WELFARE & PENSION FUNDS

425 MERRICK AVENUE, WESTBURY, NY 11590
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July 1, 2015

To All Eligible Special Part-Time Participants:

This notice, called a "Summary of Material Modifications" ("SMM"), is being provided to advise you of certain changes that the Board of Trustees has made to the UFCW Local 1500 Welfare Plan – Special Part-Time Plan (the "Plan"). After you have read this SMM, please keep it with your Summary Plan Description ("SPD") and Summary of Benefits & Coverage ("SBC") so that when you refer to either document you will be reminded of the benefit changes described in this SMM.

IMPORTANT NOTE: **All other Plan rules, including but not limited to eligibility, medical necessity and pre-certification requirements, remain in effect.**

Effective September 1, 2015, the Plan is amended as follows:

Inpatient Hospital Confinements – The Weekend Admission Restriction is removed.

Skilled Nursing Facility Benefit – A maximum of 60 days per calendar year.

Outpatient Rehabilitative Therapies – A maximum of 30 visits per calendar year for both In and Out-of-Network services combined.

Outpatient Habilitation Therapies/Services – A maximum of 30 visits per calendar year for both In and Out-of-Network services combined.

Home Health Care Visits - The number of visits allowed is increased from 40 to 200 per calendar year, for In-Network services, when such care is started within 7 days from an eligible hospital confinement. When care is rendered by an Out-of-Network provider or when there has not been a prior hospitalization, the Plan allows up to a maximum of 40 visits per calendar year. This 40 visit maximum is considered part of the 200 visit maximum per calendar year. In no event will the Plan pay for more than a total of 200 visits per calendar year for all Home Health Care Visits combined.

Hospice Care Benefit – Up to a maximum of 210 days per lifetime. This benefit is available In-Network only. Payment will be based upon the Anthem In-Network allowance.

Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six (6) months or less. Hospice care can be provided in the hospice area of a network hospital or at home. All services must be rendered by a licensed provider.

Following are additional covered services and limitations under the Hospice Care Benefit:

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN);
- Medical care given by the hospice doctor;
- Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference;
- Physical, occupational, speech and respiratory therapy when required for control of symptoms;

- Laboratory tests, x-rays, chemotherapy and radiation therapy, when required for control of symptoms;
- Social and counseling services for the patient's family, including bereavement counseling visits until one year after death;
- Transportation between home and hospital or hospice when medically necessary;
- Medical supplies and rental of durable medical equipment;
- Up to 14 hours of respite care in any week.

Emergency Ambulance Benefit – The Plan will provide coverage for land ambulance transportation to the nearest acute care hospital, in connection with emergency room care or emergency inpatient admission. Such service must be provided by a licensed ambulance service and is covered only when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

(a) placing the covered person's health in serious jeopardy, or for behavioral condition, place the health of a covered person or others in serious jeopardy; or

(b) serious impairment to a person's bodily functions or;

(c) serious dysfunction of any bodily organ or part of a person; or

(d) serious disfigurement to the covered person.

Air ambulance services are available only in situations where (1) the hospital from which you are being transferred does not have adequate facilities to provide the medically necessary services needed for your treatment and use of a land ambulance would pose an immediate threat to your health, or (2) your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by a land ambulance due to great distance and the use of a land ambulance would pose an immediate threat to your health.

Payment will be based upon the Anthem In-Network fee allowance for In-Network services and the Plan's usual & customary allowance for Out-of-Network services.

Chiropractic Care – The Plan will provide chiropractic services in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and its effects, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. Benefits are paid at 50% of the Anthem In-Network fee allowance for In-Network services and 50% of the Plan's usual & customary allowance for Out-of-Network services. Additionally, there is a maximum of 50 visits per calendar year for both In and Out-of-Network services combined.

Acupuncture – The Plan will provide benefits for medically necessary acupuncture services. Benefits will be based upon the Anthem In-Network fee allowance for In-Network services and the Plan's usual & customary allowance for Out-of-Network services.

Podiatric Care – The 10 visit calendar year maximum, for both In and Out-of-Network podiatric services, is removed. Such foot care is covered only for disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician. Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain, except capsular or bone surgery related to bunions and hammertoes and peripheral vascular disease, is not covered.

