OTHER FUND BUSINESS

Linda Gatewood

From: Linda Gatewood
Sent: Friday, September 21, 2012 3:03 PM
To: 'tmcnutt@local400.org'; 'Michelle Eubank'; 'Tom Hipkins'; 'lharris@local400.org'; 'Loeffler, Steve'; 'Alia.Samad-Salameh@shaws.com'; 'george.anderson@kroger.com'; 'Gwin, Donna'; 'hburton@morganlewis.com'; 'bss@slevinhart.com'; 'Sharon M. Goodman'; Joseph Sears; 'gmurphy@ufcw27.org'
Cc: 'Lisa Aurich'; 'Irene DiBattista'; 'Bernie Trimble'
Subject: FW: shoppers non food welfare poll

Dear Trustees:

As a result of recent collective bargaining between Locals 27 and 400, retiree health benefits for Shoppers retirees would be altered in the following manner:

- Formalize the separate existence of the Fund's retiree program by creating a separate retiree plan under the Fund, including separately tracking and reporting the assets, income and expenses of the retiree plan separately from the assets, income and expenses of the active plan, to ensure that the assets of one plan are not used to pay the liabilities of the other.

- As part of the newly formalized retiree plan:

1. Change the Rx copayments of Shoppers JSS2 non-Medicare retirees, and Medicare retirees not covered by Kaiser, from 5%/10% to 8%/13%.

Move Shoppers Kaiser Medicare retirees into the "Plan A" Medicare benefit plan which is the same as FELRA.

While the above benefit changes would only apply to Shoppers retirees, it makes sense to formalize the separate existence of all the Fund's retiree programs at the same time, by creating a separate retiree plan under the Fund covering all retirees. Within that retiree plan, benefits would be those bargained for the affected retirees.

Kaiser advised the earliest we could install the reduced level of benefits would be September 1, 2012. If we waited until the next meeting, due to the deadlines that Kaiser must use for compliance, it would shift the effective date until October 1, 2012 at the earliest.

Please advise if the retiree plan benefits may be adjusted effective September 1, 2012, as noted above.

Another change adopted by the bargainers was adding Endodontic benefits (root canal) to Shoppers employees in Plans JSS2 and Y. GDS advised they would make such a change effective as of September 1, 2012.

Please advise if Plan JSS2 and Y may be improved by adding Endodontic benefits effective September 1, 2012.

In addition, there are several other H/W changes that will need to be implemented, yet may require further coordination by the plan professionals regarding language and effective dates. They include an agreement for the Rx plan to be modified to have:

- Step therapy and (in the case of the Local 27 MOA) elimination of Proton Pump Inhibitors
- Narcotic "flags" in the local 27 MOA (note, the Fund has long had a controlled drug program, so I am unsure of the intent of the bargainers, so the plan professionals may need to review)
- Out of area retirees to be shifted to mandatory mail order

- In addition, Gardasil would be added for female participants and dependents, with restrictions on dispensing in VA to a Shopper Food Warehouse pharmacy. If the law changed in MD and DC, such dispensation would be likewise limited to Shoppers' pharmacies, but currently, coverage would be available for MD and DC eligible participants and dependents at a participating provider.

The MOAs indicated that the medical claims submission deadlines would be increased from 6 months from date of service to 12 months from date of service. In the case of FELRA, such change was made effective as of the first of the month following the date of the contract expiration.

Please advise if the plan professionals are authorized to begin implementation of those remaining bargained benefit changes, with direction from the trustees.

Unrelated to Shoppers, yet also as a result of collective bargaining, Associated Administrator's contract was recently ratified, and it likewise called for a reduction in the retiree health benefits for its Medicare retirees from the current Kaiser Medicare plan, to Kaiser's Plan A, consistent with the change adopted by the Shoppers bargainers.

Please advise if Associated's Plan TR retirees are approved to change to Kaiser Plan A as of September 1, 2012.

Bill Jensen
President
Associated Administrators, LLC
4301 Garden City Dr. Suite 201
Landover, MD 20785-2210
301-429-8960
Web page: http://www.associated-admin.com

United Food and Commercial Workers Unions
and Participating Employers
Health and Welfare Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

4301 Garden City Drive, Suite 201
Landover, Maryland 20785-6102
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

August, 2012

Summary of Material Modifications
EIN: 52-6044428

Dear Shoppers Retiree,

As a result of recent collective bargaining, your prescription benefit will change effective 9/1/12. For prescriptions filled on or after that date, you will pay an 8% co-payment if you use a participating employer pharmacy and a 13% co-pay if you use any other pharmacy that accepts Catamaran (formerly called Informed Rx/SXC). Remember that generic drugs are mandatory if available.

Continue to use the prescription card you have now. The new prescription co-pay percentage will be changed in the pharmacy system.

If you have questions about the change in prescription co-pay, please contact the Fund office. Thank you.

Sincerely,

Fund Office

ShoppersRxRetiree copay change.cgm

Linda Gatewood

From: Joseph Sears
Sent: Tuesday, September 18, 2012 10:23 AM
To: Joseph Sears; 'Tom McNutt'; 'Steve Loeffler'; 'Michelle Eubank'; 'Lavoris Harris'; 'thipkins@ufcw27.org'; 'Gwin, Donna'; ' (George.anderson@kroger.com)'; 'Samad-Salameh, Alia'
Cc: Bill Jensen; 'Sarah E. Sanchez'; 'Burton, Harry W.'; 'Barry S. Slevin'; 'Sharon M. Goodman'; Linda Gatewood
Subject: RE: Flu Shots

Good morning.

The poll (copy below) was approved, with the Shoppers Trustees abstaining from the voting. We will move forward with the implementation.

If you have any questions, please feel free to contact Bill or me.

Joe Sears
(410) 683-7710

From: Joseph Sears
Sent: Friday, September 14, 2012 11:33 AM
To: 'Tom McNutt'; 'Steve Loeffler'; 'Michelle Eubank'; 'Lavoris Harris'; 'thipkins@ufcw27.org'; 'Gwin, Donna'; ' (George.anderson@kroger.com)'; 'Samad-Salameh, Alia'
Cc: Bill Jensen; Sarah E. Sanchez; 'Burton, Harry W.'; 'Barry S. Slevin'; Sharon M. Goodman; Linda Gatewood
Subject: Flu Shots

Ladies and Gentlemen: The purpose of this email to review briefly the informal discussions that have occurred to date about how the Non Food Health & Welfare Fund might make an annual flu shot more readily available to eligible Plan participants and their eligible dependents by offering the shots under the Plan's PBM benefit as well as under the Plan's medical benefit, except for the Kroger Plans K2 and K20, as those plans do not have prescription coverage through the Fund.

To review, currently eligible participants (except for Plan Y20) and their eligible dependents may obtain a flu shot at a participating employer pharmacy under the Plans' medical benefit. The employee must pay the cost of the shot and then submit a claim to the Fund Office for reimbursement. Eligible Plan Y20 participants currently may receive flu shots only from an in-network PPO provider, under the Plan's medical benefit.

In order to make an annual flu shot more accessible to participants who are eligible for drug coverage, the Fund could permit eligible participants and dependents under each Plan to receive a flu shot at a participating employer pharmacy under the Plan's prescription benefit, using their PBM card, so that the participant or dependent would not need to pay the full cost of the shot up-front and then request reimbursement. Instead, the participating pharmacy would bill, and receive reimbursement from, the Fund.

Finally, as you know, prescription benefits carry a co-pay when dispensed at the participating employer pharmacy. However, there is no co-pay for flu shots dispensed at a doctor's office, under the Plan's medical benefit. To encourage participants to obtain a flu shot at a local participating employer pharmacy, it is recommended that the co-pay for flu shots administered pursuant to the Plans' prescription benefit be eliminated.

Please advise if using the InformedRx/Catamaran PBM card to cover flu shots at a participating employer pharmacy on the basis outlined above has your approval.

United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund

911 Ridgebrook Road
rks, Maryland 21152-9451
elephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

4301 Garden City Drive, Suite 201
Landover, Maryland 20785-6102
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

August 2012

SUMMARY OF MATERIAL MODIFICATION
EIN: 52-6044428

Dear Shoppers Participant:

As a result of recent collective bargaining, effective for claims incurred on and after September 1, 2012, the Board of Trustees is pleased to announce that coverage of Endodontic procedures (root canals) for those in Plan JSS2 and Plan Y has been added to the plan of benefits for covered Participants and their eligible dependents. While most of the Endodontic procedures are subject to a co-pay, we expect participants to see significant savings since the procedures which previously were not covered could cost as much as $1,200 per instance. To receive the benefit, the Endodontic procedures must be performed by a GDS network dentist and are subject to the same policy provisions as your other dental benefits including, but not limited to, authorization for medical necessity.

To receive the benefit at the below co-pays, the Endodontic procedures must be performed by a GDS general network dentist. The covered Endodontic procedure codes and associated co-pays are as follows:

Code	ADA Description	Co-pay
D3110	Pulp Cap Direct	$0
D3120	Pulp Cap Indirect	$0
)310	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. Thus, if the procedure is performed by a GDS in-network Endodontic Specialist, associated 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 dentist to be eligible for dental benefits.

Please insert this Summary of Material Modification in your Summary Plan Description booklet. If you have questions regarding the endodontic benefit or for assistance to find a network dentist, please contact GDS at 800-242-0450.

)ncerely,

Fund Office

MEMORANDUM

To: Board of Trustees of the
UFCW Unions and Participating Employers Health & Welfare Fund
From: William R. Jensen
Date: December 11, 2012
Subj: Perkins Payroll Audit

The attached correspondence from Perkins requests a waiver of the audit findings with respect to a plan participant of $6,709.08.

Perkins advised that contributions (and coverage) were erroneously submitted to another health fund.

The participant is now properly covered by this Fund.

Please review and advise.

June 19, 2012

Associated Administrators, L.L.C.
Attn: William R. Jensen, President
911 Ridgebrook Road
Sparks, MD 21152-9451

Re: Payroll Audit/January 2008-December 2010/

Dear Mr. Jensen:

Through numerous conversations between Ms. Danielle Winder of Washington Wholesalers Health and Welfare (Plan DVP) your company representative, Ms. Ursula Stanley (Plan Z), the Auditor-In-Charge, Mr. Phil Vivirito and I, it was concluded that it was not possible to retroactively provide the benefits of Plan Z to for which the payment determination of $6,709.08 represented.

A review of our records of the medical payments paid by us on behalf reflected that payments were made from December 2008 through September 2011 in the amounts of $192.42 per month which totaled $6,542.28. Upon our notification of the audit findings, as of October 2011 through May 2012, we have submitted payments for participation in Plan Z in the amount of $559.09 per month, totaling $4,472.72. Thus, making the total amount of medical payments made by us for to date to be $11,015.00. Due to the three month requirement of pre payments, was effectively enrolled in Plan Z as of January 1, 2012. A spread sheet is provided which details this information for your review.

In addition, to address any medical issues or past billings that would have incurred during his eligibility period in question from October 2010 through September 2011, he provided us with documentation in the form of a medical billing statement for $399.00. This account has been satisfied by us on his behalf (see attached documentation). We trust therefore that the overall actions taken by our company to address this matter will serve to satisfy the intent of the audit findings for all parties concerned.

Should there be any questions, please contact either myself at 910-339-0901, ext. 25 or my colleague, Jackie Alexander, who was assigned the task of working on this matter at ext. 27.

Sincerely,

Jackie Herring
Chief Accountant

Cc: Danielle Winder, Washington Wholesalers Health and Welfare
Ursula Stanley, UFCW & Participating Employers' Health and Welfare
Phil Vivirito, Director of Payroll & Compliance Audit, Bond Beebe
Robert Brown, Local 400 Union Representative

203 Rowan Street
Fayetteville, NC 28301
(910) 339-0901 Office
(910) 339-0906 Fax
www.perkinsmanagement.com

HUMAN RESOURCES
SUPERVALU

Human Resources Shared Services
2501-1 West Grandview Road
Phoenix, Arizona 85023-3105

Date: November 16, 2012

After a recent internal audit it was found that an overpayment was made on behalf of (XXX-XX-9052), for the period of April 2011 to September 2012. This overpayment occurred due to the associates elected dependent coverage being stopped in April 2011 due to the associates request and the fund receiving paperwork in September 2012 from the associate, resulting in the overpayment of $9,284.58. At this time we are requesting a credit on for this overpayment. Below you will find a worksheet showing how this credit was calculated.

Month	Contribution paid	Contribution S/B Paid	Credit due
Apr-11	$ 1,152.00	$ 509.00	$ 643.00
May-11	$ 1,152.00	$ 509.00	$ 643.00
Jun-11	$ 1,152.00	$ 509.00	$ 643.00
Jul-11	$ 1,152.00	$ 509.00	$ 643.00
Aug-11	$ 1,152.00	$ 509.00	$ 643.00
Sep-11	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Oct-11	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Nov-11	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Dec-11	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Jan-12	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Feb-12	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Mar-12	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Apr-12	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Jun-12	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Jul-12	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
Aug-12	$ 983.97 983.00	$ 431.22	$ 552.75 551.78
			$ 9,295.25 9,284.58

Sincerely,
Dominique Orem

SUPERVALU | Phoenix, AZ
2501 West Grandview Road, Suite 1, Phoenix, AZ 85023
Office: 602.547.5536 | Fax: 602.547.5671

National Accounts
1900 E. Golf Road, Suite 500
Schaumburg, IL 60173
Tel (847) 285-2415 Fax (847) 285-2402
Mkramer1@metlife.com

Mathew J. Kramer, CEBS
Account Executive
Registered Representative

MetLife®

April 28, 2012

Mr. Bill Jensen
Associated Administrators, LLC
c/o UFCW Unions and Participating Employers Health and Welfare Fund
10626 York Rd
Cockeysville, MD 21030

Re: UFCW – Life and AD&D Renewal

Dear Bill,

I apologize for the tardiness of this notice, but I would like to present you with the renewal for the next experience period for the UFCW Richmond Tidewater (Experience #526004) account for the period of September 1, 2012 through August 31, 2013.

