

FELRA & UFCW Health and Welfare Fund
FELRA & UFCW Active Health & Welfare Plan
FELRA & UFCW Retiree Health & Welfare Plan

PLAN X

Summary of Material Modifications

(April 2014)

This insert is a Summary of Material Modifications (changes) to your Summary Plan Description (SPD) booklet. If there is any discrepancy between the terms of the Plan or any amendments and this document, the provisions of the Plan, as amended, will control. Please keep this insert with your booklet so you will have it when you need to refer to it.

Effective January 1, 2014 – PPACA Related Benefit Changes. The following changes are made to your SPD:

- All annual limits on essential health benefits are eliminated. Previously, the annual limit was \$400,000 for Plan X.
- Pre-existing condition exclusions on all benefits except insured dental benefits are eliminated.
- Coverage for biological and adopted dependent children is extended to age 26, regardless of whether such children are eligible for other employer-sponsored coverage.
- A family \$12,700 annual out-of-pocket maximum on essential health benefits is added to the Plan.

▪ **Effective March 1, 2014 – Giant, Safeway and Associated – Collective Bargaining Changes**

The following articles apply to participants employed by Giant, Safeway and Associated Administrators and represented by Local 400 or Local 27. The changes described below are based on the collective bargaining agreement ratified in 2013.

❖ **BARGAINING CHANGE**

FELRA & UFCW Active Health & Welfare Plan, Plans I, X, XX and XXX; FELRA & UFCW Retiree Health & Welfare Plan, Non-Medicare Retirees, including CIGNA-covered Retirees:
Coordination of Benefits Provision

Effective March 1, 2014, the Plan's coordination of benefit provisions have changed as follows. If a participant or dependent is covered under another health plan as primary and has secondary coverage under the Fund, the Fund will not supplement the primary coverage if that would result in an overall payment that is more than the Fund **would have paid** as primary.

Example: Suppose your spouse has a medical claim of \$500, and your spouse's primary carrier paid 80% of the claim (\$400). You are in Plan X, so if the Fund had paid this medical claim as primary, the payment would have been 80% of approved charges, meaning the Fund would have paid a maximum of \$400. Effective March 1, 2014, the Fund would not make any payment on this claim as secondary because the primary coverage already has paid the maximum amount the Fund would have paid as primary.

❖ **BARGAINING CHANGE**

FELRA & UFCW Active Health & Welfare Plan, Plan X: In Network Only

Effective March 1, 2014, benefits will be covered only if services are performed by an in-network provider, with the exception of services provided by pathologists, anesthesiologists, radiologists, and emergency room treatment, at an in-network facility.

❖ **BARGAINING CHANGE**

FELRA & UFCW Active Health & Welfare Plan, Plans I, X, and XX; FELRA & UFCW Retiree Health and Welfare Plan, non-Medicare Retirees: Emergency Room Co-Pay

Effective March 1, 2014, there will be a \$75 co-payment for Emergency Room visits. This co-pay will be waived if you are admitted to a hospital.

❖ **BARGAINING CHANGE**

FELRA & UFCW Active Health & Welfare Plan: Plans I, X and XX; FELRA & UFCW Retiree Health & Welfare Plan, Non-Medicare Retirees: Benefit Rates

Effective for claims incurred March 1, 2014 and after, with the exception of in-network preventive care benefits, the benefits under the Plan that were covered at 100% are covered at the Major Medical or Comprehensive rate after satisfying the deductible.

For example, under **Plan X**, hospital stays will be covered at 80% up to the semi-private room rate after satisfying the deductible.

Also, medical-surgical charges, anesthesia charges, lab and x-ray charges, and radiation and chemotherapy will be covered at 80%, after the deductible, under Plan X.

As a final example, Rehabilitation and Cardiac Rehabilitation charges will be covered at 80%, after the deductible, under Plan X.

For a complete list and description, see pages 102 – 111 in your Plan I Summary Plan Description (“SPD”) booklet and pages 98-108 in your Plan X SPD booklet. The services listed on these pages generally will be paid at the medical benefit rate, for services received on or after March 1, 2014.

❖ **BARGAINING CHANGE**

FELRA & UFCW Active Health & Welfare Plan: Plans I, X, XX and XXX

Effective for claims incurred March 1, 2014 and after, in-network preventive care benefits will be covered at 100% with no cost-sharing. For a list of the preventive care benefits covered by the Plan, please contact the Fund office.

❖ **BARGAINING CHANGE**

FELRA & UFCW Active Health and Welfare Plan, Plans I, X, XX and XXX

Effective January 1, 2015, the following co-premium amounts will be deducted from participants’ payroll.

Payroll Deductions for Plan I, Plan X Full Time and Plan XX Full Time Participants will be:

- \$5 per week for individual coverage,
- \$10 per week for participant + 1 coverage, and
- \$15 per week for family coverage (2 adults + child/ren).

Payroll Deduction for Plan X and Plan XX Part Time Participants will be:

- \$5 per week for individual coverage only.

Plan X Part Time dependent coverage payroll deduction of 20% of the cost of coverage will remain in effect.

If a participant elects coverage for his dependent spouse under any of the above Plans and the spouse also is eligible for health coverage through her employer, a \$20/week surcharge will apply in addition to the above-described co-premiums.

More information about these payroll deductions will be sent to affected participants in the fall of 2014.

- **Health and Welfare Board of Trustees as of April, 2014.** The following replaces page 7 in the Plan X Summary Plan Description booklet.

FELRA & UFCW Health And Welfare Fund
Board of Trustees

Union Trustees

Secretary:

Mark Federici, President
UFCW Local 400
4301 Garden City Drive
Landover, MD 20785

Michael Boyle
UFCW Local 400
4301 Garden City Drive
Landover, MD 20785

Jason Chorpenning
UFCW Local 27
21 West Road, Second Floor
Towson, MD 21204

Eric Masten, Secretary-Treasurer
UFCW Local 27
400 Delaware Avenue
Route 113, Suite 101
Millsboro, DE 19966

Employer Trustees

Chairman:

Jason Paradis
Stop and Shop Supermarkets
1385 Hancock Street
Quincy, MA 02169

Jeffrey Champion
Director of Labor Relations, Eastern Division
Safeway, Inc.
4551 Forbes Blvd.
Lanham, MD 20706

Frank Stegman
Vice President of Labor Relations
Safeway, Inc.
4551 Forbes Blvd.
Lanham, MD 20706

Steve Stoner
Vice President, Giant Landover
Giant Food, LLC
8301 Professional Place, Suite 115
Landover, MD 20785

- **January 2014 - New Claims Address for Value Options**

Value Options, has a new address for behavioral health claims. Claims that were processed in Latham, New York should now be sent to:

Value Options Claims Department
PO Box 930321
Wixom, MI 48393-0321

Please share this information with your provider the next time you have an appointment.

