FOR YOUR BENEFIT

UFCW Unions & Participating Employers Health & Welfare Fund

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Open Enrollment Is March 15 – May 16 For Choosing Your Medical Coverage

The following article applies to actively-working participants in Plans JS, JSS2, Y, Y20 and Z only.

Open enrollment for medical coverage for the coming year is from March 15 through May 16, for coverage effective June 1, 2012. During this time, you can choose traditional Fund medical coverage or medical coverage through Kaiser Permanent HMO. This open enrollment period is for medical coverage only. It does not affect your optical, dental, or prescription drug coverage.

You will automatically remain in the coverage you have now unless you actively make a change. If you want to stay with your current coverage, whether it is traditional Fund coverage or with Kaiser Permanente, don't do anything!

How Open Enrollment Works

If you live within the Kaiser service area, the Fund office will send you a letter describing your medical coverage options, along with a packet from Kaiser Permanente which includes a Kaiser Summary of Benefits, HMO Health Plan Guide, and enrollment application. If you do not live within the Kaiser service area, you will not receive this information and you automatically will be enrolled in "traditional" Fund medical coverage.

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.

Cost

It is important that you read your open enrollment letter carefully so you'll know if there is a monthly co-payment required for your Plan or, ***if you already have a co-payment, whether it will be changing***.

I Want To Enroll In Kaiser. What Do I Do?

If you decide to enroll in the Kaiser Permanente HMO, complete the enrollment application and ***return it to the Fund office – not to Kaiser!*** This is very important because we cannot set up your coverage properly if you don't return the application to us first.

What's the difference between "traditional" Fund medical coverage and Kaiser Permanente HMO medical coverage?

Under an HMO, you must use a participating provider or facility in order to be covered. There are usually "per visit" co-payments, which you pay to the provider at the time of service. These vary depending on the service and the HMO.

Under Fund traditional coverage, you may use any doctor or hospital you wish, although you receive the best discounts if you use a CareFirst PPO provider. ***Y20 participants must use a CareFirst provider in order to receive coverage.***

Some services may be covered in full, such as inpatient hospital room and

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Summary of Material Modifications This Issue!

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board (up to the semi-private room rate, after which the remaining cost is paid under your Major Medical benefit). Most covered medical services are paid at 80% (75% for Plan Y20) up to the usual, customary, and reasonable ("UCR") amount, after satisfying your annual deductible. Other services may be covered at different percentages – see your Plan booklet for details.

Your Open Enrollment letter will show the monthly cost, if any, for all of the Fund's traditional coverage Benefit Plans. However, only one of those Plans applies to you. If you're not sure which Plan you're in, contact the Fund office. Remember, you do not choose your Plan.

Important: If you enroll in Kaiser and don't make the monthly co-pay, if any, your medical coverage will be terminated and you will not be eligible to re-enroll until the next open enrollment period.

What if I want to switch to Fund medical coverage?

If you are in Kaiser and want to switch to "traditional" Fund medical coverage, call Participant Services at (800) 638-2972 during Open Enrollment and tell the representative. ***You must make this call by May 16th in order to make the change.***

What if I don't get an open enrollment letter?

The Fund office sends open enrollment letters to all eligible participants who live within the zip code areas that Kaiser Permanente services. Therefore, if you don't receive a letter, it is likely you don't live within the Kaiser Permanente service area and cannot enroll in the HMO. If you did not receive a letter but you think you should have, contact the Fund office at (800) 638-2972 and we will check on whether Kaiser covers your area.

Always Check with Fund Office To Be Sure Your Claim Was Filed

It is your responsibility to be sure a medical claim has been filed with the Fund office when you see a doctor, go to the hospital or have lab work done. Usually, when you have these services performed, the provider submits the claim for you. But you should follow up with the Fund office to ensure that the Fund received your claim.

Verify Your Claim Was Received

1. Call the Automated Benefit Information System at (800) 638-2972 and press prompt #1, or talk with one of our Participant Service representatives to check the status of your claim.
2. Look for an Explanation of Benefits ("EOB") in the mail from the Fund office. This will let you know the claim was received. Normally, an EOB is sent to you and the provider in four to six weeks.

