FEBA UFCW

FOOD EMPLOYERS LABOR RELATIONS ASSOCIATION & UNITED FOOD AND COMMERCIAL WORKERS FUNDS

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Plan X Part Timers:
Open Enrollment for Dependent Coverage Is July 1st - July 31st. See page 6.

For Your Benefit

Open Enrollment for Medical Coverage Is July 15th – September 15th

*The following article applies to **actively working participants** in Plan I, Plan X and Plan XX.*

Open Enrollment for choosing how your medical coverage will be provided is from July 15 – September 15 for coverage effective October 1, 2012 – September 30, 2013. During open enrollment, you may choose whether your medical coverage will be provided through an HMO (Kaiser Permanente) or through the Fund under traditional medical indemnity coverage.

How Does Open Enrollment Work?

During July, you should receive a letter from the Fund office, along with a packet of important information from the HMO (Kaiser Permanente). A Benefit Summary explaining the HMO benefits will be included, along with an enrollment form. ***Please read the Kaiser Permanente information carefully.***

What If I Didn't Get an Open Enrollment Letter?

You will receive an open enrollment letter only if you live in the geographic area covered by Kaiser. If you do not live in this area, your traditional Fund coverage will continue automatically. If you didn't receive an open enrollment letter and think you should have, call the Fund office at (800) 638-2972. We will double check whether you are in Kaiser's geographic area, and if you are, we will help you get information about the HMO.

How Do I Enroll in the Kaiser HMO?

If you decide you want to enroll in the Kaiser HMO, complete the enrollment form for Kaiser Permanente and ***send it back to the Fund office (NOT to Kaiser)!*** Your Plan is the "Signature" Plan. Choose a provider from the Kaiser directory included in your packet before you enroll. After enrolling, you will receive an ID card from Kaiser. This should arrive on or shortly after October 1, 2012.

Please note: if you are currently enrolled in Fund medical coverage and you decide to switch to Kaiser, ***the change becomes effective October 1st, regardless of when your Kaiser ID card arrives.*** Starting October 1st, you must use providers in the Kaiser network. Your providers for optical, dental and prescription drug benefits remain the same whether you have Kaiser or traditional Fund coverage. Participants in an HMO no longer need their green Fund ID cards. If you come back to traditional Fund medical coverage in the future, we will send you a new Fund medical card.

What If I Want to Change to Traditional Fund Medical Coverage?

If you are currently in Kaiser and wish to change to traditional Fund medical coverage, call Participant Services at (800) 638-2972. Remember, you must make this change between July 15th and September 15th! If don't do anything!

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This issue—

Collective Bargaining Changes This Issue! See Pages 2, 4, and 5 for Important Information About Your Benefits!

The purpose of this newsletter is to explain your benefits in easy, uncomplicated language. It is not as specific or detailed as the formal Plan documents. Nothing in this newsletter is intended to be specific medical, financial, tax, or personal guidance for you to follow. If for any reason, the information in this newsletter conflicts with the formal Plan documents, the formal Plan documents always govern.

Retiree Corner

The following articles apply to Retirees.

Material Modification

Collective Bargaining Changes – Read Below For Important Information about Your Benefits

The following articles apply to FELRA and UFCW Health & Welfare Fund Retirees.

★ ★ ★ BARGAINING CHANGES ★ ★ ★

Changes for Kaiser Medicare HMO Retirees And/Or Dependents

Effective June 1, 2012, as a result of collective bargaining, the following change has been made to the Kaiser Medicare HMO retiree program:

- The office visit copayment will change from $10 to $15 per visit.
- There will be a $100 inpatient deductible which will apply to the first inpatient admission during each benefit period (calendar year).
- The prescription drug co-payments will change from:
  - $5 to $10 for mail order scripts (90 day supply),
  - $10 to $15 for scripts obtained at a Kaiser center, and
  - $15 to $25 for scripts obtained at another retail outlet.

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.

Changes for CIGNA Non Medicare Retirees And/Or Dependents

Effective June 1, 2012, as a result of collective bargaining, the following changes have been made to your benefit program:

- The co-insurance for non-Medicare retirees covered by the CIGNA self insured HMO will change from 90% to 80%.
- The deductible will increase to $300 per person, per Plan Year, and the out-of-pocket maximum will increase to $4,000 per person, per Plan Year. The CIGNA Plan Year is from June 1st – May 31st each year.