I'm happy to report that we can continue the current rates for another year. The rates for 9/1/2012 – 8/31/2013 are:

Basic Life $0.127 per $1,000
Basic AD&D $0.030 per $1,000

I would also like to request an updated census from you for the current participating members. We haven't asked for one in years and we really need these annually. It is used to report the appropriate premium taxes by State and for the underwriters to continue to monitor the underlying dynamics of the group. I was able to have the census requested waived for this renewal; however I won't be able to renew this account any further without a census being provided. Please provide a file including the date of birth, gender, coverage amount and address.

We look forward to continuing our partnership. Please confirm that you are in agreement with the letter and also let me know if you have any questions.

Sincerely,

Mat Kramer

Cc: B. Rizzo, C. Kaputska, P. Miehlke, S. Nink, D. Patton, A. Whitmer, F. Carbone

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

CareFirst BlueCross BlueShield

TO: **Members of The Board of Trustees of the UFCW Unions and Participating Employers Health and Welfare Fund**

FROM: **Joe Pedone- AVP Labor Affairs, CareFirst BlueCross BlueShield**

Steve Krasnoff- Labor Relations Account Consultant, CareFirst BlueCross BlueShield

RE: **5-Year Network Lease and FlexLink Rates (October 1, 2011 – October 31, 2016)**

DATE: **September 13, 2011**

CareFirst BlueCross BlueShield would like to thank the Board of Trustees and its members for electing our network lease and FlexLink solution as your network of choice. Our sales and operations staff has been working diligently with Associated Administrators since May 1, 2011 to implement our solution with the intention of having our networks ready for your membership to utilize effective October 1, 2011. Some of the advantages that we're looking to offer the Fund and its respective membership are outlined as follows:

(1) Cost savings that are proven to be the highest in the industry
(2) Broad access to the BlueCross BlueShield credentialed PPO network of hospitals, physicians, and labs
(3) Efficient integration of system and adjudication processes with Association Administrators via implementation and daily operations
(4) Lower appeals volume and greater member satisfaction

As a part of its agreement to partner with UFCW Unions and Participating Employers Health and Welfare Fund, CareFirst is offering a contract that consists of rates that run for five years. The rates that are being proposed are consistent with our renewal rates that are being offered to FELRA. Please find below a five year proposal which outlines a rate structure for Network Lease and FlexLink fees from 10/1/2011 through 10/31/2016:

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

CareFirst BlueCross BlueShield

Proposed 5-Year Rates

	Network Lease	Increase over Previous Year's Network Lease Rate	FlexLink	Increase over Previous Year's FlexLink Rate
10/1/2011 – 10/31/2011	$3.73 pcpm	N/A	$18.85 pcpm	N/A
11/1/2011 – 10/31/2012	$3.80 pcpm	+ 2%	$19.23 pcpm	+ 2%
11/1/2012 – 10/31/2013	$3.88 pcpm	+ 2%	$19.61 pcpm	+ 2%
11/1/2013 – 10/31/2014	$4.00 pcpm	+ 3%	$20.20 pcpm	+ 3%
11/1/2014 – 10/31/2015	$4.12 pcpm	+ 3%	$20.81 pcpm	+ 3%
11/1/2015 – 10/31/2016	$4.24 pcpm	+ 3%	$21.43 pcpm	+ 3%

(Note: pcpm is an abbreviation for "per contract per month")

This rate structure, which only impacts the administrative service fees paid to CareFirst, represents small increases to our Network Lease and FlexLink fees. These increases are consistent with the increases to all of CareFirst's ASO groups. Should you have any questions about the proposed rates, feel free to reach out to Joe Pedone at (410) 998-6916 or to Steve Krasnoff at (410) 998-7167. CareFirst wishes to thank you again for your business, and we look forward to a partnership with UFCW Unions and Participating Employers Health and Welfare Fund for many years to come.

Bill Jensen

From: Bill Jensen
Sent: Wednesday, December 05, 2012 1:40 PM
To: 'Springer, Steven P'
Cc: Taylor, Henry; Loeffler, Steve
Subject: RE: Roanoke

Steven, Under a separate email, I sent the Administrative Manager's reports, based on Mr. Loeffler's request. If acceptable, I will use your email below as the request to the trustees, and will raise it under our miscellaneous business on 12/11/12, the next meeting of the Board.
Bill

From: Springer, Steven P [mailto:steven.springer@kroger.com]
Sent: Wednesday, December 05, 2012 11:00 AM
To: Bill Jensen
Cc: Taylor, Henry; Loeffler, Steve
Subject: Roanoke

Hi Bill,

I'm following up on our discussion from Monday. You mentioned that you would send me YTD financial reports for the fund. Are those available?

We also discussed a data dump. Let's continue to pursue sending the same data package to me that you would send to a consultant. I understand you noted that you would need approval from the trustees. Let me know if I can do anything to help that piece move forward.

We want to continue to discuss hiring a consultant that would be utilized by both bargaining parties (and compensated by both parties). We have not come to a conclusion on that, but will let you know as the discussions internally conclude.

Looking forward to hearing from you.

Sincerely,
Steven

Steven Springer | Health Care Labor Strategy |
The Kroger Co. | 1014 Vine Street, Cincinnati, OH 45202 |

Office Phone: 513.762.1371
Email: steven.springer@kroger.com

---

disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain information that is confidential and protected by law from unauthorized disclosure. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

MERCER

Nancy J. Eid
Partner

333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2427
+1 612 642 8600
nancy.eid@mercer.com
www.mercer.com

Addendum to July 27, 2012 Report:

Best and Final Offers for Prescription Benefits Management Services

Submitted August15, 2012 by Mercer Health and Benefits ('Mercer')

On behalf of the **United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund ('the Fund'), Mercer** led a series of renewal negotiations with SXC, the Fund's current prescription benefits manager ('PBM') and independently solicited competitive bids from Express Scripts/Medco (herein referred to as ESI) as directed by the Fund and in anticipation of the 2013-2014 contract term.

An initial report sent by Mercer to the Fund dated July 27, 2012 summarized the preliminary results of negotiations with both PBMs and included estimated savings project the Fund could anticipate from the respective PBM, based on submitted and proposed pricing terms benchmarked against historic Fund de-identifiable paid claims information supplied by Associated Administrators, LLC ('Associated').

This addendum, issued August 15, 2012, summarizes final results of vendor negotiations with SXC and ESI, updated savings projections estimated by vendor and additional detail from the unique pricing offers submitted as final and binding by the SXC and ESI.

Summary of the Best and Final Offers

Mercer provided SXC and Medco pre-populated BAFO documents with component discounts, rebates and fee benchmarks and contract terms taken from Mercer's proprietary database of competitive pricing and contract terms currently available in the PBM industry to the Fund's peer groups. These financial and contract terms, deemed best practice in the PBM industry, were synthesized with those actual discount and pricing terms previously submitted from SXC and ESI to the Fund to optimize BAFO efforts and results.

Results

ESI waived the BAFO submission in lieu of their offer dated July 13, 2012, which ESI confirmed is their final bid. ESI submitted a traditional pricing proposal only, which includes all current Fund Participating Pharmacies and excludes the following chains from the Non-Participating Pharmacy network: Walgreens, Rite Aid, CVS and Wal-Mart.

SXC's BAFO includes 3 options:

1. A traditional (or spread) pricing arrangement with all major chains included in the Non-Participating Pharmacy network.
2. A traditional pricing arrangement with CVS **excluded** from the Non-Participating Pharmacy network.
3. A pass-through pricing arrangement with all major chains included in the Non-Participating Pharmacy network.

Estimated Impact to Future Program Costs

The Fund's projected program costs (savings) updated in Table 2.0 were estimated by Mercer, using the Fund's recent and historic (unaudited) de-identified paid claims data experience to project future savings. Mercer's estimates relied on actuarially approved trend forecasts for inflation, utilization and drug mix for the time periods under consideration. Any savings estimates or program costs projections are representative of the Fund's assumed gross annualized costs, and do not include the impact of member cost share.

The projected program costs and vendor specific savings included in this and Mercer's July 27, 2012 report are estimates, and should not be used for budgeting purposes nor are these a guarantee of future costs or actual savings the Fund may experience. Unforeseen changes in eligibility, demographics, utilization or other program or benefit design features may significantly impact actual program results.

Table 2.0 - Best and Final Pricing Results
Projected Program Savings

PBM Vendor	SXC			ESI
Pricing Type	**Traditional**	**Traditional**	**Pass Through**	**Traditional**
Non-Par Network	No Exclusions	CVS Excluded	No Exclusions	Walgreens, CVS, Rite Aid & Walmart Excluded
Projection Period:	**Projected Savings % ($$) over current gross program costs***			
10/01/2012 – 12/31/2013	9.0% ($817,000)	9.9% ($893,000)	7.3% ($657,000)	9.2% ($835,750)
01/01/2014 – 12/31/2014	8.9% ($692,000)	9.8% ($760,000)	7.2% ($560,000)	8.8% ($683,000)

*based on the Fund's utilization experience for recently reported and unaudited paid claims experience with SXC

Best and Final Offer: Contract Terms

A summary of pre-negotiated financial and contract terms included in Mercer's BAFO negotiations with SXC and ESI are noted in the following tables.

	Current SXC	BAFO SXC	BAFO ESI
Rebate Payment Cycle	Quarterly, net 180 days	Quarterly, net 180 days	Quarterly, net 180 days
Reconciliation and Guarantees	No formal reconciliation or minimum guarantee reconciliation. Rebates are subject to a lag period of up to 180 days between date(s) rebates earned vs. date(s) rebates are paid or credited back to the Fund.	Rebate payments issued quarterly for rebates earned and paid for the preceding quarters, up to 180 days. Minimum rebate guarantees must be paid to the Fund annually, with an annual reconciliation of earned vs. paid rebates reconciled within 120 days of calendar year end, and the minimum guarantees backed dollar-for-dollar.	Annual reconciliation with dollar-for-dollar guarantees on rebate minimums; reconciliation period of 210 days.
Length of Guarantees and Contract Term	N/A – Term expired 2010	2.25 years effective October 1, 2012 through December 31, 2014	One- or two-year terms effective January 1, 2013
Fund's Termination Rights	Termination with cause. The Fund forfeits earned but unpaid rebates upon notice to SXC of contract termination.	Termination without cause, with 90 days notice by the Fund, with no penalty or rebate forfeiture.	Termination without cause, penalty or rebate forfeiture; clawback of all implementation credits or Pharmacy Management Funds used.

	Current SXC	BAFO SXC	BAFO ESI
Implementation of Pricing Terms	N/A	SXC is agreeable to implementing the new terms by October 1, 2012 subject to a Letter of Intent mutually agreed upon and signed by the parties.	Pricing and terms guaranteed following execution of a signed agreement between the parties. Targeted date of January 1, 2013 assumes execution of such an agreement in advance.

KAISER PERMANENTE® Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

October 8, 2012

Bill Jenson
United Food and Commercial Workers
4301 Garden City Dr.
Ste. 201
Landover, MD 20785

SUBJECT: Kaiser Permanente Medicare Plus 2013 Contract Renewal

Dear Mr. Jenson:

Thank you for the opportunity to continue providing your Medicare-eligible retirees with quality health care services in 2012. Because committed organizations like yours continue to offer coverage for your Medicare eligible retirees, membership in Kaiser Permanente Medicare Plus has grown to more than 48,000* Medicare beneficiaries within our Mid-Atlantic States region, which includes the District of Columbia, Northern Virginia and the Maryland suburbs of Baltimore and D.C.

Your partner in health

NCQA measures health plan and health system performance in over 55 measures of quality and service for about 80% of the nation's estimated 1,000 health plans. Kaiser Permanente and Kaiser Permanente Medicare Plus are leading the country in NCQA test scores, rating number 15 in an evaluation of over 500 health plans nationally. Kaiser Permanente Medicare Plus has 4.5 Stars in the 2012 Medicare quality ratings. These indicators of quality health care are also backed by a great service team, winning the J.D. Power award for highest in member satisfaction with health plans in the Virginia-Maryland-Washington, D.C. region for a fourth consecutive year. Your organization can be proud of its commitment to retirees, just as we are proud of our commitment to providing the best to your retirees, not only in care, but in value.

Your 2013 Medicare Plus Renewal

Your Kaiser Permanente Medicare Plus health benefit plan is scheduled to renew on January 1, 2013, for the period through December 31, 2013. Your contract will automatically renew with your current benefit design and 2013 rates as approved by the state regulators and attached herein, unless you request a change in writing through your Kaiser Permanente Account Manager or our Medicare Sales department.

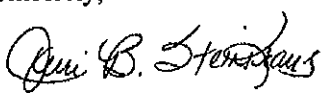
Your renewal rates and the associated Summary of Benefits for the new contract period are enclosed. **Please review the materials and indicate your agreement with the 2013 Benefits and Rates by checking the attached approval sheet. You may also indicate a change is desired to your plan on this sheet. Please return this sheet at your earliest convenience in the postage paid envelope provided, but no later than December 1, 2012. This will enable the Medicare team to begin the renewal process as soon as possible and assure that we are providing the exact benefits desired by your program. If you prefer, you may call the Group Medicare Sales team directly at (301) 816-5690 for Francesca Conner or (301) 321-5172 for Jen Marbach.**

Looking forward to 2013

In the following two pages, you will find the language changes in the Kaiser Permanente Medicare Plus Annual Notice of Change and Evidence of Coverage documents that were sent to all Medicare Plus members by October 1, 2012:

If you have any questions or need to discuss changes to the benefits offered, please contact your Kaiser Permanente Medicare Consultant or you may contact me at (301) 816-6336.

Sincerely,



Jerri B. Steinkraus
Director of Medicare Sales
Kaiser Permanente of the Mid-Atlantic States

Enclosures:

Benefits Package Approval Sheet
Postage paid Business Reply Envelope
2013 Rate and Product Overview with Summary
2013 Rate Calculation Sheet

On January 1, 2013, the following changes to Medicare coverage will go into effect for all Medicare Plus members. Some of these amounts and measurements are invisible to members of your group sponsored coverage that are richer than the standard Medicare coverage.

