WELFARE & PENSION FUNDS

425 MERRICK AVENUE
WESTBURY, NY 11590
TEL: 516-214-1300

September 30, 2014

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 the Board of Trustees has made to the UFCW Local 1500 Welfare Fund – Special Part-Time Plan (the "Plan"). After you have read this SMM, please keep it with your Summary Plan Description ("SPD") booklet so that when you refer to the SPD you will be reminded of the changes described in this SMM.

These changes are effective December 1, 2014.

1) Inpatient Hospital Confinement/Services

The maximum payment of the lesser of $15,000 and/or 31-days per hospital confinement for in-network inpatient hospital services will be eliminated. Effective December 1, 2014, subject to the precertification requirements described below, the Plan will pay 70% of the in-network allowance for covered in-patient hospital services, after satisfaction of the annual deductible, until you reach the in-network out-of-pocket maximum. Once your in-network out-of-pocket maximum is reached, the Plan will pay 100% of the in-network allowance for covered inpatient hospital services incurred after that date.

2) Utilization Management

A) Precertification, Concurrent & Retrospective Review of Services

Effective December 1, 2014, the Plan will require you to utilize MagnaCare's Utilization Management Program for precertification, concurrent and retrospective review of services. Pursuant to the terms of the Plan, your failure to precertify may result in a denial or reduction in benefits. MagnaCare's services are only advisory; the Plan is responsible in all instances for final coverage determinations.

Precertification of Benefits

Services that require precertification with MagnaCare's Utilization Management Program are as follows:

- All planned and emergency hospital admissions;
- All ambulatory surgery, whether performed in a free-standing ambulatory surgical facility or the outpatient facility of a hospital;

- Therapeutic services, such as physical therapy, occupational therapy, cardiac therapy and pulmonary therapy;
- Radiological services, such as PET Scans, CT Scans, MRIs, etc.;
- The purchase and/or replacement of durable medical equipment , prosthetics and orthotic requirements over $500;
- Care in a hospice or skilled nursing or other facility.

MagnaCare's Utilization Management Program will also provide concurrent review and recommendations regarding ongoing hospitalizations and/or treatments, as well as, coordination of discharge planning.

All other services will be subject to retrospective review by MagnaCare's Utilization Program team to determine medical necessity based upon the terms of the Plan.

To Precertify Benefits

Your treating physician may contact MagnaCare at 1-888-362-4624, Monday – Friday from 8:30 AM Eastern Time to 6:00 PM Eastern Time to initiate a precertification request. After hours, your provider may fax precertification requests, inclusive of clinical information, to 516-723-7306. Providers may also request precertifications online 24 hours per day, 7 days per week by going to www.magnacare.com, clicking on "Provider Log-in" and following the instructions.

Timeframes for Determinations of All Reviews

MagnaCare will comply with the following time frames in processing precertification and concurrent requests for services and retrospective review of services.

- ***Precertification Requests.*** Precertification means that MagnaCare's Utilization Management Program must be contacted for a coverage approval recommendation before you receive the above listed health care services. MagnaCare will review non-urgent requests for precertification within 15 calendar days from the receipt of the request. If MagnaCare cannot render a recommendation within this 15 day period, MagnaCare will be entitled to a 15 day extension for making the determination. You will be notified of any extensions. If MagnaCare does not have enough information to make a recommendation within 15 calendar days, you will be notified of the need for additional information and you will have 45 days to provide the requested information. If coverage for the requested service is recommended to be denied, you will be notified and the notification will advise you how to appeal the denial of coverage.

- ***Urgent Precertification Requests.*** If the need for the service is urgent, MagnaCare will render a recommendation as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of its receipt of the request. If the request is urgent and MagnaCare requires further information to make its recommendation, MagnaCare will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. MagnaCare will make a recommendation within 48 hours of its receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.

Pre-service Urgent Care claims are claims for benefits that, in the opinion of the treating physician with knowledge of the patient's condition, failure to make a swift determination would seriously jeopardize the claimants life, health or ability to regain maximum function or could subject the patient to severe pain that could not be adequately managed without the care or treatment requested. Such pre-service urgent care claims must be pre-certified if for one of the services listed above.

