FELRA & UFCW Health and Welfare Fund

FELRA & UFCW Active Health & Welfare Plan

FELRA & UFCW Retiree Health & Welfare Plan

PLAN I

Summary of Material Modifications

(July 2013)

This Insert is a Summary of Material Modifications (changes) to your Summary Plan Description (SPD) booklet. If there is any discrepancy between the terms of the Plan or any amendments and this document, the provisions of the Plan, as amended, will control. Please keep this Insert with your booklet so you will have it when you need to refer to it.

- **Effective July 2013 – Updated Board of Trustees.** The following replaces page 8 in the Plan I Summary Plan Description booklet.

FELRA & UFCW Health And Welfare Fund
Board of Trustees

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8301 Professional Place, Suite 115
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- **2013 Plan Year – Notice of Waiver of Annual Limit Requirements.** *(This notice applies to all Active participants with traditional Fund coverage, not HMO coverage).* Below is a Notice that we are required by federal law to send to you. This notice explains that, 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. However, plans can seek a waiver of those annual limits 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, rehabilitation, and physical exam 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 $2 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.

January 2013 Notice of Waiver of Annual Limit Requirement

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 key benefits in a year, that limit must be at least $2 million.

Your health coverage, offered by the FELRA & UFCW 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 I**	**PLAN I RETIREE**	**PLAN X**	**PLAN XX**
Comprehensive Medical	$400,000	$400,000	$400,000	$400,000
Rehabilitation	$25,000	$25,000	$25,000	$25,000
Physical Exam	$200 (once every two years)	$200 (once every two years)	N/A	N/A

This means that your health coverage may not pay for all of 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 Fund Office 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

This is to notify you that the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund ("Fund") qualifies as a "grandfathered health plan" 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 the Fund qualifies as a grandfathered health plan, 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 the Fund. However, the Fund offers 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 Fund to stop being treated as a grandfathered health plan, please contact the Participant Services at 1-800-638-2972. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

- **Effective January 1, 2013 – Gardisil Vaccine is now covered.** The Board of Trustees announced that Gardisil, the HPV vaccine for girls, now is covered under the Active Plan and Retiree Plan for dependent daughters. The following applies to Actives and Retirees who have Fund coverage.

  Virginia Participants
  Effective for Gardisil injections given January 1, 2013 and after, your dependent daughter may either receive the shot at a Giant or Safeway pharmacy at no cost to you using your Medco ID pharmacy card, or may receive the injection at the doctor's office. If the vaccine is administered at the doctor's office, the injection will be covered in full with no deductible, up to the Usual, Customary, and Reasonable (UCR) charge, while the office visit charge (if there is one) will be covered under your medical coverage at 80% for Plan I and X participants and at 75% for Plan XX participants, after satisfying the deductible.

  Maryland and DC Participants
  For Maryland and DC, this injection cannot be administered at the pharmacy; therefore, it will be covered when administered at your dependent daughter's doctor's office, effective January 1, 2013. The injection itself will be covered at 100% up to the UCR and the office visit charge (if there is one) will be covered under your medical benefit at 80% for Plans I and X and at 75% for Plan XX, after satisfying your deductible.

  You also have the choice of picking up the vaccine at the pharmacy at no charge, and bringing it to the physician's office for administration. If you do that, the office visit charge will be paid under medical, as described above.

  Delaware Participants
  Delaware law permits the vaccine to be administered at the pharmacy if certain dosage conditions are met. Check with your pharmacist to see if the shot can be administered at the pharmacy or if it must be handled at the doctor's office. Payment will be as noted above.

- **Effective June 1, 2012 – new Plan names.** ***FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan***
  The Board of Trustees formally separated the Plan for active participants and the Plan for retired participants formalized the separate existence of the Fund's plan for FELRA Actives and Retirees. The active plan now is called the **FELRA & UFCW Active Health Plan, a plan of the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund.** The retiree plan now is called the **FELRA & UFCW Retiree Health Plan, a plan of the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund.** Your benefits remain the same.