- **Effective May 22, 2013, the following is added at the end of the Claims and Appeals section of your SPD:**

If your claim is denied, in whole or in part, you are not required to appeal the decision. However, before you can file suit under Section 502(a) of the Employee Retirement Income Security Act (“ERISA”) on your claim for benefits, you must exhaust your administrative remedies by appealing the denial to the Board of Trustees. Failure to exhaust these administrative remedies will result in the loss of your right to file suit. If you wish to file suit for a denial of a claim for benefits, you must do so within three years of the date the Trustees denied your appeal. For all other actions, you must file suit within three years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Plan or the Trustees, you must file suit in the United States District Court for the District of Maryland. These rules apply to you, your spouse, dependent, alternate payee or beneficiary, and any provider who provided services to you or your spouse, dependent or beneficiary. The above paragraph applies to all litigation against the Fund, including litigation in which the Fund is named as a third party defendant.

- **Effective May 22, 2013 – Physician’s Assistants, Nurse Practitioners and Certified Surgical Assistants Are Covered Practitioners.** (Applies to non-Medicare participants and eligible dependents whose medical coverage is provided through the Fund, not an HMO). The services of Physician’s Assistants (PA) and Nurse Practitioners (NP) are covered under the Plan to the extent those services would be covered under the Plan if performed by a physician. Coverage will be provided under major medical at 75%, up to the UCR, if you are in Plan XX. The annual deductible applies.

The Board also approved coverage of Certified Surgical Assistants, Physician’s Assistants and Nurse Practitioners when they perform services as an assistant during surgery.

- **September 2013 – Revised Notice of Privacy Practices**

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Plan’s Commitment To Privacy

The Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund (the “Plan”) is committed to protecting the privacy of your protected health information (“health information”). Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. In accordance with applicable law, you have certain rights, as described herein, related to your health information.

This Notice is intended to inform you of the Plan’s legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the related regulations (“federal health privacy law”):

- to maintain the privacy of your health information;
- to provide you with this Notice describing its legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, “you” or “your” refers to participants and dependents who are eligible for benefits under the Plan.

Information Subject To This Notice

The Plan collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan’s administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Notice. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information.

Summary Of The Plan’s Privacy Practices

The Plan’s Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Plan discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan may also disclose your health information to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Plan will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Plan’s uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- Request access to your health information in an electronic format;
- Receive notice of a breach of unsecured protected health information if it affects you;
- File a complaint with the Fund office or the Secretary of the Department of Health and Human Services if you believe that your that privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in the Plan’s Privacy Practices

The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Plan’s privacy practices, or about this Notice, or if you wish to obtain additional information about the Plan’s privacy practices, please contact:

HIPAA Privacy Officer
 Associated Administrators, LLC
 911 Ridgebrook Road

Detailed Notice Of The Plan's Privacy Policies The Plan's Uses And Disclosures

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Plan uses and discloses your health information only for the administration of the Plan and the processing of your health claims.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

- 1. For Treatment.** Although the Plan does not anticipate making disclosures "for treatment," if necessary, the Plan may make such disclosures without your authorization. For example, the Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.
- 2. For Payment.** The Plan may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information with its third party administrator, Associated Administrators, LLC ("Associated"), so that it may process your claims. The Plan may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered under the Plan. Associated also may disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, Associated may disclose your health information to claims auditors to review billing practices of health care providers, and to verify the appropriateness of claims payment.
- 3. For Health Care Operations.** The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Plan may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan.

Uses and Disclosures to Business Associates

The Plan shares health information about you with its "business associates," which are third parties that assist the Plan in its operations. The Plan discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Plan shares your health information with Associated so that it may process your claims. The Plan may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Plan may disclose your health information to a translator; and Associated may provide names and address information to mailing services.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected. Similarly, Associated contracts with the subcontractors it uses to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information to the Plan Sponsor, which is the Plan's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Plan, without your authorization. The Plan also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Plan that it will protect your health information and that it has amended the Plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Plan, may make without your authorization.

- 1. Required by Law.** Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:
 - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
 - To report information related to victims of abuse, neglect, or domestic violence.

- To assist law enforcement officials in their law enforcement duties.
 - To notify the appropriate authorities of a breach of unsecured protected health information.
2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.
 3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.
 4. **Active Members of the Military and Veterans.** Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.
 5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.
 6. **Emergency Situations.** Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Notice.
 7. **Others Involved In Your Care.** Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Plan). Also, upon request, Associated may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.
 8. **Personal Representatives.** Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.
 9. **Treatment and Health-Related Benefits Information.** The Plan and its business associates, including Associated, may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.
 10. **Research.** Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.
 11. **Organ, Eye and Tissue Donation.** If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.
 12. **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan and its business associates, including Associated, do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Plan will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

Your Health Information Rights

You have the following rights regarding your health information that the Plan creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(410) 683-6500

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records. For health records that the Plan keeps in electronic form, you may request to receive the records in an electronic format.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Plan will send you a Claims History Report, which is a summary of your claims history that covers the previous two years. If you have been eligible for benefits for less than two years, then the Claims History Report will cover the entire period of your coverage.

If you do not agree to receive a Claims History Report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a two year period, state that in your written request, and that request will be accommodated. If you request a paper copy of your underlying health record or a portion of your health record, the Plan will charge you a fee of \$.25 per page for the cost of copying and mailing the response to your request. Records provided in electronic format also may be subject to a small charge.

In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for the Plan, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan, including disclosures by Associated to others. The accounting covers up to six years prior to the date of your request, except, in accordance with applicable law, the accounting will not include disclosures made before April 14, 2003. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. In response to your request for an accounting of disclosures, the Plan may provide you with a list of business associates who make such disclosures on behalf of the Plan, along with contact information so that you may request the accounting directly from each business associate. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, you will be charged for the cost of providing the accounting, but Associated will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that Associated discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is generally not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested. The Plan is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out of pocket.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Plan and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above. You may also obtain a copy of this Notice at Associated's website, www.Associated-Admin.com.

Right to Receive Notice of a Breach of Your Protected Health Information

You will be notified if your protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured—for

example, computer data that is encrypted and inaccessible without a password—or if it is determined that there is a low probability that your health information has been compromised.

Changes In The Plan's Privacy Policies

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request and will be posted for review near the front lobby of Associated's offices in Sparks, Maryland and Landover, Maryland. Any revised notice will also be available at Associated's website, www.Associated-Admin.com.

Effective Date

This Notice was first effective on April 14, 2003, and was revised, effective September 23, 2013, to reflect the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Notice will remain in effect unless and until the Plan publishes a revised Notice.

- **2013 Plan Year – Notice of Waiver of Annual Limit Requirements.** *(This notice applies to all Active participants with traditional Fund coverage, not HMO coverage).* Below is a Notice that we are required by federal law to send to you. This notice explains that, under the Patient Protection and Affordable Care Act, group health plans generally cannot have annual limits of less than \$2 million for the Plan Year beginning in 2013. However, plans can seek a waiver of those annual limits from the Department of Health and Human Services ("HHS"), if complying with the new annual limit would result in a significant decrease in employee access to benefits or a significant increase in employee payments.

