Warehouse Employees Union Local No. 730
Health and Welfare Trust Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (800) 730-2241
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (800) 730-2241
www.associated-admin.com

Summary of Material Modifications – Changes in Your Plan

June 2018

This Insert is a Summary of Material Modifications ("SMMs") to your Health and Welfare Trust Fund Summary Plan Description ("SPD") booklet. Please keep this Insert with your booklet so you will have it when you need to refer to it. If there is any discrepancy between these SMMs and the SPD or other Plan documents, as amended, the SPD and other Plan documents will control.

Landover Fund Office Moved To New Location on April 1st

On April 1, 2017, Associated Administrators, LLC moved its Landover office from 4300 Garden City Drive to 8400 Corporate Drive, just a quarter mile from the current location. The new address is:

Fund Office
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361

The Landover telephone number has not changed. It remains toll-free (800) 638-2972.

- **Effective Jan. 1, 2018 – Change in Out-of-Pocket Maximum for Active Class E Participants.**
  The out-of-pocket maximum changed as follows:
  - ✓ Medical In-Network is $6,250 per individual and $12,500 per family
  - ✓ Prescription Drugs is $1,100 per individual and $2,200 per family

- **Effective Jan. 1, 2018 – Supplement to Workers' Compensation Is Eliminated**
  The Supplemental benefits to Workers' Compensation (weekly benefit of $70 for a maximum of 52 weeks), as described on page 47 of your Summary Plan Description booklet, is eliminated.

  Very Important: If you are out on Workers' Compensation, the Fund Office still needs to receive a copy of your Workers' Compensation check stub that shows Temporary Total Disability (TTD) dates paid for eligibility purposes.

- **Effective Jan. 1, 2017 –** Change in Out-of-Pocket Maximum for Active Class E Participants. The out-of-pocket maximum is $6,100 medical and $1,050 prescription for individual coverage and $12,200 medical and $2,100 prescription for family coverage. The medical deductible is $800.

- **Effective Sept. 1, 2016 –** Pre-certification is required for outpatient procedures through Cigna's Care Management Program. Cigna Care Management will assist you and your dependents to receive the right care, at the right time, in the right place.

With Cigna's Pre-Certification Process, You Can:

- ✓ Get the most appropriate inpatient and outpatient care
- ✓ Find lower cost services
- ✓ Avoid unnecessary or uncovered medical treatment or procedures
- ✓ Improve your health with case management services,
- ✓ which helps when you need extra assistance

How Pre-Certification Works

If you use an in-network provider, you don't need to do anything for pre-certification. The provider is responsible for getting the pre-certification for all required non-emergency in-network services.

If you use an out-of-network provider for non-emergency services, you are responsible for pre-certification. To do this, call the customer service phone number on the back of your Cigna ID card. A service representative will walk you through the pre-certification process.

What Services Need to Be Pre-Certified?

Your doctor will help you decide which procedures require a hospital stay and which can be handled on an outpatient basis. Inpatient services require you to stay overnight in a hospital or related facility. Outpatient services don't require an overnight stay.

Examples of Outpatient Services

- ✓ High-tech radiology (MRIs, CAT scans, PET scans, nuclear radiology)
- ✓ Injectible drugs
- ✓ Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)
- ✓ Home health care/home infusion therapy
- ✓ Dialysis (to direct to a participating facility)
- ✓ External prosthetic appliances
- ✓ Cosmetic or reconstructive procedures
- ✓ Sleep management
- ✓ Transplants
- ✓ Radiation

Important: Even if CareAllies certifies that a procedure is medically necessary, ***it does not guarantee payment of benefits.*** Be sure the service you are receiving is covered under your Plan. For questions about your coverage, contact the Fund Office.

- **Effective Sept. 1, 2016 – Benefit Changes for Active Class E Participants.**

Medical

The medical deductible will be $800 effective January 1, 2017.
Your co-insurance will be 20% (i.e., the Fund will pay 80% of qualifying medical costs after you have reached your deductible).
Your out-of-pocket maximum will be $6,850 for individual coverage; $13,700 for family coverage.

Prescription Drug

The prescription drug benefit will be re-structured as a three-tier in-network benefit as follows:

- ✓ copay for generic prescription drugs will be $15,

- ✓ copay on brand formulary prescription drugs will be $40, and
- ✓ copay on brand prescription drugs, non-formulary, will be $75.
- ✓ Mail-order prescription drugs for a 90-day supply will have copays double the amount of the above stated copays of $30/$80/$150 respectively; i.e., copay for mail-order generic drugs will be $30.

Preventive Services

You will receive preventive services at no cost for you and your eligible dependents. This includes routine physical exams, routine gynecological exams, well-child exams, mammography screenings, colonoscopy screenings, and approved contraceptives.

Retiree Coverage

Benefits to all retirees under the Fund will terminate effective August 31, 2016. Thus, after August 31, 2016, the Fund will no longer process claims for prescriptions incurred after August 31, 2016. Letters were sent to the following retiree groups announcing this change and offering transition assistance.

