FOR YOUR BENEFIT

UFCW Unions & Participating Employers Health & Welfare Fund

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Plans Y and Z Part Timers: Open Enrollment for Dependent Coverage Is July 1st – July 31st

The following article applies to Part-Time Participants in Plans Y and Z.

July 1st to July 31st is the Open Enrollment period for adding dependent ("family") coverage to your benefits. If you are eligible for dependent coverage, but did not elect it when you first became eligible, you may add your dependent(s) to your coverage during this period. If you don't enroll your dependents in July, you must wait until the next open enrollment period in January, 2013.

Is There A Cost?

Yes, you pay 20% of the cost of the coverage and your employer pays 80%. The 20% that you are responsible for will be deducted from your paycheck by your employer. ***Do not send payment to the Fund office.*** If you elect dependent coverage, your payroll deduction will begin in September.

When Will the Coverage Begin?

Coverage for your dependents will begin September 1st.

How Many Dependents May I Add to My Coverage?

As long as they are eligible dependents under the Plan (spouse, biological children, step children and legally adopted children), you may enroll as many dependents as you have. The cost is the same regardless of the number of dependents.

The purpose of this newsletter is to explain your benefits in easy, uncomplicated language. It is not as specific or detailed as the formal Plan documents. Those documents always govern.

Enrollment is subject to the rules in your Summary Plan Description booklet.

What If I Want to Drop Dependent Coverage?

You may drop dependent coverage at any time by notifying the Fund office. Call us to request the proper form, which you must sign and return to us (it verifies that you want to stop payroll deductions). But remember, if you ***do*** drop the coverage, you will not be eligible to add it again until the open enrollment period following a twelve-month waiting period, except in special circumstances, including a birth, adoption, or marriage. Open enrollment for dependent coverage occurs twice a year, in January and in July.

I Want to Add Coverage — What's Next?

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

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

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

Contact Participant Services

If you have questions, contact Participant Services or the Eligibility Department of the Fund office at (800) 638-2972.

This issue—

Material Modification

Notice of Waiver of Annual Limit Requirement

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

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

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

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

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

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

This means that your health coverage might not pay for all the health care expenses you incur.

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

ANNUAL MAXIMUM (PER INDIVIDUAL)

BENEFIT CLASS	PLAN JS	PLAN JSS2	PLAN Y	PLAN Y20	PLAN Z	PLAN K2	PLAN K20
Major Medical[1]	$250,000	$400,000	$400,000	$100,000	$350,000	$400,000	$150,000
Rehabilitation[1]	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000
Substance Abuse	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000

[1] *Effective January 1, 2011, these limitations were converted from a lifetime limit to an annual benefit limitation. Please refer to your Summary of Material Modifications for more detail on this benefit change.*

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

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

What Can Slow Down The Processing of Claims?

The Fund office uses state-of-the-art benefit systems technology. Despite the tools we employ, claims payment is not simply a matter of feeding information into a computer. It can take as little as a few days or up to 30 days to process a claim.

When we don't have all the information, we "pend" the claim.

Below are some of the most common reasons why a claim may be pended.

- If a claim comes to us without a CareFirst discount, and our system shows that the doctor or hospital is a participating provider, we send the claim back to CareFirst to take a second look at the claim.
- **Need Accident Details**
  A letter is sent to you when it appears you have had an accident and the accident inquiry section of your claim form has not been filled out. We need details about **any** injury (not just injuries from car accidents), including how, when, and where the injury occurred, whether other people were involved, and whether another party may be responsible for the injury. We cannot process a claim relating to an accidental injury until we have these accident details.
- **Need Procedure Code**
  This notice means we have received a bill but we need a procedure code (CPT code). Procedure codes are the providers' and insurers' way of showing exactly which service was provided. Both you and your doctor's office receive a copy of this letter, but you are ultimately responsible for confirming that we get the information.
- **Need Enrollment for Baby**
  A letter is sent to you when we get a claim for a newborn, if you have not yet added the baby to your coverage. Call the Fund office immediately to enroll your newborn. Without enrollment, your baby will not have medical coverage.
- **Need Provider's Tax ID Number**
  If a provider does not give the Fund his/her tax identification number, a letter is sent to the provider requesting this information. Without this number, we cannot pay a claim.
- **Need Current Address**
  It is very important that we have your current address on file. Without a current address, your claim might be denied because we are unable to gain additional information from you.