The Board of Trustees is pleased to be able to continue coverage for the retirees. If you have questions about these changes, please contact CIGNA at (800) 244-6224.

Retiree Information Form Sent

Please Return Promptly

Each year, as required by the rules of the FELRA & UFCW Pension Plan, the Fund office sends a Retiree Information Form ("RIF") to each retiree. Although you may have completed this form last year, ***you still must complete and return this year's RIF.*** This form asks for information about your current address, your beneficiary, whether you or your spouse have other health coverage, and whether you are employed. ***Please answer all questions*** on the form to the best of your ability, sign and date it, and return it to the Fund office. If you don't answer all the questions, we will return the form to you and ask you to fully complete it.

What If You Don't Have Any Changes?

You still have to complete and sign the RIF. Even if there are no changes to report, we still need to make sure our files are correct.

Helpful Reminders

- You must report any earnings from all employers.
- You must let us know if you or your spouse has other health coverage.
- Do not attach any other correspondence (letters, checks, claims) to the RIF.
- Be sure to sign the RIF.

Failure to return the form may result in suspension of your benefits. To avoid having your benefits interrupted, ***take the time now to complete and return the RIF as soon as possible.***

Material Modification

Notice of Waiver of Annual Limit Requirement

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

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

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

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

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

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

	ANNUAL MAXIMUM (PER INDIVIDUAL)			
BENEFIT CLASS	**PLAN I**	**PLAN I RETIREE**	**PLAN X**	**PLAN XX**
Comprehensive Medical[1]	$400,000	$400,000	$400,000	$100,000
Rehabilitation[1]	$25,000	$25,000	$25,000	$25,000
Substance Abuse	$1,000	$1,000	$1,000	$1,000
Physical Exam	$200 (once every two years)	$200 (once every two years)	N/A	N/A

[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 of the health care expenses you incur.

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

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

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

Continued from page 1

What If I Want to Keep the Same Coverage I Currently Have?

If you wish to remain in the Plan you are in now (Kaiser or traditional Fund medical), ***don't do anything!***

Those enrolled in Kaiser Permanente

Remember, the co-pay for your benefits may change! You will be responsible for the new monthly co-pay unless you change to traditional Fund medical.

Is There a Cost to Enroll in Kaiser?

If there is a charge for the HMO, it will be noted in your open enrollment letter. Read your letter carefully!

What's The Difference between Traditional Fund Coverage And HMO Coverage?

Traditional Fund medical coverage varies by Plan. You must satisfy a deductible, after which a certain percentage of the expenses are covered by the Fund with the balance payable by you. Under traditional Fund coverage, participants in Plans I and X may use any provider they wish, although you will save money if you use a CareFirst provider. ***Plan XX participants must use a CareFirst provider.***

With Kaiser Permanente coverage, Plan I and Plan X participants have a $35 co-pay when visiting either a primary care physician or specialist, and there is no deductible. Plan XX participants have a $25 co-pay when visiting their primary care physician and a $50 co-pay to see a specialist. Plan XX has a $250 individual deductible or a $500 family deductible. There is no co-pay for preventive care, including most immunizations, for Plans I, X, and XX.

Under the Kaiser HMO, you must utilize a participating doctor or facility. If you do not use a participating provider for routine or follow-up care, the services rendered won't be covered. However, you are covered for emergency care worldwide.

If you don't do anything, you will remain in the Plan you have now, whether that is traditional Fund medical coverage or Kaiser Permanente HMO, for the next year.

Important Reminders about Open Enrollment

- This open enrollment period applies ***ONLY*** to your ***medical coverage*** (including mental health/substance abuse). This does not affect your optical, dental, or prescription drug coverage. Those benefits continue to be provided through Advantica EyeCare, Group Dental Service, and Express Scripts (Medco).
- Once you choose how you would like your medical coverage to be provided, ***you may not change again*** until open enrollment next year (July 15, 2013 – September 15, 2013).
- If you are a Plan X Part Timer who pays a monthly co-payment to have dependent ("family") coverage via payroll deduction, that will continue, regardless of which medical coverage option you choose— traditional Fund coverage or the HMO option.
- ***Open enrollment ends September 15th. Contact the Fund office on or before this date if you want to make a change.***

If you have questions about Kaiser Permanente coverage, call Kaiser Permanente Member Services at (301) 468-6000 or toll-free at (800) 777-7902 and speak with a representative Monday through Friday between the hours of 7:30 a.m. and 5:30 p.m. Mention the FELRA & UFCW Health and Welfare Fund and ***refer to group # 6879 if you're in Plan I or X or group # 1976 for Plan XX. This is very important.*** You can also call Kaiser's open enrollment hotline where you can leave a message requesting an enrollment kit or a return call if you have questions about Kaiser Permanente. The number is (301) 625-5377 and the line will be open during the FELRA open enrollment period (July 15th – September 15th) and messages will be checked daily.