- **Effective January 1, 2013 – elimination of Walgreens from network pharmacies.** ***FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan.*** Walgreens is no longer a part of the FELRA network of pharmacies, effective January 1, 2013. **This network change does not affect the prescription drug benefits available to you under the Plan.**

  Co-Insurance
  Plan participants share in the cost of drugs based on coinsurance levels of 8% for Plan I participants, 13% for Plan X participants and coinsurance levels for Plan XX participants that depend on the cost of the drug. Remember, Giant and Safeway pharmacy coinsurance levels are generally lower than using a non-participating employer pharmacy. Retiree reimbursement levels are typically 11% for Giant and Safeway, and 18% for other Medco network pharmacies. If you are a retiree and live out of the area of a Giant or Safeway pharmacy, you may qualify for the 11% coinsurance level.

  Questions
  If you have questions or need assistance in locating the nearest network pharmacy, please contact Medco/Express Scripts at (800) 903-8325.

- **Effective October 15, 2012, the flu shot is free with Medco Rx card at Giant or Safeway Pharmacies.** ***FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan.*** The Board of Trustees is pleased to provide an enhanced flu shot benefit for Fund participants.

  Flu Shot at Pharmacy
  Effective for flu shots given October 15, 2012 and after, you may get your flu shot at any Giant or Safeway pharmacy at **no cost to you** using your Medco Prescription Drug ID card! Simply go to your Giant or Safeway pharmacy, show your Medco ID card, and receive your flu shot.

  Flu Shot in Doctor's Office
  If you prefer to get your flu shot from your doctor or don't live near a Giant or Safeway pharmacy, the flu shot will be covered under your medical benefits. For participants and dependents with traditional Fund 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 (80% for Plans I and X, or 75% for Plan XX), after satisfying the annual deductible. Charges for an office visit should be filed just like any other medical claim.

  For participants in the Kaiser Permanente HMO (actives and retirees) who prefer to get a flu shot from their doctor, the flu shot is covered in full, with no co-pay if you use a Kaiser physician. Further, actively working participants in Kaiser who use Medco for their prescription benefit may have their flu shots administered at a Giant or Safeway pharmacy using the Medco ID card, at no cost.

- **Clarification regarding Life Insurance Beneficiary Payment Process. No change in benefit.** ***FELRA & UFCW Active Health & Welfare Plan.*** The Board of Trustees has adopted the following clarification to the Fund's Summary Plan Description ("SPD") regarding the default payment method applicable to the life insurance benefit under Plans I, X, and XX.

  The following language is added to the end of the Life Benefit and Accidental Death and Dismemberment sections of your SPD:

  DEFAULT PAYMENT FORM FOR LIFE INSURANCE BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT

  1. Beneficiaries who are residents of Maryland, Virginia or the District of Columbia and are eligible to receive a life benefit or accidental death & dismemberment benefit of less than $5,000 will receive their payment in one lump sum, unless the Beneficiary elects another form of payment from the options available.

  2. Beneficiaries who are residents of Maryland, Virginia and the District of Columbia, and are eligible to receive a life benefit or accidental death & dismemberment benefit of $5,000 or greater will have their payment deposited into a Personal Transition Account in the Beneficiary's name, established and maintained by ING/ReliaStar,

unless the Beneficiary elects another form of payment from the options available. The proceeds in the Account will earn interest at a guaranteed minimum rate, and the Beneficiary may write drafts against the Account of at least $250 at a time, up to the full amount of the Account. The Beneficiary may close the Account at any time by requesting payment of the full balance of the Account. ING/ReliaStar will maintain the Account and will periodically request that the Beneficiary confirm his/her intent to continue the Account. If the Beneficiary does not affirmatively confirm his/her intent to keep the Account active, and if there is no financial activity with the Account (excluding credited interest) or other customer initiated activity for a period of 18 months, ING/ReliaStar will close the Account. Upon closing the Account, ING/ReliaStar will pay out the remaining proceeds to the Beneficiary. If ING/ReliaStar cannot locate the Beneficiary, it will pay any remaining funds to the state government in the state in which the Account was established.

The default payment option for Beneficiaries residing in other states may be different. For more information on those benefit options, please contact ING at 888-238-4840.

- **Effective October 15, 2012,** the Board of Trustees announced an enhanced delivery of the flu shot benefit for Fund participants. Effective for flu shots given October 15, 2012 and after, you may get your flu shot at any Giant or Safeway pharmacy at **no cost to you** using your Medco Prescription Drug ID card! Simply go to your Giant or Safeway pharmacy, show your Medco ID card, and receive your flu shot.