Allow Time

It generally isn't necessary for you to call about your claim. We will send you a letter if your claim is not complete. The only reason you may want to call is to confirm we received a bill from your provider. However, before you call, please allow ample time for the bill to get to us. Some providers don't bill us right away.

Material Modification

K2 And K20 Participants: Changes As A Result of Health Care Reform (PPACA)

The Summary of Material Modifications that appeared in the March 2012 ***For Your Benefit*** *newsletter also applies to K2 and K20 participants. The article is reprinted below.*

Effective January 1, 2011— changes as a result of Health Care Reform (PPACA) — Dependent Children Eligibility

Under "Dependent Eligibility," the section entitled "Who is an Eligible Dependent?" and the paragraph entitled "Legal Custody" are deleted and replaced with the following:

Who Is an Eligible Dependent?
Eligible dependents include your spouse and children, as defined in this Section.

Biological Children, Adopted Children and Children Placed for Adoption – For Plans K2, K20, T, Z, Y and Y20

Medical and Prescription Drug Benefit Eligibility
Generally, your biological children, adopted children and children placed with you for adoption are eligible for medical and prescription drug benefit coverage as your dependents if they are:

- Under age 26; and
- Not eligible for coverage under another employer-sponsored group health plan (other than this Plan or a plan covering their parent(s)).

Optical Benefit Eligibility
Generally, your biological children, adopted children and children placed with you for adoption are eligible for optical benefit coverage as your dependents:

- Through the end of the calendar year in which the dependent turns age 23; and
- Provided they are not eligible for coverage under another employer-sponsored group health plan (other than this Plan or a plan covering their parent(s)).

Dental Benefit Eligibility
For active participants, subject to the requirements described in the dental benefit sections of your SPD, your biological children, adopted children, children placed for adoption, are eligible for dental benefit coverage as your dependents if they are:

- Under age 19;
- Not Married;
- Not employed on a regular full time basis; and
- Dependent on you for financial support.

Note: Children of retirees are not eligible for dental, optical or prescription benefits. For active participants, children under age four are not eligible for dental benefits.

Biological Children, Adopted Children and Children Placed for Adoption – All Plans *Other Than Plans K2, K20, T, Z, Y and Y20*

Generally, your biological children, adopted children and children placed with you for adoption are eligible for medical, prescription drug, dental, and optical benefit coverage as your dependents if they are:

- Under age 26; and
- Not eligible for coverage under another employer-sponsored group health plan (other than this Plan or a plan covering their parent(s)).

Note: Children of retirees are not eligible for dental, optical or prescription benefits. For active participants, children under age four are not eligible for dental benefits.

Stepchildren and Children over whom you have Legal Custody – All Plans
Stepchildren and children over whom you have legal custody are eligible for medical, optical, dental, and prescription drug coverage as your dependents if they are:

- Under age 19 (unless eligible for student coverage—see "Full Time Student Coverage" below);
- Not married;
- Not employed on a regular full-time basis; and
- Dependent on you for financial support.

Note: Children of retirees are not eligible for dental, optical or prescription benefits. For active participants, children under age four are not eligible for dental benefits.

Coverage for Dependents of Kroger Richmond Tidewater Participants
Dependents of Kroger Richmond Tidewater participants are covered for optical, dental, drug and medical until age 26.