- ✓ Pre-Medicare HMO Retirees who are interested in purchasing an individual medical plan through the state or federal healthcare marketplace, may contact the CLRA Group, LLC, an insurance brokerage firm the Fund has engaged who has experience in assisting individuals in enrollment.
- ✓ Retirees with Fund prescription coverage can contact the CLRA Group, LLC, to offer assistance with coverage options.
- ✓ CLRA Group, LLC phone number is (855) 215-2572.

- **Effective July 2014,** ReliaStar/NG changed its name to Voya Financial, which applies to Plan C and Plan E participants who have Life Insurance benefits and Accidental Death and Dismemberment benefits under the Plan. The new name reflects the company's relationship to its parent company Voya Financial. Nothing else has changed – the address, phone number, policy, and coverage all remain the same.

- **April 2014 – ReliaStar/ING changed name to Voya Financial.**
  Your Life Insurance benefits and Accidental Death and Dismemberment benefits under the Plan are now under Voya Financial.

- **April 2014 – Dental Health Centers**
  Dental Health Centers has a new address and phone number:
  Dental Health Centers & Associates
  1450 Mercantile Lane – Suite 131
  Largo, MD 20774
  Telephone (301) 583-1400

- **Effective January 1, 2014,** the overall annual dollar limit on essential health benefits under the Plan is eliminated for participants and eligible dependents. This change to the terms of the Plan is required by the Patient Protection and Affordable Care Act (PPACA).

- **Effective January 1, 2014,** you will not be denied coverage if you or your eligible dependent(s) have a pre-existing condition. This change to the terms of the Plan is required by the Patient Protection and Affordable Care Act (PPACA).

- **Effective January 2014 – Revised Notice of Privacy Practices**
  This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

  Your Rights
  You have the right to:
  - ✓ Get a copy of your health and claims records

- ✓ Correct your health and claims records
- ✓ Request confidential communication
- ✓ Ask us to limit the information we share
- ✓ Get a list of those with whom we've shared your information
- ✓ Get a copy of this privacy notice
- ✓ Choose someone to act for you
- ✓ File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- ✓ Answer coverage questions from your family and friends
- ✓ Provide disaster relief
- ✓ Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- ✓ Help manage the health care treatment you receive
- ✓ Run our organization
- ✓ Pay for your health services
- ✓ Administer your health plan
- ✓ Help with public health and safety issues
- ✓ Do research
- ✓ Comply with the law
- ✓ Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- ✓ Address workers' compensation, law enforcement, and other government requests
- ✓ Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- ✓ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- ✓ We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- ✓ You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- ✓ We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- ✓ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- ✓ We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- ✓ You can ask us not to use or share certain health information for treatment, payment, or our operations.

- ✓ We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- ✓ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- ✓ We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- ✓ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- ✓ We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- ✓ You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- ✓ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- ✓ We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- ✓ Share information with your family, close friends, or others involved in payment for your care
- ✓ Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- ✓ Marketing purposes
- ✓ Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
- ✓ We can use and disclose your information to run our organization and contact you when necessary.
- ✓ We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- ✓ Preventing disease
- ✓ Helping with product recalls
- ✓ Reporting adverse reactions to medications
- ✓ Reporting suspected abuse, neglect, or domestic violence
- ✓ Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- ✓ We can share health information about you with organ procurement organizations.

- ✓ We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- ✓ We can use or share health information about you:
- ✓ For workers' compensation claims
- ✓ For law enforcement purposes or with a law enforcement official
- ✓ With health oversight agencies for activities authorized by law
- ✓ For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- ✓ We are required by law to maintain the privacy and security of your protected health information.
- ✓ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ✓ We must follow the duties and privacy practices described in this notice and give you a copy of it.
- ✓ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Date of Notice: January 2014

HIPAA Privacy Officer

Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(800) 730-2241

- **Effective April 1, 2013 – Class C Participants (Adams Burch Actives) and Pre-Medicare Retirees: OptumRx is your new prescription drug provider.** OptumRx is a UnitedHealthcare Group company.

  New ID Card
  UnitedHealthcare mailed a new health plan ID card to Class C participants and pre-Medicare HMO retirees. Beginning April 1, 2013, it is important that you present your new card to the pharmacy when filling a prescription or to the doctor at your next doctor's visit to ensure your updated information is on file.

  What Happens To My Mail Service Prescription(s)?
  Most mail service prescriptions with remaining refills will automatically transfer. Prescriptions for certain medications such as control substances will not transfer and also expired prescriptions or those with no more refills will require a new prescription. OptumRx will contact you when it's time to process your refill order.

  If there are no more refills for your medication, you'll need a new prescription. You can contact your doctor for a new prescription. New prescription orders are delivered by standard U.S. mail and will arrive around 10 business days from the date of OptumRx receiving your order. If you have an email address on file with UnitedHealthcare, you can expect to receive an email when your prescription ships. If you don't have an email address on file, you'll receive a phone call.

  Will The Medication Look The Same?
  Brand medications will look the same as your current prescription. Generics may look different, as OptumRx may use a different manufacturer for some medications. You can rest assured that the U.S. Food and Drug Administration (FDA) approved generic medications are required to be the same strength and follow the same quality standards. If you have questions about your medications, OptumRx's registered pharmacists are available 24 hours a day, 7 days a week, by calling toll-free at 1-888-739-5820.

  Specialty Medications
  There are no changes to your benefits or services if you receive a specialty medication through the OptumRx Specialty Pharmacy. Please continue to order your specialty prescriptions from OptumRx by calling 1-888-739-5820.

