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, 2013. During this time, you can choose traditional Fund medical coverage or medical coverage through Kaiser Permanente 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 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.

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.***

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.

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.

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 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

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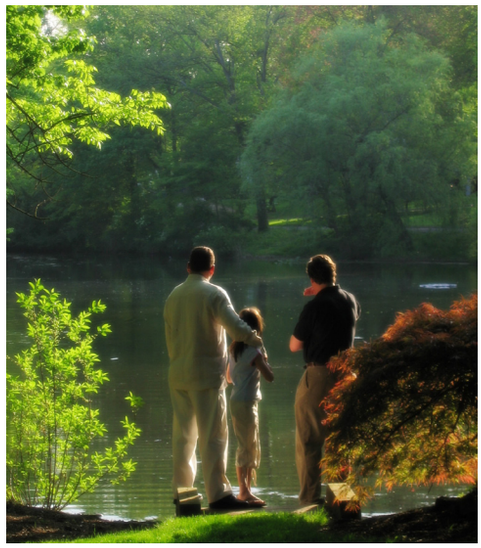
Summary of Material Modifications This Issue!

- UFCW Unions & Participating Employers **Active Health and Welfare Plan***
- UFCW Unions & Participating Employers **Retiree Health and Welfare Plan***
- UFCW Unions & Participating Employers **Pension Fund**
- UFCW Unions & Contributing Employers **Legal Benefits Fund**

**Benefit Plans of the UFCW Unions and Participating Employers Health & Welfare Fund*



This issue—

Notice of Waiver of Annual Limit Requirement

Effective 2013 Plan Year. To the right is a Notice that we are required by federal law to send to you. Under the Patient Protection and Affordable Care Act, group health plans generally cannot have annual limits of less than $2 million for the Plan Year beginning in 2013. 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 and rehabilitation benefits that are below $2 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 December 31, 2013. 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.

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. The Board of Trustees is proud of the affordable health benefits that they have been able to provide over many years.

Please contact the Fund Office at 800-638-2972 with any questions.

JANUARY 2013 NOTICE OF WAIVER OF ANNUAL LIMIT REQUIREMENT

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

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 $2 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:

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
Rehabilitiation[1]	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000

[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.*

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 $2 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 December 31, 2013.

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, contact the Administrative Manager at 301-459-3020 or 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.

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.

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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.

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

- Let us know if you have a new telephone number. ***This is very important if we have to contact you.***
- 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.

Note: If you are changing your beneficiary or tax deduction, please call the Fund Office. We will send you the necessary form to be completed and returned to the Fund Office. No changes will be made until the proper form is completed.

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.

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 September 1, 2012–new plan names.** The Board of Trustees formally separated the Plan for active participants and the Plan for retired participants. The active plan now is called the UFCW Unions and Participating Employers Active Health Plan, a plan of the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund. The retiree plan now is called the UFCW Unions and Participating Employers Retiree Health Plan, a plan of the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund. Your benefits remain the same.

  You may continue to use your current medical card (whether your benefits are provided through Fund medical coverage or Kaiser Medicare coverage) and your current prescription ID card from Catamaran Rx (formerly called InformedRx/SXC).

- **The following applies to Plans JSS2, Y and Y20, but does not apply to Plans K2 and K20. Effective October 1, 2012–Flu shot is free with Rx ID card at any Shoppers or Kroger Pharmacy.** The Board of Trustees is pleased to announce an enhanced flu shot benefit for Fund actives and retirees covered by **Plans JSS2, Y, and Y20.** Effective for flu shots given October 1, 2012 and after, you may get your flu shot at any Shoppers or Kroger pharmacy at **no cost to you**, using your InformedRx/ Catalyst Prescription Drug ID card. Simply go to your Shoppers or Kroger pharmacy, show your InformedRx/ Catalyst ID card and receive your flu shot.

  The following applies to Plans JSS2, Y, Y20, and K2 and K20 participants:

  If you prefer to get your flu shot from your doctor or don't live near a Shoppers or Kroger pharmacy, the shot is still covered under your medical benefits. For those with Fund medical coverage, the injection itself is covered at 100% up to the Usual, Customary and Reasonable fee, and the office visit charge (if there is one) is covered under your Major Medical or Comprehensive benefit at the applicable co-payment of 80% (or 75% for Plan Y20) after satisfying the annual deductible. Submit your paid receipt to the Fund Office and you will be reimbursed. Charges for an office visit should be filed with the Fund Office. For participants in the Kaiser Permanente HMO (actives and retirees), the flu shot is covered in full with no co-pay if you use a Kaiser physician. However, actively working participants in Kaiser who use InformedRx/Catalyst (now called Catamaran) for their prescription benefit also may get a flu shot at a Shoppers or Kroger pharmacy using their prescription ID card.

