UFCW Unions & Participating Employers
Health and Welfare Fund

Plan Y

Summary of Material Modifications

May 2015

This insert is a Summary of Material Modifications (changes) to your Summary Plan Description (SPD) booklet dated November 2006. If there is any discrepancy between the information printed on this insert and the Plan, the Plan will govern. Please keep this insert with your booklet so you will have it when you need to refer to it.

- **Effective February 1, 2015 – CBA Changes:**
  - **Plan Y participants must use a CareFirst provider in order to be covered for medical benefits! Non-CareFirst providers will be covered for anesthesiologists, radiologists, pathologist and treatment by emergency room physicians only if incurred at in-network facilities. Please be sure your provider participates with CareFirst before incurring charges. For mental health and substance abuse services, you must use a Value Options network provider.**

  - Basic benefits (such room and board in the hospital paid at 100%) will be eliminated. A Comprehensive Medical plan paid at 80% (after meeting the deductible) will apply to all covered charges.

  - In-Network preventive care benefits will be covered at 100% with no cost to the participant.

  - There will be an emergency room co-pay of $75.00 which will be waived if you are admitted to the hospital.

  - Coordination of benefits will be subject to a non-duplication rule. This means that any secondary payment will be determined by calculating primary payment, subtracting it from what the Fund's payment ***would have been***, and paying the remaining amount, if any. For example, if your enrolled spouse's plan pays a charge at 70% and the Fund's plan covers it at 80%, the Fund would pay 10% as a secondary benefit. However, if your spouse's plan pays 80% and the Fund's plan also pays 80%, the Fund would not make any additional secondary payment.

  - There is a $4,000 out-of-pocket maximum per individual per calendar year for medical benefits with an $8,000 out-of-pocket maximum per family. Covered charges in excess of the out-of-pocket maximum will be paid at 100% of allowable charges.

  - There is a $2,600 out-of-pocket for prescription drug benefits per individual with a $5,200 out-of-pocket maximum per family. Covered charges in excess of the out-of-pocket maximum will be paid at 100% of allowable charges.

- **Effective February 1, 2015 – Coverage of Emergency Services**
  Emergency services will be covered as follows, regardless of whether you receive treatment in-network or out-of-network:

	Facility Charges	Physician Charges
Plan Y	$75 co-pay 20% co-insurance of usual, customary, and reasonable charges, plus balance-billing up to In-Network rate.	20% co-insurance of usual, customary, and reasonable charges, plus balance-billing up to In-Network rate.
Plan Y20	$75 co-pay 25% co-insurance of usual, customary, and reasonable charges, plus balance-billing up to In-Network rate.	25% co-insurance of usual, customary, and reasonable charges, plus balance-billing up to In-Network rate.

- **Effective February 1, 2015 – Preventive Services Benefits**
  The UFCW Unions and Participating Employers Health and Welfare Fund provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). **Effective February 1, 2015,** preventive services are provided for participants employed by Shoppers and covered under Plan Y, Y20 or JSS2 on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments). For a list of covered preventive services for all adults, women (including pregnant women), children, immunizations, preventive medications, office visit coverage, and preventive services coverage limitations and exclusions, log in to www.associated-admin.com. Click on "Your Benefits" located at the left side of screen and choose "UFCW Union and PE Health and Welfare Fund." On the UFCW homepage, under "Important Notices," you can view the Preventive Services Benefits.

- **2015 - ING Changed Name To Voya Financial**
  Your life insurance benefits and Accidental Death and Dismemberment benefits under the Plan have long been insured through ING. Recently, ING changed its name to Voya Financial. The new name reflects the company's relationship to its parent company, Voya Financial. Nothing else has changed – the address, phone number, policy, and coverage all remain the same.

- **2015 - Group Vision Service Has New Address.** Group Vision Service (GVS), your vision provider, has a new address:
  Group Vision Service
  6700 Alexander Bell Drive, Suite 200
  Columbia, MD 21046
  All telephone numbers remain the same (301) 770-1480 or toll free (800) 242-0450. Please make this change in your Summary Plan Description booklet.