  Website
  To access your prescription and mail service information online, log into www.myuhc.com and visit the "Pharmacies and Prescriptions" page. If you still have questions, call customer service at 1-800-815-8958. This phone number is listed on the back of your new ID card.

- **Effective January 1, 2013,** the overall annual dollar limit on essential health benefits under the Plan has increased from $1,250,000 to $2,000,000 for participants and eligible dependents.

  This Plan Is "Grandfathered" under the PPACA
  The Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (i.e., the Affordable Care Act). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office toll free at 1-800-730-2241. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

- **Effective January 1, 2012, as required by the Mental Health Parity and Addiction Equity Act ("MHPAEA"),** all participants in Class E are not required to obtain pre-authorization before receiving outpatient Mental Health/Substance Abuse treatment. Inpatient Mental Health/Substance Abuse treatment requires pre-authorization through Cigna (CareAllies).

- **Effective January 1, 2012, for Class E Participants:**
  Both inpatient treatment and outpatient treatment for Mental Health/Substance Abuse ("MH/SA") are now available through Cigna Healthcare Network Provider.

  Coverage is provided for both inpatient and outpatient MH/SA up to the limits of the Plan. The 180-day hospital stay limit applies to a combination of MH/SA and medical/surgical. The 90-day inpatient visit limit applies to a combination of both MH/SA and medical/surgical. In order to obtain MH/SA services in-network, you may contact Cigna /CareAllies toll free at 800-768-4695 and select the prompt for Behavioral Health.

  To locate a provider in the Cigna network, log onto www.Cignasharedadministration.com. Select "For Taft-Hartley Plan Members." At the bottom of that site, click on the drop down box, bottom of page, and choose "Cigna Behavioral" and then hit "go." From here you can select "Find a Therapist/Psychiatrist" in the list of resources and information.

  The former Employee Assistance Program has been replaced by the Cigna Mental Health/Substance Abuse network. C. A. Mayo and Associates is a participating provider in the Cigna Mental Health/Substance Abuse network.

- **Effective January 1, 2012 for Class C (Adams Burch) and Pre-Medicare Retirees with HMO Benefits**
  Benefits provided by UnitedHealthcare (UHC) **no longer have the following limits** due to the regulations of the Mental Health Parity and Addiction Equity Act.
  - ✓ No day limit for in-network, inpatient detoxification.
  - ✓ No day limit for inpatient Mental Health/Substance Abuse treatment.

  Additional HMO Benefit Changes
  - ✓ Out-of-network benefits are the same for Medical/Surgical as well as Mental Health/Substance Abuse services.
  - ✓ The co-insurance amounts for outpatient MH/SA office visits are eliminated.
  - ✓ The limited out-of-network benefit for MH/SA will be the same as for Medical/Surgical.
  - ✓ The copayment is the same regardless if you visit your primary care physician or a specialist for MH/SA.

- **Effective January 1, 2012,** the overall annual dollar limit on essential health benefits under the Plan has increased from $1,000,000 to $1,250,000 for participants and eligible dependents.

- **Effective January 1, 2011 – changes as a result of Health Care Reform ("PPACA"):**
  CLASS E benefits in the SPD are modified as follows:

Comprehensive Medical Benefits

Eligible	Benefit
Participant & Eligible Dependents	$100 deductible per person per calendar year; maximum family deductible is $200 per calendar year. 80% of eligible Usual, Customary and Reasonable ("UCR") charges paid; maximum out-of-pocket expense is $1,000 per person per calendar year, after which benefits are paid at 100% to an annual maximum of $1,000,000 per person for the calendar year 2011, $1,250,000 for the calendar year 2012, and $2,000,000 for the calendar year 2013.

Organ Transplant Benefits

Eligible	Benefit
Participant & Eligible Dependents	Comprehensive coverage up to UCR amount. Annual maximum of $1,000,000 per person for the calendar year 2011, $1,250,000 for the calendar year 2012, and $2,000,000 for the calendar year 2013.

Mental Health Benefits

Eligible	Benefit
Participant & Eligible Dependents	Hospital Room & Board – 30 days per calendar year under Comprehensive coverage up to semi-private room rate. $100 confinement up to annual maximum (included in regular room & board maximums). Inpatient Hospital Services – Comprehensive coverage up to UCR amount.

- **Effective January 1, 2011, update the ELIGIBILITY, "Dependent Eligibility" subsection of the SPD as follows:**

  Dependent Eligibility
  Eligible dependents include your legal spouse and children only. The children are your biological children, stepchildren, or legally adopted children under the age of 26 who are not eligible for other employment-based health coverage (or eligible for employment-based health coverage through their spouse). Eligibility ends at the end of the month in which a dependent child attains age 26. When a dependent child is no longer eligible because of his or her age, the dependent child may elect COBRA continuation coverage.

- **Effective January 1, 2011, the ELIGIBILITY, "Student Coverage" subsection of the SPD is eliminated because, as described above, dependent eligibility has been extended until age 26.**

  NOTE: See the "Required Notices" section of this SMM for information about a 30-day Special Enrollment period available to newly eligible dependents to obtain health coverage under the Plan as a result of these changes in eligibility.