Because your plan currently has annual limits on comprehensive medical, rehabilitation, and physical exam benefits that are below \$2 million and the Fund's benefit consultant projected that the Fund's cost of benefits would increase if it were required to increase these annual limits to \$2 million, the Board of Trustees obtained a waiver of the annual limits until December 31, 2013. If the Fund did not obtain the waiver, the Trustees would have been required to consider decreasing benefits or increasing participant cost sharing, such as increases in deductibles, co-payments and co-insurance. To avoid having to consider decreasing benefits or increasing the out of pocket costs you pay for your health coverage, the Trustees decided that the best approach was to apply to HHS for the waiver.

You should be aware that as a result of obtaining the waiver, there will be no reductions in the current package of health benefits you are receiving. The Board of Trustees is proud of the affordable health benefits that they have been able to provide over many years.

January 2013 Notice of Waiver of Annual Limit Requirement

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain 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 \$2 million.

Your health coverage, offered by the FELRA & UFCW Health and Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

BENEFIT CLASS	ANNUAL MAXIMUM (PER INDIVIDUAL)			
	PLAN I	PLAN I RETIREE	PLAN X	PLAN XX
Comprehensive Medical	\$400,000	\$400,000	\$400,000	\$100,000
Rehabilitation	\$25,000	\$25,000	\$25,000	\$25,000
Physical Exam	\$200 (once every two years)	\$200 (once every two years)	N/A	N/A

This means that your health coverage may not pay for all of the health care expenses you incur.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least \$2 million this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until December 31, 2013.

If you are concerned about your plan’s lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Fund Office at (800) 638-2972. In addition, if you live in Maryland, you can contact the Maryland Office of the Attorney General, Health Education and Advocacy Unit, at (877) 261-8807. If you live in Virginia, you can contact the Virginia Consumer Assistance Program, at (877) 310-6560.

Notice of Grandfathered Health Plan

This is to notify you that the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund (“Fund”) qualifies as a “grandfathered health plan” under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act).

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Because the Fund qualifies as a grandfathered health plan, certain provisions of the Affordable Care Act that apply to other plans—for example, the requirement for the provision of preventive health services without any cost sharing—do not currently apply to the Fund. However, the Fund offers other consumer protections under the Affordable Care Act, including the elimination of all lifetime limits on essential benefits.

If you have questions about which protections apply and which protections do not apply to a grandfathered health plan, or about what might cause the Fund to stop being treated as a grandfathered health plan, please contact the Participant Services at 1-800-638-2972. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

- **Effective June 1, 2012 – new Plan names. *FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan***

The Board of Trustees formally separated the Plan for active participants and the Plan for retired participants formalized the separate existence of the Fund's plan for FELRA Actives and Retirees. The active plan now is called the **FELRA & UFCW Active Health Plan, a plan of the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund**. The retiree plan now is called the **FELRA & UFCW Retiree Health Plan, a plan of the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund**. Your benefits remain the same.

- **Effective January 1, 2013, Gardasil Vaccine is now covered. *FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan***. The Board of Trustees is pleased to announce that Gardasil, the HPV vaccine for girls, now is covered under the Active Plan and Retiree Plan for dependent daughters. The following applies to Actives and Retirees who have Fund coverage.

The following applies to Actives and Retirees who have Fund coverage.

Virginia Participants

Effective for Gardasil injections given January 1, 2013 and after, your dependent daughter may either receive the shot at a Giant or Safeway pharmacy at no cost to you using your Medco ID pharmacy card, or may receive the injection at the doctor's office. If the vaccine is administered at the doctor's office, the injection will be covered in full with no deductible, up to the Usual, Customary, and Reasonable (UCR) charge, while the office visit charge (if there is one) will be covered under your medical coverage at 80% for Plan X participants, after satisfying the deductible.

Maryland and DC Participants

For Maryland and DC, this injection cannot be administered at the pharmacy; therefore, it will be covered when administered at your dependent daughter's doctor's office, effective January 1, 2013. The injection itself will be covered at 100% up to the UCR and the office visit charge (if there is one) will be covered under your medical benefit at 80% for Plan X, after satisfying your deductible.

You also have the choice of picking up the vaccine at the pharmacy at no charge, and bringing it to the physician's office for administration. If you do that, the office visit charge will be paid under medical, as described above.

Delaware Participants

Delaware law permits the vaccine to be administered at the pharmacy if certain dosage conditions are met. Check with your pharmacist to see if the shot can be administered at the pharmacy or if it must be handled at the doctor's office. Payment will be as noted above.

- **Effective January 1, 2013 – elimination of Walgreens from network pharmacies. *FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan***. Walgreens is no longer a part of the FELRA network of pharmacies, effective January 1, 2013. **This network change does not affect the prescription drug benefits available to you under the Plan.**

Co-Insurance

Plan participants share in the cost of drugs based on coinsurance levels of 13% for Plan X participants. Remember, Giant and Safeway pharmacy coinsurance levels are generally lower than using a non-participating employer pharmacy. Retiree reimbursement levels are typically 11% for Giant and Safeway, and 18% for other Medco network pharmacies. If you are a retiree and live out of the area of a Giant or Safeway pharmacy, you may qualify for the 11% coinsurance level.

Questions

If you have questions or need assistance in locating the nearest network pharmacy, please contact Medco/Express Scripts at (800) 903-8325.

- **Effective October 15, 2012, the flu shot is free with Medco Rx card at Giant or Safeway Pharmacies. *FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan.*** The Board of Trustees is pleased to provide an enhanced flu shot benefit for Fund participants.

Flu Shot at Pharmacy

Effective for flu shots given October 15, 2012 and after, you may get your flu shot at any Giant or Safeway pharmacy at **no cost to you** using your Medco Prescription Drug ID card! Simply go to your Giant or Safeway pharmacy, show your Medco ID card, and receive your flu shot.

Flu Shot in Doctor's Office

If you prefer to get your flu shot from your doctor or don't live near a Giant or Safeway pharmacy, the flu shot will be covered under your medical benefits. For participants and dependents with traditional Fund coverage, the injection itself is covered at 100% up to the Usual, Customary, and Reasonable fee, and the office visit charge (if there is one) is covered under your Major Medical or Comprehensive benefit (80% for Plan X), after satisfying the annual deductible. Submit your paid receipt for the injection to the Fund office and you will be reimbursed. Charges for an office visit should be filed just like any other medical claim.

For participants in the Kaiser Permanente HMO (actives and retirees) who prefer to get a flu shot from their doctor, the flu shot is covered in full, with no co-pay if you use a Kaiser physician. Further, actively working participants in Kaiser who use Medco for their prescription benefit may have their flu shots administered at a Giant or Safeway pharmacy using the Medco ID card, at no cost.

- **Clarification regarding Life Insurance Beneficiary Payment Process. No change in benefit. *FELRA & UFCW Active Health & Welfare Plan.*** The Board of Trustees has adopted the following clarification to the Fund's Summary Plan Description ("SPD") regarding the default payment method applicable to the life insurance benefit under Plans I, X, and XX.