  Flu shots will also continue to be covered under your medical benefits as they have been, if you prefer to get your shot from your doctor or don't live near a Giant or Safeway pharmacy. For those with Fund medical, the injection itself is covered at 100% up to the Usual, Reasonable, and Customary fee, and the office visit charge (if there is one) is covered under your Major Medical or Comprehensive benefit (80% for Plan I), 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 just as any other medical claim.

  For participants in Kaiser Permanent 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 Medco for their prescription benefit have the choice to have their shots administered at a Giant or Safeway pharmacy using the Medco ID card.

- **Effective October 15, 2012 – the flu shot is free with Medco Rx card at Giant or Safeway Pharmacies.** The Board of Trustees announced an enhanced delivery of the flu shot benefit for Fund participants. Effective for flu shots given October 15, 2012 and after, you may get your flu shot at any Giant or Safeway pharmacy at **no cost to you** using your Medco Prescription Drug ID card! Simply go to your Giant or Safeway pharmacy, show your Medco ID card, and receive your flu shot.

  Flu shots will also continue to be covered under your medical benefits as they have been, if you prefer to get your shot from your doctor or don't live near a Giant or Safeway pharmacy. For those with Fund medical, the injection itself is covered at 100% up to the Usual, Reasonable, and Customary fee, and the office visit charge (if there is one) is covered under your Major Medical or Comprehensive benefit (80% for **Plans I** and X, or 75% for Plan XX), 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 just as any other medical claim.

  For participants in Kaiser Permanent 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 Medco for their prescription benefit have the choice to have their shots administered at a Giant or Safeway pharmacy using the Medco ID card.

- **Effective June 1, 2012,** ***FELRA & UFCW Retiree Health & Welfare Plan,*** as a result of Collective Bargaining, the following change has been made to the Kaiser Medicare HMO retiree program:
  - The office visit copayment will change from $10 to $15 per visit.
  - There will be a $100 inpatient deductible which will apply to the first inpatient admission during each benefit period (calendar year).

The prescription drug co-payments will change from:

- $5 to $10 for mail order scripts (90 day supply),
- $10 to $15 for scripts obtained at a Kaiser center, and
- $15 to $25 for scripts obtained at another retail outlet.

- **Effective April 2, 2012, Medco Health Solutions, Inc. ("Medco") merged with Express Scripts.** ***FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan.*** Your prescription benefits **remain the same.** Continue to use your Medco prescription card at the same pharmacies as before. Remember, you will receive the best discounts if you use a Giant or Safeway pharmacy. CVS, Wal-Mart, Rite Aid and Walgreens pharmacies are not part of the Fund's pharmacy network. For additional information about participating pharmacies, call (800) 903-8325. You can also log on to Medco's website at www.medco.com and click "Locate a pharmacy."

- **April 1, 2012 - Extended Time To File Medical Claims. Bargaining Change to Giant and Safeway participants in Plan I, Plan X, and Plan XX and their eligible dependents.** ***FELRA & UFCW Active Health & Welfare Plan and FELRA & UFCW Retiree Health & Welfare Plan.***

  As a result of recent collective bargaining, the Board of Trustees is pleased to announce that effective for dates of service on and after April 1, 2012, participants with Fund medical coverage have one year from the date of service to file a claim. Any medical claim incurred on or after April 1, 2012 will be subject to this timeframe.

  Also, you now have 45 days from the post mark date on a request from the Fund for additional information to return the information to the Fund office. Previously, this timeframe was 30 days.

- **Effective June 1, 2012,** as a result of Collective Bargaining, the following changes have been made to Plan I for non-Medicare Retirees and/or Dependents enrolled in CIGNA:

  - The co-insurance for non-Medicare retirees covered by the CIGNA self insured HMO will change from 90% to 80%.
  - The deductible will increase to $300 per person, per Plan Year, and the out-of-pocket maximum will increase to $4,000 per person, per Plan year. The CIGNA Plan Year is from June 1st – May 31st each year.

- **Effective April 2, 2012,** Medco Health Solutions, Inc. ("Medco") merged with Express Scripts. **Your prescription benefits remain the same.**

- **Effective January 1, 2011.** Below is a Notice that we are required by federal law to send to you. This notice applies to participants with traditional Fund coverage, not HMO coverage. 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, rehabilitation, substance abuse and physical exam 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.

  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.