- **Effective January 1, 2011, update the DEFINITION OF TERMS, "Eligible Dependent" definition as follows:**

ELIGIBLE DEPENDENT. "Eligible Dependent" means any one of the following persons who is not employed by any contributing employer whose employees are covered for benefits provided by the Fund:

1. The participant's legal spouse.
2. The participant's child or children under 26 years of age (see page 19 for more details) who is/are not eligible for other employment-based health coverage (or eligible for employment-based health coverage through their spouse). "Child" shall mean the child, step-child, legally adopted child, or a child living with the participant who is under the participant's legal guardianship and who is dependent on the participant for one-half of his/her support. For purposes of this provision, the Trustees may rely on evidence that a child has been claimed as a dependent on the participant's tax return. In the absence of such evidence or if there is information which raises questions about the accuracy of such evidence, the Trustees may rely on any other information which establishes that the participant provides at least one-half of the child's support.

- **Effective January 1, 2011, Eliminate the Plan's Overall Lifetime Benefit Maximum/Introduce New Annual Benefit Maximum**
  Effective January 1, 2011, the Plan's overall lifetime dollar limit will be eliminated. The Plan will introduce an escalating annual dollar limit on essential health benefits.

REQUIRED NOTICES

In addition to the benefit changes described previously in this SMM, the federal Patient Protection and Affordable Care Act ("PPACA") requires that we provide you with certain notices about the Plan. Those notices are below. All changes or descriptions outlined in the notices are effective January 1, 2011.

Elimination of the Plan's Lifetime Benefit Dollar Limit/Conversion of Lifetime Dollar Limit to Annual Limit.
The $1,000,000 lifetime limit on the dollar value of benefits under the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund (the "Plan") no longer applies. Any individuals whose coverage ended by reason of reaching the lifetime limit under the Plan are eligible to enroll in the Plan.

In addition, for the three consecutive Plan Years beginning January 1, 2011, the following overall annual limits on the value of all essential health benefits provided under the Plan will be in effect for members (and their dependents) for all plan options:

- ✓ 2011: $1,000,000
- ✓ 2012: $1,250,000
- ✓ 2013: $2,000,000

Extended Eligibility for Dependent Coverage/Special Enrollment Period
Individuals whose coverage ended or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26 are now eligible to enroll in the Plan. Individuals may request enrollment for such children within 30 days of the date you were first notified of the right to enroll them for coverage. In cases where a newly eligible dependent is requesting coverage, but the request is received *after* the close of the initial 30-day enrollment period, coverage will be effective on the first day of the month following the date of the request and enrollment by the Fund Office.

- **Effective January 1, 2011, update the EXCLUSIONS UNDER COMPREHENSIVE MEDICAL BENEFIT, Class E, as follows:**

  Pre-Existing Condition Exclusion
  Effective January 1, 2011, no pre-existing condition exclusion will be imposed on children under the age of 19.

- **Effective February 1, 2010, CareCentrix became Cigna's new Durable Medical Equipment provider** for Plan E participants who have Fund coverage. CareCentrix provides the following services:

  - ✓ Durable medical equipment (e.g., beds, wheelchairs, walkers)
  - ✓ Respiratory equipment (e.g., oxygen CPAP, ventilators)
  - ✓ Enteral nutrition (e.g., pumps and nutritional support)
  - ✓ Home health care (e.g., nursing, therapies, social work and home health aides)
  - ✓ Home infusion products
  - ✓ Other specialty services (e.g., insulin pumps and supplies, CPM machines and supplies, wound vacuums and supplies)

  Because Cigna has a contract with certain suppliers, Cigna is able to offer this equipment at a significant savings. Durable medical equipment is covered under your Comprehensive Medical benefits at 80%, so these savings also reduce your out-of-pocket expenses.

  A single call to Cigna coordinates complete care. Cigna is available 24/7. Call Member Services toll-free at 1-800-244-6224 (also on the back of your CIGNA ID card).

- **Effective August 1, 2010 – Benefit Changes for United Healthcare HMO Coverage.** The Fund's HMO Plan provider, United Healthcare, made changes to the benefits of active participants in Class C who have HMO coverage. You should have received a new United Healthcare ID card to use for your medical benefits.

  Below are some of the benefit changes.
  - ✓ **Maternity Services**
    - One specialist co-payment covers all prenatal office visits.
  - ✓ **Prosthetic Devices, Durable Medical Equipment (DME)**
    - You pay the coinsurance amount specified in the underlying Plan design.
    - Prosthetic devices have a benefit maximum of $2,500 per policy year.
    - DME has a benefit maximum of $2,500 per policy year. Upgrades are not permitted.
  - ✓ **Ostomy**
    - Ostomy and urological supplies are also covered at the coinsurance amount with a $2,500 maximum per policy year.
  - ✓ **Eye Refraction Exams**
    - Specialist office visit co-pays apply. One routine exam every other policy year permitted. Refractive exams are not covered out of network.
  - ✓ **Rehabilitative Services**
    - Pulmonary rehab is limited based on medical necessity with a maximum of 20 visits per policy year; cardiac rehab is limited based on medical necessity with a maximum of 36 visits per policy year.
  - ✓ **Home Health Care**
    - Home Health Care is limited based on medical necessity with a maximum of 60 visits per policy year.
  - ✓ **Accumulators (deductibles, out-of-pocket maximum, etc.)**

- Flat dollar co-pays do not apply to your out-of-pocket maximum. There is a separate deductible for in-network and out-of-network benefits.