- **Effective September 1, 2012–CBA Change – Plan JSS2 and Plan Y Participants: Endodontic Procedures (Root Canals) Now Covered.** As a result of recent collective bargaining, the Board of Trustees is pleased to announce that coverage of Endodontic procedures (root canals) has been added

for Participants and Dependents in Plan JSS2 and Plan Y whose employers ratified the 2012 bargaining agreement. While most of the Endodontic procedures are subject to a co-pay, participants should see significant savings since the procedures previously were not covered under Plans JSS2 and Y and could have cost as much as $1,200 per instance. To be covered, **the Endodontic procedures must be performed by a GDS general network dentist** and are subject to the same policy provisions as your other dental benefits including, but not limited to, authorization for medical necessity.

The below co-pays apply to endodontic procedures performed by a GDS general network dentist:

Code	ADA Description	Co-pay
D3110	Pulp Cap Direct	$0
D3120	Pulp Cap Indirect	$0
D3310	Endodontic Therapy–Anterior Tooth	$125
D3320	Endodontic Therapy–Bicuspid Tooth	$125
D3330	Endodontic Therapy–Anterior Tooth–Molar	$250

All co-pays and fees are due at the time of service, and all dental services must be performed by a network general dentist to be eligible for dental benefits.

If the procedure is performed by a GDS in-network Endodontic Specialist, the Participant is responsible for an additional $100 Specialist fee charge on the last three procedures reflected in the above chart. Thus, if the procedure is performed by a GDS in-network Endodontic Specialist, co-pays are as follows:

Code	ADA Description	Co-pay
D3110	Pulp Cap Direct	$0
D3120	Pulp Cap Indirect	$0
D3310	Endodontic Therapy–Anterior Tooth	$225
D3320	Endodontic Therapy–Bicuspid Tooth	$225
D3330	Endodontic Therapy–Anterior Tooth–Molar	$350

All co-pays and fees are due at the time of service, and all dental services must be performed by a network endodontic specialist to be eligible for dental benefits.

If you have questions regarding the endodontic benefit or for assistance in finding a network dentist, please contact GDS at 800-242-0450.

- **Effective September 1, 2012–CBA Change for Shoppers Kaiser Medicare HMO Retirees:** The following applies to retirees formerly employed by Shoppers, and their dependents, who are enrolled in the Fund's Kaiser Permanente Medicare HMO Option.

As a result of collective bargaining, the Trustees have adopted the following change to the Kaiser Medicare HMO retiree program, effective **September 1, 2012:**

- The office visit copayment will change from $10 to $15 per visit.
- There will be a $100 inpatient copayment which will apply to the first inpatient admission during each benefit period.
- The prescription drug co-payments will change as follows:
  - From $5 to $10 for mail order scripts (up to a 90 day supply) from the Kaiser Permanente mail order pharmacy;
  - From $10 to $15 for scripts obtained at a Kaiser Center Pharmacy (up to a 60 day supply);
  - $22.50 for 90 day supply script obtained at a Kaiser Center Pharmacy rather than mail order;
  - From $15 to $25 for scripts obtained at a participating retail pharmacy.

You will receive a separate mailing and a new Evidence of Coverage directly from Kaiser Permanente. The Board of Trustees is pleased to be able to continue coverage for retirees. If you have questions regarding your Kaiser benefits, please call (800) 777-7902.

- **JS Participants–Clarification regarding Retiree Eligibility**

The following is a clarification to the second paragraph under the section entitled ***"Retiree Eligibility,"*** on page 17 of the UFCW Unions and Participating Employers Health and Welfare Fund Plan JS Summary Plan Description:

If you are an active participant in this Plan, and you retire from the UFCW Unions and Participating Employers Pension Fund, the FELRA & UFCW Pension Fund, the Atlanta UFCW Pension Fund, or the UFCW International Union Industry Pension Fund, and elect to waive your COBRA rights, you may be eligible for retiree benefits beginning with the effective date of your retirement. However, former participants who retire on a deferred vested pension are not eligible for health and welfare benefits from this Plan. Further, if, after you retire, you become employed for more than 40 hours per month by any employer who provides health and

welfare benefits and pays at least 80% of the total cost, your retiree health benefits will be suspended until you are no longer employed.

- **Effective September 1, 2012–Change in prescription drug co-payments for JSS2 retirees formerly employed by Shoppers who have Fund coverage, not Medicare Kaiser Permanente coverage.** As a result of recent collective bargaining, your prescription benefit has changed. For prescriptions filled on or after September 1, 2012, you will pay an 8% co-payment if you use a participating employer pharmacy and a 13% co-payment if you use any other pharmacy that accepts Catamaran. Remember that generic drugs are mandatory if available.

InformedRx/SXC (which used to be NMHC) is now called Catamaran.

Continue to use the prescription card you have now. The new prescription co-payment percentage will be changed in the pharmacy system.

- **Effective 2012–Dental Benefits for Dependents.** For 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.

- **Effective January 1, 201–K2, K20, Y, Y20, JS, JSS2, T, and Z Participants: 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, and 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 Richmond Tidewater Plan Participants
Dependents of 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 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 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, 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.

UFCW Unions & Participating Employers Pension Fund

No changes.

UFCW Unions & Contributing Employers Legal Benefits Fund

No changes.

UFCW Unions and Participating Employers
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451