Open Enrollment – Plans Y and Z is July 1-31. See page 7.

FOR YOUR BENEFIT

UFCW Unions & Participating Employers Health & Welfare Fund
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Material Modification

Active Plan No Longer Has Annual Major Medical Benefit Maximum On Essential Health Benefits

The following applies to participants with traditional Fund coverage, not HMO coverage.

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

New Claims Address For CareFirst

The following article applies to participants whose medical coverage is provided through the Fund, not an HMO.
This information does NOT apply to Kroger participants.

If you have a blue ID card, your claims that are not filed electronically should now be sent to:

CareFirst/Network Leasing
PO Box 981633
El Paso, TX 79998-1633

Please share this information with your provider the next time you have an appointment. Note: all claims, including secondary claims, must be filed within 365 days.

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.

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Reviewing Your Vision Benefits

Your vision benefits under the Plan are insured by Group Vision Service ("GVS"). You have a choice of independent optometrists and ophthalmologists, as well as retail locations such as LensCrafters, Sears Optical, JCPenney Optical, Target Optical and participating Pearle Vision locations.

When Using A GVS Network Provider

- Schedule an exam with the provider of your choice. When scheduling your appointment, inform the provider that you are a GVS member and provide your name and date of birth. The provider will verify your eligibility and Plan benefits prior to your appointment.
- If you have already made an appointment, show your ID card at the time of service or provide your name and date of birth for quick verification of eligibility and Plan coverage.
- You are responsible for paying the provider at the time of service for co-payments/costs that exceed your Plan coverage.

When Using An Out-Of-Network Provider

- If you visit a doctor who is not in the GVS network, you are required to pay the entire amount for the exam and eyewear at the time of service.
- Complete a claim for reimbursement (an out-of-network ("OON")) claim form that you can print from the GVS website at www.gvsmd.com. Click "Members" and then click "Forms").
- Out-of-network amounts are the maximum reimbursable amounts that may be paid to you after you file an OON claim. See your Vision Benefit Summary for OON benefit amounts.

Personalized Member Website Access

For benefits specific to your Plan, log on to the GVS website and follow the steps mentioned below.

1. You must first register on the GVS website – www.gvsmd.com
2. Under the **MEMBER** tab, select "**View Your Benefits**."
3. Welcome to the GVS Member - Click ***here*** to Login/Register.
4. Select "**Register for an account**."
5. When you enter the Member Site to Register for an Account, use the **last four digits** of your Social Security Number and pick your own user ID.
6. The site will send you an email confirmation and password selection information.

Please Identify Payments Sent To The Fund Office

When you send a check or money order to the Fund office, write its purpose on the check. Why? Because the Fund office handles a variety of benefits, such as Health and Welfare, Pension, Legal and others.

We process checks for:

- COBRA payments,
- Dependent coverage co-payments,
- HMO co-payments,
- Retiree co-payments, and more.

Sometimes, the Fund office receives envelopes containing nothing but a check. We then must determine where the payment should be applied. With the number of people making payments, and the variety of reasons, this can be a difficult and time-consuming task.

If we cannot identify a check, the time it takes us to track down the correct department could cause the payment's deadline to pass. It's possible that someone could lose coverage for late payment while we are in the process

of identifying the check. Although coverage would be re-established once the mystery is solved, we don't want this to happen to you.

To keep it from happening, please note the reason for your payment right on your check.

The more specific information you supply, the more easily and quickly your payment can be posted.

ING Changed Name To ReliaStar/Voya Financial

The following article applies to active participants only.

Your life insurance benefits and Accidental Death and Dismemberment benefits under the Plan have long been insured through ING.

Recently, ING changed its name to ReliaStar/Voya Financial. 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.***

Y2 And Y20 Participants: When Lab Work Is Needed, You Must Use LabCorp or Quest

Y2 and Y20 participants ***must*** use Lab Corporation ("LabCorp") or Quest Diagnostic Patient Service Centers ("Quest") in order for laboratory services to be covered under the Fund. LabCorp and Quest are participating providers in the CareFirst PPO network.

Inform Your Doctor

Be sure your doctor knows before the lab work is performed that you will be covered for lab work only if the bill comes to the Fund directly from a LabCorp or Quest facility. Even if your doctor has a contract with LabCorp or Quest to perform lab work in his/her office, tell him/her that only lab work performed at a LabCorp or Quest facility will be covered. Your Plan will not pay for lab work performed and billed from your doctor's office.

Locating Labs

To locate the most current list of LabCorp or Quest facilities, log on to their websites or call them:

- www.labcorp.com or with their patient customer service (800) 845-6167, or
- www.questdiagnostics.com or by telephone at (800) 377-8448.

Have Weekly Disability Form Signed After Surgery

When you have surgery, your Weekly Disability—sometimes called Accident and Sickness (A&S)—form should not be completed by your employer or your physician until after your surgery occurs. Pre-dating a Weekly Disability form could cause a delay in receiving Weekly Disability benefits. Your claim could be "pended" (held back from payment) until the Fund office receives verification of the actual date of surgery.