- ***Concurrent Requests.*** Concurrent review means that MagnaCare reviews coverage for your ongoing care during your treatment or hospital stay. It also means a request for additional services after a recommendation to authorize coverage for services has been made and service is still ongoing. If the request for review is for urgent/expedited care, a recommendation will be made within 24 hours, provided the request for continued care is received at least 24 hours before the last day of service or treatment which was previously approved. If the request for review involves urgent/expedited care and the request is not received within 24 hours of the last previously approved service or treatment, MagnaCare will render its recommendation within 72 hours. For all non-urgent concurrent requests, all reviews will be conducted before the last day of service or treatment which was previously approved.

- ***Retrospective Requests.*** Retrospective review is conducted after you receive medical services. MagnaCare will complete all retrospective reviews of coverage for services already provided within 30 calendar days of receipt of the clinical information. If MagnaCare does not have enough information to make a recommendation within 30 calendar days, the patient is notified and given at least 45 days to respond to the notice. If no response is received within this time frame, a denial of coverage is rendered. You will receive notification of all determinations. For denials, the notification will tell you how to appeal the denial of coverage recommendation.

If a Request is Denied

All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is recommended to be denied for lack of medical necessity, or because the service has been determined to be experimental or investigational, MagnaCare's Utilization Program will send a notice to you and your doctor with the reasons for the denial recommendation. The notice will also advise that your physician has the right to request a peer to peer review.

You will have the right to appeal the denial within 180 days of receipt for non-urgent claims. MagnaCare will decide the Level I appeal. You will receive a response from MagnaCare within 30 days of receipt of your appeal.

For urgent/expedited claims, you and/or your physician have the right to an expedited 24-72 hour appeal.

If MagnaCare's determination on the Level I appeal upholds the denial, you have the right to file a Level II appeal with the Fund. If the Fund upholds the denial on appeal, you have the right to request an external review.

External Reviews of Health Care Claims

If your appeal of a claim is denied, whether it's a pre-service, post-service, or urgent care claim, you may request further review by an Independent Review Organization ("IRO"), if the denial meets the criteria set forth below. In the normal course, you may **only** request external review after you have exhausted the internal review and appeals process described above.

External reviews are **only** available for the following types of denials of claims:

- A denial that involves medical judgment, including those based on the Fund's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Fund.

Your request for external review of a denial must be made, in writing, within four (4) months of the date that you receive the denial you are appealing. Because the Fund's internal review and appeals process must be exhausted before external review is available, external review of claims will only be available for denials of appeals and not initial claim denials.

Preliminary Review

(a) Within five (5) business days of the Fund's receipt of your external review request, the Fund will complete a preliminary review of the request to determine whether:

- You are/were covered by the Fund at the time coverage for the health care item or service is/was requested or, in the case of a retrospective review, were covered at the time the health care item or service was provided;
- The denial does not relate to your failure to meet the Fund's requirements for eligibility;
- You have exhausted the Fund's internal claims and appeals process; and
- You have provided all of the information and forms required to process an external review.

(b) Within one (1) business day of completing its preliminary review, the Fund will notify you, in writing, as to whether your request meets the threshold requirements for external review. If applicable, this notification will inform you:

- If your request is complete and eligible for external review, or
- If your request is complete but not eligible for external review. In such case, the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)), or

- If your request is not complete, the notice will describe the information or materials needed to make it complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review by an Independent Review Organization (IRO)

If the request is complete and eligible, the Fund will assign the request to an Independent Review Organization or "IRO." The Fund has contracted with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you, in writing, of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).

(b) Within five (5) business days after the assignment to the IRO, the Fund will provide the IRO with the documents and information it considered in making its denial determination.

(c) If you submit additional information related to your claim, the assigned IRO must, within one (1) business day, forward that information to the Fund. Upon receipt of any such information, the Fund may reconsider its denial of the claim which is the subject of the external review. Reconsideration by the Fund will not delay the external review. However, if upon reconsideration, the Fund reverses its original denial of the claim, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. However, the IRO will be bound to observe the terms of the Fund's plan of benefits to ensure that the IRO decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Fund's requirements for coverage, including the standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of an item or service. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Fund, reports from appropriate health care professionals, appropriate practice guidelines, the applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

(e) The assigned IRO will provide written notice of its final external review decision to you and the Fund within 45 days after the IRO receives the request for the external review.