- **2015 - CareFirst Has New Address.**
  If you have a blue ID card, your claims that are not filed electronically should now be sent to:
  CareFirst/Network Leasing
  PO Box 981633
  El Paso, TX 79998-1633
  Please share this information with your provider the next time you have an appointment.

- **Effective January 1, 2014 – Active Plan No Longer Has Annual Major Medical Benefit Maximum on Essential Health Benefits.** The overall annual dollar limit on essential health benefits under the Active Plan has been eliminated for participants and eligible dependents.

- **Effective July 2, 2013 – Three-year statute of limitations to file suit against the Fund.**
  The following SMM apply to both the Active Health & Welfare Plan and Retiree Health & Welfare Plan.
  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.

- **Participants Employed by, or Retired from, Shoppers: Extended Time To File Medical Claims (Plans Y, Y20 and JSS2)**

  This change applies to participants actively employed by, or retired from, Shoppers Food Warehouse, and their eligible dependents, *with traditional Fund medical coverage.*

  As a result of collective bargaining, the Board of Trustees is pleased to announce that effective for dates of service on and after July 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 July 1, 2012 will be subject to this timeframe.

- **March 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 March 1, 2013 – Gardisil Vaccine Is Now Covered – UFCW Active and Retiree Plans.**
  The following applies to participants employed by, or retired from, Shoppers Food Warehouse, and their eligible dependent daughters who have traditional Fund coverage.
  The Board of Trustees announced that Gardisil, the HPV vaccine for girls, is now covered for dependent daughters of participants employed by, or retired from, Shoppers Food Warehouse.

  Receiving the Injection at a Shoppers Pharmacy
  - **Virginia Participants**
    Your dependent daughter may choose to receive the Gardisil injection at a Shoppers pharmacy at no cost to you when you use your Informed Rx/Catamaran ID pharmacy card.

  - **Maryland and DC Participants**
    For Maryland and DC participants, state law does not permit this injection to be administered at a store pharmacy; therefore, it will be covered when administered at the doctor's office.

Receiving the Injection at the Physician's Office

Participants may pick up the injection from the pharmacy at no charge. Maryland and DC participants would then return to the doctor's office with the injection for administration, while Virginia participants may choose to have the injection administered either at the pharmacy or the physician's office. Or you may both obtain the vaccine, and have it administered, at the physician's office.

Cost

The injection itself is covered at 100%, up to the usual, customary and reasonable (UCR) rate. The office visit charge (if there is one) is covered under your medical benefit at 80% for Plans JSS2 and Y and at 75% for Y20, after satisfying your deductible.

- **Effective 2013.** The Fund's disease management provider is now Conifer, formerly known as InforMed. The phone number is (800) 459-2110 and the fax number is (410) 972-2044.

- **Effective 2013 Plan Year – Notice of Waiver of Annual Limit Requirement.**

  Below is a Notice that we are required by federal law to send to you. 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. 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 benefits and rehabilitation 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 $1.25 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.

  <u>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</u>. 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

This notice applies to participants with traditional Fund coverage, not HMO coverage.
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 $2 million.

Your health coverage, offered by the United Food and Commercial Workers Unions and Participating Employers 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:

	ANNUAL MAXIMUM (PER INDIVIDUAL)						
BENEFIT CLASS	PLAN JS	PLAN JSS2	PLAN Y	PLAN Y20	PLAN Z	PLAN K2	PLAN K20
Major Medical[1]	$250,000	$400,000	$400,000	$100,000	$350,000	$400,000	$150,000
Rehabilitation[1]	$ 25,000	$ 25,000	$ 25,000	$25,000	$ 25,000	$ 25,000	$ 25,000

[1] *Effective 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 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 Administrative Manager at 301-459-3020 or 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.