The following language is added to the end of the Life Benefit and Accidental Death and Dismemberment sections of your SPD:

DEFAULT PAYMENT FORM FOR LIFE INSURANCE BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

1. Beneficiaries who are residents of Maryland, Virginia or the District of Columbia and are eligible to receive a life benefit or accidental death & dismemberment benefit of less than \$5,000 will receive their payment in one lump sum, unless the Beneficiary elects another form of payment from the options available.
2. Beneficiaries who are residents of Maryland, Virginia and the District of Columbia, and are eligible to receive a life benefit or accidental death & dismemberment benefit of \$5,000 or greater will have their payment deposited into a Personal Transition Account in the Beneficiary's name, established and maintained by ING/ReliaStar, unless the Beneficiary elects another form of payment from the options available. The proceeds in the Account will earn interest at a guaranteed minimum rate, and the Beneficiary may write drafts against the Account of at least \$250 at a time, up to the full amount of the Account. The Beneficiary may close the Account at any time by

requesting payment of the full balance of the Account. ING/ReliaStar will maintain the Account and will periodically request that the Beneficiary confirm his/her intent to continue the Account. If the Beneficiary does not affirmatively confirm his/her intent to keep the Account active, and if there is no financial activity with the Account (excluding credited interest) or other customer initiated activity for a period of 18 months, ING/ReliaStar will close the Account. Upon closing the Account, ING/ReliaStar will pay out the remaining proceeds to the Beneficiary. If ING/ReliaStar cannot locate the Beneficiary, it will pay any remaining funds to the state government in the state in which the Account was established.

The default payment option for Beneficiaries residing in other states may be different. For more information on those benefit options, please contact ING at 888-238-4840.

- **Effective June 1, 2012, *FELRA & UFCW Retiree Health & Welfare Plan***, as a result of Collective Bargaining, the following change has been made to the Kaiser Medicare HMO retiree program:
 - The office visit copayment will change from \$10 to \$15 per visit.
 - There will be a \$100 inpatient deductible which will apply to the first inpatient admission during each benefit period (calendar year).

The prescription drug co-payments will change from:

- \$5 to \$10 for mail order scripts (90 day supply),
- \$10 to \$15 for scripts obtained at a Kaiser center, and
- \$15 to \$25 for scripts obtained at another retail outlet.

- **Effective May 1, 2012, Endodontic procedures (Root Canals) now covered. *FELRA & UFCW Active Health & Welfare Plan***. The following applies to participants and eligible dependents under Plan X whose employers entered into a ratified 2012 bargaining agreement with the Local Union.

As a result of recent collective bargaining, effective for claims incurred ***on and after*** May 1, 2012, the Board of Trustees is pleased to announce that coverage of endodontic procedures (root canals) has been added to Plan X for covered Participants and their eligible dependents. While most endodontic procedures are subject to a co-pay, you should see significant savings since the procedures which previously were not covered could cost as much as \$1,200 per procedure. **To receive the benefit, the endodontic procedures must be performed by a GDS network dentist**, and the procedures are subject to the same policy provisions as your other dental benefits including, but not limited to, authorization of medical necessity.

The below co-pays apply to endodontic procedures performed by a GDS general network dentist. The covered endodontic procedure codes and associated co-pays are as follows:

<u>Code</u>	<u>ADA Description</u>	<u>Co-pay</u>
D3110	Pulp Cap Direct	\$0
D3120	Pulp Cap Indirect	\$0
D3310	Endodontic Therapy - Anterior Tooth	\$125
D3320	Endodontic Therapy - Bicuspid Tooth	\$125
D3330	Endodontic Therapy - Anterior Tooth - Molar	\$250

All co-pays and fees are due at the time of service, and all dental services must be performed by a GDS network general dentist to be eligible for the above co-pays and coverage.

If the procedure is performed by a GDS in-network endodontic specialist, the Participant is responsible for an additional \$100 specialist fee on the last three procedures listed above. Thus, if the procedure is performed by a GDS in-network endodontic specialist, the co-pays are as follows:

<u>Code</u>	<u>ADA Description</u>	<u>Co-pay</u>
D3110	Pulp Cap Direct	\$0
D3120	Pulp Cap Indirect	\$0
D3310	Endodontic Therapy - Anterior Tooth	\$225
D3320	Endodontic Therapy - Bicuspid Tooth	\$225
D3330	Endodontic Therapy - Anterior Tooth - Molar	\$350

All co-pays and fees are due at the time of service, and all dental services must be performed by a GDS network endodontic specialist dentist to be eligible for the above co-pays and coverage.

If you have questions regarding the endodontic benefit or need assistance to find a network dentist, please contact GDS at (800) 242-0450.

- **April 1, 2012 - Extended Time To File Medical Claims.** *FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan.* Bargaining change to Giant and Safeway participants in Plan I, Plan X, and Plan XX and their eligible dependents.

As a result of recent collective bargaining, the Board of Trustees is pleased to announce that effective for dates of service on and after April 1, 2012, participants with Fund medical coverage have one year from the date of service to file a claim. Any medical claim incurred on or after April 1, 2012 will be subject to this timeframe.

Also, you now have 45 days from the post mark date on a request from the Fund for additional information to return the information to the Fund office. Previously, this timeframe was 30 days.

- **Effective October 15, 2012**, the Board of Trustees announced an enhanced delivery of the flu shot benefit for Fund participants. Effective for flu shots given October 15, 2012 and after, you may get your flu shot at any Giant or Safeway pharmacy at **no cost to you** using your Medco Prescription Drug ID card. Simply go to your Giant or Safeway pharmacy, show your Medco ID card, and receive your flu shot.

Flu shots will also continue to be covered under your medical benefits as they have been, if you prefer to get your shot from your doctor or don't live near a Giant or Safeway pharmacy. For those with Fund medical, the injection itself is covered at 100% up to the Usual, Reasonable, and Customary fee, and the office visit charge (if there is one) is covered under your Major Medical or Comprehensive benefit (80% for Plan X), after satisfying the annual deductible. Submit your paid receipt to the Fund office and you will be reimbursed. Charges for an office visit should be filed with the Fund office just as any other medical claim.

For participants in Kaiser Permanent HMO (actives and retirees), the flu shot is covered in full, with no co-pay if you use a Kaiser physician. However, actively working participants in Kaiser who use Medco for their prescription benefit have the choice to have their shots administered at a Giant or Safeway pharmacy using the Medco ID card.

- **Effective April 2, 2012, Medco Health Solutions, Inc. ("Medco") merged with Express Scripts.** *FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan.* Your

prescription benefits **remain the same**. Continue to use your Medco prescription card at the same pharmacies as before. Remember, you will receive the best discounts if you use a Giant or Safeway pharmacy. CVS, Wal-Mart, Rite Aid and Walgreens pharmacies are not part of the Fund's pharmacy network. For additional information about participating pharmacies, call (800) 903-8325. You can also log on to Medco's website at www.medco.com and click "Locate a pharmacy."