If you think we did not receive your claim, contact the provider and ask the billing department to re-submit it. This will protect you from having your claim denied for late filing.

If your claim is filed more than 180 days from the date of service, your claim will be denied. Don't let this happen to you!

Privacy Statement Available Upon Request

As you know, in accordance with federal law, the UFCW Unions & Participating Employers Health & Welfare Fund has established Privacy Practices, which are the rules on how protected health information (PHI) about you may be used and disclosed by the Fund and other parties under the Health Insurance Portability and Accountability Act of 1996 and how you can get access to this information.

The Notice of Privacy Practices that you received in April 2003 (or when you first became a participant, if later) describes these rules. If you would like another copy of the "Statement of Privacy Practices," log onto www.associated-admin.com and click on the words "Your Benefits," located on the left side of the screen. Select "UFCW and Participating Employers" and print the Statement of Privacy Notice. You can also call the Fund office at (800) 638-2972 or write to:

HIPAA Privacy Officer
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451

Receiving Help Through The Employee Assistance Program

The following article applies to active participants in Plans K2, Y, Z, T and TR.

The Employee Assistance Program ("EAP"), administered by ValueOptions, is available to help you and your eligible dependents with problems not covered by your medical and mental health benefits. The EAP provides free, confidential, short-term counseling or referral to a specialist for a total of six EAP sessions in your lifetime. Only ValueOptions therapists can provide EAP services.

How do EAPs work?

EAPs are confidential, multifaceted counseling, education and referral programs designed to help you with personal problems, including:

- stress
- parenting problems
- adolescent behavioral problems
- adolescent substance abuse
- marital difficulties
- financial trouble
- substance abuse
- coping with an accident or trauma
- depression
- anxiety
- grief and loss
- caregiving issues
- life phase adjustment:
  - o early adult
  - o midlife including caring for aging parents
  - o retirement

How do I get help?

Call ValueOptions at (800) 454-8329 to schedule an appointment. They are available 24 hours a day, 7 days a week. You do not need a referral to contact ValueOptions.

Weekly Disability Form Should Be 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 in order to get your paperwork ready, 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 income, it is possible that the surgery could be cancelled or postponed to another date, and if that happens, your Weekly Disability form no longer would 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.

Material Modifications

Summary of Material Modifications

Below are Material Modifications (changes) made to your Plans over the past year. Please read and clip them where indicated so you can keep them with your Summary Plan Description ("SPD") booklets and your other benefits information.

UFCW Unions & Participating Employers Health and Welfare Fund

Effective January 1, 2011 – changes as a result of Health Care Reform (PPACA). The Board of Trustees of the UFCW Unions & Participating Employers Health and Welfare Fund ("Fund") has adopted the following changes to the UFCW Unions & Participating Employers Health & Welfare Plan in order to comply with the Patient Protection and Affordable Care Act (PPACA). *These changes do not apply to Richmond Tidewater Plan participants.*

Elimination of Pre-existing Condition Exclusions

Under the heading "Eligibility" or "Employee Eligibility," the section entitled "Pre-Existing Condition Exclusions" is revised by deleting the first sentence and replacing it with the following:

The Fund does not impose a general pre-existing condition exclusion on medical or prescription drug benefits under the Plan.

For Plans JS, JSS2, T, Y, Y20, and Z, under the heading "Eligibility" or "Employee Eligibility," the section entitled "Pre-Existing Condition Exclusions" is further revised by adding the following sentence to the end of that section:

Further, with respect to medical and prescription drug benefits under the Plan, the specific pre-existing condition exclusions described in this Summary Plan Description do not apply to participants or dependents under the age of 19.

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 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 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 Full Time Students – Legal Custody and Stepchildren – Plans 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 and optical** 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.

Coverage for Full Time Students – Legal Custody and Stepchildren – Plans Other Than 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, 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.