Should you have any questions about your benefits under the HMO plan, please contact United Healthcare at (800) 815-8958. Use your new policy number 729899 to identify yourself as a Warehouse Employees Union Local No. 730 Health and Welfare HMO participant.

- **Effective June 16, 2010 – Eligibility ends on last day of month contributions were made.** The Board of Trustees adopted the following change to your Health and Welfare benefits:

  If your employer decides it will no longer participate in the Health and Welfare Trust Fund, your eligibility for benefits will end on the last day of the month for which contributions were paid. For example, if at the time your employer terminates its participation in the Fund it has paid contributions for the month of March, your benefits will terminate on March 31. If you are enrolled as a participant in the Fund and your employer determines it will no longer be a contributing employer in the Fund, you will receive notice from the Fund Office informing you that you are no longer eligible for benefits.

- **Effective February 1, 2010 – CareCentrix is Cigna's new durable medical equipment provider.** This change applies to Plan E participants with Fund coverage.

  CareCentrix provides the following services:
  - ✓ Durable medical equipment (e.g., beds, wheelchairs, walkers)
  - ✓ Respiratory equipment (e.g., oxygen CPAP, ventilators)
  - ✓ Enteral nutrition (e.g., pumps and nutritional support)
  - ✓ Home health care (e.g., nursing, therapies, social work and home health aides)
  - ✓ Home infusion products
  - ✓ Other specialty services (e.g., insulin pumps and supplies, CPM machines and supplies, wound vacuums and supplies)

  Because Cigna has a contract with certain suppliers, Cigna is able to offer this equipment at a significant savings. Durable medical equipment is covered under your Comprehensive Medical benefits at 80%, so these savings also reduce <u>your</u> out-of-pocket expenses.

  A single call to CIGNA coordinates complete care and services and is available 24/7. Call Member Services toll-free at 1-800-244-6224 (also on the back of your Cigna ID card).

- **Effective January 1, 2010, eligibility and COBRA waiver for dependent student coverage.** The Board of Trustees adopted the following change to your Health and Welfare benefits:

  The "Dependent Eligibility" and "Student Coverage" subsections of the Eligibility section of the SPD is revised as follows to reflect the Fund's longstanding practice with respect to Student Coverage and COBRA Coverage:

  Dependent Eligibility
  Eligible dependents include your legal spouse and children only. The children are your biological children, stepchildren, or legally adopted children under the age of 19 who are not married and who are dependent on you for support. Eligibility ends at the end of the month in which a dependent child attains age 19. When a dependent child is no longer eligible because of his or her age, the dependent child may elect COBRA continuation coverage, or may waive his or her right to COBRA and, if eligible, receive Student Coverage.

Student Coverage

If a dependent child who reaches age 19 waives his or her right to COBRA, the Fund will provide Student Coverage to your dependent child from age 19 to age 23 as long as the child is unmarried, proof that the child is registered as a full-time student in an accredited school is submitted to the Fund Office, and your support of the child is reflected on your federal income tax return. You must fill out and return a Student Certification, notarized by the school, every year that the dependent is a student. Eligibility ends at the end of the month in which a dependent child no longer meets the requirement for student coverage or attains age 23, whichever comes first. COBRA continuation coverage will not be available when Student Coverage ends.

If eligibility ends, and your unmarried child from age 19 to age 23 subsequently becomes a registered full-time student in an accredited school, and your support of your child is reflected on your federal income tax return, eligibility will be reinstated on the first of the month following receipt of a completed valid Student Certification. The Fund will not provide retroactive coverage for the break in eligibility.

Effective January, 1, 2010, an unmarried, full-time student at an accredited school who is covered by the Plan and who takes a medically necessary leave of absence ("medical leave") will maintain his or her health benefits for up to one year. For purposes of this rule, a medical leave occurs when the student starts a leave of absence from the accredited school that (i) begins while the student is suffering from a serious illness or injury, (ii) is medically necessary, and (iii) would ordinarily cause the student to lose full-time student status for purposes of coverage under the terms of the Plan. A covered student on a medical leave will be treated as meeting the student coverage requirements for up to one year from the date of leave or until the date the child would otherwise lose coverage under the terms of the Plan (such as attaining age 23), whichever is earlier. To be eligible for this coverage, the student must be covered by the Plan immediately before the first day of the medical leave. Also, to be covered under this provision, the Plan must be provided with a certification from the student's treating physician that the student is suffering from a serious illness or injury, and that the medical leave is medically necessary. In addition, you must fill out and return a Student Certification that states that the student is on a medical leave.

- **Effective January 1, 2010, Michelle's Law extends student coverage during illness.** Add the following language to the end of the Student Coverage section in your SPD:

  An unmarried, full-time student at an accredited school who is covered by the Plan and who takes a "medically necessary leave of absence" ("medical leave") will maintain his or her health benefits for up to one year. For purposes of this rule, a medical leave occurs when the student at an accredited school starts a leave of absence that:

  1. begins while the student is suffering from a serious illness or injury,
  2. is medically necessary, and
  3. would ordinarily cause the student to lose full-time student status for purposes of coverage under the terms of the Plan.