- **Effective March 2012 – The following sentence is added to the beginning of your SPD:** The Board of Trustees of the FELRA and UFCW Health and Welfare Fund adopted the following clarification to the Fund's Summary Plan Descriptions ("SPDs") for the FELRA & UFCW Active Health and Welfare Plan and the FELRA & UFCW Retiree Health and Welfare Plan.

This document functions as both the Plan Document and the Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

- **Effective January 1, 2011.** Below is a Notice that we are required by federal law to send to you. This notice applies to participants with traditional Fund coverage, not HMO coverage. Under the Patient Protection and Affordable Care Act ("PPACA"), group health plans generally cannot have annual limits of less than \$1.25 million for the Plan Year beginning in 2012. Plans can seek a waiver of that annual limit from the Department of Health and Human Services ("HHS") if complying with the new annual limit would result in a significant decrease in employee access to benefits or a significant increase in employee payments.

Because your plan currently has annual limits on comprehensive medical, rehabilitation, substance abuse and physical exam benefits that are below \$1.25 million and the Fund's benefit consultant projected that the Fund's cost of benefits would increase if it were required to increase these annual limits to \$1.25 million, the Board of Trustees obtained a waiver of the annual limits until January 1, 2014. If the Fund did not obtain the waiver, the Trustees would have been required to consider decreasing benefits or increasing participant cost sharing, such as increases in deductibles, co-payments and co-insurance. To avoid having to consider decreasing benefits or increasing the out of pocket costs you pay for your health coverage, the Trustees decided that the best approach was to apply to HHS for the waiver.

You should be aware that as a result of obtaining the waiver, there will be no reductions in the current package of health benefits you are receiving. The Board of Trustees is proud of the affordable health benefits that they have been able to provide over many years.

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least \$1.25 million.

Your health coverage, offered by the Food Employers Labor Relations Association & United Food and Commercial Workers Health and Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

BENEFIT CLASS	ANNUAL MAXIMUM (PER INDIVIDUAL)			
	PLAN I	PLAN I RETIREE	PLAN X	PLAN XX
Comprehensive Medical ¹	\$400,000	\$400,000	\$400,000	\$100,000
Rehabilitation ¹	\$25,000	\$25,000	\$25,000	\$25,000
Substance Abuse	\$1,000	\$1,000	\$1,000	\$1,000

Physical Exam	\$200 (once every two years)	\$200 (once every two years)	N/A	N/A
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¹Effective January 1, 2011, these limitations were converted from a lifetime limit to an annual benefit limitation. Please refer to your Summary of Material Modifications for more detail on this benefit change.

This means that your health coverage might not pay for all of the health care expenses you incur.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least \$1.25 million this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until January 1, 2014.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, please contact the Fund Office toll-free at 800-638-2972. In addition, if you live in Maryland, you can contact the Maryland Office of the Attorney General, Health Education and Advocacy Unit, at (877) 261-8807. If you live in Virginia, you can contact the Virginia Consumer Assistance Program, at (877) 310-6560.

- **Effective January 1, 2011 – changes as a result of Health Care Reform (PPACA).** The Board of Trustees of the FELRA and UFCW Health and Welfare Fund (“Fund”) has adopted the following changes to the FELRA and UFCW Health and Welfare Plan in order to comply with the Patient Protection and Affordable Care Act (PPACA).

Eligible dependents include your spouse and children, as defined in this Section.

Biological Children, Adopted Children and Children Placed for Adoption

Medical and Prescription Drug Benefit Eligibility

Generally, your biological children, adopted children and children placed with you for adoption are eligible for medical and prescription drug benefit coverage as your dependents if they are:

- Under age 26; and
- Not eligible for coverage under another employer-sponsored group health plan (other than this Plan or a plan covering their parent(s)).

Optical Benefit Eligibility

Generally, your biological children, adopted children and children placed with you for adoption are eligible for optical benefit coverage as your dependents:

- Through the end of the calendar year in which the dependent turns age 23; and
- Provided they are not eligible for coverage under another employer-sponsored group health plan (other than this Plan or a plan covering their parent(s)).

Dental Benefit Eligibility

For active participants, subject to the requirements described in the dental benefit sections of your SPD, your biological children, adopted children, children placed for adoption, are eligible for dental benefit coverage as your dependents if they are:

- Under age 19,
- Not Married,
- Not employed on a regular full time basis, and
- Dependent on you for financial support.

Dental benefits for dependent children terminate at the end of the year in which the dependent turns 19. Student coverage does not include dental benefits.

Note: Children of retirees are not eligible for dental benefits. For active participants, children under age four are not eligible for dental benefits.

Stepchildren and Children over Whom You Have Legal Custody

Medical and Optical Benefit Eligibility

Stepchildren and children over whom you have legal custody are eligible for medical and optical coverage as your dependents if they are:

- Under age 19 (unless eligible for student coverage—see “Full Time Student Coverage” below),
- Not married,
- Not employed on a regular full-time basis, and
- Dependent on you for financial support.

Dental and Prescription Drug Eligibility

Stepchildren and children over whom you have legal custody are eligible for dental and prescription drug coverage as your dependents if they are:

- Under age 19,
- Not Married,
- Not employed on a regular full-time basis, and
- Dependent on you for financial support.

Note: If you have had court-awarded legal custody of a child for at least six months, you may enroll that child as your dependent. You must submit a copy of the court-entered custody order along with the applicable enrollment form. Further, you must submit a notarized letter to the Fund office every six months, confirming the continuation of custody.

To be eligible for coverage, stepchildren must reside with the eligible participant. The Plan requires you to submit evidence of your dependent(s)' eligibility status – for your children: a birth certificate, adoption papers, or other proof of adoption or placement for adoption acceptable to the Trustees; for your spouse: a marriage license for your spouse. In the case of a stepchild, a copy of the divorce decree indicating custody is required as evidence.

Coverage for Full Time Students

Dependent stepchildren and children over whom you have legal custody generally are eligible for **medical and optical benefits** under the Fund until the end of the calendar year in which they turn age

19. However, if your son or daughter will be a full-time student at an accredited college or university, medical and optical coverage may be continued until the earliest of the last day of the calendar month in which he/she marries, ceases to be financially dependent on you for support, ceases to be a full-time student, or the end of the calendar year in which he/she turns age 23.

In order to ensure continued coverage under the Plan, Dependents and/or Participants (as applicable) must respond to any request for information issued by the Fund for the purpose of confirming continued eligibility for benefits. Failure to respond to such requests may result in the suspension or termination of coverage.

Loss of Dependent Eligibility

The following paragraph is added to the end of the "Loss of Dependent Eligibility" section in your Plan X Summary Plan Description booklet, page 20:

A dependent child's eligibility for dental and optical benefits will terminate upon the earliest to occur of:

1. the end of the calendar year in which the child has his or her 19th birthday (unless he or she is eligible for student coverage);
2. the end of the month in which the child begins regular full time employment;
3. the end of the calendar year in which the child ceases to be dependent on you for support; or
4. the end of the month in which the child is married.