Notice of Early Retiree Reinsurance Program Participation

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an

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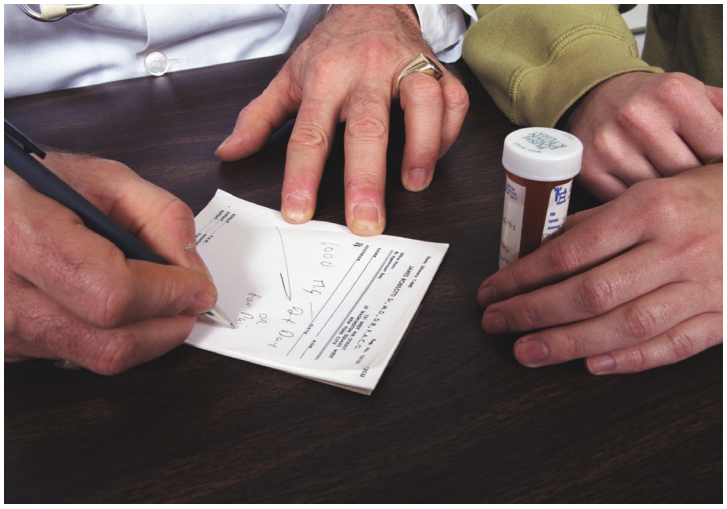
employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses the Fund for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, the Fund may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs.



If the Fund chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this Fund chooses to use the reimbursements for this purpose. The Fund may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in the Fund's costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

Effective October 1, 2011, CareFirst replaced OneNet PPO as your new Preferred Provider Organization ("PPO"). *(Note: this change does not apply to participants in Plans K2, K20, and Richmond Tidewater).* When you use a provider (whether a hospital, physician, or other health care provider) who is in the CareFirst network, you will receive discounted rates that are generally lower than out-of-network provider fees.

New ID Card

A new medical ID card was sent to you. ***Be sure to show the new ID card to all providers of service so that your claims are filed and processed correctly!***

Locating A CareFirst Provider

You may call the CareFirst telephone number located on the back of your medical ID card.

- If you received a white ID card with blue writing, call: (800) 235-5160.
- If you received a white ID card with black writing, call: (800) 810-2583.

You may go online to the CareFirst website, www.carefirst.com.

White ID Card Holders with Blue Writing

Click on "Members and Visitors," then on "Find a doctor or other provider in your Plan." On the next screen, click on the "Find a Doctor" link. Blue ID card holders should click on the button that reads, "Within MD/DC/Northern VA" under "PPO.' Click on "Continue." You may refine your search by clicking on "Type of Doctor" or "Type of Facility" and then clicking "Continue."

White ID Card Holders with Black Writing

Click on "Members and Visitors," then on "Find a doctor or other provider in your Plan." On the next screen, click on the "Find a Doctor" link. White ID card holders should click on the button that reads, "Outside MD/DC/Northern VA" under "PPO." Click on "Continue." You may refine your search by clicking on "Type of Doctor" or "Type of Facility" and then clicking "Continue."

UFCW Unions & Participating Employers Pension Fund

Effective August 1, 2011, the Board of Trustees welcomed Fresh and Green's (Local 400, Washington, D.C.) as a participating employer in the UFCW Unions & Participating Employers Pension Fund.

Fresh and Green's is added as a participating employer on page 47 of the UFCW Unions & Participating Employers Pension Fund Summary Plan Description booklet.

UFCW Unions & Contributing Employers Legal Benefits Fund

No changes.

RIFs Are Being Sent. *Complete And Return Promptly.*

The following article applies to you if your pension is through UFCW Unions & Participating Employers Pension Fund. It does not apply to participants whose pensions are through the Retail Clerks Union and Employers Pension Plan, usually referred to as the "Atlanta Pension Fund."

Within the next few months, the Fund office will send all retirees a Retiree Information Form (RIF) to be completed and returned to the Fund office. The form is required by the Board of Trustees and asks questions about your current address, your beneficiary, whether you and/or your spouse have other health coverage, and whether you are employed.