Surgical Benefit for an Assistant Surgeon – The Plan will allow services of an Assistant Surgeon, when medically necessary and when required due to proper medical protocol and the facility does not have a physician on staff able to assist in the procedure. Additionally, the surgical procedure requiring these services must be a covered service under the Plan. Payment will be based upon the Anthem In-Network fee allowance for In-Network services and the Plan's usual & customary allowance for Out-of-Network services.

Inpatient Medical (Physician) Visits – The Inpatient Medical Visits benefit is amended as follows:

(1) The Plan will pay for medical visits for surgical confinements, as medically indicated. Such services must be consistent with the diagnosis/condition for which the patient is being hospitalized and the services are not considered as part of post-operative care. Payment will be based upon the Plan's current payment schedule for inpatient medical visits.

(2) The limitation of one (1) physician visit per day for all areas of specialties is removed. All medical visits must be medically necessary based upon the age, diagnosis/condition and treatment being rendered while confined as a bed-patient in an eligible facility.

Diagnostic Laboratory & X-Ray Benefit – The Plan will cover charges for the interpretation of diagnostic radiological testing while confined as a bed-patient in an eligible facility, provided that the test itself was medically necessary and a

covered service under the Plan. Payment will be based upon the Plan's current allowance for Diagnostic Laboratory & X-Ray Benefit services.

Durable Medical Equipment – The Plan will cover orthotics, when medically necessary. Payment will be based upon the Plan's current allowance for Durable Medical Equipment services.

Transplants – The Plan will cover medically necessary transplant services of a covered individual. No benefits are allowed for any expenses of any donor. Payment will be based upon the Anthem In-Network fee allowance for In-Network services and the Plan's usual & customary allowance for Out-of-Network services.

Effective October 1, 2015 – The Prescription Drug Benefit is amended to include Utilization Management (hereinafter "UM") administered by Express Scripts, Inc. (hereinafter "ESI"). The Plan's UM program will consist of 3 components: (1) Prior Authorization (hereinafter "PA") of medications, (2) Step Therapy and (3) Drug Quantity Maintenance.

Prior Authorization. PA is a program that monitors certain prescription drugs for safety and cost. PA reviews are done before the medication is dispensed to ensure the necessity of the drug.

The ESI PA program was developed under the guidance and direction of independent, licensed physicians, pharmacists and other medical experts utilizing the most current research on the medication. These experts recommend prescription drugs that are appropriate for the PA program and ESI chooses the drugs that will be covered. Drugs which may require pre-authorization include those prescribed for conditions other than the conditions for which the FDA has approved the drug and drugs which might be used for non-medical purposes.

The PA program works as follows: when your pharmacist tries to fill a prescription, the computer system will indicate "prior authorization required". This means that information is needed to determine if the Plan covers the drug. You can then ask your doctor to contact ESI or prescribe another medication that does not require PA. ESI's PA phone lines are open Monday – Friday, 8am to 9pm Eastern Time. The number to call is (800) 417-1764.

If the doctor provides information sufficient to establish that the medication is medically necessary, ESI will allow the prescription to be processed. Thereafter, you only pay the applicable co-payment at the pharmacy. If the medication is not deemed medically necessary, it will not be covered and your physician has the option of prescribing another medication. If a medication is deemed not medically necessary and you may choose to fill it anyway, but you will be responsible for the full cost of the drug.

Step Therapy. Step Therapy is a program for people who take prescription drugs regularly to treat a medical condition such as arthritis, asthma or high blood pressure. It allows you to receive the affordable treatment you need while helping the Plan contain costs.

Step Therapy medications are grouped into categories based upon treatment and cost. The categories are:

- Front-line drugs – the first step. These drugs are generic and sometimes lower-cost brand drugs proven to be safe, effective and affordable. In most cases, you should try these drugs first because they provide the same health benefit as a more expensive drug but at a lower cost.
- Back-up drugs – step 2 and step 3. These are brand name drugs that generally are necessary for only a small number of patients.

The ESI Step Therapy program was developed under the guidance and direction of independent, licensed physicians, pharmacists and other medical experts utilizing the most current research on medication. These experts recommend prescription drugs that are appropriate for the Step Therapy program and ESI chooses the drugs that will be covered.

The Step Therapy program works as follows: the first time you submit a prescription that is not for a front-line drug, your pharmacist will inform you that, unless you wish to pay the entire cost of the prescription, you need to try a front-line drug first. To receive a front-line drug, ask your pharmacist to call your doctor and request a new prescription or contact your doctor to get a new prescription.

