

Optional Retiree Health Plan — Plan M

The Trustees of both the UFCW Unions and Employers Midwest Health Benefits Fund and the UFCW Unions and Employers Midwest Pension Fund, have adopted an optional health plan for retirees who are not yet eligible for Medicare. The plan provides some coverage during the time between retirement and eligibility for Medicare coverage (generally age 65). If you elect this optional coverage, you are responsible for making the monthly payment.

You also may have the right to COBRA continuation coverage of the health coverage you had as an active employee. See below under “How to Apply” for further information.

Who is Eligible

You may elect the retiree health plan for yourself and/or for your qualified dependents if:

- at the time of your termination of active employment, you were covered under one of the health plans for active employees of the UFCW Midwest Health Benefits Fund; and
- you are now receiving, or soon will be receiving, a pension from a UFCW pension fund.

Qualified dependents include only your lawful spouse of the opposite sex and your unmarried children, legally-adopted children and step-children (if both the step-child and the step-child's natural parent live with you), who are under age 19, dependent on you for more than one-half of their support and live with you in a regular parent-child relationship for more than one-half of each year, or who are otherwise specified in a Qualified Medical Child Support Order (QMCSO). Unmarried children remain eligible (1) until age 23 if they are attending school full-time (proof of student status is required) and are financially dependent on you for more than one-half of their support; or (2) as long as incapacity and dependency continue, but not beyond the date on which your coverage ends, if they are incapable of self-support due to mental retardation or physical handicap, dependent on you for more than one-half of their financial support and maintenance, and reside with you permanently and regularly for more than one-half of each year or live in a treatment center.

You are not eligible to elect this plan until you have left employment and have filed an application for immediate commencement of your pension.

Any retiree, spouse or qualified dependent who is eligible for Medicare and/or covered under any other group policy or plan as an employee is not eligible for this plan.

How to Apply

At the time you leave active employment, you have the option to continue your coverage by making self-payments under COBRA directly to the Benefits Fund Office. Contact the Billing Department at the Benefits Fund Office for COBRA information and rates. When your COBRA continuation coverage period ends, you may then apply for the retiree health coverage. Or you may apply for the retiree coverage immediately after leaving employment. If you have not yet left employment, you are not eligible to apply for the plan.

(continued on reverse)

To apply for optional retiree health coverage, complete and return the "Application for Plan M" to the Benefits Fund Office along with a check or money order for the first monthly payment:

- Retiree Only or Spouse Only Coverage\$530 per month*
- Family Coverage (retiree, spouse and any qualified dependents)\$812 per month*

**these rates are effective as of 10/01/2009*

After verification of your application, coverage will become effective on the first day of the month for which you receive, or are eligible to receive after application has been made, your first pension benefit. A physical examination is not required to obtain coverage.

Payment Methods

The monthly payment will be deducted from your pension benefit.

If you are not receiving a pension benefit from us or if the amount of your benefit is less than the monthly payment:

- you may have the payment transferred to us automatically each month by electronic deduction from your bank account. Complete and return the "Authorization Agreement for Electronic Transfer of Payment" form.
- you may send us a check or money order by the first of every month. You are responsible for making timely and accurate payments. Late payers will be terminated with no opportunity for reinstatement.

Limited Application Period

You must apply for the optional retiree health plan between the time you leave employment or stop making COBRA payments and 60 days after receipt of your first pension benefit. Your application period ends 60 days after receipt of your first pension benefit. If you do not apply before that date, you will be required to complete an "Evidence of Health Status" form. You and/or your dependents must be in "good health." Coverage must be approved by the Trustees and, if approved, may be subject to restrictions.

Termination of Coverage

Coverage will be terminated when you, your spouse or your dependent become eligible for Medicare or become covered under any other group policy or plan as an employee and/or when your dependent is no longer qualified, as defined. If only one of you becomes eligible for Medicare or another group policy or plan as an employee, the other(s) can continue the coverage until each becomes eligible for Medicare or another group policy or plan as an employee, or is no longer a qualified dependent, as defined.

In no event may you or a dependent re-enroll after termination of coverage for any reason other than your return to employment with an employer who is required to contribute on your behalf into a United Food and Commercial Workers fund.

Additional Information

If you have any questions about the coverage provided or about filing a claim for benefits, contact the Claims Office at 1300 Higgins Road, Suite 300, Park Ridge, Illinois 60068-5713, 847-384-7000 or 800-621-5133.

United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund

1300 Higgins Road # 300 ♦ Park Ridge IL 60068-5713 ♦ 847-384-7000 ♦ 800-621-5133 ♦ FAX 847-384-0197 ♦ TDD 847-384-0199

APPLICATION FOR PLAN M — OPTIONAL RETIREE HEALTH BENEFITS PLAN

For Retirees and/or Their Qualified Dependents Not Yet Eligible for Medicare

Name		UFCW ID# or Social Security Number
Street Address, City, State and ZIP Code		
Area Code/Phone	Birthdate	Last Day Worked
Name and Address of Store Retired From		

Application is to include:

- Retiree only monthly payment of \$530*
- Spouse only monthly payment of \$530*
- Family Coverage monthly payment of \$812*

**these rates are effective as of 10/01/2009*

Qualified dependents include only your lawful spouse of the opposite sex and your unmarried children, legally-adopted children and step-children (if both the step-child and the step-child's natural parent live with you), who are under age 19, dependent on you for more than one-half of their support and live with you in a regular parent-child relationship for more than one-half of each year, or who are otherwise specified in a Qualified Medical Child Support Order (QMCSO). Unmarried children remain eligible (1) until age 23 if they are attending school full-time (proof of student status is required) and are financially dependent on you for more than one-half of their support; or (2) as long as incapacity and dependency continue, but not beyond the date on which your coverage ends, if they are incapable of self-support due to mental retardation or physical handicap, financially dependent on you for more than one-half of their support and maintenance, and reside with you permanently and regularly for more than one-half of each year or live in a treatment center.

If dependents (spouse and/or children) are included in the application, please complete the following:

Spouse's Name		Birthdate	Social Security #
Child's Name	Child's Birthdate	Child's Soc Sec #	Sex
			<input type="checkbox"/> Female <input type="checkbox"/> Male
			<input type="checkbox"/> Female <input type="checkbox"/> Male

I hereby make application for the Optional Retiree Health Benefits Plan. I understand that benefits, participation rules, and monthly payment rates are subject to change as determined by the Board of Trustees and that coverage will terminate on the date I, my spouse or any qualified covered dependent become eligible for Medicare, become covered under any group insurance plan or policy as an employee, or is no longer a qualified dependent, as defined. I further understand that re-enrollment after termination of coverage for any reason other than my return to work for an employer who is required to make contributions on my behalf into a United Food and Commercial Workers fund is not allowed.

Signature _____ Date _____

Enclose check or money order payable to UFCW Midwest Health Fund covering the first month's payment.

Office Use: File # _____ Eff Date _____ Coverage _____ Ded or ET or Bill _____
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