For example, let's say you are scheduled for surgery next Friday and you ask your physician and your employer to complete their sections of your Weekly Disability form before you have stopped working so that you can submit the form to the Fund office. While your intention is to avoid a delay in your benefit, it is possible that the surgery could be cancelled or postponed to another date, and if that happens, your Weekly Disability form would no longer be accurate as submitted.

90 Days To Submit Your Initial Claim Form

A completed initial claim form (in the format approved by the Board of Trustees), must be received by the Fund office within 90 days from the date your disability began. Continuation forms are sent to you every six weeks (or as needed) and must be returned within four weeks of the date sent by the Fund office. If your continuation form is not returned on time, you will not receive any additional Weekly Disability benefits for that disability.

Key Points To Remember:

- Weekly Disability benefits will not be payable for days used as vacation days or other time paid by your participating employer.
- Your participating employer must complete its section of the form.
- The disability must be verified in writing on the claim form by a physician legally licensed to practice medicine, a Certified Alcohol Counselor, or a Master's Level Social Worker who is approved by ValueOptions, depending on the disability.
- You must be seen in-person by a physician either in his/her office, at your home, or at a hospital.
- All questions on the claim form must be answered. Incomplete forms will be returned for completion.
- No disability will be considered as beginning more than three days prior to the first visit to a physician during the disability period.
- No disability will be considered as beginning until after your last day worked.
- You cannot collect Workers' Compensation and Weekly Disability benefits at the same time.
- You must be actively receiving treatment from a physician to improve the condition which is causing your disability.

When You Need Physical Therapy, Call Conifer First

The following article applies to active and retired participants who have traditional Fund medical coverage (not to those who have HMO coverage or who are Medicare eligible).

The Fund office covers the cost of seeing a physical therapist if the physical therapy is medically necessary. Your physical therapist ***must*** contact Conifer (formerly known as InforMed) at (800) 459-2110 to be sure your treatment is covered.

How Many Visits Will The Fund Cover?

The Fund generally provides benefits for two visits per week for six weeks. If you need treatment beyond six weeks, your provider must certify the additional care with Conifer.

Example

Let's say you hurt your back and, after Conifer determined that physical therapy was medically necessary, you have physical therapy twice a week, for six weeks. If your doctor decides you need additional treatment, he/she must contact Conifer to certify the additional sessions. ***Don't wait until your final week of therapy to re-certify, because additional visits may be denied while the new information is being reviewed.***

Remember, you are responsible for any charges not authorized by Conifer.

How Are Pension Benefits Calculated?

The following article applies to active participants in the UFCW Unions & Participating Employers Pension Fund ***other than former UFCW Local 400 Meat and Poultry participants whose benefits earned under the former Meat and Poultry Plan are calculated in a different way.***

The amount of your pension depends on your total years of Benefit Service and the applicable benefit rates. If you had both full time and part time service, the benefit amount with respect to each is calculated separately and then added together. If you had transfers of employment, or you worked for more than one Participating Employer, several periods of your service may have to be calculated separately and then added together.

Your participation in the Pension Plan begins on the first day of the month in which the first contribution is made on your behalf, but in no case later than 12 months following the date you became covered by a Collective Bargaining Agreement requiring contributions. This is your Effective Date.

How Are Your Years Of Service Calculated?

Future Service Credit is the period of employment with a Participating Employer in a job classification covered by a collective bargaining agreement with a Participating Union between your Effective Date and the date you terminate covered employment. Future Service Credit is based on the regular time hours you work, according to the following schedule:

Full Time Participants	Part Time Participants	Future Service Credit
1600 hours or more	800 hours or more	1 year
1200 to 1599 hours	600 to 799 hours	3/4 year
800 to 1199 hours	400 to 599 hours	1/2 year
400 to 799 hours	200 to 399 hours	1/4 year
under 400 hours	under 200 hours	None

How Are Benefits Calculated?

Your years of benefit service are multiplied by the applicable benefit level. For example, Mr. Smith has 10 years of full time benefit service and the benefit level from his employer is $16.75.

FT Service 10.00 x $16.75 Benefit Level = $167.50

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What Types Of Pension Are Available Under The Plan?