(f) The assigned IRO's notice of its decision will contain the following information, unless such information is inconsistent with applicable current law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial;
- The date the IRO received the assignment to conduct the review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding, except to the extent that other remedies may be available to you or the under applicable State or Federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

Expedited External Review of Health Claims

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial of an appeal that involves a medical condition for which the time to complete a standard external review would seriously jeopardize your life or health or your ability to regain maximum function; or, you receive a denial of an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review of Expedited External Reviews

Immediately upon receipt of the request for expedited external review, the Fund will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above are met. The Fund will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above.

Review by an Independent Review Organization (IRO)

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Fund will assign an IRO. The Fund will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review noted above. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the internal claims and appeals process. However, the IRO will be bound to observe the terms of the Fund's plan of benefits to ensure that the IRO decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Fund's requirements for coverage, including the Fund's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of an item or service, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice of final external review is not provided in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Fund.

After External Review

If, upon external review, the IRO reverses the denial of your claim, upon the Fund's receipt of notice of such reversal, the Fund will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Fund may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision. If the final external review upholds the denial of the claim, the Fund will not provide coverage or payment for the reviewed claim. If you are dissatisfied, you may seek judicial review as permitted under ERISA Section 502(a).

B) Case Management

MagnaCare's Utilization Management Program also provides Case Management. Case Management is assistance when you are faced with a chronic or catastrophic illness or injury. MagnaCare's nurses will help you:

- Find appropriate, cost-effective healthcare options;
- Reduce medical cost; and
- Assure quality medical care.

A Case Manager serves as a single source for patient, provider and Fund, to help assure that the treatment, level of care and facility are appropriate for the needs of the patient. Examples of cases where Case Management can help are:

- Cancer;
- Stroke;
- AIDS;
- Chronic illnesses;
- After surgery or an illness.

Assistance from Case Management is evaluated and provided on a case by case basis. In some situations, MagnaCare's Utilization Management Program staff will initiate the review of a patient's health status and the attending physician plan of care. The Case Manager may determine that a level of benefits is not necessary, appropriate and cost effective and may suggest other covered treatment options. Case Management is performed on a voluntary basis. Case Management is not a clinical service; it is only designed to facilitate the patient's use of cost-effective services for which coverage.

3) MagnaCare Medical Identification Cards

You will be receiving new MagnaCare identification cards to be used beginning December 1, 2014. Please continue to use your current MagnaCare identification card up to that date. Please destroy your current card on December 1, 2014, to ensure you will not present the expired medical card to any of your health care providers.

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

Sincerely,

The Board of Trustees

WELFARE & PENSION FUNDS
425 MERRICK AVENUE
WESTBURY, NY 11590
TEL: 516-214-1300

September 30, 2014

IMPORTANT NOTICE – CHANGE TO YOUR PREVENTIVE CARE BENEFITS

To All Eligible Special Part-Time Plan Participants:

Earlier this year, the UFCW Local 1500 Welfare Fund (the "Fund") Special Part-Time Plan (the "Plan") was modified in several ways. One modification was the implementation of a Preventive Care Benefit at no cost to you if you utilize an In-Network provider. However, to make some of these services more accessible to individuals covered under the Plan, the Trustees of the Fund have amended the Plan to allow all Participants to receive certain vaccinations through the Prescription Drug Benefit without the necessity of a visit to a physician. Accordingly, effective November 1, 2014, the Fund will cover vaccinations for Influenza (Flu), Herpes Zoster (Shingles) & Pneumonia, whether received from a physician or an eligible pharmacy.

PLEASE NOTE THAT THIS BENEFIT WILL NOT BE COVERED IF THE VACCINATION IS PROVIDED BY ONE OF THE EXCLUDED PHARMACIES LISTED IN YOUR SUMMARY PLAN DESCRIPTION. NO PAYMENT WILL BE MADE FOR ANY SERVICES PROVIDED BY THESE PHARMACIES.

If you need assistance locating a participating eligible pharmacy near you, contact Express Scripts Inc. at 1-877-861-8145 or you can access this information at Express-Scripts.com. If you have any questions regarding coverage, please contact Associated Administrators at 1-855-266-1500.

The Trustees are happy to offer you this option for access to your vaccines.

Sincerely,

The Board of Trustees

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