2013 Part D Global Thresholds

Initial Coverage Limit (ICL): changes from $2,930 to $2,970 (affects all Direct Pay Part D Plan designs)
Catastrophic Limit: (TrOOP): changes from $4,700 to $4,750; TDS changes from $6,657.50 to $6,733.75 for non-applicable beneficiaries and from $6,730.39 to **$6,954.52** for applicable beneficiaries

2013 Part D Global Low Income Cost-sharing Subsidy (30-day supply) affecting all Part D Plan Designs

- LICS 1: Pre-TrOOP copays change from $2.60 to $2.65 Pref & Non-Pref Generic; from $6.50 to $6.60 Pref & Non-Pref Brand; after TrOOP $0 Copay
- LICS 2: Pre-TrOOP copays from $1.10 to $1.15 for Pref & Non-Pref Generic; and from $3.30 to $3.50 for Pref & Non-Pref Brand after TrOOP $0 Copay
- LICS 3: Pre & Post-TrOOP copays $0 Pref & Non-Pref Generic; $0 Pref & Non-Pref Brand after TrOOP $0 Copay
- LICS 4: Pre-TrOOP cost-shares 15% Pref & Non-Pref Generic; 15% Pref & Non-Pref Brand after TrOOP copays from $2.60 to $2.65 Pref & Non- Pref Generic from $6.50 to $6.60 Pref & Non-Pref Brand

2013 Part D Global Coverage Gap Discount for Non-LIS and Non-RDS members:

- Preferred & Non-Preferred Generic: changes from 14% discount to 21% discount (i.e. member pays no more than 79% of plan's cost in 2013 – was 86% in 2012)
- Preferred & Non-Preferred Brand changes from 50% discount received to 52.5% discount but in addition, member pays dispensing fee (i.e. member pays no more than 47.5% plus dispense fee)
- Low income members do not have a coverage gap and the above discounts are not applicable to them.
-

2013 Retiree Drug Subsidy

- Cost threshold changes from $320 to $325
- Cost limit changes from $6,500 to $6,600

On January 1, 2013, the following changes to Medicare coverage will go into effect for all Medicare Plus members within their applicable benefits package:

Benefit	PBP 801 Employer Group w/ Part D	PBP 805 Employer Group w/ Part D	PBP 999 (Grp 017 & 030) EGHP
Annual Physical Exam*	$0	$0	$0
Part B Drugs for Peritoneal Dialysis	$0	$0	$0
Part B Oral Chemotherapy Drugs (all jurisdictions) affects all Plan designs except Plan K	$0	$0	$0
Part D Covered Drugs Definition • **Barbiturates** • **Benzodiazepines**	Part D Drug definition now includes: •Barbiturates when used for medical indications of epilepsy, cancer, or chronic mental health disorder, and •Benzodiazepines	Part D Drug definition now includes: •Barbiturates when used for medical indications of epilepsy, cancer, or chronic mental health disorder, and •Benzodiazepines	N/A
Preventive Dental	Certain preventive care dental services will now be covered twice per contract year. This will impact services such as: • Prophylaxis (Routine cleanings) • Oral examination • Topical fluoride applications • Dental X-rays	Certain preventive care dental services will now be covered twice per contract year. This will impact services such as: • Prophylaxis (Routine cleanings) • Oral examination • Topical fluoride applications • Dental X-rays	Certain preventive care dental services will now be covered twice per contract year. This will impact services such as: • Prophylaxis (Routine cleanings) • Oral examination • Topical fluoride applications • Dental X-rays

* Non-preventive issues and services managed during a scheduled preventive visit or service may result in additional charges for those non-preventive issues or services.

2013 Medicare Cost Renewal
Kaiser Permanente Medicare Plus*

*an HMO with a Section 1876 Medicare Cost contract
and Part D Prescription Drug benefits

United Food and Commercial Workers (Non-Food)

Group Number: 11215-7

Effective Date: January 1, 2013 through December 31, 2013

Premium Rate	Medicare Plus Plan C with Medicare Part D
For each CMS accreted Medicare Beneficiary	$ 305.18 monthly
Hearing Aid Rider	$ N/A monthly
CAM Rider	$ N/A monthly
APP	$ N/A monthly
Total Premium Per Enrollee	$ 305.18 monthly

- Each subscriber must continue to pay Part B premium. Failure to maintain Part B will result in termination of Medicare HMO by the Centers for Medicare and Medicaid Services (CMS).
- This plan is open to persons with Medicare Part A and Part B, regardless of age. Medicare Plus is also available to persons with Medicare Part B only. Please consult your Account Manager for administration of the Medicare Plus Part B only rate.
- A member can select a Primary Care Physician (PCP) from a Kaiser Permanente Medical Center or affiliated participating Medicare Plus provider from the Medicare Plus Directory (the Kaiser Permanente Signature network).
- This product does **not** contain a "Lock – in provision". Care coordinated by the PCP or Kaiser Permanente of the Mid-Atlantic States (except for emergencies or urgently needed out-of-area care) will be covered under the "In Plan" benefit. Care not provided by or authorized by Kaiser Permanente may be filed by the provider directly to Medicare for reimbursement, subject to Medicare deductibles and coinsurance.
- Medicare contracts are renewed with CMS annually on the calendar year, and all mandated benefits may be adjusted on January 1st of each year as dictated by CMS or state mandate.

United Food and Commercial Workers (Non-Food)

Group Number: 11215-7

Effective Date: January 1, 2013 through December 31, 2013

Premium Rate	Medicare Plus Plan C with Medicare Part D
For each CMS accreted Medicare Beneficiary	$ 305.18 monthly
Hearing Aid Rider	$ N/A monthly
CAM Rider	$ N/A monthly
APP	$ N/A monthly
Total Premium Per Accreted Enrollee	$ 305.18 monthly

- ☐ **This Medicare Plus rate and benefit configuration is accepted for the year 2013.**
- ☐ **This Medicare Plus rate and benefit configuration is NOT valid for the year 2013. Please contact me immediately to discuss.**

2013 KP MAS Medicare Cost (Medicare Plus) Group Rates

Group Name:	United Food and Commercial Workers (UFCW) - Non Food	**Underwriting Signature:**	Alex Haybok
Group Number:	11215 - 7	**Comments:**	
Effective Date:	1/1/2013	**Date:**	7/6/2012

Illustrative Only
Base rate for Medicare mandated benefits

Year	2013			
Jurisdiction	MD			
Plan	C (with Part D Rx)			
Commissions	NA			
Is this a National Group?	No			
Benefit Description:			Group Half Months Late	0
Office visit		$5		
Inpatient Copay		$0		
RX* MO/KP/ANP		3/5/10-withD		
Dental		standard		
Vision		standard		
DME		$0		
ER		$50		
Additional Rider Benefits:				
Hearing Aid		none		
Sexual Dysfunction Drugs		none		
Chiropractic & Acupuncture		none		
Total pmpm (Medicare A, B, & D)		$305.18		(includes applicable state mandates)
		$0.00	0	Half months APP Load
Total pmpm (Medicare A, B, & D) & APP Load		$305.18		
Total pmpm (Medicare B & D Only)		$767.71		(includes applicable state mandates)
		$0.00	0	Half months APP Load
Total pmpm (Medicare B & D Only) & APP Load		$767.71		

Rates are illustrative only. Rates are subject to CMS and DOI approval. Rates are subject to revision.
*60 day supply

Medicare Plus Benefits—2013 Plan C with D

BENEFIT	Plan C with D
Annual Deductible	No Annual Deductible
Annual Out-of-Pocket Maximum	$3,400
Primary Care Physician Visits (Family Care, Internal Medicine)	$5 copayment
Specialist	$5 copayment
Routine Physical Exams	$5 copayment
Diagnostic Imaging	$0 for lab and x-ray
Therapeutic Radiology	$5 copayment
Medicare Covered Preventive Care	$0 copayment
Prescription Drugs	
Mail Order from Kaiser Permanente	$3 Generic or Brand Up to 90 days maintenance
Kaiser Permanente Medical Center Rx	$5 Generic or Brand Up to 60 days supply
Affiliated Network Pharmacy Giant, Rite Aid, Safeway, Target, Walmart	$10 Generic or Brand Up to 60 days supply
Inpatient Hospitalization	$0 per benefit period
Outpatient Surgery @ Surgery Center	$0 copayment
Emergency Visits	$50 copayment
Ambulance	$0 copayment
Inpatient mental health	$0 per benefit period
Outpatient mental health	$5 copayment per visit
Inpatient chemical dependency	$0 per benefit period
Outpatient chemical dependency	$5 copayment per visit
Other Health Services	
Medicare Covered Chiropractic	$5 copayment per visit
Physical and Speech Therapy	$5 copayment per visit
Home Health, Hospice	$0 copayment
Durable Medical Equipment	$0 copayment
Dental discount plan (25% discount when seen by participating dentists	$30 examination, cleaning 2x per year
Vision hardware discounts (office visit copayment will apply)	25% off frames and lenses at Kaiser Permanente vision centers

2013 Medicare Cost Renewal
Kaiser Permanente Medicare Plus*

*an HMO with a Section 1876 Medicare Cost contract
and Part D Prescription Drug benefits

United Food and Commercial Workers (Non-Food)-Shoppers

Group Number: 11215-9

Effective Date: January 1, 2013 through December 31, 2013

Premium Rate	Medicare Plus Plan A with Medicare Part D
For each CMS accreted Medicare Beneficiary	$ 208.55 monthly
Hearing Aid Rider	$ N/A monthly
CAM Rider	$ N/A monthly
APP	$ N/A monthly
Total Premium Per Enrollee	$ 208.55 monthly

- Each subscriber must continue to pay Part B premium. Failure to maintain Part B will result in termination of Medicare HMO by the Centers for Medicare and Medicaid Services (CMS).
- This plan is open to persons with Medicare Part A and Part B, regardless of age. Medicare Plus is also available to persons with Medicare Part B only. Please consult your Account Manager for administration of the Medicare Plus Part B only rate.
- A member can select a Primary Care Physician (PCP) from a Kaiser Permanente Medical Center or affiliated participating Medicare Plus provider from the Medicare Plus Directory (the Kaiser Permanente Signature network).
- This product does **not** contain a "Lock – in provision". Care coordinated by the PCP or Kaiser Permanente of the Mid-Atlantic States (except for emergencies or urgently needed out-of-area care) will be covered under the "In Plan" benefit. Care not provided by or authorized by Kaiser Permanente may be filed by the provider directly to Medicare for reimbursement, subject to Medicare deductibles and coinsurance.
- Medicare contracts are renewed with CMS annually on the calendar year, and all mandated benefits may be adjusted on January 1st of each year as dictated by CMS or state mandate.

United Food and Commercial Workers (Non-Food)-Shoppers

Group Number: 11215-9

Effective Date: January 1, 2013 through December 31, 2013

Premium Rate	Medicare Plus Plan A with Medicare Part D
For each CMS accreted Medicare Beneficiary	$ 208.55 monthly
Hearing Aid Rider	$ N/A monthly
CAM Rider	$ N/A monthly
APP	$ N/A monthly
Total Premium Per Accreted Enrollee	$ 208.55 monthly

- ☐ **This Medicare Plus rate and benefit configuration is accepted for the year 2013.**
- ☐ **This Medicare Plus rate and benefit configuration is NOT valid for the year 2013. Please contact me immediately to discuss.**

2013 KP MAS Medicare Cost (Medicare Plus) Group Rates

Group Name: United Food and Commercial Workers (UFCW) - Non Food
Group Number: 11215 - 9
Effective Date: 1/1/2013

Underwriting Signature: Alex Haybok
Comments:
Date: 9/4/2012

Illustrative Only
Base rate for Medicare mandated benefits

Year	2013			
Jurisdiction	MD			
Plan	A (with Part D Rx)			
Commissions	NA			
Is this a National Group?	No			
Benefit Description:			Group Half Months Late	0
Office visit		$15		
Inpatient Copay		$100		
RX* MO/KP/ANP		10/15/25-withD		
Dental		standard		
Vision		standard		
DME		$0		
ER		$50		
Additional Rider Benefits:				
Hearing Aid		none		
Sexual Dysfunction Drugs		none		
Chiropractic & Acupuncture		none		
Total pmpm (Medicare A, B, & D)		$208.55		(includes applicable state mandates)
		$0.00	0	Half months APP Load
Total pmpm (Medicare A, B, & D) & APP Load		$208.55		
Total pmpm (Medicare B & D Only)		$671.05		(includes applicable state mandates)
		$0.00	0	Half months APP Load
Total pmpm (Medicare B & D Only) & APP Load		$671.05		

Rates are illustrative only. Rates are subject to CMS and DOI approval. Rates are subject to revision.
*60 day supply

Medicare Plus Benefits—2013 Plan A with D

BENEFIT	Plan A with D
Annual Deductible	No Annual Deductible
Annual Out-of-Pocket Maximum	$3,400
Primary Care Physician Visits (Family Care, Internal Medicine)	$15 copayment
Specialist	$15 copayment
Routine Physical Exams	$15 copayment
Diagnostic Imaging	$0 for lab and x-ray
Therapeutic Radiology	$15 copayment
Medicare Covered Preventive Care	$0 copayment
Prescription Drugs	
Mail Order from Kaiser Permanente	$10 Generic or Brand Up to 90 days maintenance
Kaiser Permanente Medical Center Rx	$15 Generic or Brand Up to 60 days supply
Affiliated Network Pharmacy Giant, Rite Aid, Safeway, Target, Walmart	$25 Generic or Brand Up to 60 days supply
Inpatient Hospitalization	$100 per benefit period
Outpatient Surgery @ Surgery Center	$0 copayment
Emergency Visits	$50 copayment
Ambulance	$0 copayment
Inpatient mental health	$100 per benefit period
Outpatient mental health	$15 copayment per visit
Inpatient chemical dependency	$100 per benefit period
Outpatient chemical dependency	$15 copayment per visit
Other Health Services	
Medicare Covered Chiropractic	$15 copayment per visit
Physical and Speech Therapy	$15 copayment per visit
Home Health, Hospice	$0 copayment
Durable Medical Equipment	$0 copayment
Dental discount plan (25% discount when seen by participating dentists	$30 examination, cleaning 2x per year
Vision hardware discounts (office visit copayment will apply)	25% off frames and lenses at Kaiser Permanente vision centers

2013 Medicare Cost Renewal
Kaiser Permanente Medicare Plus*

*an HMO with a Section 1876 Medicare Cost contract
and Part D Prescription Drug benefits

UFCW Part-time and Spouse

Group Number: 18506-0, 1, 2

Effective Date: January 1, 2013 through December 31, 2013

Premium Rate	Medicare Plus Plan HIGH OPTION with Medicare Part D
For each CMS accreted Medicare Beneficiary	$ 103.00 monthly
Hearing Aid Rider	$ N/A monthly
CAM Rider	$ N/A monthly
APP	$ N/A monthly
Total Premium Per Enrollee	$ 103.00 monthly

- Each subscriber must continue to pay Part B premium. Failure to maintain Part B will result in termination of Medicare HMO by the Centers for Medicare and Medicaid Services (CMS).
- This plan is open to persons with Medicare Part A and Part B, regardless of age. Medicare Plus is also available to persons with Medicare Part B only. Please consult your Account Manager for administration of the Medicare Plus Part B only rate.
- A member can select a Primary Care Physician (PCP) from a Kaiser Permanente Medical Center or affiliated participating Medicare Plus provider from the Medicare Plus Directory (the Kaiser Permanente Signature network).
- This product does **not** contain a "Lock – in provision". Care coordinated by the PCP or Kaiser Permanente of the Mid-Atlantic States (except for emergencies or urgently needed out-of-area care) will be covered under the "In Plan" benefit. Care not provided by or authorized by Kaiser Permanente may be filed by the provider directly to Medicare for reimbursement, subject to Medicare deductibles and coinsurance.
- Medicare contracts are renewed with CMS annually on the calendar year, and all mandated benefits may be adjusted on January 1st of each year as dictated by CMS or state mandate.