Coverage for Full Time Students – Legal Custody and Stepchildren – Plans K2, K20, T, Z, Y and Y20
Generally, stepchildren and children over whom you have legal custody are eligible until the end of the calendar **year** in which they turn age 19. However, if your son or daughter is a full-time student at an accredited college or university, **medical,**

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optical, dental and prescription drug coverage may be continued until the earliest of the last day of the calendar month in which he/she marries, ceases to be financially dependent on you for support, ceases to be a full-time student, or the end of the calendar year in which he/she turns age 23.

If you have had court-awarded legal custody of a child for at least six months, you may enroll that child as your dependent. You must submit a copy of the court-entered custody order along with the applicable enrollment form. Further, you must submit a notarized letter to the Fund office every six months, confirming the continuation of custody.

To be eligible for coverage, stepchildren must reside with the eligible participant. The Plan requires you to submit evidence of your dependent(s)' eligibility status – for your children: a birth certificate, adoption papers, or other proof of adoption or placement for adoption acceptable to the Trustees, and for your spouse: a marriage license. In the case of a stepchild, a copy of the divorce decree indicating custody is required as evidence.

In order to ensure continued coverage under the Plan, Dependents and/or Participants (as applicable) must respond to any request for information issued by the Fund for the purpose of confirming continued eligibility for benefits. Failure to respond to such requests may result in the suspension or termination of coverage.

Notice of Grandfathered Health Plan

Plans JS, JSS2, T, Y, Y20, K2, K20 and Z under the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund ("Fund") qualify as "grandfathered health plans" under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act).

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Because these Plans qualify as grandfathered health plans, certain provisions of the Affordable Care Act that apply to other plans—for example, the requirement for the provision of preventive health services without any cost sharing—do not currently apply to these Plans. However, the Plans offer other consumer protections under the Affordable Care Act, including the elimination of all lifetime limits on essential benefits.

If you have questions about which protections apply and which protections do not apply to a grandfathered health plan, or about what might cause the Plans to stop being treated as a grandfathered health plan, please contact Participant Services at 1-800-638-2972. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-327 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Material Modification

Dental Benefits for Dependents

The below information applies to participants in Plans T, Z, Y, Y20, K2 and K20.

Dental benefits for dependents terminate at the end of the year in which the dependent turns age 19. Student coverage does not include dental benefits.

Coordination of Benefits

The following article applies to participants in Plans K2, K20, T, Z, Y and Y20

Coordination of Benefits ("COB") applies when a participant or eligible dependent is entitled to benefits under any other kind of group health coverage in addition to coverage under the Fund. When duplicate coverage exists, the primary plan usually pays a reduced amount. **The Fund will never pay, either as the primary or secondary plan, benefits which, when added to the benefits payable by the other plan for the same service, exceed 100% of the Usual, Customary, and Reasonable ("UCR") charge.** This applies whether or not a claim is filed under Medicare or another plan.

Certain Rules Apply

- If one plan does not have a coordination of benefits rule, it will be primary. Otherwise, the plan which covers the person as an employee is the primary plan. The plan which covers the person as a dependent is the secondary plan.
- If a participant is covered as an employee under more than one plan, the plan with the earliest effective date of coverage is the primary plan.
- When both parents are covered by different plans, and the parents are not separated or divorced, and the claim is for a dependent child, the primary plan is the plan of the parent whose birthday falls earliest in the year. If both parents have the same birthday, the plan which has covered a parent longer pays first. However, if the other plan does not have a birthday rule and instead has a rule based on the gender of the parent and as a result of this, the two plans do not agree which is primary, the plan of the father will pay first.

