the Trustees will decide the claimant’s appeal no later than the second meeting following receipt of the request for review. If special circumstances require further extension of time for processing, the Trustees will decide the appeal no later than the third meeting following receipt by the Plan Administrator of the claimant’s request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

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

1. the specific reason for reasons for the adverse determination;
2. reference to the specific plan provisions on which the benefit determination is based;
3. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant’s claim for benefits (whether a document, record, or other information is relevant to a claim for benefit shall be determined by reference to regulations issued under ERISA by the Department of Labor);
4. a statement of the claimant’s right to bring an action under Section 502 (a) of ERISA;
5. If an internal rule, guideline, protocol or similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such rule, guideline, protocol or similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as a mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.”
Calculating Time Periods on Appeal. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be started on the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Extension of Time. A claimant may voluntarily agree to provide the Plan additional time within which to make a decision on a claim or an appeal.

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

PATIENT-PHYSICIAN RELATIONSHIP - You and your eligible Dependents will have free choice of any physician, dentist, chiropractor or nurse - midwives practicing within the scope of their license. The Plan will in no way disturb the patient-physician relationship.

ALTERED OR FORGED CLAIM FORMS - Any claim form submitted by or on your behalf that contains a material alteration or forged information, will be rejected by the Plan.

RIGHT TO RECEIVE INFORMATION - If you file a claim for benefits under this Plan, you may be required to furnish to the Plan such information as is necessary to process your claim.

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

SAVINGS CLAUSE - Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Plan.

CONSTRUCTION - All questions of interpretation of the Plan provisions shall be decided exclusively by the Trustees in their sole discretion under the express authority granted to them by the Trust Agreement of the United Food & Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan. The Trustees shall be the sole arbiter of questions of eligibility and the amounts of benefits. This Fund is intended to comply with the terms and conditions of the Trust Agreement of United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan MED-1000 Plan.
GENERAL INFORMATION (continued)

NOTICE NO FUND LIABILITY - The use of the services of any hospital, clinic, doctor, dentist, podiatrist, optician or any other person or establishment rendering health care or services whether specifically designated by the Fund or otherwise (hereinafter referred to as “provider”) under the Plan is the VOLUNTARY ACT of the EMPLOYEE AND/OR HIS or HER DEPENDENT. Some benefits may only be obtained from providers designated by the Plan. In such situations, the designation is not meant to be a recommendation or instruction to use such provider. An Employee and/or his Dependent should select a provider or course of treatment based on all appropriate factors, only one of which is coverage under the Plan. Said providers are independent contractors, not employees of the Plan.

The Plan and Fund make no representation regarding the quality of service or treatment provided by any provider and ARE NOT RESPONSIBLE FOR ANY ACTS OF COMMISSION OR OMISSION OF ANY PROVIDER in connection with the services or treatments provided herein. THE PROVIDER IS SOLELY RESPONSIBLE for the services and treatments to be rendered under this Plan.

WORKER’S COMPENSATION - Benefits under this Plan are not in lieu of nor do they affect any requirements for worker’s compensation insurance.
SUBROGATION AND RESTITUTION

The Plan has no obligation to pay benefits if a third party may be financially responsible for any damages, including medical expenses, arising from an accident, injury or sickness. If a third party is withholding payment of your claim pending investigation or legal action, you may request that the Plan pay the standard benefits to which you would be entitled if no third party liability existed.

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

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

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

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

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

If you recover any damages from an Uninsured/Underinsured Motorist Policy or your own homeowner’s insurance policy, the proceeds of that policy are subject to the same lien and trust as any proceeds you recovered from the third party. The first priority lien applies to the proceeds from such policy, and you also hold these proceeds in trust for the exclusive benefit of the Plan. Any recovery will be presumed to be recovery for medical expenses, regardless of allocation.
Pursuant to the above lien and trust, your obligation to repay the Plan for any benefits you received takes first priority over your other claims against the third party. This priority applies regardless of whether the recovery from the third party fully compensates you for all claims or whether you have been “made whole.” The “make whole” doctrine does not apply to this provision. Your obligation to repay the Plan from any recovery also takes first priority over any deduction from the recovery for attorney’s fees or costs of litigation unless otherwise agreed by the Plan in writing.

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

In the event you fail to fully cooperate with the Plan in accordance with this provision, the Plan may deny and/or cease paying benefits related to the injury, and all amounts previously paid by the Plan will immediately become due and payable to the Plan. A violation of this provision constitutes a violation of the Plan, and the Plan has the right to seek equitable relief to enjoin such violation and/or submit the matter to binding arbitration as more specifically described in the Subrogation/Restitution Agreement that you will be required to execute.
Federal law mandates that group plans provide individuals and their families with the option of continuing their medical coverage when there is a “qualifying event” that would result in a loss of coverage through self-payment of contributions.