Notice of Grandfathered Health Plan

Plans JS, JSS2, T, Y, Y20, K2, K20 and Z under the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund ("Fund") qualify as "grandfathered health plans" 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 these Plans qualify as grandfathered health plans, 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 these Plans. However, the Plans offer 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 Plans to stop being treated as a grandfathered health plan, please contact Participant Services at 1-800-638-2972. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-327 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

- **Change in Life Insurance Payment Process – "UFCW Active Plan"**
  DEFAULT PAYMENT FORM FOR LIFE INSURANCE BENEFIT
  1. Beneficiaries who are residents of Maryland, Virginia or the District of Columbia and are eligible to receive a life 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 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 options for Beneficiaries residing in other states may be different. For more information on those benefit options, please contact ING at 888-238-4840.

- **Effective October 1, 2012 – Flu shot is free with Rx ID card at any Shoppers or Kroger Pharmacy.** The Board of Trustees announced an enhanced flu shot benefit for Fund actives and retirees covered by Plans Y and Y20. Effective for flu shots given October 1, 2012 and after, you may get your flu shot at any Shoppers or Kroger pharmacy at **no cost to you**, using your InformedRx/Catalyst Prescription Drug ID card. Simply go to your Shoppers or Kroger pharmacy, show your InformedRx/Catalyst ID card and receive your flu shot.

  If you prefer to get your flu shot from your doctor or don't live near a Shoppers or Kroger pharmacy, the shot is still covered under your medical benefits. For those with Fund medical 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 at the applicable co-payment of 80% (or 75% for Plan Y20) 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.

  For participants in the Kaiser Permanente 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 InformedRx/Catalyst (now called Catamaran) for their prescription benefit also may get a flu shot at a Shoppers or Kroger pharmacy using their prescription ID card.

- **Effective September 1, 2012- New plan names.** The Board of Trustees formally separated the Plan for active participants and the Plan for retired participants. The active plan now is called the UFCW Unions and Participating Employers Active Health Plan, a plan of the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund. The retiree plan now is called the UFCW Unions and Participating Employers Retiree Health Plan, a plan of the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund. Your benefits remain the same.

  You may continue to use your current medical card (whether your benefits are provided through Fund medical coverage or Kaiser Medicare coverage) and your current prescription ID card from Catamaran Rx (formerly called InformedRx/SXC).

- **Effective September 1, 2012 – CBA Change - Plan JSS2 and Plan Y Participants: Endodontic Procedures (Root Canals) Now Covered.** As a result of recent collective bargaining, the Board of Trustees is pleased to announce that coverage of Endodontic procedures (root canals) has been added for Participants and Dependents in Plan JSS2 and Plan Y whose employers ratified the 2012 bargaining agreement. While most of the Endodontic procedures are subject to a co-pay, participants should see significant savings since the procedures previously were not covered under Plans JSS2 and Y and could have cost as much as $1,200 per instance. To be covered, **the Endodontic procedures must be performed by a GDS general network dentist** and are subject to the same policy provisions as your other dental benefits including, but not limited to, authorization for medical necessity.

The below co-pays apply to endodontic procedures performed by a GDS general network dentist:

Co-pay When Using a GDS General Network Dentist

Code	ADA Description	Co-pay
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 network general dentist to be eligible for dental benefits.

If the procedure is performed by a GDS in-network Endodontic Specialist, the Participant is responsible for an additional $100 Specialist fee charge on the last three procedures reflected in the above chart. Thus, if the procedure is performed by a GDS in-network Endodontic Specialist, co-pays are as follows:

Code	ADA Description	Co-pay
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 network endodontic specialist to be eligible for dental benefits.

If you have questions regarding the endodontic benefit or for assistance in finding a network dentist, please contact GDS at 800-242-0450.

- **Effective September 1, 2012 – CBA Change for Shoppers Kaiser Medicare HMO Retirees:**
  The following applies to retirees formerly employed by Shoppers, and their dependents, who are enrolled in the Fund's Kaiser Permanente Medicare HMO Option.