For questions about the enrollment process or eligibility, call the Fund office at (800) 638-2972.

★ ★ ★ **BARGAINING CHANGE** ★ ★ ★

Extended Time To File Medical Claims

The following applies to participants in Plan I, Plan X, and Plan XX who are employed by Giant or Safeway, and their eligible dependents.

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

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

Material Modifications

Collective Bargaining Changes – Read Below for Important Information about Your Benefits

The following articles apply to participating employees of those employers who entered into a ratified 2012 bargaining agreement with the Local Union.

★ ★ ★ **BARGAINING CHANGE** ★ ★ ★

Endodontic Procedures (Root Canals) Now Covered

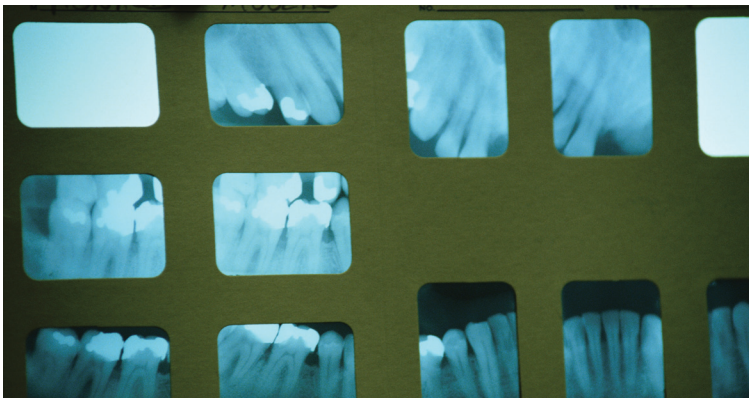
The following applies to participants and eligible dependents under Plan X whose employers entered into a ratified 2012 bargaining agreement with the Local Union.

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

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
D3310	Endodontic Therapy - Anterior Tooth	$125
D3320	Endodontic Therapy - Bicuspid Tooth	$125
D3330	Endodontic Therapy - Anterior Tooth - Molar	$250

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



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

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 GDS network endodontic specialist dentist to be eligible for the above co-pays and coverage.

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

Plan X Part Timers: July 1st – July 31st Is Open Enrollment for Adding Dependent Coverage

The following article applies only to Plan X part time participants.

July 1st to July 31st will be the second Open Enrollment period (there are two each year) for adding dependent ("family") coverage to your benefits. If you are eligible for dependent coverage but did not elect it when you first became eligible, you may add the coverage in July. The coverage will be effective September 1st. The next open enrollment will be in January for coverage effective March 1, 2013.

Is there a cost?

Yes, there is a cost. It is 20% of the overall cost of your health and welfare coverage, payable via payroll deduction. Contact your employer for the exact amount which applies to you. ***Do not send payment to the Fund office.*** If you elect dependent coverage, your payroll deduction will begin in September.

When will the coverage begin?

Coverage for your dependents will begin September 1st.

How many dependents may I cover?

As long as they are eligible dependents under the Plan, you may enroll as many dependents as you have. The cost is the same regardless of the number of dependents.

What if I want to drop dependent coverage?

You may drop dependent coverage at any time throughout the year provided you notify the Fund office ***in writing***. You may call us to request the proper form, which you must sign and return to us (it verifies that you wish to stop payroll deductions). However, please remember that if you ***do*** drop the coverage, you will not be eligible to add it again until the open enrollment period *following* a twelve-month waiting period, except in special circumstances such as a birth, adoption or marriage. Open enrollment for dependent coverage occurs twice a year: in January and in July.

How Do I Add My Dependents?

To add dependent coverage, call the Fund office at (800) 638-2972 during the open enrollment period and let us know. We'll send you an enrollment form and begin the process for starting your payroll deduction. ***We must have the completed enrollment form returned to us (along with any forms of proof which may be required, such as copies of birth certificates, etc.) before dependent coverage will begin.***

What If I Don't Have Dependents Now, But I Do Later?