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 Food Employers Labor Relations Association& United Food and Commercial Workers 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 I**	**PLAN I RETIREE**	**PLAN X**	**PLAN XX**
Comprehensive Medical[1]	$400,000	$400,000	$400,000	$100,000
Rehabilitation[1]	$25,000	$25,000	$25,000	$25,000
Substance Abuse	$1,000	$1,000	$1,000	$1,000
Physical Exam	$200 (once every two years)	$200 (once every two years)	N/A	N/A

[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 of 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.

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.

- **Effective April 1, 2012 – Bargaining Change to Giant and Safeway participants in Plan I, Plan X, and Plan XX and their eligible dependents.**

  As a result of recent collective bargaining, the Board of Trustees is pleased to announce that effective with dates of service April 1, 2012 and after, participants with Fund medical coverage have one year from the date of service to file a claim. Any medical claim incurred on or after April 1, 2012 will be granted this timeframe.

  You now have 45 days from the post mark date on a request for additional information to return it to the Fund office. Previously, this timeframe was 30 days.

Notice of Grandfathered Health Plan

This is to notify you that the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund ("Fund") qualifies as a "grandfathered health plan" 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 the Fund qualifies as a grandfathered health plan, 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 the Fund. However, the Fund offers 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 Fund to stop being treated as a grandfathered health plan, please contact the Participant Services at 1-800-638-2972. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

- **Effective January 1, 2011.** Pursuant to the Patient Protection and Affordable Health Care Act (PPACA), effective January 1, 2011, the Board of Trustees of the FELRA & UFCW Health and Welfare Fund ("Fund") has made several changes to the Fund's Plan of benefits.

  - **Extension of Coverage for Dependent Children**

  Effective January 1, 2011, your eligible dependents include your spouse and your children, as defined below.

  Generally, your biological children, adopted children and children placed with you for adoption are eligible for medical and prescription coverage as your dependent if they are:

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

  Your biological and adopted children also will be eligible for optical benefits until the end of the calendar year in which they turn 23. Note: if you are a part-time comprehensive retiree, your biological and adopted children only will be eligible to receive medical benefits under the Plan.

  Stepchildren and children over whom you have legal custody, as well as biological children, adopted children, and children placed for adoption, who do not meet the above criteria, are eligible for coverage as your dependent if they are:

  - Under age 19 (unless eligible for student coverage)
  - Not married
  - Not employed on a regular full time basis, and
  - Dependent on you for financial support

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

  Costs of Dependent Coverage

  If you are actively working, you had the opportunity to enroll your dependent child for medical coverage under these new rules during the special enrollment period that ran from December 3, 2010 to January 4, 2011. There is no cost to Plan I participants for dependent coverage. However, if you are a part time participant or your dependent is entitled to or was offered group coverage from an employer that does not participate in the FELRA & UFCW Health and Welfare Fund, this Plan will not provide those benefits.

  If you are enrolled for Kaiser Permanente HMO coverage as an actively working Plan I participant, there is a $100 per month co-premium for HMO coverage.

  If you are a retiree and you enrolled new dependents during the special enrollment period, your retiree co-payment may have changed. Please refer to the "family" rates on the FELRA & UFCW Health and Welfare Fund Retiree Co-Pay Rate Chart, dated July 1, 2010 to see your new co-payment.

If you were eligible for, but not enrolled in Fund retiree coverage, you were given the opportunity to enroll your dependents during the special enrollment period, under the new rules stated above, provided you met the following conditions: (a) you enrolled yourself as well as your dependent for coverage; (b) you waited at least 12 months since the time you dis-enrolled (or chose not to enroll); and (c) the dependent you enrolled was covered under the Plan as your dependent at the time you retired from active work.

- **Elimination of Pre-existing Condition Exclusions Applicable to Children**

Effective January 1, 2011, the pre-existing condition exclusions under the Plan no longer apply to participants and dependents under the age of 19. Specifically, this means that the general pre-existing condition exclusion applicable to dependent children over whom a participant has legal custody is eliminated. Further, the following specific pre-existing condition exclusions under the Plan do not apply to participants and dependents under age 19: (a) the exclusion on dental work required as the result of an injury occurring before the patient was covered under the Fund (if diagnosis of injury was medical in nature); (b) the exclusion on prosthetics appliances for conditions that arose before coverage began under the Fund; (c) the exclusion for cosmetic services arising from the correction of congenital defects or conditions from traumatic injures occurring before coverage began under the Fund.