UFCW

Group Number: 18506-0, 1, 2

Effective Date: January 1, 2013 through December 31, 2013

Premium Rate	Medicare Plus Plan HIGH OPTION with Medicare Part D
For each CMS accreted Medicare Beneficiary	$ 103.00 monthly
Hearing Aid Rider	$ N/A monthly
CAM Rider	$ N/A monthly
APP	$ N/A monthly
Total Premium Per Accreted Enrollee	$ 103.00 monthly

- ☐ **This Medicare Plus rate and benefit configuration is accepted for the year 2013.**
- ☐ **This Medicare Plus rate and benefit configuration is NOT valid for the year 2013. Please contact me immediately to discuss.**

Medicare Plus Application, Administration and Eligibility Guidelines

* Each enrollment application is considered an individual enrollment for Medicare coverage with CMS. A spouse must complete their own application to be enrolled. Spouses cannot be linked in "family" plans.

* CMS states that original, applications for Kaiser Permanente Medicare Plus with a signature can be processed. Phone or online enrollments cannot be accepted. Facsimiles or emailed applications may be accepted.

* Errors/omissions on the application will generate a call and letter from the Membership Processing Department. Errors or missing information must be corrected and returned to Kaiser Permanente Medicare Membership Processing within 30 days or the application will be denied. All applicants will be notified in writing as to the status of their application form both at receipt and at completion of enrollment or denial.

* CMS regulations require the earliest coverage date will be the first of the month following the date of receipt of the enrollment application (or of all necessary information). Applications can be accepted up to 90 days in advance of the desired effective date.

* In the event that a member would like to disenroll from Kaiser Permanente Medicare Plus, EACH member must request disenrollment in writing. The member may also request disenrollment at their local Social Security office or at the Railroad Retirement Board, or by calling 1-800-MEDICARE. Retroactive terms are not permitted. First of month following receipt of request will apply. Disenroll forms are available.

* Termination of group coverage must be requested a minimum of 30 days in advance. CMS requires the Plan to notify the member in writing, in advance, as well as provide automatic conversion information.

* Removing a member from your group account will not result in member termination from Kaiser Permanente Medicare Plus. If group benefits are terminated, the Medicare Plus member will be notified in writing, and then automatically transferred to Kaiser Permanente Medicare Plus on a direct pay basis pending payment or a signed, written directive of the member to change coverage.

* If a Medicare Plus member discontinues payment for Medicare Part B premium, enrolls in another Medicare HMO or Medicare Part D provider, or notifies Medicare or Kaiser that they have moved from the service area, CMS will automatically terminate Kaiser Permanente Medicare Plus coverage. Re-enrollment into Medicare Plus will be according to CMS rules and require a new enrollment form. Kaiser Permanente cannot make retroactive adjustments. Any retroactivity must be requested of CMS by the Plan to the appropriate contact, and CMS will reply to instruct the Plan.

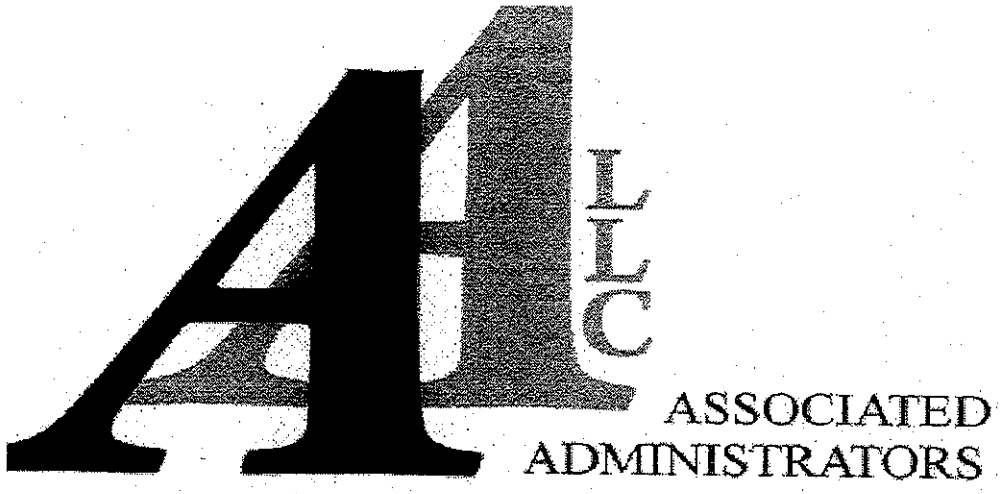
* Medicare Part D Low Income Subsidy (LIS) members are identified by CMS to the plan on a monthly basis. Kaiser Permanente will send a quarterly report to the employer with a reimbursement check. The employer will disburse the LIS back to the member pro-rated for the retiree's contribution to the premium. If the employer pays 100% of the premium, the employer can keep the entire LIS amount.

* CMS may impose a Late Enrollment Penalty (LEP) on Medicare beneficiaries who do not enroll in Medicare Part D when they initially become eligible for Medicare Part B and Part D coverage. This charge is assessed by CMS (not Kaiser Permanente) and is not included in the quoted Kaiser Permanente Medicare Plus rates. LEP appears on the group bill labeled Late Enrollment Penalty. If they have been covered by a prescription drug benefit equal or greater to Medicare Part D benefits, and the applicant provides dates of Creditable Coverage, CMS will not charge the LEP. When the LEP is charged, the member is notified in writing with instructions to correct the LEP by signing a form testifying to the nature and dates of their prior prescription drug coverage. The form is returned to CMS (not Kaiser Permanente).

* A Member's Evidence of Coverage is not based on each individual's place of residence. Coverage and mandated benefits for group members are based on Employer's group contract address.

TO BE ELIGIBLE, each applicant:

- Must reside and maintain permanent residence within the CMS approved service area
- Must have Medicare Part A and Part B, or Part B only (if arranged by employer for billing).
- Cannot have end-stage renal disease (exception made for current Kaiser Permanente plan members who were members at time of ESRD diagnosis, or if applicant can document successful kidney transplant.)

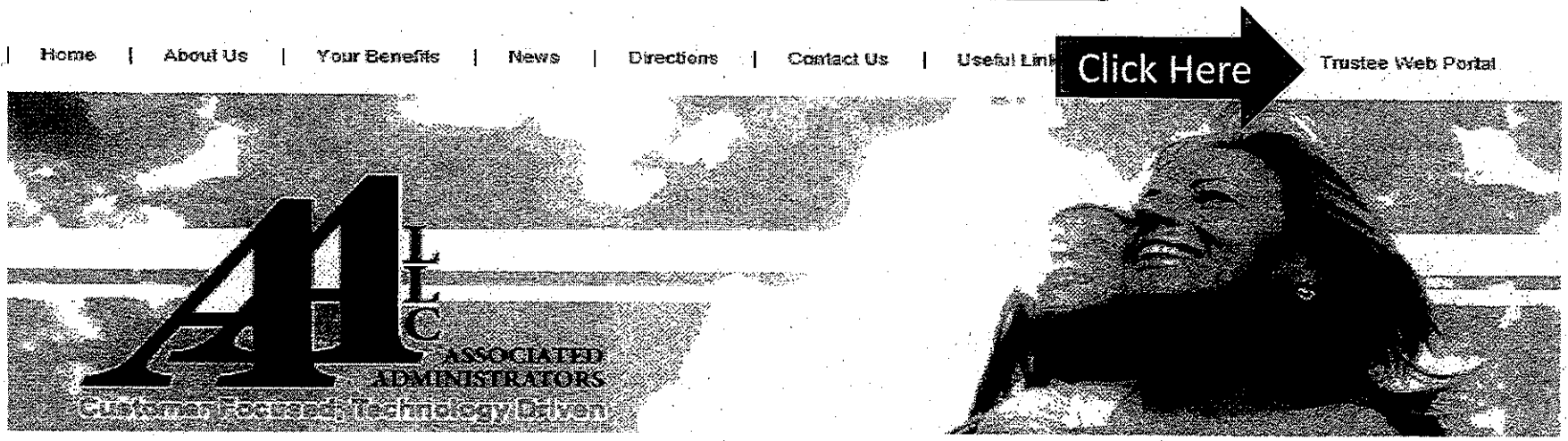


TRUSTEE WEBPORTAL OVERVIEW

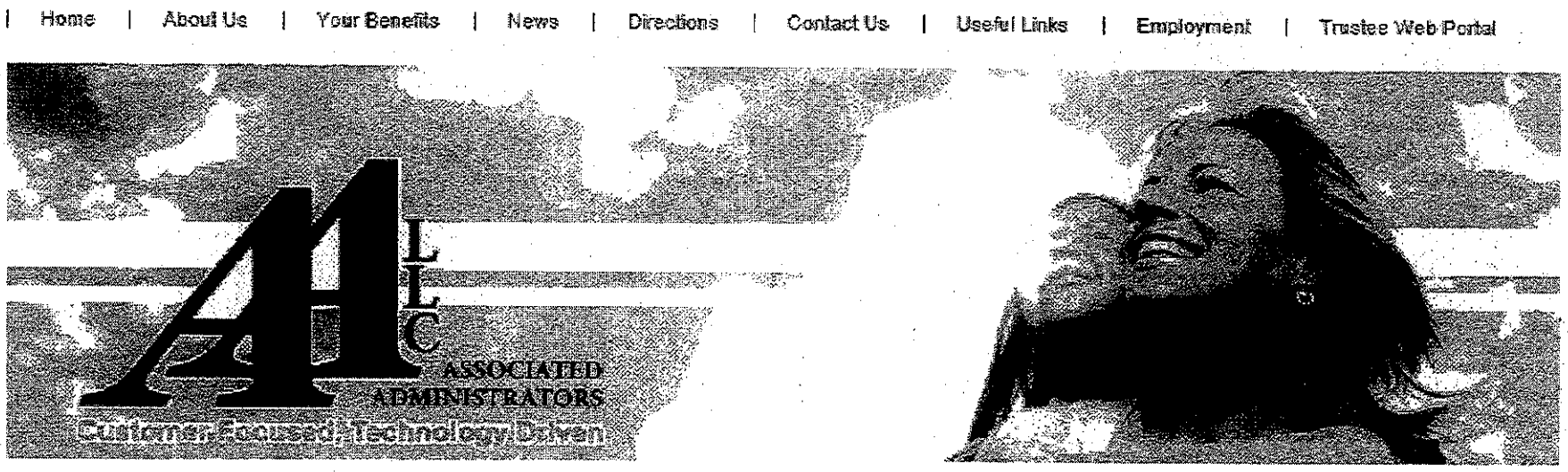
This secure portion of our website was established to allow our clients to access meeting materials in advance of scheduled meetings and to reduce the amount of paper used. An additional benefit is that you may access meeting materials at any time and not have to store this information on your own computer.

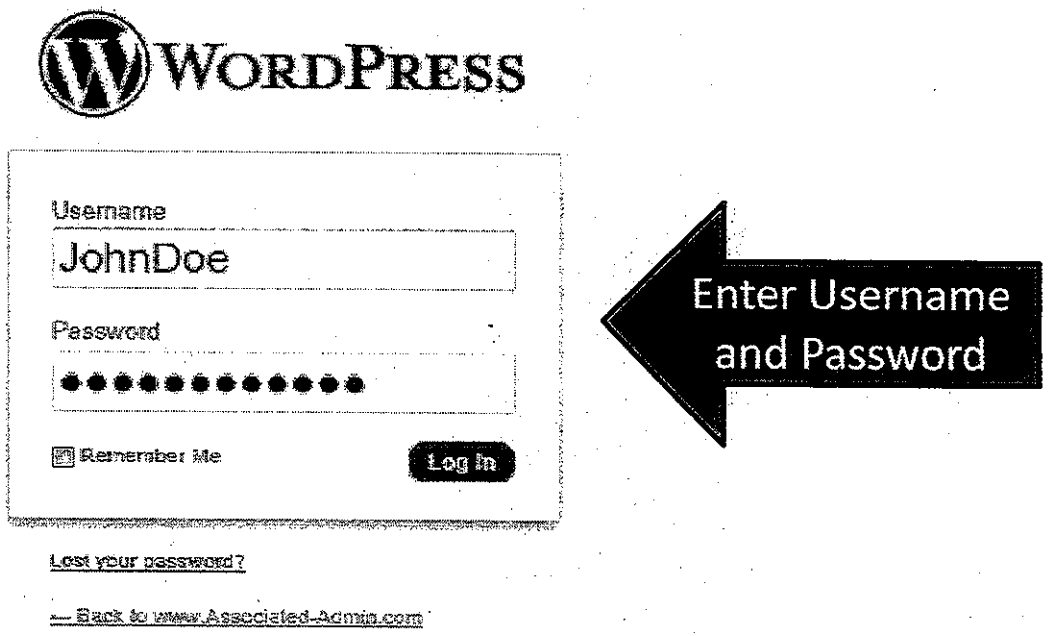
We hope that you find this Trustee Web Portal to be a useful tool. Please contact your Account Executive if you have any questions.