  A covered student on a medical leave will be treated as meeting the student coverage requirements for up to one year from the date of leave or until the date the child would otherwise lose coverage under the terms of the Plan (such as attaining age 23), whichever is earlier. To be eligible for this coverage, the student must be covered by the Plan immediately before the first day of the medical leave. Also, to be covered under this provision, the Plan must be provided with certification from the student's treating physician that the student is suffering from a serious illness or injury, and that the medical leave is medically necessary. In addition, you must fill out and return a Student Certification that states that the student is on a medical leave.

  NOTE: Changes to Dependent Eligibility and Student Coverage effective January 1, 2010 are superseded by changes due to PPACA, effective January 1, 2011.

- **Effective December 17, 2009, change in quantity limits of prescription drugs.** The following change applies to active participants and retirees in **Class E** (not participants in Class C HMO or participants in the Pre-Medicare HMO) who have prescription drug coverage through the Fund.

  Based on the recommendation of Cigna Rx and in accordance with the industry standard for dispensing limits, the Board of Trustees approved a modification to the rule.

  In accordance with standard dispensing limits, Class E active participants and retirees with Fund prescription drug coverage can fill a prescription for a 34-day supply up to 180 tablets before authorization is required. Drugs which are prescribed for more than a 34-day supply or 180 tablets will require pre-authorization.

  In order to obtain a pre-authorization, please contact the number on the back of your Cigna ID card toll-free at (800) 244-6224.

  Please make this change in your SPD on page 81 under "Exclusions/Restrictions."

- **Effective April 1, 2009, update to ELIGIBILITY, "Enrolling Dependents" subsection of the SPD:**
  If your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or if your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP, and you return the enrollment card and all necessary documentation (such as, notice from the state regarding eligibility for Medicaid or CHIP) to the Fund Office within 60 days of such event, your dependents' coverage will begin immediately. Otherwise, if you do not return the enrollment card and necessary documentation within 60 days, your dependents will be enrolled for coverage on the first of the month following receipt of your completed enrollment card and necessary documentation.

- **Effective April 1, 2009, update to ELIGIBILITY, "Special Note for Class C participants with Optimum Choice HMO coverage" subsection of the SPD:**
  If your dependents lose Medicaid or CHIP coverage as a result of a loss of eligibility for such coverage or if your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP, you must return the enrollment card within 60 days of such event in order for your dependents to be covered immediately. If you do not return the enrollment card within such 60 day period, your dependents will have to wait until open enrollment next July for coverage beginning in August.

  Please refer to your SPD for more information about the current provisions of the Plan, including the meaning of certain terms used in this SMM.

- **August 1, 2009,** Cigna HealthCare replaced Informed Rx/NMHC as your new prescription drug provider. A letter and a new medical/prescription ID card was mailed to Plan E participants. Retirees who have prescription drug coverage only received a new prescription ID card.

  Did my prescription benefits change?
  No, your Fund prescription benefits remain the same. Your co-payment is still $1.00 per prescription and you must request generic drugs, if available. You can also use the same pharmacies as before, but remember that WalMart pharmacies are not part of the network, and prescriptions filled there are not covered.

New ID card
Your new ID card should be used for BOTH your medical and prescription drug coverage. On and after August 1, 2009, you must use your new ID card. Discard your previous medical and pharmacy ID cards. (Retirees: your ID card is to be used only for prescription drug coverage.)

Where can I learn more information?
You can access the Cigna member website by logging onto www.Cigna.com. Here you can receive information regarding your prescription drug benefits, locate local network pharmacies, compare your co-payment at each pharmacy, access an exercise calculator via "Healthy Links", and receive information about dietary guides and recipe substitutes. To access the website enter your member identification number (ID), located on your prescription card, and your date of birth in the "Members Login" box located on the right side of the screen; then click "Login."

You may also contact the Customer Service Department toll-free at (800)-Cigna24 for general prescription drug benefit information. Other benefits questions should be directed to the Fund office at (800) 730-2241.

In your SPD, in the Prescription Drug Benefits section, pages 80 and 81, please replace NMHC with Cigna HealthCare, and wherever NMHC also appears in the SPD.

- **Effective August 1, 2009,** Group Vision Services ("GVS") is your new optical provider and replaces the coverage you had through Spectera/United HealthCare Specialty Benefits or with Group Vision Associates ("GVA") (depending upon your vision plan).

  Starting August 1, 2009, your vision benefits under GVS remain exactly the same. However, participants who utilize the GVA plan are no longer required to call the Fund office to receive a vision voucher. Participants must also use a vision provider in the improved GVS network.

  No Change in Benefits
  Your optical benefits remain the same. For more information about your vision benefits, refer to your Summary Plan Description booklet.

  ID Card
  GVS will mail you an ID card for you to use for your optical benefits. If you do not have your ID card with you when you go to your optician's office, don't worry. Simply give them your name and date of birth and have them call customer service at 1-866-265-4626 to verify your eligibility. If you had an appointment scheduled on or after August 1st with Spectera or GVA, you need to go to www.gvsmd.com to see if your provider participates with them.