  As a result of collective bargaining, the Trustees have adopted the following change to the Kaiser Medicare HMO retiree program, effective **September 1, 2012**:

  - The office visit copayment will change from $10 to $15 per visit.
  - There will be a $100 inpatient copayment which will apply to the first inpatient admission during each benefit period.
  - The prescription drug co-payments will change as follows:
    - From $5 to $10 for mail order scripts (up to a 90 day supply) from the Kaiser Permanente mail order pharmacy;
    - From $10 to $15 for scripts obtained at a Kaiser Center Pharmacy (up to a 60 day supply);
    - $22.50 for 90 day supply script obtained at a Kaiser Center Pharmacy rather than mail order;
    - From $15 to $25 for scripts obtained at a participating retail pharmacy.

You will receive a separate mailing and a new Evidence of Coverage directly from Kaiser Permanente. The Board of Trustees is pleased to be able to continue coverage for retirees. If you have questions regarding your Kaiser benefits, please call (800) 777-7902.

- **Effective July 1, 2012 – Expended Time To File Medical Claims – UFCW Active and Retiree Plans.**
  Applies to participants actively employed by, or retired from, Shoppers Food Warehouse, and their eligible dependents, with traditional Fund medical coverage.

  As a result of collective bargaining, the Board of Trustees announced that effective for dates of service on and after July 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 July 1, 2012 will be subject to this timeframe.

- **Effective 2012 - Dental Benefits for Dependents.** (Applies to participants in Plans T, Z, Y, Y20, K2 and K20). Dental benefits for dependents terminate at the end of the year in which the dependent turns age 19. Student coverage does not include dental benefits.

- **Effective October 1, 2011,** CareFirst replaced OneNet PPO as your new Preferred Provider Organization ("PPO"). 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.

  New ID Card
  A new medical ID card was sent to you. ***Be sure to show the new ID card to all providers of service so that your claims are filed and processed correctly!***

  Locating A CareFirst Provider
  - You may call the CareFirst telephone number located on the back of your medical ID card.
    - If you received a white ID card with blue writing, call: (800) 235-5160.
    - If you received a white ID card with black writing, call (800) 810-2583.
  - You may go online to the CareFirst website, www.carefirst.com.

    - **White ID Card Holders with Blue Writing**
      Click on "Members and Visitors," then on "Find a doctor or other provider in your Plan." On the next screen, click on the "Find a Doctor" link. Blue ID card holders should click on the button that reads, "Within MD/DC/Northern VA" under "PPO.' Click on "Continue." You may refine your search by clicking on "Type of Doctor" or "Type of Facility" and then clicking "Continue."

    - **White ID Card Holders with Black Writing**
      Click on "Members and Visitors," then on "Find a doctor or other provider in your Plan." On the next screen, click on the "Find a Doctor" link. White ID card holders should click on the button that reads, "Outside MD/DC/Northern VA" under "PPO." Click on "Continue." You may refine your search by clicking on "Type of Doctor" or "Type of Facility" and then clicking "Continue."

- **Effective January 1, 2011.** The Board of Trustees of the United Food and Commercial Workers Unions and Participating Employers Health & Welfare Fund ("Fund") has adopted the following changes to the United Food and Commercial Workers Unions and Participating Employers Health & Welfare Plan in order to comply with the Patient Protection and Affordable Care Act. Please keep this document with your Summary Plan Description ("SPD").

  Elimination of Pre-existing Condition Exclusions

  Under the heading "Eligibility" or "Employee Eligibility," the section entitled "Pre-Existing Condition Exclusions" is revised by deleting the first sentence and replacing it with the following:

The Fund does not impose a general pre-existing condition exclusion on medical or prescription drug benefits under the Plan.

For Plans JS, JSS2, T, Y, Y20, and Z, under the heading "Eligibility" or "Employee Eligibility," the section entitled "Pre-Existing Condition Exclusions" is further revised by adding the following sentence to the end of that section:

Further, with respect to medical and prescription drug benefits under the Plan, the specific pre-existing condition exclusions described in this Summary Plan Description do not apply to participants or dependents under the age of 19.

Dependent Children Eligibility

Under "Dependent Eligibility," the section entitled "Who is an Eligible Dependent?" and the paragraph entitled "Legal Custody" are deleted and replaced with the following:

Who Is an Eligible Dependent?
Eligible dependents include your spouse and children, as defined in this Section.