Extension of Coverage for Dependent Children.

- **Effective January 1, 2011**, your eligible dependents include your spouse and your children, as defined below.

Generally, your biological children, adopted children and children placed with you for adoption are eligible for medical and prescription coverage as your dependent if they are:

- Under age 26
- Not eligible for coverage under another employer-provided group health plan (other than this Plan or a plan covering their parent(s)).

Your biological and adopted children also will be eligible for optical benefits until the end of the calendar year in which they turn 23. Note: if you are a part-time comprehensive retiree, your biological and adopted children only will be eligible to receive medical benefits under the Plan.

Stepchildren and children over whom you have legal custody, as well as biological children, adopted children, and children placed for adoption, who do not meet the above criteria, are eligible for coverage as your dependent if they are:

- Under age 19 (unless eligible for student coverage)
- Not married
- Not employed on a regular full time basis, and
- Dependent on you for financial support.

In order to ensure continued coverage under the Plan, Dependents and/or Participants (as applicable) must complete any request for information issued by the Fund for the purpose of confirming continued eligibility for benefits. Failure to respond to any such requests may result in the suspension or termination of coverage.

Costs of Dependent Coverage

If you are actively working, you had the opportunity to enroll your dependent child for medical coverage under these new rules during the special enrollment period that ran from December 3, 2010 to January 4, 2011. If you are a Plan X part time participant, the cost of dependent coverage is \$202.40 per month, deducted weekly from your paycheck by your employer. There is no cost for Plan X full time participants to have dependent coverage.

If you are enrolled for Kaiser Permanente HMO coverage as an actively working participant, the above co-premiums apply. In addition, there is a \$100 per month co-premium for HMO coverage for Plan X participants.

If you were eligible for, but not enrolled in Fund retiree coverage, you were given the opportunity to enroll your dependents during the special enrollment period, under the new rules stated above, provided you met the following conditions: (a) you enrolled yourself as well as your dependent for coverage; (b) you waited at least 12 months since the time you dis-enrolled (or chose not to enroll); and (c) the dependent you enrolled was covered under the Plan as your dependent at the time you retired from active work.

Elimination of Pre-existing Condition Exclusions Applicable to Children.

Effective January 1, 2011, the pre-existing condition exclusions under the Plan no longer apply to participants and dependents under the age of 19. Specifically, this means that the general pre-existing condition exclusion applicable to dependent children over whom a participant has legal custody is eliminated. Further, the following specific pre-existing condition exclusions under the Plan do not apply to participants and dependents under age 19: (a) the exclusion on dental work required as the result of an injury occurring before the patient was covered under the Fund (if diagnosis of injury was medical in nature); (b) the exclusion on prosthetics appliances for conditions that arose before coverage began under the Fund; (c) the exclusion for cosmetic services arising from the correction of congenital defects or conditions from traumatic injuries occurring before coverage began under the Fund.

Retroactive Termination of Coverage

The Fund reserves the right to retroactively terminate your and your dependents' coverage under the Plan if you or any of your dependents engage in fraud and/or intentionally misrepresent or omit a material fact relevant to your Plan coverage, or if you or your participating employer fail to timely pay any applicable premium or contribution to the Fund relating to your benefits. Failure to follow the terms of the Plan, including but not limited to failing to notify the Fund of a change in dependent status, accepting benefits in excess of what is covered under the Plan, and accepting benefits after you or your dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having full knowledge of all the eligibility terms of this Plan.

- **Effective June 23, 2011**, the Board of Trustees broadened the Plan's coverage of routine gynecological exams. These exams are now covered without the requirement that a PAP test be performed during the exam. Coverage for a gynecological exam will be provided under your Major Medical at 80%, up to the UCR rate if you are in Plan X. The annual deductible applies.
- **Michelle's Law - Effective January 1, 2010**, the following language is added at the end of the subsection entitled "Student Coverage" in your SPD:

If a dependent child enrolled in Student Coverage ceases to be a full-time student at an accredited school because of a medically necessary leave of absence resulting from a serious injury or illness, coverage under this Plan will be extended to the dependent during his or her leave of absence until the earlier of

1. the one-year anniversary of the date on which the dependent child's leave of absence began, or
2. the date on which the dependent child's coverage under the Plan would otherwise terminate in accordance with this subsection.

To be eligible for this extended coverage, you must provide the Plan with written certification from the dependent child's treating physician that his or her leave of absence from school is medically necessary and is as a result of a serious illness or injury. The extended coverage will not be provided until the date such certification is received by the Fund, but will be retroactive to the date on which his/her leave of absence began.

- **January 1, 2010, Collective Bargaining resulted in changes for Participants employed by Associated Administrators, LLC.**

Participants with Fund Medical Coverage

For participants whose medical coverage is provided through the Fund, the changes are as follows:

- A routine PSA (prostate specific antigen) test for male participants and dependents age 50 and over is covered under your medical benefits. Coverage will be at 100%, up to the usual, customary, and reasonable ("UCR") amount, with no deductible, once every 12 months.
- A routine colonoscopy is covered for participants and dependents age 50 and over, once every five years. The test is covered at 100%, up to the UCR, with no deductible.
- **For Plan X participants:** The annual deductible has increased from \$200 to \$300 per calendar year. The new deductible began with claims for dates of service on and after January 1, 2010.

Participants Enrolled in Kaiser Permanente HMO

For Kaiser Permanente participants, coverage has been added for prosthetics (artificial devices to replace all or part of the function of a permanently inoperative or non-functional body part). See your Kaiser Evidence of Coverage or call Kaiser's Member Services with questions.

- **Effective August 1, 2009, Advantica EyeCare** became your new optical provider, replacing UnitedHealthCare Vision/Spectera, previously known as United Optical.

The change from UnitedHealthCare Vision/United Optical to Advantica did not affect your optical coverage. Your covered benefits are the same. *However*, non covered items have different discounts than those that were available through United Optical.

New ID Card

An ID card from Advantica was sent to you for your optical benefits. Before you schedule a vision appointment, contact Advantica at (866) 425-2323 to confirm that the provider participates with them. If the provider does not participate with Advantica, any services you receive from that provider on and after August 1, 2009 will not be covered under the Plan.

Wider Network

Advantica has an expanded network with providers located in major malls and other convenient locations including Pearl Vision, Sears, and JC Penney, as well as many individual providers.

Locating A Provider

To locate the most current providers in the Advantica network, log on to the website at <http://www.advanticaeyecare.com/locate-an-eye-care-provider.aspx>. Click on "Locate a Provider" and select "FELRA & UFCW Health and Welfare Fund." The names of providers are updated regularly. You can also call Advantica's Customer Service at (866) 425-2323.