  Improved Network
  GVS has an expanded network with providers located in major malls and convenient city locations. It will now be easier for you to locate a vision provider closer to home or work.

  Out-of-Network
  If you are a Giant Warehouse Employee or Local 730 Staff participant, out-of-network benefits are not payable under this plan, except when approved in advance by GVS, and only in limited circumstances. Contact GVS at 1-866-935-5277 to request authorization prior to obtaining out-of-network services.

Locating a Provider
To locate the most current providers in the GVS network, log on to its website at www.gvsmd.com. The names of providers are updated regularly. You can also call GVS' customer service toll-free at 1-866-265-4626.

In your SPD, in the Vision Benefits section, pages 82 and 83, please replace Spectera/United Optical with GVS, and on pages 84 through 86, please replace Group Vision Associates ("GVA") with GVS.

- **Effective September 25, 2008,** the Board of Trustees of The Warehouse Employees Union Local No. 730 Health and Welfare Fund approved the following changes to the "Exclusions under Comprehensive Medical Benefit" for Class E participants.

  - On page 60 of your Health and Welfare Summary Plan Description, change #8 to read:
    "Suicide, attempted suicide or self-inflicted injury, except if those actions or the injury are the result of a mental condition, such as clinical depression."

  - On page 61, change #14 to read:
    "Injuries sustained while in the commission of a criminal or illegal act, except if the participant is the victim of an act of domestic violence."

- **Effective September 1, 2008,** Cigna HealthCare replaced OneNet as your new PPO for participants in Class E. Starting September 1, 2008, you should use a provider (whether a hospital, physician, or other health care provider) who is in the Cigna network to receive a reduced rate (lower out-of-pocket expenses) for your medical benefits. Remember, Cigna HealthCare discounts claims when you use one of their participating providers, but Cigna does NOT provide your benefits -- the Plan does. Your coverage has NOT changed and is still provided and paid for by the Fund.

  Did My Benefits Change?
  No. You have the same coverages, payment structures, exclusions, etc. as before. CIGNA PPO has in-network and out-of-network benefits just like the coverage you had with OneNet. You do not need a referral to see a specialist and you do not need to select a Primary Care Physician.

  How Do I Locate Providers?
  To locate the most current providers in the Cigna network, log on to its website at www.Cignasharedadministration.com. The names of providers are updated regularly. If you wish to receive a CIGNA Provider Directory, call the Fund Office toll-free at (800) 730-2241 and we will mail one to you.

  What If My Doctor Is Not in the CIGNA Network?
  If your doctor/provider is not in the Cigna network and you would like Cigna to consider including your doctor in the network, call the Fund Office at (800) 730-2241 to receive a nomination form.

  New ID Cards
  A new Fund ID card showing CIGNA as your new provider was sent to Class E participants. It is very important that you show this new ID card to all providers of care!

  In your SPD on pages 48 and 49, and wherever OneNet PPO appears, replace it with Cigna HealthCare PPO.

- **Effective September 1, 2008**, CareAllies, a subsidiary of CIGNA HealthCare, replaced Optum/CARE Programs as your new Utilization Management ("UM") provider, for participants in Class E. Effective

September 1, 2008, you must contact CareAllies toll- free at (800) 768-4695 to pre-certify ALL non-emergency or elective hospital stays and within 48 hours after an emergency admission. Remember, you must certify all hospital stays in order for the Fund to pay any benefits. If you do not, then you will be responsible for the entire bill.

To locate a CareAllies provider, log on to www.Cignasharedadministration.com or call (800) 768-4695. Note: CareAllies providers are the same providers as CIGNA. You will not see the name CareAllies on the website. Click on Cigna Healthcare Physician or Hospital Directory to locate a provider.

New Medical Care Enhancements
CareAllies offers members enhancements such as the following programs:

- ✓ **24-hour NurseLine,** where you can receive helpful information from registered nurses, anytime, day or night. The telephone number for NurseLine is (800) 768-4695. To speak to a nurse, first select #3, "Health Information." Next, select #1 and you will be connected with a nurse.
- ✓ **Case Management Program** is a patient-focused program intended to provide assistance and care coordination to chronically or critically ill patients (i.e., cancer, serious spinal cord injury, diabetes, heart disease, etc.). You may call CareAllies at (800) 768-4695 (choose option #3) to make use of this helpful program.
- ✓ **Maternity Management Program** allows participants to receive valuable prenatal guidance and high-risk maternity screening.
- ✓ **LifeSource Organ Transplant Program** provides care coordination in transplant centers across the country as well as case management to participants and eligible dependents.
- ✓ **Healthy Rewards℠ Program** is a discount program for weight management, nutrition, tobacco cessation, fitness, and a wide range of other popular health and wellness issues. These programs range from discounts on such items as vision care, dental care and gym membership.
- ✓ **myCareAllies.com** website offers secure, convenient, and fast access to your personal health and wellness.

To learn more about any of the above-mentioned enhancement programs, log on to www.myCareAllies.com. The password to log on to myCareAllies is LOCAL730 (password is not case sensitive). NOTE: Do not leave a space in between the word Local and 730, or the password will not work.