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

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

1. termination of the Employee’s employment for any reason, except gross misconduct;
2. a reduction in hours worked by the Employee;
3. death of a covered Employee;
4. divorce or legal separation of the Employee and spouse;
5. a dependent child ceasing to be an Eligible Dependent, under the provisions of the Plan;
6. a Dependent ceasing to be eligible due to the Employee becoming entitled to Medicare; or
7. a proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.

NOTICE REQUIREMENTS
Notice from Contributing Employers
The Contributing Employer must notify the Plan Administrative Manager in writing within 30 days after the date of the following Qualifying Events:

1. reduction of hours and/or termination of your employment;
2. your death;
3. your eligibility for Medicare, when known; or
4. bankruptcy proceeding under Title 11, United States Code.

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

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

1. divorce or legal separation from your spouse;
2. your child ceasing to be a Dependent;
3. determination by Social Security that the person is disabled; or
4. within 30 days of the date that the covered person is determined by Social Security to no longer be disabled.
Financial Responsibility for Failure to Give Notice - If an Individual fails to give proper notice within 60 days of the date of the qualifying event, or a Contributing Employer within 30 days of the date of the Qualifying Event, and as a result, the Plan pays a claim for an Individual whose coverage terminated due to a qualifying event and who does not elect continuation of coverage under this provision, then the Individual or the Contributing Employer, as appropriate, shall be obligated to reimburse the Plan for any claims that should not have been paid. If an Individual fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that Individual.

If a Contributing Employer fails to give proper notice within 30 days of the Qualifying Event as required and, the Individual is, as a result, permitted to elect, and does elect continuation coverage more than 90 days after the date of the Qualifying Event, the Employer shall be obligated to reimburse the Plan for all claims paid by the Plan on behalf of the Individual. The Trustees, in their sole discretion, may limit the application of this subsection where it appears, based on all circumstances that the Individual would have elected continuation coverage within 90 days of the Qualifying Event had notice of the right to such an election been provided during the period.

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

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

Special COBRA rights, including a second opportunity to elect COBRA, apply to employees who have been terminated or experience a reduction of hours and who qualify for trade adjustment assistance under the Trade Act of 2002.

Under new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act-index.esp.
MAXIMUM PERIOD ALLOWED UNDER CONTINUATION COVERAGE
Up to a maximum of 18 months are allowed from the date coverage would have otherwise terminated, if coverage is being continued for you and your dependents because you ceased covered employment, including retirement, or had a reduction in hours of employment for any reason other than gross misconduct.

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

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

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

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

SELF-PAYMENT
Self-payment, if elected, must be made from the date of termination. No lapse in coverage is permitted.
1. If you elect to continue coverage within 60 days after your eligibility terminates, contributions due for the period between termination and the election date must be postmarked and sent to the Administrative Manager within 45 days after the election.
2. After the initial election and payment of contributions, subsequent payments are due at the Administrative Manager’s Office on the first day of each month. There shall be a 30-day grace period following the due date. This grace period does not apply to the first payment but only to the monthly payments thereafter. Once you are initially notified, you will not receive any further notices from the Plan or the Administrative Manager.

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

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

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

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

**TERMINATION OF COBRA COVERAGE**

(ALL INDIVIDUALS)

COBRA continuation coverage will terminate on the earliest of:

1. the first day of the month for which contribution is not paid on time;
2. the date you or the qualified beneficiary becomes covered under another employer sponsored group health plan that does not exclude or limit coverage for pre-existing medical conditions, or whose preexisting condition limitation or exclusion does not apply to you or the qualified beneficiary due to the requirements of the Health Insurance Portability and Accountability Act of 1996;
3. the date you become entitled to Medicare benefits;
4. the date that the Plan stops providing any group health plan coverage; or
5. the date the Employer is no longer a Contributing Employer and does not have a Collective Bargaining Agreement requiring contributions to the Plan.

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

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

**BENEFITS PROVIDED**

**Type of Benefit for Continuation Coverage**

The medical benefits provided to any Individual electing continuation coverage shall be the same benefits that he or she was eligible to receive on the date before the occurrence of any qualifying event. Any amendment to the Plan of Benefits adopted by the Board of Trustees applicable to active employees modifying coverage shall also apply to any person eligible for benefits under continuation coverage. However, Life, Accidental Death and Dismemberment, and Accident and Sickness Benefits shall not be available.
CONTINUATION AND REINSTATEMENT OF COVERAGE ON ACCOUNT OF QUALIFIED UNIFORMED SERVICE

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

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

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

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

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

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996

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

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

Definitions

1. **Medical Child Support Order** means any judgment, decree or order issued by a Court of competent jurisdiction which provides for child support with respect to a child of a Covered Employee under the Plan or provides for coverage to such child pursuant to state domestic relations law, or enforces a law relating to medical child support described in Section 1908 of the Social Security Act.

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

Notice of Receipt of Claim

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

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

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

Designation of Representative

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

Payment of Benefits Pending Trustees’ Decision

Pending a decision by the Board of Trustees as to whether a Medical Child Support Order is “qualified”, any amount which would be payable for benefits on behalf of such alternate recipient may be withheld.