PLEASE NOTE: Only your doctor can change your current prescription to a first-step drug covered by this program.

If you have already been taking a medication regularly and you need the medication immediately, you can ask the pharmacists to contact your doctor for a new prescription for a front-line medication or you can discuss with the pharmacist the possibility of filling a small quantity of the medication you have been taking. However, you might have to pay the full cost of that medication. Thereafter, to ensure your medication will be covered by the Plan in the future, ask your doctor to write a new prescription for a front-line drug.

If you cannot take a front-line drug, under step therapy, a more expensive brand-name medication is usually covered as a back-up, provided that you meet the following 3 criteria: (1) you have already tried the generic drug covered under the step therapy program, (2) you can't take the generic drug (for example, due to an allergy) and (3) your doctor decides, for medical reasons, that you need a brand-name medication.

If one or more of these situations applies to you, your doctor can contact ESI and request an "override" or an authorization to allow you to take a back-up drug or another alternative.

The Plan's Step Therapy program applies to the Mail Order program of the Plan as well.

Drug Quantity Management (DQM). DQM is a program that is designed to make use of prescription drugs safer and more affordable. It provides the medication you need while making sure you receive it in the amount (or quantity) considered safe.

There are certain medications in this program. For those medications, you may only receive a specified amount. The quantity dispensed allows you to receive medication (1) in the daily dose considered safe and effective by the U.S. Food & Drug Administration (hereinafter "FDA") (i.e., for a medication you take once a day, the Plan will allow you to fill a prescription for 30 pills/capsules) and/or (2) in a more cost effective manner (i.e., if a prescription is available in different strengths, sometimes you can take a higher strength pill rather than 2 smaller strength pills). In that way, you would have one co-payment instead of two.

The ESI DQM program follows guidelines developed by the FDA. These guidelines recommend the maximum quantities considered safe for prescribing certain drugs. The DQM program includes drugs which might be unsafe if the quantity you receive is larger than the guidelines recommend (i.e., it includes medications that are not easily measured like nose sprays and inhalers).

DQM works as follows: When you submit your prescription, your pharmacist's computer system will note that the prescription is for a non-covered amount of medication. This could mean that you have asked for a prescription too soon or your doctor wrote the prescription for a quantity larger than the Plan covers.

If the quantity on your prescription is too large, you can ask the pharmacist to fill the prescription as written, but for the amount allowed under the DQM guidelines. You will pay the appropriate co-payment. This may mean you will have to fill the prescription more frequently which, in turn, could end up costing you additional co-payments OR you can ask the pharmacist to contact your doctor to discuss changing the prescription (for example if the issue is the strength of the medication and your physician is prescribing a low dosage medication, the pharmacist and doctor can discuss the possibility of having a higher strength medication dispensed) OR your doctor can contact ESI and request a PA for the medication as written. If the request is denied, you can still get the medication, however, it will be dispensed in the quantity recommended by the DQM. In those cases, you will continue to pay the Plan's co-payment each time you get a refill.

The DQM program applies to the Plan's Mail Order option as well. In those cases, ESI will try to contact your doctor to suggest either changing your prescription or asking for a PA. If your doctor is unavailable at the time ESI contacts him/her and ESI does not hear from him/her within 2 days, ESI will fill your prescription for the quantity covered under the DQM.

PLEASE NOTE: The DQM program does not deny you access to your needed medication. It simply ensures that the Plan provides the prescription drugs you need in the quantities that follow the Plan's guidelines for safe and economical use, as determined by the FDA.

IMPORTANT NOTICE

If you are currently receiving any medication that falls within the above noted 3 programs, ESI will be sending you correspondence prior to the October 1, 2015 effective date. The PA and Step Therapy notices will list the medication(s) you are taking that fall within these respective programs. The Step Therapy notice will provide suggested alternatives while the PA notice will advise you of the medication that needs PA. ESI will be sending you these notices well in advance of the effective date so that there will be little, if any, disruption in your medication. If you receive a letter from ESI, please bring it to your doctor so he/she can review your treatment options. ESI maintains lists of the respective medication for each program. To review these lists, go to the ESI website, Express-Scripts.com or call the ESI at the number noted above.

If you have any questions regarding any of the information in this notice, please contact the Plan Office at 1-800-522-0456 or Associated Administrators, LLC at 1-855-266-1500.

Sincerely,
The Board of Trustees