- **Effective August 1, 2009**, the Board of Trustees of the FELRA and UFCW Health and Welfare Fund adopted the following change to your benefits:

Your covered optical benefits under the Plan will remain exactly the same as your benefits under the Fund's prior optical provider. However, non-covered optical benefits will be paid differently. For example, if you select non-covered frames, you will receive a \$100 allowance toward the cost of the frames, and a 15% discount. We recommend that you check with your optical provider, Advantica EyeCare, before purchasing non-covered frames, or any other non-covered service or supply, so that you know the cost that you will be responsible for ahead of time.

You can reach Advantica's Customer Service at (866) 425-2323. Please add the above language to the "Optical Benefits" section of your SPD.

- **Special Enrollment for Dependents – Medicaid and Children's Health Insurance Program ("CHIP") - Effective April 1, 2009.** The following is added to the Section of your SPD entitled "Eligibility for Dependents."

If you turned down coverage for either yourself or your dependents when you were first eligible and, later, you or your dependents lose eligibility for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP"), you may be able to enroll yourself and/or your dependents for coverage under the Fund. However, you must request enrollment under the Fund within 60 days of the date that CHIP or Medicaid assistance terminates for you or your dependent.

In addition, you may be able to enroll yourself and your dependents in this Plan if you or your dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. Again, you must request enrollment within 60 days of the date you or your dependent become eligible for premium assistance through Medicaid or CHIP, in order to be covered under the Fund.

To request special enrollment or obtain more information, contact the Fund office.

- **Family and Medical Leave Act ("FMLA") Changes for Military Service:**

- **Effective January 16, 2009**, the following sentence is added to the end of the section entitled "Continuation of Coverage under the Family and Medical Leave Act."

Eligible employees are entitled to up to 12 weeks per year of unpaid leave for a qualifying exigency that arises in connection with the active military service of a child, spouse, or parent.

- **Effective January 28, 2008**, the following is added to the end of the first paragraph under the section entitled “Continuation of Coverage under the Family and Medical Leave Act.”

You may be entitled to up to 26 weeks of FMLA leave if you are injured in military service, or to care for a family member who is injured in military service. Contact the Fund office for more information.

- **Effective November 1, 2008**, for participants who have Fund coverage (not HMO or Medicare Supplemental Retiree coverage), **CareFirst PPO** replaced OneNet PPO as the new Preferred Provider Organization (“PPO”). Starting November 1, 2008, when you use a provider (whether a hospital, physician, or other health care provider) who is in the CareFirst network, you will receive discounted rates that are generally lower than usual provider fees. In late October, you received a new Fund ID card showing CareFirst as your new PPO provider and SHPS as your utilization management provider. It is very important that you show this new ID card to all providers of care and tell them your coverage has changed. This will ensure your claim is filed on time, and sent to the right place.

Locating a CareFirst Provider

- Go online to the CareFirst website, www.CareFirst.com. Click on “Members and Visitors,” then click on “Find a Doctor.” Under “Search the Provider Type,” click on either medical or facilities, depending upon your needs. If you are looking for a medical plan, white ID card holders should search under the heading at the bottom of the page which says, “Other Networks,” then choose the “PPO-National/International Blue Cross Blue Shield Directory” link. Green ID card holders should look under the header “Select Your Medical Plan” and choose “BluePreferred (PPO).”
 - To locate a provider by telephone, green ID card holders should call (800) 235-5160 and white ID card holders should call (800) 810-2583. These numbers are on your ID card.
- **Effective November 1, 2008**, for participants who have Fund coverage, not HMO or Medicare Supplemental Retiree coverage, Carewise Health, a SHPS Company, replaced Optum/CARE Programs as your new Utilization Management (“UM”) and Case Management provider. Value Options still handles your mental health benefits.

Starting November 1, 2008, you must contact SHPS to pre-certify ALL non-emergency or elective hospital stays and within 24 hours after an emergency admission. To pre-certify, call SHPS toll free at 866-511-1462. Remember, you must certify all hospital stays in order for the Fund to pay any benefits related to the hospital stay. This is very important!

A new Fund medical ID card showing SHPS as your new UM provider was sent to all participants who have Fund, not HMO, coverage. It is very important that you show your new ID card to all providers of care!

SHPS Case Management

If you have a sudden illness or injury or a chronic, ongoing health condition, SHPS (also called Carewise Case Management) will provide a specially trained registered Nurse (backed by a team of board-certified specialists) to assist you in managing your condition.

Your Case Manager will establish a personal relationship with you and your family, answer questions about your diagnosis and treatment options, help you navigate the healthcare system and make sure that all your care providers are working together on a clear and focused treatment plan that will ensure you the best possible outcome.

Your Case Manager will also help you maintain continuity of care as you work with various doctors, specialists and other providers. This includes reviewing your treatments and procedures at every step of the way, to make sure that each meets nationally recognized standards of evidence-based medicine.

- **Effective October 1, 2008, Medco Health Solutions, Inc. (“Medco”)** became your new prescription drug provider. Also, Accredo has replaced Ascend as your specialty pharmacy provider. A new prescription drug ID card and a Welcome Packet from Medco were sent to participants. The Medco prescription card replaced the white NMHC prescription card. However, your prescription drug coverage (such as your co-pay or rules of the Plan) did not change.

Pharmacy Network Change

You will receive the best discounts if you use a Giant, Safeway, or SuperFresh pharmacy. Effective September 30, 2008, CVS, Wal-Mart and Rite Aid pharmacies are no longer part of the Fund’s pharmacy network. Prescriptions filled at these pharmacies will not be covered under the Plan.

For additional information about participating pharmacies, call Medco Member Services at 1-800-903-8325. You can also log on to Medco’s website at www.medco.com and click “Locate a pharmacy.”

- As a result of Collective Bargaining, benefits changed effective **July 1, 2008**, for actively working participants with Giant, Safeway and Giant Delaware, and effective **November 1, 2008**, for actively working participants employed by SuperFresh with Fund Medical Coverage.
 - Routine PSA tests (prostate specific antigen tests) for male participants and dependents age 50 and over are covered at 100%, up to the usual, customary, and reasonable (“UCR”) amount, with no deductible, once every 12 months.
 - Routine colonoscopies for participants and dependents age 50 and over are covered at 100%, up to the usual, customary, and reasonable (“UCR”) amount, with no deductible, once every five years.

Annual Deductible for Plan X Participants: The annual deductible increased from \$200 to \$300 per calendar year. If you already met the \$200 deductible for 2008, the Fund office will simply apply another \$100 for the deductible on future claims for the remainder of 2008. If you have not yet met the \$200 deductible for 2008, you now need to meet a \$300 deductible before benefits will begin to be paid. No claims will be reprocessed.

The new deductible began with claims incurred November 1, 2008 and after for actively working participants employed by SuperFresh. For actively working participants with Giant, Safeway and Giant Delaware, the new deductible began with claims incurred July 1, 2008 and after.

Participants Enrolled in Kaiser Permanente HMO

For Kaiser Permanente participants, coverage has been added for prosthetics (artificial devices to replace all or part of the function of a permanently inoperative or non-functional body part). See your Kaiser Evidence of Coverage or call Kaiser’s Member Services with questions.