When two or more plans cover a child whose parents are separated or divorced, benefits will be paid as follows:

- If a court determines financial responsibility for a child's heath care expenses, the plan of the parent having that responsibility pays first.
- If a court determination has not been made or the court divides the financial responsibility equally, the plan of the parent with custody pays before the plan of the other parent. The plan of the step-parent married to the parent with custody of the child pays before the plan of the parent who does not have custody.
- **IMPORTANT:** When an eligible dependent under the Plan is offered a program of health, dental, drug, and/or vision benefits by another employer as a result of his or her employment, and the dependent has the option of selecting the other employer's health coverage or receiving cash or another financial incentive, this Plan coordinates its benefits as if the other employer's health coverage were applicable. It does so even when the dependent does not elect the coverage under the other employer-sponsored plan.

  Before the Fund will pay benefits to an employed dependent, he or she must provide the Fund office with information explaining the other employer's health coverage, if any.

Medicare – COB if You Are "Actively Working"

If you work for an employer with fewer than 20 employees, and the Fund has obtained an exception from the Health Care Financing Administration ("HCFA") for your employer, then Medicare is primary for you and your dependents. Otherwise, the following rules apply:

- All active participants over age 65 and spouses over age 65 of active participants of any age will be entitled to receive coverage under this Plan under the same conditions as a participant or participant's spouse under age 65. **The Plan cannot be "secondary" to Medicare** for employees and spouses over age 65 by paying only those medical expenses Medicare does not cover.
- Absent an election (described below), the Plan will be the primary payor of medical costs for active participants, and spouses over age 65 of active participants of any age, with Medicare providing secondary coverage. This means you will be reimbursed first under this Plan (except in the case of End Stage Renal Disease ("ESRD"). If there are covered expenses

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not paid by the Plan, Medicare may reimburse you – if the expenses are covered by Medicare. To get reimbursement from Medicare, you must enroll and, for Medicare Part B coverage, you must pay a monthly premium.

1. Election of Medicare

If you are age 65 or older, you are entitled to elect Medicare as your primary coverage in lieu of the Plan. However, an active participant over age 65 or an active participant's spouse over age 65 will automatically continue to be covered by this Plan as the primary plan unless you:

- Notify the Fund office, in writing, that you do not want coverage under this Plan, or
- You cease to be eligible for coverage under this Plan. **If you elect Medicare as your primary coverage, the Plan cannot, under law, pay benefits secondary to Medicare.**

2. Disability

If you are actively employed and you or your eligible dependent(s) are under age 65 and are entitled to Medicare due to a disability (other than ESRD), the Plan will pay benefits as primary.

3. End Stage Renal Disease ("ESRD")

If you or your eligible dependent(s) become entitled to Medicare based on ESRD, and the Plan is currently paying benefits as primary, the Plan will remain primary for the first 30 months of your entitlement to Medicare due to ESRD to the extent required by law. If the Plan is currently paying benefits secondary to Medicare, the Plan will remain secondary upon your entitlement to Medicare due to ESRD.

COB with an HMO

If you have primary coverage under an HMO through your work, and secondary coverage under the Fund as a dependent, **you must follow the rules of the HMO in order to have remaining balances considered for payment by the Fund as secondary payer.** If you go outside of your HMO for services (or otherwise fail to follow the rules of the HMO), and then submit the bill to the Fund for secondary payment, it will be denied.

For purposes of coordinating benefits, an HMO is treated the same as any other plan. **If you fail to follow the rules of any primary plan, including an HMO, the Fund will not pay benefits as either primary or secondary.**

Important: To ensure that the Fund coordinates and pays your benefits properly, you must keep the Fund informed of any and all coverage for you and your eligible dependent.

Retiree Information Form Sent
Please Return Promptly

The following article applies to you if you receive a pension from the UFCW Unions & Participating Employers Pension Fund (usually referred to as the "Non-Food Pension Fund"). It does not apply to participants who receive pensions from the Retail Clerks Union and Employers Pension Plan, usually referred to as the "Atlanta Pension Fund."

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

What If You Don't Have Any Changes?

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

Helpful Reminders

- Do not attach checks or claims to the RIF.
- Let us know if you, or your spouse, have other health coverage.
- Be sure to sign the RIF.

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

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