Even if you completed this form last year, you still must complete and return this year's RIF. It is very important that the retiree complete all sections of this form and promptly send it back to the Fund office. ***If we don't receive your RIF, your benefits may be suspended until it is received.*** The Fund office will include a postage-paid, return envelope with the first mailing.

Helpful Reminders

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

No one but the retiree can sign the RIF, unless an individual holds a Power of Attorney for the retiree. A copy of any such Power of Attorney must be on file with the Fund office. If, for health reasons, the retiree is unable to sign the form and there is no Power of Attorney on file, then the retiree must sign an "X" on the RIF and have it notarized by a Notary Public.

Make the Most of Your Pension Appt– Have Info Ready Before Coming In

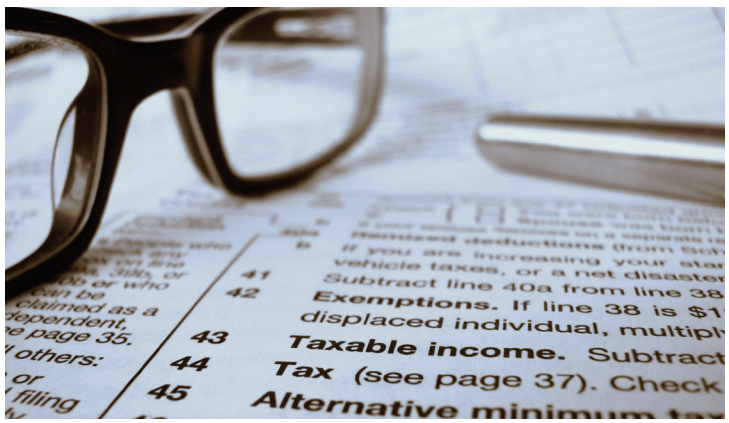
While most calls can be handled over the phone, our Pension Department staff is available to meet with you in-person to go over your pension options and the steps to follow for your retirement. ***BUT***, we won't be able to help you at the meeting unless you have already sent in a Benefit Service Request Form ***and received back*** a Pension Estimate Statement. We recommend you send that Form in about a year before you retire.

Why is that? Because in order to have an estimate of how much your pension will be ***and*** what your options are, we have to verify your amount of service (with ***all*** employers--for example, you may have worked for more than one employer under the Plan or have service under another pension fund that must be considered).

Your employer(s) verifies your length of service as well as the ***type*** of pension service (full time vs. part time, for example, or time worked in various job classifications).

All of these things affect the final amount of your pension. Sometimes this involves pulling old records, which are not easily accessible, and it takes time.

If you wish to have a personal consultation, it is helpful to make an appointment ahead of time. If you take the time to come to the Fund office, we want to be sure a representative has your information and can help you.



HEALTH CORNER

Heart Disease And Its Effect On The Family

Heart disease is a family affair. When one member of a family gets sick, all the others must make adjustments and be prepared to learn new roles, not just for the patient's health but for their own.

Those who live with a heart patient need to be ready for possible changes in the patient's emotional state. Heart patients are suddenly dealing with anxiety and may slip into depression.

Experts say communication is the key to keeping families emotionally healthy. Everyone needs to talk honestly about what they're feeling. No one, including children, should be left out of the loop. Children tend to blame themselves when their parents fall ill, so the real nature of the disease, and its causes, should be made clear to them.
Talking things out not only can defuse sources of stress; it also promotes the intimacy and emotional support that heart patients need. A Duke University study of hospitalized heart disease patients showed that those with strong support from family and friends (as revealed on questionnaires) were less likely to be depressed one month after leaving the hospital than were those who had weak support. Other studies have shown that depression greatly increases the chance of recurring heart disease and early death.

Source: Center for the Advancement of Health; Herbert N. Budnick, PhD. By Tom Gray © 2000-2012 Lifescape. ValueOptions Solutions Newsletter, February 2012.

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