Biological Children, Adopted Children and Children Placed for Adoption – For Plans T, Z, Y and Y20

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.

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

Stepchildren and Children over whom you have Legal Custody – All Plans

Stepchildren and children over whom you have legal custody are eligible for medical, optical, dental, and prescription drug 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.

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

Coverage for Full Time Students – Legal Custody and Stepchildren – Plans T, Z, Y and Y20
Generally, stepchildren and children over whom you have legal custody are eligible until the end of the calendar **year i**n in which they turn age 19. However, if your son or daughter is 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.

Coverage for Full Time Students – Legal Custody and Stepchildren – Plans Other Than T, Z, Y, and Y20
Generally, stepchildren and children over whom you have legal custody are eligible until the end of the calendar **year i**n in which they turn age 19. However, if your son or daughter is a full-time student at an accredited college or university, **medical, optical, dental and prescription drug** 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.

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; and for your spouse: a marriage license. In the case of a stepchild, a copy of the divorce decree indicating custody is required as evidence.

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.

- **Effective January 1, 2011.** The Fund is required under the Patient Protection and Affordable Care Act ("PPACA") to provide you with the following Notice.

Notice of Opportunity to Enroll
in Connection with Extension of Dependent Coverage to Age 26

Individuals biological and adopted dependent children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 may be eligible to enroll in the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund. Participants may request enrollment for such children until

December 20, 2010 (30 days from the date the Notice was sent to you). Enrollment will be effective retroactively to January 1, 2011.

- **Effective January 1, 2011.** Pursuant to the Patient Protection and Affordable Health Care Act (PPACA), effective January 1, 2011, the Board of Trustees of the UFCW Unions and Participating Employers Health and Welfare Fund ("Fund") has made several changes to the Fund's Plan of benefits.

1. 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)).

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.

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 November 19, 2010 to December 20, 2010.

2. 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 pre-existing condition exclusions on specific benefits under the Plan do not apply to participants and dependents under age 19.

3. Elimination of Certain Lifetime Limits.

The following lifetime benefit maximums under the Fund are eliminated, effective January 1, 2011. If you previously lost coverage under the Fund because you reached or exceeded one of these lifetime maximums, you are again eligible to receive such benefits, subject to the terms of the Plan.

Comprehensive Medical /Major Medical	Plans JSS2, K2, Y	$400,000
	Plans T, Z	$350,000
	Plan JS	$250,000
	Plan K20	$150,000
	Plan Y20	$100,000

Rehabilitation Benefits	All Plans	$ 25,000

4. Changes to Annual Limits.

Effective January 1, 2011, the following annual limits are added to the Plan:

Comprehensive Medical /Major Medical	Plans JSS2, K2, Y	$400,000
	Plans T, Z	$350,000
	Plan JS	$250,000
	Plan K20	$150,000
	Plan Y20	$100,000
Rehabilitation Benefits	All Plans	$ 25,000

Retroactive Termination of Coverage

Effective January 1, 2011, 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.

Notice of Early Retiree Reinsurance Program Participation

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses the Fund for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, the Fund may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the Fund chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this Fund chooses to use the reimbursements for this purpose. The Fund may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in the Fund's costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

- **Effective January 1, 2011.** Pursuant to the Patient Protection and Affordable Health Care Act (PPACA), the UFCW Unions & Participating Employers Health and Welfare Fund ("Fund") is extending coverage for biological and adopted dependent children until the child's 26th birthday, unless the dependent child is eligible for employer-sponsored health coverage from a Plan other than that of the dependent's parent (such as through the dependent's employment or through his/her spouse's employment). However, if your adult child would not be entitled to coverage under this new rule because he is eligible for coverage through his employer or his spouse's employer, but your child would qualify for student coverage under the Plan's current

rules, your child still will be eligible for coverage until the calendar year in which he or she attains age 23, assuming he or she submits appropriate documentation of full-time student status to the Fund office.