STEP 1: THE TRUSTEE WEBPORTAL CAN BE ACCESSED AT www.associated-admin.com



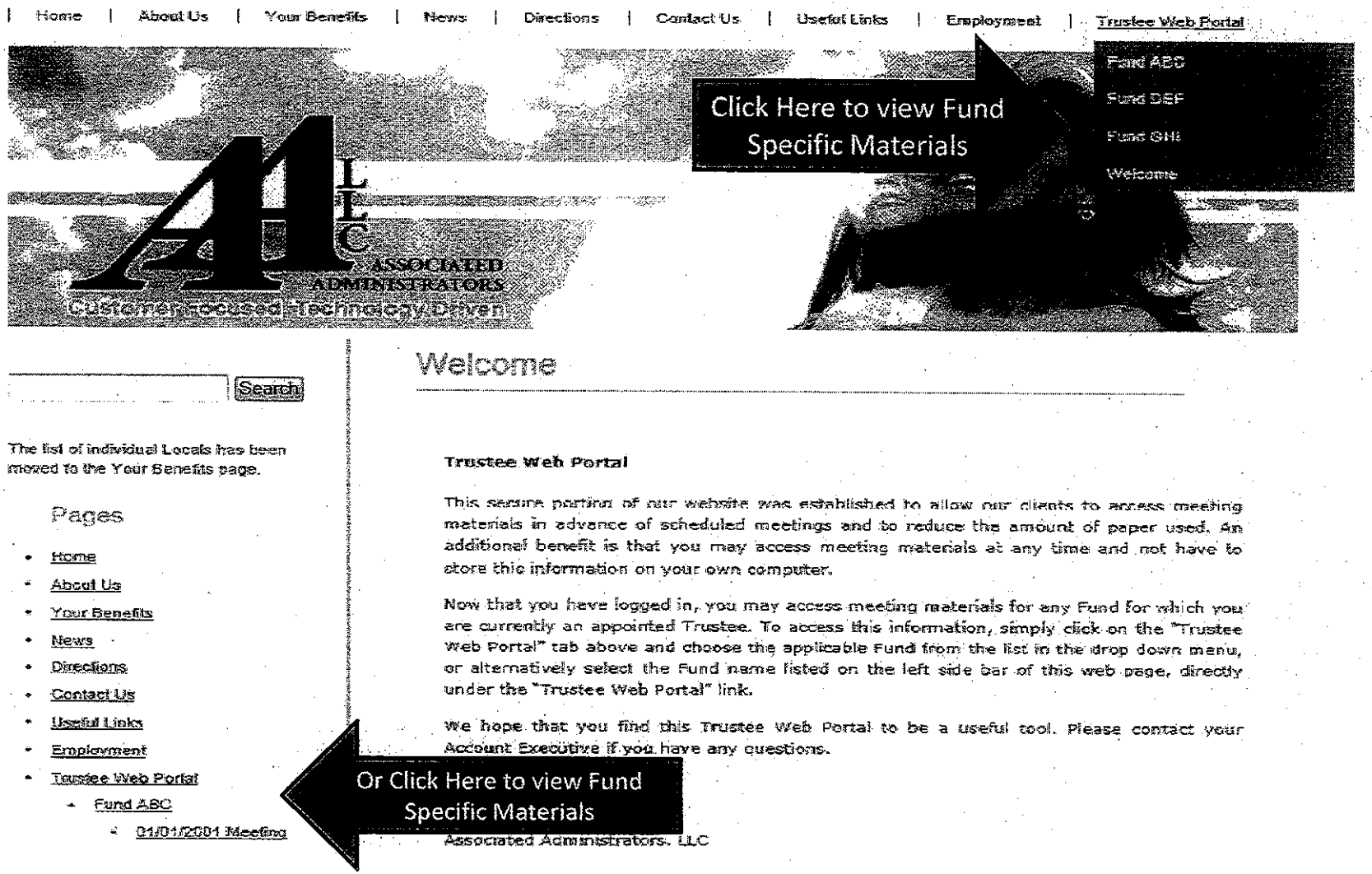
STEP 2: LOGIN

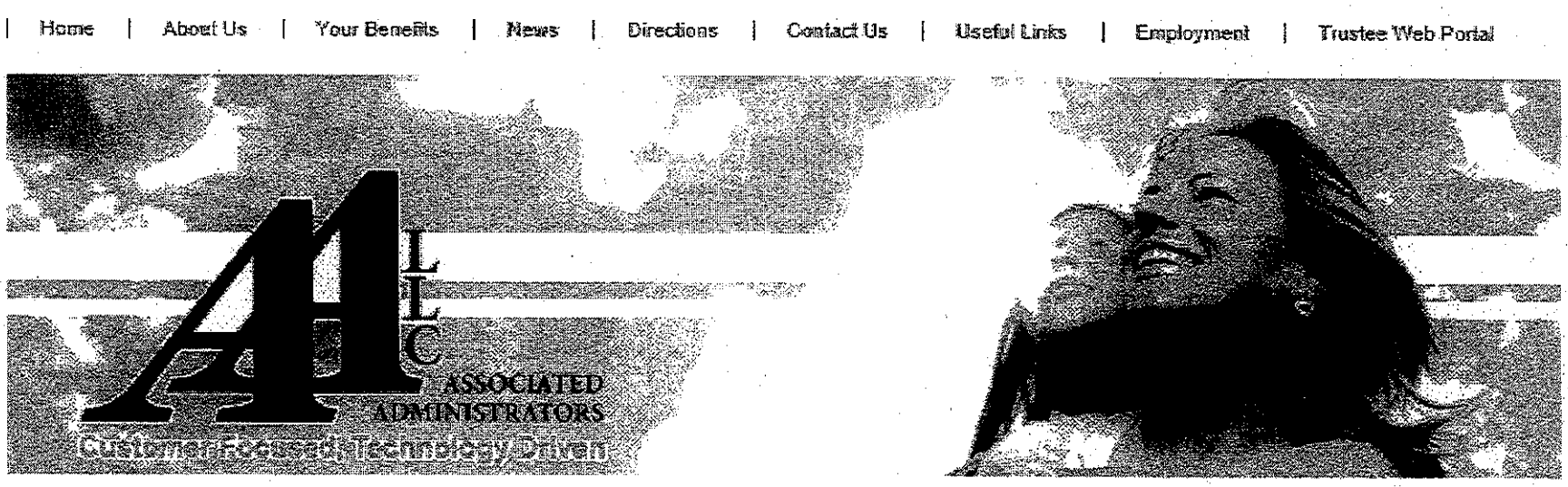

| Home | About Us | Your Benefits | News | Directions | Contact Us | Useful Links | Employment | Trustee Web Portal
ALLC
ASSOCIATED
ADMINISTRATORS
Customer Focused, Technology Driven
Search
The list of individual Locals has been moved to the Your Benefits page.
Pages
Trustee Web Portal
To view the Funds associated with your Trustee Web Portal account please Login.
Click here to Login



A username and password will be sent to you by Associated Administrators, LLC. Enter your username and password and then click on the log in button

STEP 3: ACCESS INFORMATION. Once you have logged in, you may access meeting materials for any Fund for which you are currently an appointed Trustee. To access this information, simply click on the "Trustee Web Portal" tab above and choose the applicable Fund from the list in the drop down menu, or alternatively select the Fund name listed on the left side bar of this web page, directly under the "Trustee Web Portal" link.





Access meeting materials by clicking on the links shown above.

PROPOSALS

US IMAGING

A Radiology Solution

US Imaging Program Overview

US Imaging Is A Success

Over 200 Clients

- Significant employee engagement
- Growing number of facilities within our network

Average Client Savings of 36%

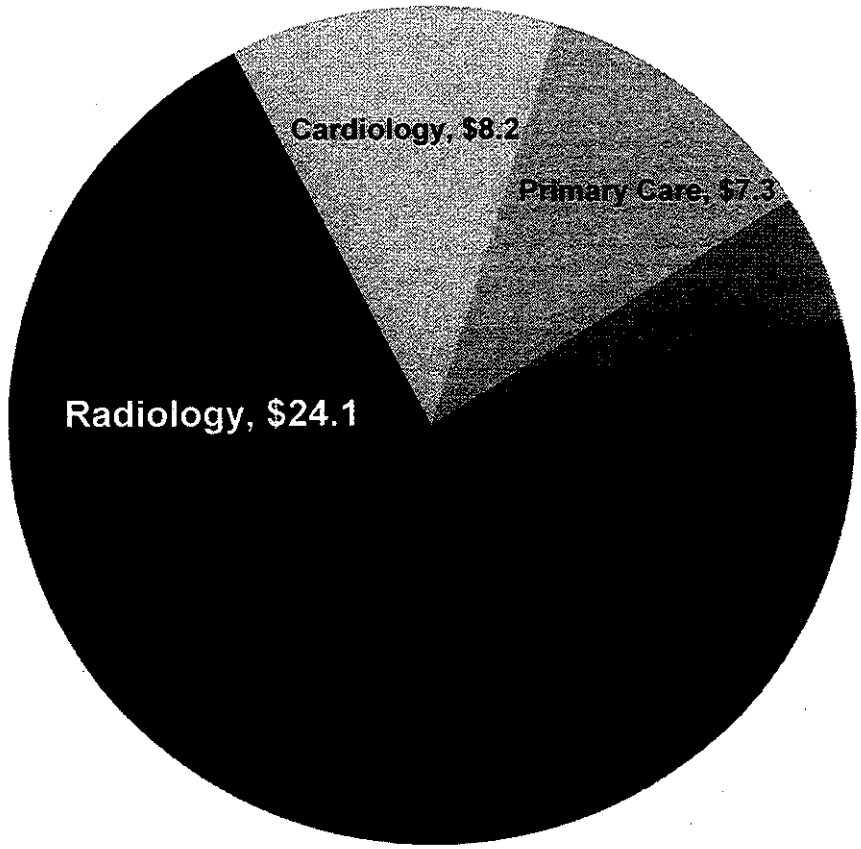
- Clients savings analyses have exceeded 50%
- Average out-of-pocket member savings of $180

VIP concierge scheduling in conjunction with *preauthorization* generates optimal savings and member satisfaction

- 94% of USI members are highly satisfied with our service
- "Great program," "ease of use," and "knowledgeable staff"
- Expedited appointments, education, and appointment reminders create "peace of mind"

Financial Impact of Imaging on Hospital Profit

Top Five Outpatient Hospital Service Lines by Contribution to Profit (Billions)*



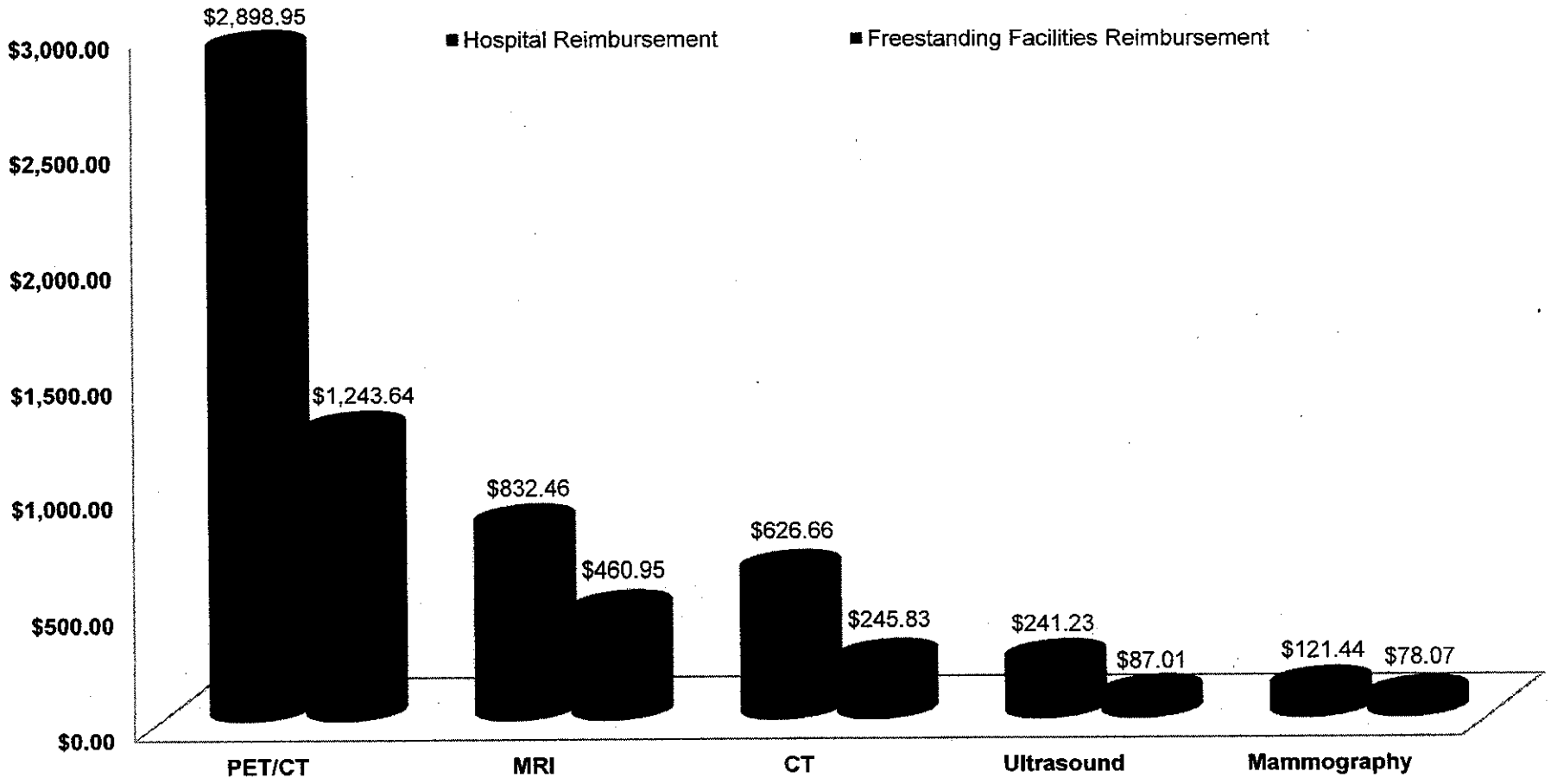
■ Radiology 37% ■ Cardiology 12% ■ Primary Care 11% ■ Lab 5% ■ Orthopedics 5% ■ Other 30%