Type of Benefit	Age And Service Requirements
Normal Retirement	Age 65 and at least 5 years of Benefit Service
Early Retirement (Non Reduced)	Age 60 and at least 10 years of Benefit Service
Early Retirement (Reduced)	Age 55 and at least 15 years of Benefit Service. Reduced from Age 60
Disability Retirement	Any age and at least 10 years of Benefit Service. Must have Social Security Disability Award and the disability must have begun prior to termination of covered employment
Deferred Vested Pension	Age 65 and at least 10 years of Vesting Service at termination, or 5 years Vesting Service if actively working after 1/1/99
Early Deferred Vested	Age 55 and at least 15 years Benefit Service. Reduced from Age 60
Death Benefit ***(Does not apply to Deferred Vested Pensions or Giant Food Pharmacy workers).*** Effective April 28, 2010, the Death Benefit is paid as a monthly annuity equal to the deceased pensioner's life annuity amount until the Death Benefit amount has been paid in full.	Majority Benefit Service FT -- $2,500 Majority Benefit Service PT -- $1,500
Pre-Retirement Surviving Spouse's Pension	At least 10 years Vesting Service, or 5 years Vesting Service if actively working after 1/1/99. Pension begins when Participant would have attained earliest retirement age.
Joint & Survivor Pension	Percentage of pension continues to spouse after death of Participant
Five Year Certain	60 pension payments guaranteed

What Forms Of Benefit Payment Are Available Under The Plan?

Type of Benefit	Age And Service Requirements
100% Joint & Survivor	After your death, your spouse will receive 100% of your monthly pension benefit for as long as he/she lives.
75% Joint & Survivor	After your death, your spouse will receive 75% of your monthly pension benefit for as long as he/she lives.
66 2/3% Joint & Survivor	After your death, your spouse will receive 66 2/3% of your monthly pension benefit for as long as he/she lives.
50% Joint & Survivor	After your death, your spouse will receive one half of your pension benefit for as long as he/she lives.
Life Annuity – Waiver of Joint and Survivor Pension	If you are single or if you and your spouse elect to waive the above Joint and Survivor Options within 90 days before the date your benefits are scheduled to start, you will receive a single life annuity, payable until your death. In order for any spousal waiver to be effective, both you and your spouse must sign a notarized waiver statement on the form provided by the Fund office, and return that statement to the Fund office before your pension is due to start.
Lump Sum	If the current value of your pension, determined using your age and the actuarial factors applicable to the Plan, is $5,000 or less when you retire and apply for your benefit to begin, your benefit will be paid as a single lump sum. No other forms of benefit are available to you under the Plan.

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 Active 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, 2015.

Cost

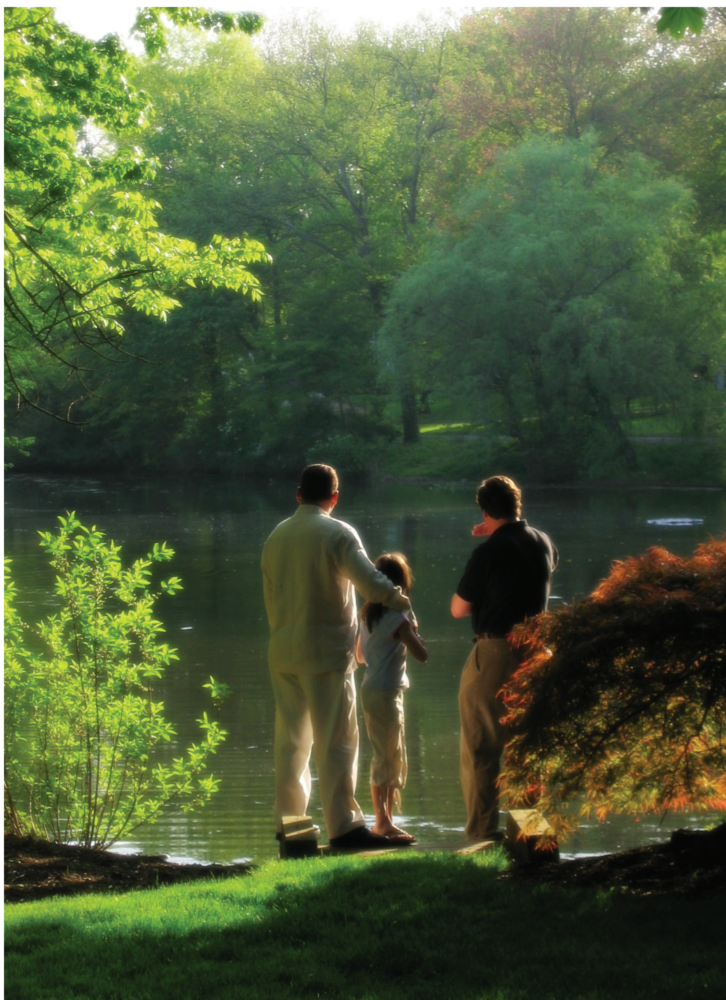
You pay 20% of the cost of the coverage and your employer pays 80%. The 20% that you are responsible for will be deducted from your paycheck by your employer, beginning in September. ***Do not send payment to the Fund office.***

Coverage Begins

Coverage for your dependents will begin September 1st.

Adding Dependents To Your 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. Enrollment is subject to the rules in your Summary Plan Description booklet.



When You Need 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.

How To Add Dependent Coverage

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.

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