Example 1:
Let's say your biological dependent child is 22, a full-time college student, and employed part-time. Further, the child is eligible for group health coverage through his employer. Under these circumstances, your child will continue to be eligible for dependent coverage under the Plan until the end of the year in which he turns 23, provided he continues to satisfy all other eligibility requirements.

Example 2:
Assume the same facts as in Example 1 above, except that your child is not eligible to receive group health coverage from his employer. Under these circumstances, your child will continue to be eligible for dependent coverage under the Plan until he turns 26, provided he continues to satisfy all other eligibility requirements.

If your dependent is a child of whom you have legal custody or is your stepchild, the eligibility rules relating to his/her coverage have not changed.

If you have eligible dependent children under age 26 who are not currently enrolled in the Fund, you may enroll them for coverage between now and December 20, 2010. If you enroll them no later than December 20, 2010 by filling out the enclosed form, the dependent child's coverage will begin January 1, 2011.

Note: If you, as the participant, are not currently enrolled for health coverage under the Fund and you want to enroll your dependent child, you may enroll both yourself and your dependent child by December 20, 2010, and all rules applicable to participant and dependent coverage will apply to you.

Because it is considered "grandfathered" under the PPACA rules, your Plan excludes coverage for dependent children under age 26 if the child is eligible to enroll in an employer-sponsored plan other than the plan of his/her parent. That means if your child under age 26 is eligible for other employer-sponsored health plan coverage through his/her own employment or through his/her spouse's employment (even if he/she didn't enroll for it), he/she is not eligible to enroll for dependent coverage under the Fund.

If your dependent child does not have, or will lose, coverage prior to January 1, 2011, you must enroll for coverage by returning the enrollment form no later than December 20, 2010.

Example:
Let's say your biological or adopted dependent child is 21 and not attending college. In order for your dependent child to be covered under the Fund, you must enroll him/her by completing the enclosed form. Coverage which ended prior to December 31, 2010 will begin again on January 1, 2011 and continue until the child's 26th birthday.

Co-Payments May Apply for Some Plans, as they do for Other Similarly-Situated Participants
If you are actively working, you may enroll your dependent child in Fund indemnity coverage or Kaiser Permanente HMO coverage (if applicable to your Plan of benefits). If you enroll for Fund coverage, and you are a Part Time employee in Plan Y or Plan K2, you must make a co-payment which is 20% of the cost of the coverage, deducted from your paycheck by your employer. If you are a Full Time employee in Plan Y20, K2 or K20, you must pay $10 per week for you and one dependent or $15 per week for you and more than one dependent (family coverage), which will be deducted weekly from your paycheck by your employer. Part Time employees in Plan Y20 and K20 are not eligible for dependent coverage. However, for all Plans, you still must enroll your dependent if you want coverage for the dependent to age 26, as described above.

If you enrolled for Kaiser Permanente HMO coverage as an actively-working participant, your Plan may have a monthly co-payment. This will not change.

If you are a retiree and have children eligible to apply for dependent coverage to age 26 under PPACA, and those dependents were: (1) enrolled for coverage on the date you retired; or (2) were not eligible to enroll on the date of your retirement due to age, you may apply for dependent Fund coverage or Kaiser Permanente Medicare HMO coverage, depending on where you live and your Medicare status.

Once the Fund office receives the completed enrollment form, it will be processed. If more information is needed, the Fund office will contact you. The weekly deduction from your paycheck or monthly deduction from your pension check, if applicable, will be implemented effective for coverage starting January 1, 2011.

- **Effective July 1, 2010, Group Vision Services ("GVS")** became your new vision provider, replacing your coverage through United Optical (Spectera).

  Improved Network – One-Stop Shopping
  GVS has an extended network of providers located in major malls and convenient city locations, making it easy to find a provider. You have a choice of independent optometrists and ophthalmologists, as well as retail locations such as LensCrafters, Sears Optical, JCPenney Optical and participating Pearle Vision locations.

  Locating a Provider
  To locate the most current providers in the GVS network, log on to the GVS website at www.gvsmd.com. The names of providers are updated regularly. You can also call GVS' customer service toll-free at 1-866-265-4626.