*Source: Improving Radiology Revenue Opportunities for Community Hospitals Through Higher Quality Service Levels (2007 Data), Radisphere National Radiology Group, 2010, http://www.healthleadersmedia.com/content/253589.pdf

US IMAGING

A Radiology Solution

Average Revenue per Modality: Hospitals Vs. Freestanding Facilities*



* Source: Hospital-based Versus Freestanding Outpatient Imaging Services, Radiology Business Journal, May 4, 2011, http://www.imagingbiz.com/articles/view/hospital-based-versus-freestanding-outpatient-imaging-services

US IMAGING

A Radiology Solution

Trends in Outpatient Advanced Imaging

Currently, advanced imaging contributes 10 cents of every dollar spent on health care and is projected to grow at a rate of 9-12% per year. Reasons include:

- Advancements in technology
- Aging population
- Shift towards diagnostic imaging as a preventative test
- CT screenings for lung cancer becoming more prevalent as a diagnostic screening tool with smokers and former smokers

VIP Appointment Scheduling Service and Cost Transparency

- After-hours and weekend appointments to reduce lost time at work
- Access to quality facilities instead of costly facilities & hospitals
- Reduction in out-of-pocket coinsurance costs
- Transparent cost information before an employee seeks care

Case Study:

A USI member was referred for 3 CT scans to a hospital-based imaging center. The total cost of the scans would have been $4223. USI scheduled the member at a more convenient facility for a total cost of only $1350. Since the member had a 20% co-insurance, she saved $574 and her employer saved $2,298!

VIP Customer Service

US Imaging makes the process simple for employees. We provide the following services:

1. Arrange for an appointment at a time/location convenient for the employee
2. Ensure the equipment is appropriate for the employee's needs
3. Provide written appointment confirmation and directions
4. Obtain copy of the prescription from referring physician
5. Submit prescription and billing information to facility in advance
6. Make a reminder call to the employee before the appointment
7. Contact employee after exam to ensure satisfaction

150

US Imaging Model Comparison

- **There is no PMPM or administrative fee when clients meet 3 basic program requirements**
  - Printing standard preauthorization contact and claims submission information on the client's primary medical benefit card
  - Establishing a plan design differential
  - Designing co-branded member education material
- **US Imaging does not perform clinical review but can integrate with third-party pre-certification programs through our Case Management Appointment Tool (CMAT)**
- **Employees are scheduled into a cost effective network**
  - Radiology Benefit Management (RBM) programs do not guide patients away from high cost facilities

151

National Savings Opportunity for 52,000 Covered Lives

Modality	Units	Allowed Amount	Annual Savings Using USI	% of Savings Against Allowed
CT	3,486	$3,058,582	$1,306,467	43%
MRI	2,644	$2,912,863	$778,863	27%
PET	94	$323,646	$136,046	42%
Advanced Imaging	6,224	$6,295,091	$2,221,376	35%

Modality	Per Unit Allowed Amount	Per Unit USI Amount
CT	$877	$503
MRI	$1,102	$807
PET	$3,443	$1,996

Sample Employee Savings Opportunity for 52,000 Covered Lives

In addition to the employer saving with USI, the employees of this group save $222,138 in out-of-pocket expenses

Employee Out-Of-Pocket 10% Coinsurance	Allowed Amount	Without USI Employee Out-Of-Pocket Expense	With USI Employee Out-Of-Pocket Expense
CT	$3,058,582	$305,858	$175,212
MRI	$2,912,863	$291,286	$213,400
PET	$323,646	$32,365	$18,760
TOTAL	$6,295,091	$629,509	$407,372

153

Quality Facilities Equal Lower Costs

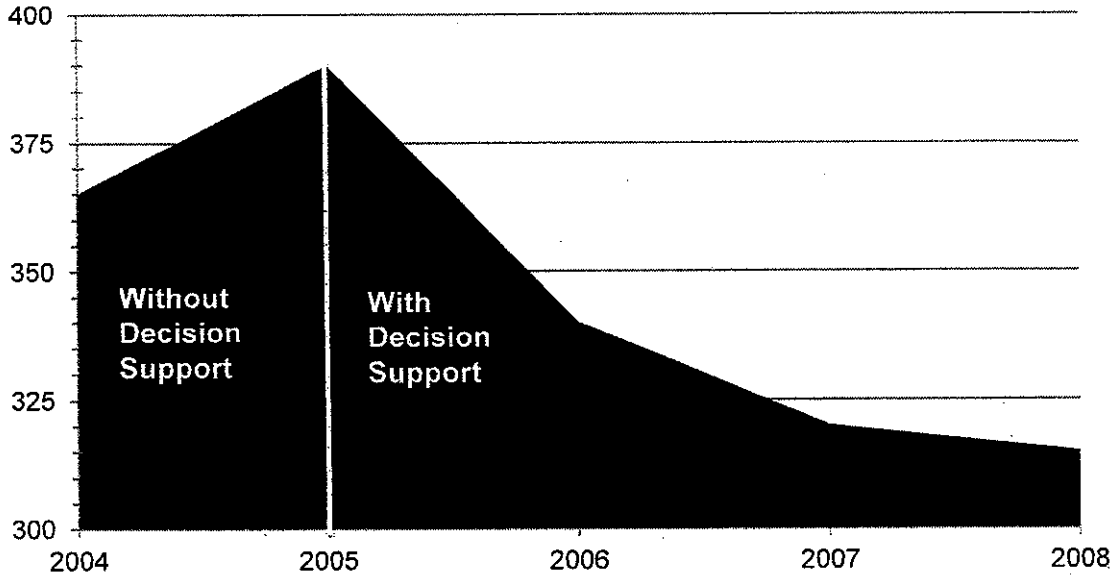
- US Imaging contracts with ACR accredited radiology centers that meet high standards for excellence
  - ACR (American College of Radiology) accreditation is the "gold standard" for identifying high quality facilities

    90% of the US Imaging facilities have been designated as ACR accredited
  - Poor imaging equipment can produce substandard image quality resulting in the need for repeat imaging
- In addition to confirming ACR accreditation status, US Imaging ensures that each facility meets the following criteria:
  - License for the facility is up to date
  - Facility has appropriate malpractice coverage
  - Magnet strength/slices are appropriate for services provided

154

Optional Decision Support Add-On

Decision support systems are transparent, efficient, practical and consistent



The impact of decision support on MRI, CT and nuclear cardiology tests per 1,000 health-plan enrollees (2)

Results from a pilot project in Minnesota (1)

- Claims for Advanced Imaging decreased 3% year over year
- 9% utilization reduction compared against previous four year trend

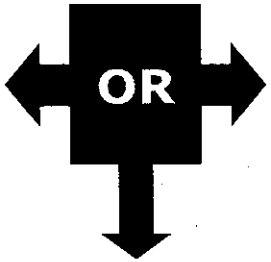
- Cost effective alternative to RBMs with a lower PMPM fee and similar "sentinel effect"
- Providing members with access to the appropriate imaging study for the right reason the first time
- Reducing unnecessary radiation exposure to members
- Avoiding costly procedures that are not consistent with evidence-based clinical guidelines

(1) Source: Radiology Decisions lead to cost savings, Health Management Technology, May2010, http://www.healthmgttech.com/index.php/solutions/payers/radiology-decisions-lead-to-cost-savings.html
(2) Source: Will Decision Support Deflect Preauthorization?, Radiology Business Journal, October 13, 2010, http://www.imagingbiz.com/articles/view/will-decision-support-deflect-preauthorization

How it Works

Employee is prescribed an MRI/CT/PET

Employee calls to notify US Imaging and schedule the test at a convenient time and location



Referring doctor's office calls to notify US Imaging and refer an appointment on behalf of the employee

US Imaging confirms member eligibility, schedules appointment at USI-contracted facility (if applicable) and provides an authorization confirmation to the referring physician

The US Imaging facility submits a HCFA 1500 or EDI claim to US Imaging for payment

US Imaging adjudicates the claim and submits an invoice for payment

US Imaging sends an EOP and payment to the facility

156

Summary

US Imaging	
Fast Implementation	Implementation time is generally 30 to 45 days. The US Imaging program can be rolled out at any time during the year.
Works in Tandem with Existing Administrator(s)	US Imaging is a program that enhances your existing benefit plan. US Imaging simply requires an employee eligibility file to ensure proper administration of your program.
Transparency and Consumer Driven	US Imaging is a quality and consumer-focused program providing employees with transparency, allowing them to better understand differences in cost and quality when making healthcare decisions.
Dedicated Team	US Imaging will have a dedicated customer service team for the employer. We will assign a dedicated account representative as a single point of contact.

Directions for Covered Lives and Claims File

Format (All files)
Provide data in a tab or pipe delimited text file or in a MS Excel file or MS Access database.

Data Delivery and Encryption (All files)
All data should be posted on our FTP server to ensure HIPAA compliance. Please contact us for hostname name and login information.

Covered Lives (Covered Lives File)
Covered lives includes all members and dependents that are enrolled in the medical plan. This may include COBRA and retirees depending on individual benefit design. Information should be provided regardless of whether they are included in the claim file.

Please exclude any membership with primary coverage under Medicare or those who receive primary medical benefits from another carrier outside the company medical plan.

Place of Service (Claims file)
Provide claims for place of service ***11 and 22 only***.

Procedure Codes (Claims file)

Provide all claim lines that include any of the following codes:

- CPT Codes: 70000-79999
- Revenue Codes: 255, 320-359, 400-409, 610-619, 621, 920, 921, 929, and 972-974
- HCPCS Codes : C8900-C8920, G0130, G0219, G0235, G0252, S8037, S8042, S8092

Each claim line should include either a CPT code or a revenue code or a HCPCS code from the range found on the prior page. If a claim line has both a CPT code and a HCPCS code available, please include both values in their respective fields.

Exclude denied claims (Claims file)
Denied claims should NOT be included. Only final adjudicated service lines should be provided.

Date Range (Claims file)
Provide 12 months of data. The latest date of service should be 3 months old.

Guidelines / Comments (Claims file)
Provide descriptions or crosswalks for non-standard coded fields (*e.g. place of service*).

Provide record counts for each file submitted to ensure no data was lost during file transfer.

Please exclude any claims for members with primary coverage under Medicare or those who receive primary medical benefits from another carrier outside the company medical plan.

File Layout

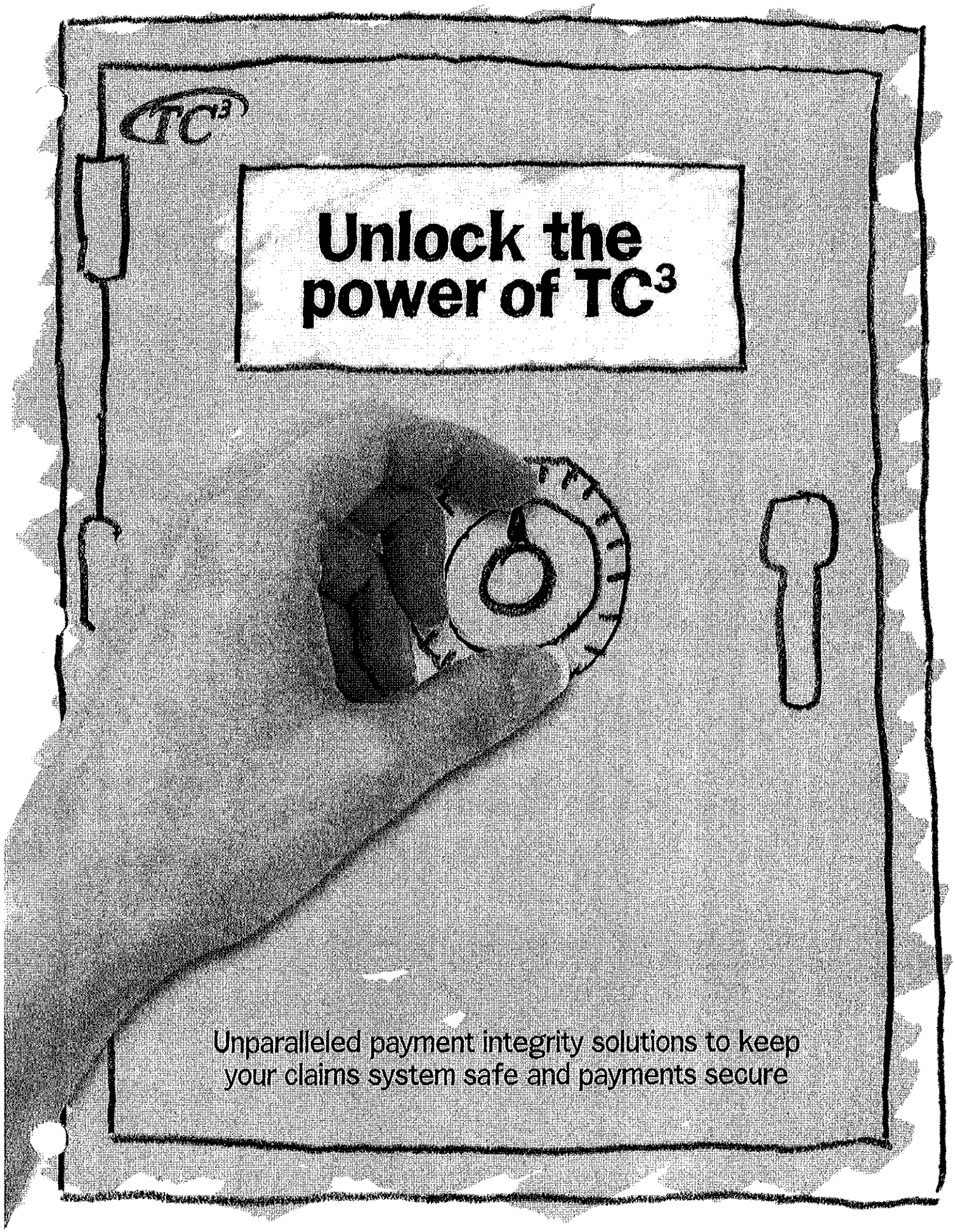
Covered Lives File Layout:

- Zip Code
- Total # of covered lives in the zip code

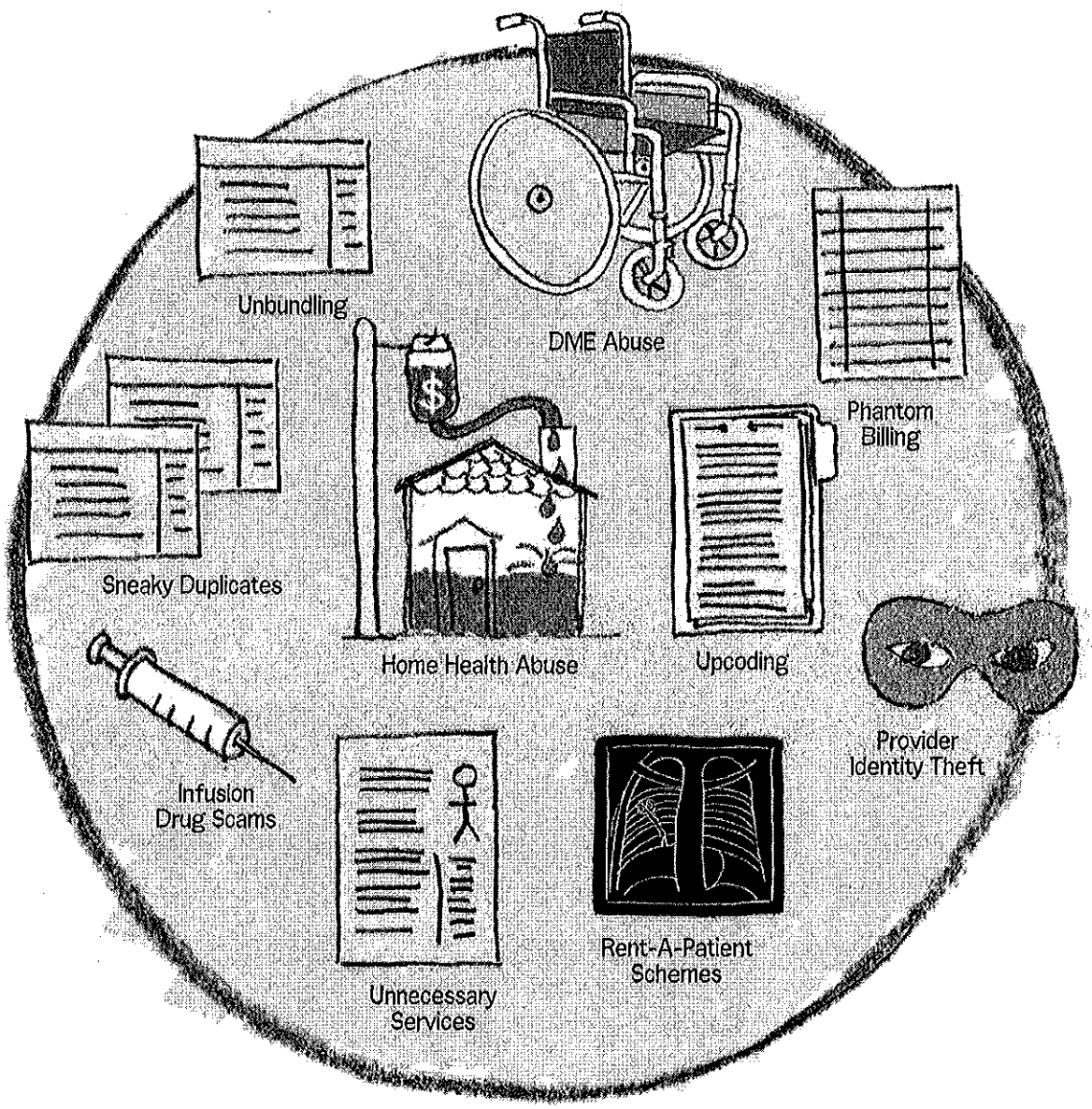
Alternatively, we can accept a current roster file in the format provided to your medical carrier or vendors including an X12 834 file.

Claims File Layout:

- Claim ID
- Member ID
- Date of service
- Place of Service
- Referring Provider NPI
- Rendering Provider Tax ID
- Rendering Provider Name
- Rendering Provider Address 1
- Rendering Provider Address 2
- Rendering Provider Zip Code
- Billing Provider Name
- Billing Provider Address 1
- Billing Provider Address 2
- Billing Provider Zip Code
- Units
- CPT code
- Revenue code
- HCPCS code
- Modifier 1
- Modifier 2
- Diagnosis 1
- Diagnosis 2
- Billed Amount
- Deductible Amount
- Coinsurance Amount
- Copay Amount
- COB Amount
- Allowed Amount
- Paid Amount


TC³
Unlock the power of TC³
Unparalleled payment integrity solutions to keep your claims system safe and payments secure

Everyday your claims system is at risk.



Given the huge increase in the types of threats in today's healthcare system, protecting your plan assets is more essential than ever. If left unprotected, a fraud, waste or abuse scheme could quickly take advantage of vulnerabilities in your claims system, allowing numerous overpayments to slip through your fingers. Meanwhile, inappropriate or invalid payments processed could take months or even years to recover, and only a fraction of those payments may actually be recouped.

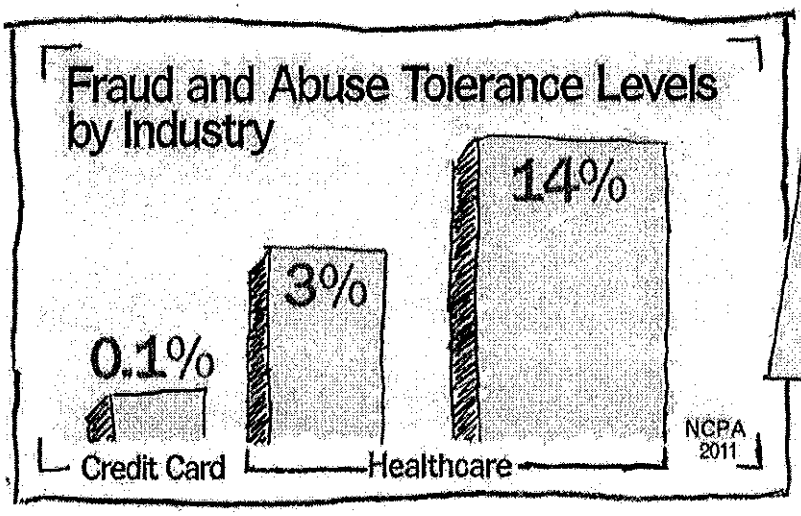
The Status Quo Must Change!

The key to significantly improving the ROI of payment integrity efforts is to adopt the same strategy employed in the financial services and credit card industry – that is to identify these threats on a pre-payment basis.

The amount of fraud tolerated varies widely from industry to industry.

The credit card industry's accepted threshold is 0.1%. Today, the healthcare industry tolerates 3-14%. A "pay and chase" only strategy is not the answer. We must collectively adopt and deploy new and enabling pre-payment technologies and strategies to identify and stop the overpayments before they go out the door.

How much is too much?



Every $2 million invested in fighting overpayments returns $17.3 million in recoveries. (NHCAA - 2008)

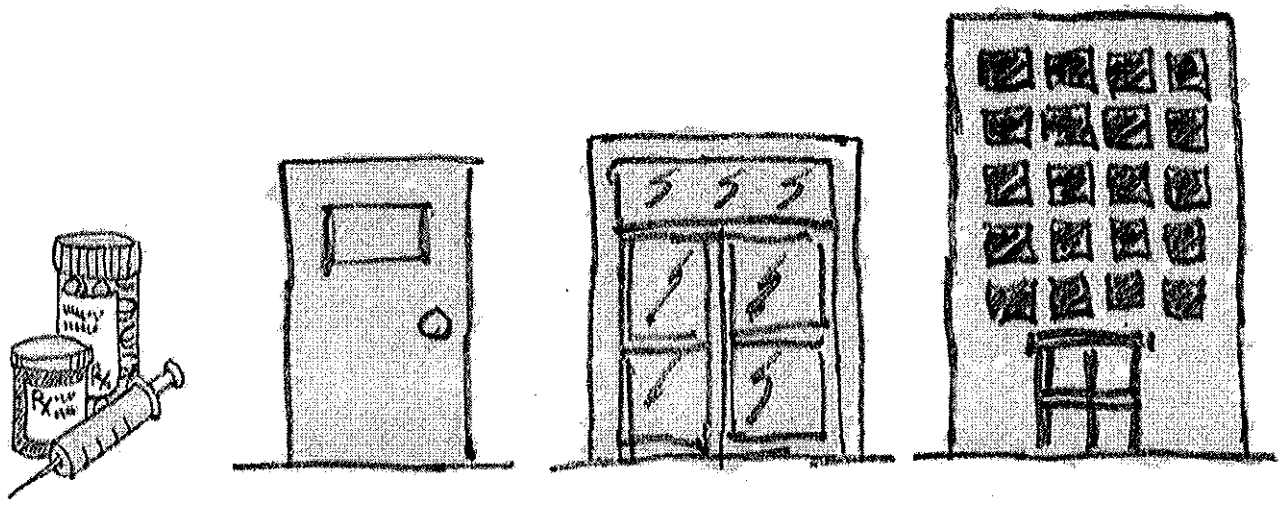
Nearly a 9 to 1 ROI

Medicare Fraud: one of, if not, the most profitable crimes in America... is bigger than the [illegal] drug business.

CBS 60 Minutes (October 25, 2009)

Introducing TC³'s TruClaim℠ Payment Integrity Suite.

The all-in-one Overpayment Detection and Prevention Suite that protects your claims adjudication system from exposed gaps, fraud, waste and abuse threats, user errors, and overpayments.



Rx Provider Clinic Hospital

TC³ provides total claims payment protection from all types of fraud, waste and abuse.

The complexities of healthcare billing requires the scrutiny of experts. TC³'s comprehensive solutions stop all types of healthcare overpayments. From medical coding specialists to our advanced TruClaim Analytics, the TC³ team is equipped with deep resources to protect your plan assets with a smarter, more efficient way to accurately validate claim payments.

Drawing from our extensive healthcare experience, we specialize in the areas of fraud, waste and abuse so you can rest assured that we'll find these threats before they find your payment system. Whether you need a full-service approach or additional resources to supplement your current payment integrity program, our customized solutions allow you to focus on your core competencies while we concentrate on ours.

Whatever your requirements, we offer the most robust payment integrity solutions in the industry.

TC³ TruClaim℠ Payment Integrity Suite

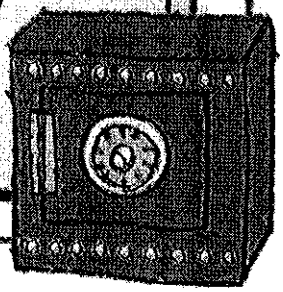
Unmatched in Claims Payment Protection

- ☑ Pre-payment Detection Technology
- ☑ Suspect Provider Match Program
- ☑ Fraud Diagnostics (Rules Driven)
- ☑ Fraud Analytics (Algorithms)
- ☑ Case Investigations – SIU Services
- ☑ Code Edit Compliance
- ☑ Case Tracker (Case Management System)
- ☑ Post-payment Discovery & Recovery
- ☑ Out-of-Network Repricing
- ☑ Medical Bill Review and Negotiations
- ☑ Data Analytics & Reporting

TC³'s unparalleled service keeps your claims system safe and payments secure.

The TC³ Difference:

- Proactively uncover fraud before claims are paid
- Customize rules and edits to your workflow and payment policies
- Maintain compliance with real time deployment of the latest code edits and rules
- No software to download or install – quick deployment
- Full integration with the majority of commercial claim systems
- Full-service SIU with extensive healthcare fraud, correct coding and data mining expertise to supplement your internal efforts
- Recoup overpayments through retrospective discovery
- Low risk – high ROI – off budget expense with contingency pricing model
- Mature, scalable solution with proven results



TC³ provides a comprehensive suite of robust payment integrity services to help increase your productivity while keeping your claims system safe and payments secure.

As effective as our software is, it's only as good as the people that use it. Our dedicated investigators, certified coders, clinicians and data analysts average over 10 years of experience. They are committed to uncovering overpayments so you don't have to. And with our proven track record of successfully working with all payer types nationally, we understand your business.

The combination of our expertise, sophisticated technology, and full-service ensures your claims data is not compromised so you can stay focused on managing your business, not worrying about fraud, waste and abuse.

Leave it to our experts. Contact us at Info@tc3health.com for a no obligation assessment of your payment integrity and investigation needs.

July 26, 2012

William Jensen
President
Associated Administrators, LLC
4301 Garden City Drive
Landover, MD 20785

Dear William Jensen:

I oversee the business development efforts in the state of MD for Navitus Health Solutions, a PBM that currently administers the pharmacy benefits for more than 2.5 million individuals throughout the country. Our clients include unions, private employers, state and county governments and health plans.

Founded on the principles of complete financial and operational transparency, stewardship and service excellence, the "Navitus Model" simplifies pharmacy benefit management and ensures complete alignment of Navitus' interests with those of plan sponsors.