In your SPD in the section "Certification Procedures for Hospital Admissions" on page 51, and wherever Optum/CARE Programs appear, replace it with CareAllies utilization management.

All hospital stays must be certified by CareAllies in order to be considered for payment under the Fund for Class E participants. If you (or a family member or the provider of service) do not contact CareAllies within 48 hours of emergency admission, the Fund will not pay for any of your stay. Please make this correction on page 51 of your Summary Plan Description.

- **Effective July 23, 2008**, the Board of Trustees approved a clarification to the rule that you must enroll in Optimum Choice HMO within 30 days from the date your active Fund coverage terminates or waive your eligibility for benefits. This rule applies to non-Medicare-eligible retirees and their eligible spouses in Class E. Now, retirees who return to work for another employer with benefits will have additional means to secure HMO coverage.

Clarification to the Current Rule:
The Trustees approved a clarification to the 30-day rule. If a retiree returns to work for a different employer following retirement, and that employer offers health benefits, then the retiree may request a

"placeholder" at the termination of the Fund coverage and elect the Pre-Medicare HMO benefit instead within the 30 days following termination of the new employer's benefits.

Please note this clarification of the rule found on page 22 of your Summary Plan Description.

- **Effective July 23, 2008,** the Board of Trustees approved the Amateur Auditor Program. When you help the Fund office by finding and correcting errors in hospital or physician bills, the Fund will pay you half of what is recovered, up to $1,000, through the Amateur Auditor Program.

  How Can I Get A Reward?
  When you receive your Explanation of Benefits ("EOB") after your claim is processed, look to see if the services billed are correct. Did you actually have the lab test performed? Was the x-ray taken? Is there a duplicate charge? Were you really in the hospital for the days billed?

  If you see something wrong, call the hospital billing office or your doctor's office and request the itemized bill to be sent to you. Explain the error to the hospital or doctor's office, and ask them to correct it and to send you the corrected bill. This is very important! The provider should then re-submit the claim with the corrected information.

  Keep track of the names of the people you spoke with and the dates, and show the Fund office both the wrong bill and the corrected bill. We'll send you half of the amount recovered, up to $1,000!

  You can still call our Participant Services department toll free at (800) 730-2241 about an error and we will have it corrected. However, that does not qualify you for the reward. To receive the reward, you must both find the error and have it corrected.

Changes in Brand Name of Providers (But NOT a change in benefits):

- **Effective August 1, 2008,** Spectera changed its brand name to UnitedHealthcare Vision for Class E participants who are employed by Giant Warehouse or with the Local 730 staff. There is no change in your vision benefits, no change in your provider network, and no disruption to your benefits. To locate a provider, log on to its new member website at www.myuhcvision.com or call (800) 638-3120.

- **Effective August 1, 2008,** your prescription drug services are provided through informedRx™ (formerly NMHC). There is no change in your prescription benefits, no change in your provider network, and no disruption to your benefits.

  Please make this change in your Summary Plan Description booklet on page 78. If you need emergency dental services, and you are unable to contact and be treated by any of the participating dentists or the emergency staff at Dental Health Centers, you can receive reimbursement up to a maximum of ***$50 per person***, ***per year,*** when you send a copy of the paid bill, along with a note explaining the circumstances, to: Dental Health Centers, 3700 Donnell Drive, Suite 215, Forestville, Maryland 20747.

Corrections to Your Booklet

- **Page 24.** Under the section entitled COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, fourth paragraph, ninth line down, it reads "...before the 6th day of COBRA..." when it should be ***"...before the 60th day of COBRA..."***.
- **Page 53.** On page 53, second paragraph, under the heading Hospital Expense Benefits for Class E, please add the heading ***Newborns' and Mothers' Health Protection Act of 1996*** above that paragraph and the sentence, ***"The Fund cannot and does not require that providers obtain authorization for prescribing a length of stay not in excess of the above period of time."*** at the end of the paragraph.

- **Page 56.** Add the heading ***Women's Health and Cancer Rights Act of 1998 (WHCRA)*** at the top of the page, above the first paragraph.
- **Page 82.** Under the section entitled Vision Benefits, change the last sentence of the first paragraph to read: *"You will be responsible for a $10 co-payment per visit* ***and a $10 material co-payment when you receive glasses or contacts,*** *which is payable to the optometrist or ophthalmologist."*

- **Board of Trustees** – The most current Board of Trustees are shown below. Please make this change on page 4 of your SPD booklet.

Union Trustees

Ritchie Brooks, Chairman
Warehouse Employees Union
Local No. 730
2001 Rhode Island Avenue, NE
Washington, DC 20018

Roy Essex
Warehouse Employees Union
Local No. 730
2001 Rhode Island Avenue, NE
Washington, DC 20018

Tyrone Richardson, Alternate
Warehouse Employees Union
Local No. 730
2001 Rhode Island Avenue, NE
Washington, DC 20018

Reginald Johnson
7611 Don Drive
Clinton, MD 20735

Employer Trustees

Frank Stegman
c/o Fund Office
911 Ridgebrook Road
Sparks, MD 21152

Jason Paradis
Ahold USA
1385 Hancock Street
Quincy, MA 02169

Lynell Johnson
Eight O'Clock Coffee
3300 Pennsy Drive
Landover, MD 20785