- **Retroactive Termination of Coverage**

The Fund reserves the right to retroactively terminate your and your dependents' coverage under the Plan if you or any of your dependents engage in fraud and/or intentionally misrepresent or omit a material fact relevant to your Plan coverage, or if you or your participating employer fail to timely pay any applicable premium or contribution to the Fund relating to your benefits. Failure to follow the terms of the Plan, including but not limited to failing to notify the Fund of a change in dependent status, accepting benefits in excess of what is covered under the Plan, and accepting benefits after you or your dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having full knowledge of all the eligibility terms of this Plan.

- **Michelle's Law - Effective January 1, 2010,** the following language is added at the end of the subsection entitled "Student Coverage" in your SPD:

If a dependent child enrolled in Student Coverage ceases to be a full-time student at an accredited school because of a medically necessary leave of absence resulting from a serious injury or illness, coverage under this Plan will be extended to the dependent during his or her leave of absence until the earlier of

1. the one-year anniversary of the date on which the dependent child's leave of absence began, or
2. the date on which the dependent child's coverage under the Plan would otherwise terminate in accordance with this subsection.

To be eligible for this extended coverage, you must provide the Plan with written certification from the dependent child's treating physician that his or her leave of absence from school is medically necessary and is as a result of a serious illness or injury. The extended coverage will not be provided until the date such certification is received by the Fund, but will be retroactive to the date on which his/her leave of absence began.

- **January 1, 2010, Collective Bargaining resulted in changes for Participants employed by Associated Administrators, LLC.**

Participants with Fund Medical Coverage
For participants whose medical coverage is provided through the Fund, the changes are as follows:

- A routine PSA (prostate specific antigen) test for male participants and dependents age 50 and over is covered under your medical benefits. Coverage will be at 100%, up to the usual, customary, and reasonable ("UCR") amount, with no deductible, once every 12 months.

- A routine colonoscopy is covered for participants and dependents age 50 and over, once every five years. The test is covered at 100%, up to the UCR, with no deductible.

Participants Enrolled in Kaiser Permanente HMO

For Kaiser Permanente participants, coverage has been added for prosthetics (artificial devices to replace all or part of the function of a permanently inoperative or non-functional body part). See your Kaiser Evidence of Coverage or call Kaiser's Member Services with questions.

- **Special Enrollment for Dependents – Medicaid and Children's Health Insurance Program ("CHIP") - Effective April 1, 2009.** The following is added to the Section of your SPD entitled "Eligibility for Dependents."

  If you turned down coverage for either yourself or your dependents when you were first eligible and, later, you or your dependents lose eligibility for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP"), you may be able to enroll yourself and/or your dependents for coverage under the Fund. However, you must request enrollment under the Fund within 60 days of the date that CHIP or Medicaid assistance terminates for you or your dependent.

  In addition, you may be able to enroll yourself and your dependents in this Plan if you or your dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. Again, you must request enrollment within 60 days of the date you or your dependent become eligible for premium assistance through Medicaid or CHIP, in order to be covered under the Fund.

  To request special enrollment or obtain more information, contact the Fund office.

- **Family and Medical Leave Act ("FMLA") Changes for Military Service:**

  - **Effective January 16, 2009,** the following sentence is added to the end of the section entitled "Continuation of Coverage under the Family and Medical Leave Act."

    Eligible employees are entitled to up to 12 weeks per year of unpaid leave for a qualifying exigency that arises in connection with the active military service of a child, spouse, or parent.

  - **Effective January 28, 2008,** the following is added to the end of the first paragraph under the section entitled "Continuation of Coverage under the Family and Medical Leave Act."

    You may be entitled to up to 26 weeks of FMLA leave if you are injured in military service, or to care for a family member who is injured in military service. Contact the Fund office for more information.

- **Effective August 1, 2009,** Advantica EyeCare® became your new optical provider, replacing UnitedHealthCare Vision/Spectera, previously known as United Optical. The change from UnitedHealthCare Vision/United Optical to Advantica does not affect your optical coverage.

  New ID Card

  An ID card was mailed to you from Advantica to use for your optical benefits. If you have an upcoming appointment already scheduled with a United Optical/Spectera provider, you must contact Advantica at (866) 425-2323 to see if the provider participates with them. If the provider does not participate with Advantica, any services you receive from that provider on and after August 1st will not be covered under the Plan.