“Qualified” Medical Child Support Order

1. Review by Legal Counsel - All Medical Child Support Orders shall be immediately submitted to legal counsel for the Fund. A legal opinion as to whether the Order is a “qualified” Medical Child Support Order within the meaning of ERISA shall be provided to the Board of Trustees within sixty (60) days, if possible.
QUALIFIED MEDICAL CHILD SUPPORT ORDERS (continued)

2. Trustees Decision – The Board of Trustees shall decide whether an Order is a “qualified” Medical Child Support no later than 120 days after receipt of the Order, unless circumstances require more time. If the Trustees decide that a Medical Child Support Order is not “qualified” the notice of denial of the claim shall be provided in the same manner as other claims are denied by the Trustees.

3. Appeal of the Trustees’ Decision – A party may file an appeal of the Trustees’ decision by filing a notice of appeal within 180 days after receipt of the Trustees’ decision. The appeal shall be governed by the Claims Review Procedure.

4. Notices – The Board of Trustees shall notify the Covered Employee, the alternate recipient or their designated representative of all Trustees’ decisions.

Trustee Responsibility

If the Trustees act in accordance with the provisions of these procedures and ERISA in treating a Medical Child Support Order as being (or not being) a qualified medical child support order, the Plan’s obligation to the Covered Employee and each alternate recipient shall be discharged to the extent of any payment made pursuant to such act of the Trustees.

Reimbursements to Alternate Recipient

Any payment for benefits made pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient or an alternate recipient’s custodial parent or legal guardian shall be made to the alternate recipient’s custodial parent or legal guardian.
INFORMATION REQUIRED BY THE EMPLOYEE 
RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

FUND NAME
United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan, also referred to as “MED 1000.”

BOARD OF TRUSTEES
A Board of Trustees is responsible for the administration of this Health and Welfare Plan. The Board of Trustees consists of an equal number of Union and Employer representatives, selected by the Union and the Employers who have entered into a collective bargaining agreement which relate to the Health and Welfare Plan. The Trustees are the Plan Administrators. The names and addresses of the Trustees are as follows:

<table>
<thead>
<tr>
<th>UNION TRUSTEES</th>
<th>EMPLOYER TRUSTEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ricky Burris</td>
<td>Paul Glenn</td>
</tr>
<tr>
<td>UFCW Local 1000</td>
<td>The Kroger Company</td>
</tr>
<tr>
<td>967 Wall Street</td>
<td>19245 David Memorial Dr.</td>
</tr>
<tr>
<td>Grapevine, TX 76051</td>
<td>Shenandoah, TX 77385</td>
</tr>
<tr>
<td>Bryan Wynn</td>
<td>Michael White</td>
</tr>
<tr>
<td>UFCW Local 1000</td>
<td>The Kroger Company</td>
</tr>
<tr>
<td>967 Wall Street</td>
<td>1014 Vine Street</td>
</tr>
<tr>
<td>Grapevine, TX 76051</td>
<td>Cincinnati, OH 45202</td>
</tr>
</tbody>
</table>

PLAN ADMINISTRATIVE MANAGER
The day to day administration of the Plan is handled by National Employee Benefits Administrators, Inc., the Administrative Manager.

IDENTIFICATION NUMBER
The number assigned to the Board of Trustees by the Internal Revenue Service is 31-1586967.

PLAN’S FISCAL YEAR END
The date of the end of the Plan year is December 31.

SOURCE OF CONTRIBUTIONS
The amount of employer contributions is determined by the provisions of its collective bargaining agreement with employee representatives. Employee payroll deductions are also a source of contributions.

AGENT FOR SERVICE OF LEGAL PROCESS
The Plan’s agent for service of legal process is:

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

Service of legal process may also be made upon a Trustee.
INFORMATION REQUIRED BY THE EMPLOYEE
RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
(continued)

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

FUND ASSETS
All assets and reserves are invested by the Board of Trustees.

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

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

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

3. In the event of termination by action of the Trustees;

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

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

6. Upon a termination of the Plan.

FILING CLAIMS
Refer to the section entitled “How to File a Claim” for information on filing claims.

APPEAL OF DENIED CLAIMS
Refer to the section entitled “Claims Review and Appeal Procedures” for information on appealing denied claims.
STATEMENT OF RIGHTS UNDER THE EMPLOYEE
RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in United Food and Commercial Workers Local 1000 and Kroger Dallas Health and Welfare Plan - MED 1000, you are entitled to certain rights and protection under ERISA which provides that all plan Participants shall be entitled to:

1. Examine, without charge, at the Administrative Managers Office and at other specified locations, all plan documents, including collective bargaining agreements; a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

3. Receive a summary of the Fund’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

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

5. 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 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 Plan benefit or exercising your rights under ERISA.

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim 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 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 fees. If you lose, the court may order you to pay these cost and fees, for example, if it finds your claim frivolous. If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N. W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.