  If you have an appointment scheduled on or after July 1, 2010 with a provider that participates with United Optical (Spectera), that appointment may not be covered by the Fund. Please go to www.gvsmd.com to see if your provider participates with GVS.

  ID Card Mailed
  An ID card was sent to you from GVS to use for your optical benefits. However, if you haven't received your card or do not have your ID card with you when you go to your eye appointment, don't worry. Simply give your provider your name and date of birth and have your provider call customer service at 1-866-265-4626 to verify your eligibility.

- **Effective January 1, 2010, Life Insurance Increased for Shoppers.** The life insurance benefit for Shoppers participants increased to $20,000 for full-time participants and to $10,000 for part-time participants.

- **Effective January 1, 2010, Michelle's Law.**
  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 section.

  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.

- **Effective April 1, 2009, Special Enrollment for Dependents—Medicaid and "CHIP"**
  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 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 becomes 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.

- **Effective January 16, 2009, "FMLA" Changes for Military Service,** 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 August 1, 2008,** InforMed (pronounced IN-for-med) replaced Optum/CARE program as your new Utilization Management ("UM") provider.

  Contact InforMed (not Optum/CARE) at (866) 290-8147 to pre-certify <u>all</u> non-emergency hospital stays and within 24 hours after an emergency admission. Remember, you must certify all hospital stays in order to receive coverage under your plan. This is very important!

  <u>Did My Benefits Change?</u>
  No. You have the same coverages, payment structures, exclusions, etc.

  <u>When Do I Have to Pre-Certify Care?</u>
  You have to call InforMed to certify the following procedures:
  - All elective (non-emergency) hospital admissions
  - Surgical procedures performed at the outpatient center of a hospital or at an ambulatory surgical center
  - All inpatient and outpatient rehabilitation care
  - Home Care
  - Hospice Care
  - Within 24 hours of emergency admission to a hospital.

  Every place "Optum/CARE" appears in your SPD, please change the name of the provider to InforMed.

- **Effective August 1, 2008,** InforMed provides a "disease management" service to all active participants **except** those who are Medicare eligible or who are in an HMO.

  What is disease management?
  It is a program designed to assist participants with chronic, ongoing health conditions such as diabetes, lung/breathing problems, heart conditions and more. A personal nurse can answer questions and help you make lifestyle changes which may help your condition. InforMed will also provide "Ask A Nurse" services to members. Call InforMed toll-free at 1-866-290-8147 if you are interested in this program.

- **Effective August 1, 2008**, As a result of recent Collective Bargaining and Plan Amendments adopted by the Board of Trustees, benefits changed for Fund participants, employed by Shoppers and Fund retirees formerly employed by Shoppers. The changes are outlined below.
  - **Colonoscopy Covered**
    Routine colonoscopies for participants and dependents age 50 and over are covered as a basic benefit, with no deductible, at 100%, up to the usual, customary, and reasonable ("UCR") amount, once every five (5) years.

  - **PSA Tests (Prostate Specific Antigen Tests) Covered**
    Routine PSA tests (prostate specific antigen tests) for male participants and dependents age 50 and over are covered as a basic benefit, with no deductible, at 100%, up to the usual, customary, and reasonable ("UCR") amount, once every twelve (12) months.

  - **Prosthetics**
    Prosthetics are now covered for Kaiser Permanente participants.

- **Effective July 8, 2008,** as a result of Collective Bargaining and amendments adopted by the Board of Trustees, life insurance changed for participants in Shoppers Plan Y as follows:
  Full Timers: Your life insurance increased to $15,000
  Part Timers: Your life insurance increased to $7,500.

- **Effective March 2008,** in the Dental Benefit Section of your SPD, on page 84, the first sentence of the Subsection entitled "Appeals Process," 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 if you do not wish to file a grievance, you have the right to appeal the denied claim to GDS within 180 days of the denial.

- **January 1, 2007,** OneNet PPO (formerly Alliance) removed Quest Diagnostic Laboratories (Quest) as a network provider. For laboratory services incurred on or after 1/1/07, and to receive significant discounts, use a LabCorp lab network provider.