If you don't have any dependents and you then get married, have a child, adopt a child, etc., you may add dependent coverage no matter what time of year, as long as you add the dependent within 30 days from the date he/she first became your dependent (for example, within 30 days from the date of marriage, 30 days from the date of birth, etc.).

Contact Participant Services

If you have questions, contact Participant Services at (800) 638-2972.

Medco Rx Merged With Express Scripts

Effective April 2, 2012, Medco Health Solutions, Inc. ("Medco") merged with Express Scripts. Your prescription benefits **remain the same**. Continue to use your Medco prescription card at the same pharmacies as before. Remember, you will receive the best discounts if you use a Giant or Safeway pharmacy. CVS, Wal-Mart and Rite Aid pharmacies are not part of the Fund's pharmacy network. For additional information about participating pharmacies, call (800) 903-8325. You can also log on to Medco's website at www.medco.com and click "Locate a pharmacy."

New Kaiser Permanente Medical Centers

The following article applies to Actives and Medicare Retirees who have HMO coverage through Kaiser Permanente.

Kaiser Permanente has opened a new state-of-the-art medical center in Gaithersburg, Maryland. The new center, available for both Kaiser Medicare and Kaiser Actives, is located at 655 Watkins Mill Road, Gaithersburg. It is a full-service facility offering ambulatory surgery, cardiology, neurology, pulmonary, pharmacy, 24/7 observation unit, among many other services.

More Centers to Open

In the Mid-Atlantic region, Kaiser will be constructing four new facilities and expanding two existing medical centers:

Opening Summer 2012

NEW Tysons Corner Medical Center
8008 West Park Drive, McLean, Virginia

- Full-service facility

Opening Summer 2012

Ashburn Medical Center (Expansion and renovation)
43480 Yukon Drive, Suite 100, Ashburn, Virginia

- Loudoun Medical Center will close and services will relocate to the Ashburn Medical Center.

Opening Fall 2012

NEW Northwest D.C. Medical Center
2301 M Street, N.W., Washington, D.C.

- West End Medical Center will close and all service will relocate to the Northwest D.C. Medical Center.
- Service include: adult primary care, pharmacy, enhanced behavioral health services, radiology, laboratory, and obstetrics and gynecology.

Opening Summer 2013

NEW South Baltimore Medical Center
1701 Twin Springs Road, Baltimore, Maryland

- Full-service facility.
- Services include: 24/7 urgent care, ambulatory surgery, primary care, pharmacy, advanced imaging services, a wide array of specialty care services, and more.

Expansion set to be complete 2013

Largo Medical Center (Expansion and renovation)
1221 Mercantile Lane, Largo, Maryland

- Full-service facility.
- Services include: 23-hour-stay clinical observation unit, urgent care, ambulatory surgery, bone density, interventional radiology, nuclear cardiology, and more.

Is Your Heartburn a Sign of GERD?

Almost everyone knows what it's like to have heartburn. Heartburn causes a painful, burning feeling in the center of your chest. If you get this feeling a lot, you may have gastroesophageal reflux disease (GERD), a form of heartburn that could require medical attention.

Talk with your doctor if you have these symptoms:

- Heartburn that occurs several times a week or more.
- Heartburn and trouble with food getting stuck in your esophagus.
- Heartburn that causes coughing.

Lifestyle Choices May Help

If you would like to reduce your GERD symptoms, try some lifestyle changes. Here are some tips that may help:

- Don't eat foods that trigger heartburn. Trigger foods may include fatty or fried foods, alcohol, chocolate, peppermint, garlic and onion, citrus, tomato-based foods, and caffeine.
- Eat smaller meals.
- Avoid carbonated drinks, particularly soda with caffeine.
- Don't lie down after a meal.
- If you are overweight, get help to lose weight.
- Quit tobacco. It can worsen GERD.
- Raise the head of your bed 6 inches. Put blocks under your bed frame or place a foam wedge under the head of your mattress. This prevents stomach acid from backing into your esophagus while you sleep. Using extra pillows will probably not work.

If lifestyle changes do not relieve your GERD symptoms, there are over-the counter and prescription medicines that can help.

This information is general and is not intended to replace the advice of your doctor. Consult your personal physician about your own medical condition. The above information was obtained with permission from Health Dialog. 845865v1

Dependent Child Dental Coverage

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

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