  Wider Network

  Advantica has an expanded network with providers located in major malls and other convenient locations including Pearl Vision, Sears, and JC Penney, as well as many individual providers. It will be easy for you to locate a vision provider closer to home or work.

  Locating Provider

  To locate the most current providers in the Advantica network, log on to the website at http://www.advanticaeyecare.com/locate-an-eye-care-provider.aspx. Click on "Locate a Provider" and select "FELRA

& UFCW Health and Welfare Fund." The names of providers are updated regularly. You can also call Advantica's Customer Service at (866) 425-2323.

- Participants may use LabCorp or Quest Diagnostic Laboratories ("Quest") for laboratory services. To find the nearest LabCorp location, call (888) 522-2677, or go to their website www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220, or visit their website www.questdiagnostics.com/appointment to self-schedule an appointment.

- **Effective August 1, 2009,** the Board of Trustees of the FELRA and UFCW Health and Welfare Fund adopted the following change to your benefits:
  Your covered optical benefits under the Plan will remain exactly the same as your benefits under the Fund's prior optical provider. However, non-covered optical benefits will be paid differently. For example, if you select non-covered frames, you will receive a $100 allowance toward the cost of the frames, and a 15% discount. We recommend that you check with your optical provider, Advantica EyeCare, before purchasing non-covered frames, or any other non-covered service or supply, so that you know the cost that you will be responsible for ahead of time.

  You can reach Advantica's Customer Service at (866) 425-2323. Please add the above language to the "Optical Benefits" section of your SPD.

- **Effective November 1, 2008**, for participants who have Fund coverage (not HMO or Medicare Supplemental Retiree coverage), CareFirst PPO replaced OneNet PPO as the new Preferred Provider Organization ("PPO"). Starting November 1, 2008, 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 usual provider fees. In late October, you received a new Fund ID card showing CareFirst as your new PPO provider and SHPS as your utilization management provider. It is very important that you show this new ID card to all providers of care and tell them your coverage has changed. This will ensure your claim is filed on time, and sent to the right place.

  Locating a CareFirst Provider

  - Go online to the CareFirst website, www.CareFirst.com. Click on "Members and Visitors," then click on "Find a Doctor." Under "Search the Provider Type," click on either medical or facilities, depending upon your needs. If you are looking for a medical plan, white ID card holders should search under the heading at the bottom of the page which says, "Other Networks," then choose the "PPO-National/International Blue Cross Blue Shield Directory" link. Green ID card holders should look under the header "Select Your Medical Plan" and choose "BluePreferred (PPO)."
  - To locate a provider by telephone, green ID card holders should call (800) 235-5160 and white ID card holders should call (800) 810-2583. These numbers are on your ID card.

- **Effective November 1, 2008,** for participants who have Fund coverage, not HMO or Medicare Supplemental Retiree coverage, Carewise Health, a SHPS Company, replaced Optum/CARE Programs as your new Utilization Management ("UM") and Case Management provider. Value Options still handles your mental health benefits.

  Starting November 1, 2008, you must contact SHPS to pre-certify ALL non-emergency or elective hospital stays and within 24 hours after an emergency admission. To pre-certify, call SHPS toll free at 866-511-1462. Remember, you must certify all hospital stays in order for the Fund to pay any benefits related to the hospital stay. This is very important!

  A new Fund medical ID card showing SHPS as your new UM provider was sent to all participants who have Fund, not HMO, coverage. It is very important that you show your new ID card to all providers of care!

  SHPS Case Management

  If you have a sudden illness or injury or a chronic, ongoing health condition, SHPS (also called Carewise Case Management) will provide a specially trained registered Nurse (backed by a team of board-certified specialists) to assist you in managing your condition.

Your Case Manager will establish a personal relationship with you and your family, answer questions about your diagnosis and treatment options, help you navigate the healthcare system and make sure that all your care providers are working together on a clear and focused treatment plan that will ensure you the best possible outcome.

Your Case Manager will also help you maintain continuity of care as you work with various doctors, specialists and other providers. This includes reviewing your treatments and procedures at every step of the way, to make sure that each meets nationally recognized standards of evidence-based medicine.