- **Please make the following correction to your SPD:**
In the Exclusions and Limitations section, page 107, add the following exclusion: “Services of a Physician’s Assistant (“PA”) are not covered.”
- **On page 21 of the Plan X SPD, under “Legal Custody,”** a sentence reads “If you are a full timer and have legal custody of a child, ...etc.” Please mark out “full timer.” Both Full Timers and Part Timers may enroll children who are dependents as a result of Legal Custody (assuming you are eligible for Dependent Coverage).
- The following is a clarification to the section “Anesthesia Services,” located on page 103 of your SPD. Please add the following to that section: The Fund covers the services of a Certified Registered Nurse Anesthetist (“CRNA”) when administering anesthesia, but **only** if an anesthesiologist is not also administering anesthesia.

- If you receive anesthesia and the Fund is billed for the services of both a CRNA and an anesthesiologist for the same operation, the Fund will pay only the anesthesiologist, not the CRNA. Services of a CRNA are only covered if an anesthesiologist has not billed the Fund.
- **September 2007. The following is intended to clarify the description of a second Qualifying Event, found in the COBRA Section** of your Summary Plan Description (“SPD”) in the fourth paragraph under the heading "Notification Requirements" (see page 27 of the Plan X SPD.)

If you become eligible for COBRA Continuation Coverage under the Plan as a result of your termination of employment or a reduction in your hours, and you elect to receive COBRA Continuation Coverage for yourself and your dependents, generally you and your dependents will be entitled to continue your COBRA Continuation Coverage for up to 18 months, subject to the limitations described in your SPD. If, during that 18-month Coverage period, a second qualifying event (described below) occurs, your dependents may be eligible to receive an additional 18 months of COBRA Continuation Coverage, for a total of 36 months of Coverage. Under no circumstances will COBRA Continuation Coverage extend beyond 36 months.

Second qualifying events include the death of the Participant, divorce or separation from the Participant or a dependent child’s ceasing to be eligible for coverage as a dependent under the Fund. The events described in this paragraph are second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. Consequently, since the Plan’s eligibility rules permit active Participants and their dependents to remain covered after the Participant becomes eligible for Medicare, eligibility for Medicare is not a second qualifying event (so it does not extend COBRA coverage).

Here are some examples of how these rules work:

1. You and your dependents are currently receiving COBRA Continuation Coverage under the Plan for an 18-month period as a result of your termination of employment. If you and your spouse are divorced during that 18-month period, your dependents would be entitled to extend their COBRA Continuation Period for an additional 18 months.
2. You and your dependents are receiving COBRA Continuation Coverage under the Plan for an 18-month period as a result of your termination of employment and, during that 18-month period, you become eligible for Medicare because you have attained age 65. Your dependents will not be entitled to extend their period of COBRA Continuation Coverage under the Plan, because your eligibility for Medicare would not have caused you to lose coverage under the Plan if you were still an active Participant under the Plan on your 65th birthday.

Please remember that your spouse and dependents must notify the Fund office in writing and in accordance with the notification procedures described in your SPD in order to extend their period of COBRA Continuation Coverage upon the occurrence of a second Qualifying Event.

- **The Section entitled “Overpayment” on page 6 is amended by adding the following:**

The *Fund* shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the *Fund* on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the *Fund* under this section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the *Fund* until paid to the *Fund*. By accepting benefits from the Fund, you and your dependent consent and agree that a

constructive trust, lien, and/or equitable lien by agreement in favor of the *Fund* exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the *Fund* in reimbursing it for all of its costs and expenses related to the collection of those benefits.

- **March 2008. The first sentence of the Subsection entitled “Appeals Process,” which appears near the end of your SPD’s Dental Benefit Section, is deleted and replaced with the following:**

If your dental claim is denied by GDS and you are not satisfied with the result of the GDS Grievance Procedure, described above, or you do not wish to file a grievance, you have the right to appeal the denied claim within 180 days of the denial.

- **March 2008. Add the following to page 74:**

Anti-Obesity drugs will be covered with prior authorization from NMHC Rx. In order to be approved, the patient must have a Body Mass Index (BMI) of 30 or greater, coupled with another disease indicator. If approved, medication is authorized for a three-month period. If, after three months, the patient has lost at least five pounds, the medication will be approved for up to another nine months. At the end of the first year, if the patient has maintained at least a 5% weight loss from his/her original weight, another year of medication will be approved. At no time will medication be covered for more than a two-year period.

- On page 126 of your SPD, please change the first sentence in item number 6, in the section entitled Claims Filing and Review Procedure, to read:

Accident & Sickness claims must be filed within **90 days** from the first date of disability. Medical claims or itemized bills must be filed within **180 days** of the date of service.

- **June 2006. Certificate of Creditable Coverage** (Add to page 16 of your SPD.)

If you lose Fund coverage, including COBRA continuation coverage, for any reason, the Fund will send you and/or your dependents a Certificate of Creditable Coverage. A copy of the Fund’s procedures for requesting a HIPAA Certificate of Creditable Coverage can be obtained without charge from the Fund Office.

If you need a Certificate of Coverage, write or call the Fund office at: FELRA & UFCW Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451, Attn: HIPAA Certificate of Coverage.

Procedure for Obtaining a HIPAA Certificate of Creditable Coverage

The Fund will send a Certificate of Creditable Coverage to you and your dependents that show your period of coverage under the Fund. This certificate will be sent within a reasonable time after you lose coverage under the Fund for any reason, or after you would have lost coverage under the Fund absent your election of COBRA continuation coverage. You do not need to make a request to receive a Certificate upon termination of Fund coverage or commencement of COBRA continuation coverage. In addition, you and your Dependents may request a Certificate of Creditable Coverage at any time while you are covered under the Fund and for up to two years after you lose coverage under the Fund by writing to:

FELRA & UFCW Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: HIPAA Certificate of Coverage
Telephone No. 410-683-6500

Notice of Special Enrollment Period

If you decline enrollment for yourself or your dependents (including your spouse) under the Fund because

of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Fund if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards that other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund office at:

FELRA & UFCW Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: Special Enrollment
Telephone No. 410-683-6500

▪ **Qualified Medical Child Support Order Procedures** (Add to page 20 of your SPD.)

A copy of the Fund's Procedures for determining whether an order is a Qualified Medical Child Support Order ("QMCSO") can be obtained without charge from the Fund Office. If you need a copy of the Fund's QMCSO Procedures, write or call the Fund office at:

FELRA & UFCW Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: QMCSO
Telephone No. 410-683-6500

▪ **Clarification to Routine Mammograms:** Routine annual mammograms are covered for participants and eligible dependents ***age 40 and over***.

▪ **Appeals – Change of Address.** On pages 132, 136, and 136 of your SPD, please change the address of where to send Appeals to:

Board of Trustees
FELRA & UFCW Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: Appeals Dept.