UFCW Local 1500
AFL-CIO, CLC

WELFARE AND PENSION FUNDS

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December 30, 2013

IMPORTANT NOTICE – CHANGE TO YOUR HEALTH PLAN BENEFITS
EFFECTIVE MARCH 1, 2014
CHANGES TO SPECIAL PART-TIME PLAN

To All Eligible Special Part-Time Participants:

The Trustees of the U.F.C.W. Local 1500 Welfare Fund (the "Fund") announce the following changes to your health plan ("the Plan").The first two changes listed below are effective January 1, 2014. All other changes are effective March 1, 2014. We are committed to keeping you informed and making you aware of benefit changes to the Plan, most of which are a result of the passage of the Patient Protection and Affordable Care Act ("ACA"). As of March 1, 2014, the Plan will no longer be a grandfathered plan within the meaning of ACA.

I. Annual Maximums Eliminated Effective January 1, 2014

The annual maximums on the following covered services are eliminated: $15,000 for eligible medical services, $5,000 for outpatient chemotherapy, radiation therapy, and hemodialysis, $5,000 for diagnostic x-ray and lab work, $3,500 for rehabilitative therapies, $5,000 for durable medical equipment and supplies, $1,000 for podiatric surgery, and the $2,500 annual maximum for prescription drugs. There will be no overall annual maximum for medical and prescription drug benefits provided by the Fund.

II. Member Weekly Contributions Effective March 1, 2014

Effective March 1, 2014, any participant eligible for coverage under the Plan will need to make a weekly pre-tax payroll contribution of $15.00 in order to maintain coverage under the Plan. You will be receiving documents in January that must be completed and returned to the Fund Office. These documents authorize the weekly payroll deduction for your coverage. Failure to authorize the required weekly pre-tax payroll contribution is cause for suspension and/or termination of your coverage under the Plan.

Please note, you have the right to reject (or "opt-out") of this coverage. If you opt out of this plan and remain without health coverage for a certain period, you face the possibility of governmental penalties and fines being levied against you. You are urged to go to your State's Insurance Marketplace to research your options prior to opting out of this Plan.

III. Freezing the Special Part-Time Plan Effective March 1, 2014

The Plan will be frozen effective March 1, 2014. This means that any participant not already enrolled in the Plan as of February 28, 2014, will not be eligible to enroll in the Plan after that date. However, all individuals who are participants in the Plan as of March 1, 2014, will continue to be covered under the Plan, as the Plan is modified by the changes listed in this Summary of Material Modifications ("SMM"), provided you make the required weekly contribution discussed above.

IV. Plan Design Changes Effective March 1, 2014

	In-Network	**Out-of-Network**
Deductible (Single/Family)	$300	$750
Co-Insurance Paid by the Fund Paid by the Patient	 70% of the In-Network Fee Schedule 30% of the In-Network Fee Schedule,	 60% of the Usual & Customary Rate 40% of the Usual & Customary Rate
Out-of-Pocket Maximum (Single/Family) (includes deductibles, co-insurance and co-pays for covered charges)	$6,350	$6,350
Primary Care Physician Copay	$25	
Specialists Physician Copay	$40	
Emergency Room Copay (waived if admitted)	$100	$100
Prescription Drug Benefit	20% Co-insurance, up to a maximum of $10 generic, $25 preferred brand, $50 non-preferred brand	20% Co-insurance, up to a maximum of $10 generic, $25 preferred brand, $50 non-preferred brand

V. The Health Insurance Marketplace

The Marketplace was created by the Affordable Care Act. It is an organized way for private insurance companies to offer approved, standardized health plans to individuals without health insurance (and their dependents). You can compare plans based on price, benefits, and quality and then apply and enroll in your preferred plan. Based on your household income, family size, and whether you have other group health coverage, you may also be eligible for a federal subsidy to help you buy insurance coverage. The Marketplace's open enrollment to obtain coverage runs through March 31, 2014. Contact your state's Marketplace for more details on available plans and how to enroll.

VI. Preventive Care Benefits Improved Effective March 1, 2014

The Fund will cover preventive care visits, without cost to you, when you use In-Network providers only. If you use an out-of-network provider for preventative care services when an in-network provider is available, your claim for benefits will be treated like any other out-of-network claim. This means that if you use an out-of-network provider for preventative care, when an in-network provider is available, you will be responsible for applicable copayments. Participants covered under this Plan will be eligible for certain types of free screenings and tests if they use in-network providers. Covered preventive services will include services with an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF), vaccines recommended by the Centers for Disease Control and Prevention (CDC), and services outlined in the Bright Futures guidelines developed by the American Academy of Pediatrics.