Time and time again (see case studies enclosed), our model is producing greater savings compared to "traditional" PBMs. This savings, combined with client and member satisfaction rates of 95 percent or greater has resulted in tremendous growth our company. In 2012 the Pharmacy Benefit Management Institute (PBMI) independently surveyed PBM customers throughout the United States for their 2012 Customer Satisfaction Report. Of all the PBMs reported on, Navitus received the highest rating. A summary of this report as well as some general Navitus information is enclosed.

I would like to schedule a meeting with you to introduce myself and to discuss having Associated Administrators include Navitus in future PBM marketing efforts. Please contact me at directly at (914) 572-0531 or via email at mike.krause@navitus.com.

I look forward to your response.

Very truly yours,

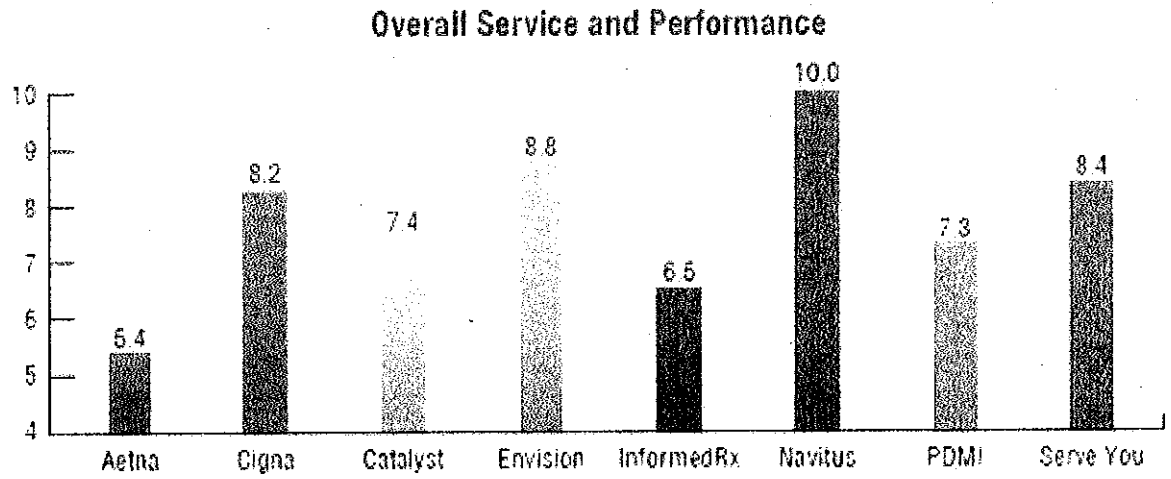
Michael J. Krause
Regional Vice President, Sales

Navitus is proud to have received the highest possible rating—a score of 10— in the Pharmacy Benefit Management Institute (PBMI) 2012 Customer Satisfaction Report. More than 318 U.S. employers, health plans and union groups, representing more than 50 million members, rated their PBMs on overall performance and a wide variety of service indicators. Service functions included such areas as administration, pharmacy network, clinical programs, member websites, management reporting, and Medicare Part D offerings.

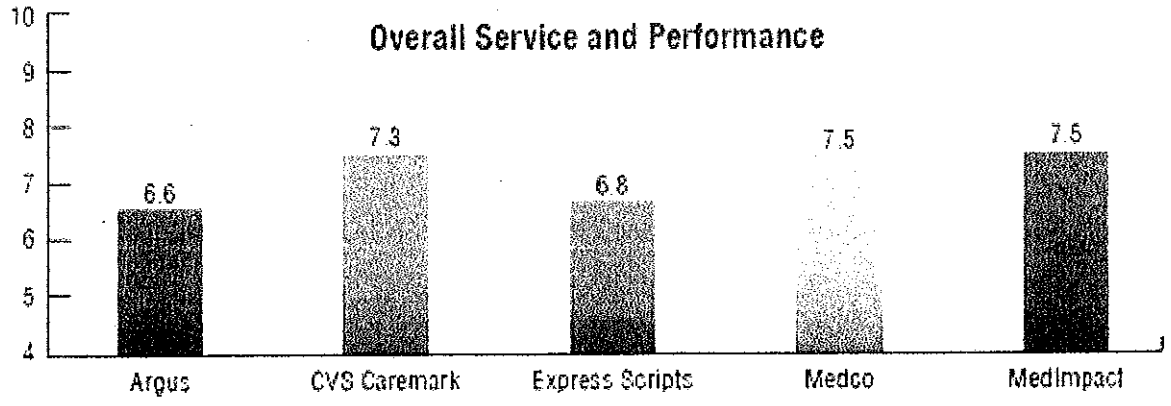
Navitus differentiates itself based on its business model of full transparency, 100 percent pass-through, and ensured alignment to client goals. Affirming our model is a significant value proposition, clinical excellence, and a passion for managing our clients' pharmacy benefits with integrity.

As the following charts depict, Navitus outperformed all PBMs represented in the survey, including all of the top-tier PBMs that manage 20 million or more members.

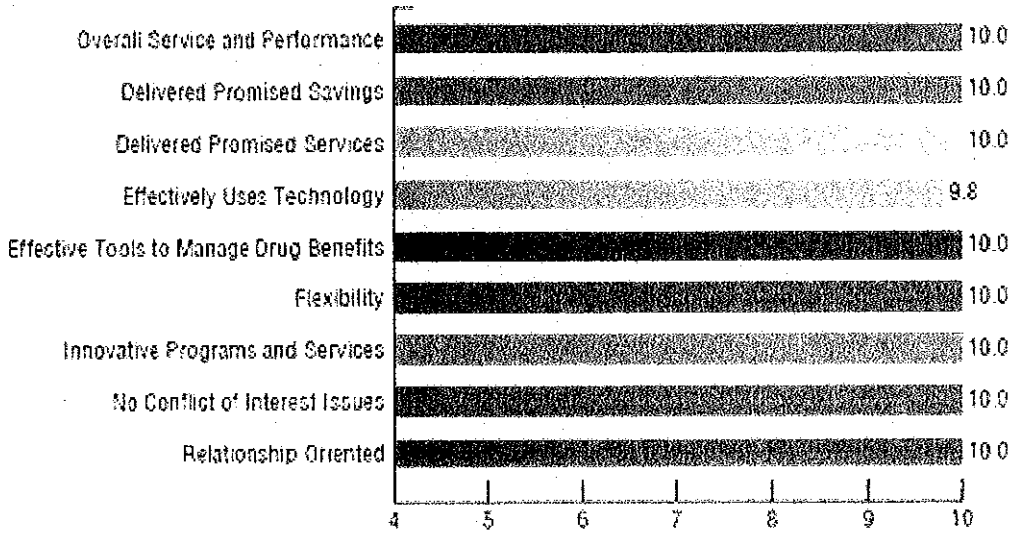
Overall Ranking – PBMs with 20 million or fewer members



Overall Ranking – PBMs with 20 million or more members



The following depicts Navitus' scores by key attributes, which demonstrates that the high-touch Navitus business model resonates with its clients.



Survey respondents clearly indicated higher satisfaction with PBMs that are completely transparent and aligned with their interests. This preference is reflected in the mean overall satisfaction rating of 8.4 for respondents reporting that their PBM is completely transparent, compared to a mean of 4.8 for those reporting that their PBM is not transparent. Further, a strong positive relationship was noted between reported alignment and overall satisfaction.

We are extremely proud of achieving this notable accomplishment, which endorses the value our clients and members receive with our business model. The results of this survey validate our commitment to lowest-net-cost performance and delivery of clinical and service excellence.

MEMORANDUM

To: **Board of Trustees of the**
UFCW Unions and Participating Employers Health and Welfare Fund
From: **William R. Jensen**
Date: **December 11, 2012**
Subj: **Tertiary Discounter Proposal**

Attached is correspondence indicating that CareFirst's tertiary discounter for out-of-network claims has terminated its service effective December 1, 2012.

CareFirst recommends that the Fund hire HRGI, with a cost at the same level as charged to CareFirst, 30% of savings.

Please advise regarding the replacement of CareFirst's tertiary discounter.

W.R.J.

ncas®
The Team Approach to Benefit Administration

1501 S. Clinton Street
7th Floor
Baltimore, MD 21224
410-528-2222
Fax 410-528-2201

November 19, 2012

Associated Administrators
Attn: Bill Jensen
4301 Garden City Drive, Suite 201
Landover, MD 20785

RE: Three Rivers Provider Network (TRPN)

Dear Bill:

As you know based on our prior conversations, NCAS is unable to continue to pass out-of-network claims to TRPN for tertiary re-pricing on behalf of Associated Administrators.

Effective December 1, 2012, NCAS will furnish Associated Administrators re-pricing information for participating CareFirst BCBS network providers only. To ensure continued availability of discounts for out-of-network claims, it is necessary for Associated Administrators to establish a direct contractual and claims routing relationship with a network of its choosing (e.g. TRPN, HRGI, MultiPlan, etc.).

NCAS recommends that Associated Administrators consider HRGI as a potential solution for out-of-network claims. Historical review of the overall NCAS block of business has revealed that HRGI provides greater access and cost savings in comparison to TRPN alone. More specifically, NCAS has consistently experienced cost savings of greater than 30% with HRGI whereas prior TRPN savings yielded 15%. HRGI leverages multiple subordinate networks and also provides claims negotiation services as part of their core offerings. Moreover, use of HRGI does not diminish or remove accessibility to TRPN providers since TRPN is a sub-network of HRGI.

Again, our recommendation is for Associated Administrators to immediately enter into a direct contractual relationship with HRGI or any other vendor of its choosing to ensure uninterrupted services and continued savings for out-of-network claims.

Please know that we will assist and support Associated Administrators in any way possible to provide for a smooth and seamless transition.

Best regards,

Keith N. Rambo, RHU®, REBC®
Vice President, Operations

CC: Jim Dunham; Joe Pedone; Steve Krasnoff; Terry Valliant; Doug Fletcher

Memo

To: Mr. Bill Jensen- President, Associated Administrators, LLC
The Trustees of the Health and Welfare Fund of FELRA
From: Steve Krasnoff- Labor Relations Account Consultant, CareFirst
Subject: Proposed Tertiary Network Solution
Date: Wednesday, July 11, 2012

CareFirst and NCAS are putting forth a recommendation that Associated Administrators pursue a direct contract with HealthRisk Resource Group (HRGI) via a direct arrangement for repricing out-of-network claims. HRGI affords greater network penetration and increased overall savings for client benefit over TRPN's network solution. HRGI provides two options for obtaining out-of-network discounts on claims. They offer a network comprised of approximately 12 sub-networks, as well as, an option for provider specific discount negotiation. The two options can be combined or placed in any order of process, based on the request to HRGI. As such, all claims can pass through their networks for potential match on the provider affiliation with the HRGI networks first and then go for possible discount negotiation if the provider is not participating with one of the sub-networks. The Networks can be utilized in conjunction with the negotiation service or as a standalone option, at the discretion of the claim payer.

HRGI can be setup as a direct link to receive out-of-network claims directly from Associated Administrators via an EDI claim file. This is a standard course of moving claims in today's environment and can be setup in a relatively short amount of time. Additionally, HRGI also offers a web portal that provides access to claims being negotiated and past claims history, as well as, reporting capabilities.

The TRPN savings report previously furnished to Associated Administrators represented 15% average savings off of billed charges. CareFirst Administrators and NCAS are requesting a savings report from HRGI based on the same claims data to ensure an apples-to-apples comparison. For NCAS and CareFirst, there has been an experience of approximately a 31% average savings on claims sent to HRGI for out-of-network discount processing. The average turnaround time for return of claims is 1.9 days. The success rate is average 63% on claims submitted for discount. See below supporting summary:

2012 YTD Client Summary - CareFirst Administrators

Service Type	Claims Submitted	Eligible Claims Processed	Claims with Savings	Claim Penetration Rate	Total Charges Submitted	Eligible Charges Reviewed	Charges with Savings	Charge Penetration Rate	Total Savings	Average Savings Percent	Average TAT
Fee Negotiation	3,002	2,531	1,099	43%	$4,320,701	$3,714,522	$2,684,101	72%	$911,203	34%	2.35
Supplemental Networks	1,215	1,215	1,215	100%	$714,530	$714,530	$714,530	100%	$157,908	22%	1.27
Total	**4,217**	**3,746**	**2,314**	**62%**	**$5,035,231**	**$4,429,052**	**$3,398,631**	**77%**	**$1,069,111**	**31%**	**1.81**

2012 YTD Client Summary - NCAS

Service Type	Claims Submitted	Eligible Claims Processed	Claims with Savings	Claim Penetration Rate	Total Charges Submitted	Eligible Charges Reviewed	Charges with Savings	Charge Penetration Rate	Total Savings	Average Savings Percent	Average TAT
Fee Negotiation	6,699	5,523	2,525	45.72%	$8,050,931	$6,571,549	$5,330,879	81.12%	$1,732,128	32.49%	2.66
Supplemental Networks	3,053	3,053	3,053	100%	$2,022,469	$2,022,469	$2,022,469	100%	$515,722	25.50%	1.28
Total	**9,752**	**8,576**	**5,578**	**65.04%**	**$10,073,400**	**$8,594,018**	**$7,353,348**	**85.56%**	**$2,247,850**	**30.57%**	**1.97**

The required workflow process (see attached) necessitates for NCAS to take in all claims. After pricing the claims, NCAS will pass the complete file (in-network priced and out-of-network) directly to Associated Administrators. Associated Administrators in turn would send the out-of-network claims to HRGI for pricing (via their direct contract with HRGI). The out-of-network link will need to be directly between Associated Administrators and HRGI.

CareFirst and NCAS are in the process of putting together the cost structure that would be levied on FELRA for the repricing arrangement that would potentially be set up with HRGI. This will be submitted in the near future in the form of a memorandum that will be addressed to Mr. Jensen of Associated Administrators and to the Health and Welfare trustees of FELRA.

We are happy to facilitate a meeting between Associated Administrators and our HRGI contact and assist Associated Administrators with coordinating the overall arrangement to the extent that Associated deems appropriate and necessary.

Proposed Work Flow for Netlease Processing with HRGI integration with A.A.