- Examples of preventive services that will be provided free of charge in-network include screening for colorectal cancer (including polyp removal during a preventive colonoscopy), cervical cancer, osteoporosis, cholesterol abnormalities, high blood pressure, diabetes, sexually transmitted diseases, depression, obesity and tobacco use.

In addition, aspirin will be covered, but *only* when prescribed by a physician.

Additional Preventive Services for Women

The Fund will also provide coverage for certain Preventive Services for women as required by the Affordable Care Act (ACA). Coverage will be provided in-network with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the services recommended in the Health Resources and Services Administration (HRSA) guidelines, including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women. If you could use an out-of-network provider for preventative care services when an in-network provider is available, your claim for benefits will be treated like any other out-of-network claim. This means that if you use an out-of-network provider for preventative women's care, when an in-network provider is available, you will be responsible for applicable copayments.

Covered Preventive Services for women include, but are not limited to, well-woman visits, contraceptive methods and counseling for all FDA-approved methods (including but not limited to, barrier methods, hormonal methods, implanted devices, and sterilization), human papillomavirus (HPV) testing, counseling for sexually transmitted infections, screening and counseling for HIV, screening and counseling for interpersonal and domestic violence, screening for gestational diabetes, and breast-feeding support, supplies and counseling (including equipment rental and/or purchase). In addition, the Fund will cover screenings for women whose family history are associated with an increased risk of mutations in the BRCA 1 and BRCA 2 genes, to include both genetic counseling and BRCA testing, if recommended by a health care provider.

A copy of the full rules regarding the scope of the Plan's Preventive Services coverage for adults is available by calling Associated Administrators at 1-855-266-1500.

VII. Out-of-Network Emergency Services Covered Same as In-Network Effective March 1, 2014

In cases of medical emergencies outside of the Fund's network service area (New York, New Jersey and Connecticut), the emergency room benefit will be the same whether the emergency room used was in-network or out-of-network.

VIII. New Claims and Appeals Procedures Effective March 1, 2014

The Fund's claims and appeals procedures will comply with ACA, including the requirement to provide an external review by an independent external review organization, known as an Independent Review Organization (IRO), for certain claims, after the Fund's internal appeals processes are exhausted. The decision of the IRO will be binding on the Fund. A copy of the Fund's full claims and appeals procedures, including the new external review procedures, is available.

IX. Participation in Approved Clinical Trials Effective March 1, 2014

A. Benefit Description

Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer of other life-threatening disease will be covered, provided the charges are those that are:

(a) Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Fund if the individual were not participating in the Approved Clinical Trial; and

(b) Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

You and your eligible dependents are eligible for payment of charges for participation in an Approved Clinical Trial if:

(a) You satisfy the protocol prescribed by the Approved Clinical Trial provider; and

(b) Either: (1) The individual's network participating provider determines that participation in the Approved Clinical Trial would be medically appropriate; or (2) the individual provides the Fund with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

An Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease. The Approved Clinical Trial's study or investigation must be:

(a) Approved or funded by one or more of: (1) the National Institutes of Health (NIH), (2) the Centers for Disease Control and Prevention (CDC), (3) the Agency for Health Care Research and Quality (AHCRQ), (4) the Centers for Medicare and Medicaid Services (CMS), (5) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), of the Department of Veterans Affairs (VA); (6) a qualified non-governmental research entity identified by NIH guidelines for grants; (7) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

(b) A study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

(c) A drug trial that is exempt from investigational new drug application requirements.

B. Limitations and Exclusions for Clinical Trial Coverage

No benefits will be paid for:

- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

- Expenses at an out-of-network provider if a network provider will accept the patient in an Approved Clinical Trial.

This notice is intended to serve as a Summary of Material Modifications ("SMM") for the U.F.C. W. Local 1500 Welfare Fund Special Part-Time Plan, as required by the Employee Retirement Income Security Act of 1974 (ERISA). It describes changes to information presented in your Summary Plan Description (SPD) booklet, Plan communications, and any previous SMMs. Please keep it with your SPD and other benefits materials for future reference.

If you have any questions regarding any of the information in this notice, please contact the Fund Office at 1-800-522-0456.

Sincerely,

The Board of Trustees