- **Effective October 1, 2008**, Medco Health Solutions, Inc. ("Medco") became your new prescription drug provider. Also, Accredo has replaced Ascend as your specialty pharmacy provider. A new prescription drug ID card and a Welcome Packet from Medco were sent to participants. The Medco prescription card replaced the white NMHC prescription card. However, your prescription drug coverage (such as your co-pay or rules of the Plan) did not change.

Pharmacy Network Change

You will receive the best discounts if you use a Giant, Safeway, or SuperFresh pharmacy. Effective September 30, 2008, CVS, Wal-Mart and Rite Aid pharmacies are no longer part of the Fund's pharmacy network. Prescriptions filled at these pharmacies will not be covered under the Plan .

For additional information about participating pharmacies, call Medco Member Services at 1-800-903-8325. You can also log on to Medco's website at www.medco.com and click "Locate a pharmacy."

- As a result of Collective Bargaining, benefits changed effective July 1, 2008, for actively working participants with Giant, Safeway and Giant Delaware, and effective November 1, 2008, for actively working participants employed by SuperFresh with Fund Medical Coverage.
  - Routine PSA tests (prostate specific antigen tests) for male participants and dependents age 50 and over are covered at 100%, up to the usual, customary, and reasonable ("UCR") amount, with no deductible, once every 12 months.
  - Routine colonoscopies for participants and dependents age 50 and over are covered at 100%, up to the usual, customary, and reasonable ("UCR") amount, with no deductible, once every five years.

Annual Deductible for Plan I Participants: The annual deductible increased from $200 to $300 per calendar year. If you already met the $200 deductible for 2008, the Fund office will simply apply another $100 for the deductible on future claims for the remainder of 2008. If you have not yet met the $200 deductible for 2008, you now need to meet a $300 deductible before benefits will begin to be paid. No claims will be reprocessed.

The new deductible began with claims incurred November 1, 2008 and after for actively working participants employed by SuperFresh. For actively working participants with Giant, Safeway and Giant Delaware, the new deductible began with claims incurred July 1, 2008 and after.

Participants Enrolled in Kaiser Permanente HMO

For Kaiser Permanente participants, coverage has been added for prosthetics (artificial devices to replace all or part of the function of a permanently inoperative or non-functional body part). See your Kaiser Evidence of Coverage or call Kaiser's Member Services with questions.

Please make the following corrections to your SPD:

- On page 84, under "Diabetic Benefit," please change the first sentence to read: If you or a covered dependent have Diabetes Mellitus, you may be reimbursed up to $500 **every year** for the cost of blood sugar monitors (like Glucometer and Accu-Check) and other supplies, such as Chemstrips.

- In the Exclusions and Limitations section, page 118, add the following exclusion: "Services of a Physician's Assistant ("PA") are not covered."

- The following is a clarification to the section "Anesthesia Services," located on page 107 of your SPD. Please add the following to that section: The Fund covers the services of a Certified Registered Nurse Anesthetist ("CRNA") when administering anesthesia, but ***only*** if an anesthesiologist is not also administering anesthesia.

If you receive anesthesia and the Fund is billed for the services of both a CRNA and an anesthesiologist for the same operation, the Fund will pay only the anesthesiologist, not the CRNA. Services of a CRNA are only covered if an anesthesiologist has not billed the Fund.

- On page 115, under the "Physical Exam Benefit" section, change the third sentence to read: You may use the full amount of the benefit yourself, your spouse may use the full amount, or you and your spouse together may use the full amount – for example, up to ***$100*** for you and up to ***$100*** for your spouse. The combined total per member and spouse is ***$200***.

  Delete the section "If You Reach The Benefit Maximum" on page 115 and refer to page 112, "If You Reach The Benefit Maximum."

- **The following is intended to clarify the description of a second Qualifying Event, found in the COBRA Section** of your Summary Plan Description ("SPD") in the fourth paragraph under the heading "Notification Requirements" (see page 29 of the Plan I SPD.)

  If you become eligible for COBRA Continuation Coverage under the Plan as a result of your termination of employment or a reduction in your hours, and you elect to receive COBRA Continuation Coverage for yourself and your dependents, generally you and your dependents will be entitled to continue your COBRA Continuation Coverage for up to 18 months, subject to the limitations described in your SPD. If, during that 18-month Coverage period, a second qualifying event (described below) occurs, your dependents may be eligible to receive an additional 18 months of COBRA Continuation Coverage, for a total of 36 months of Coverage. Under no circumstances will COBRA Continuation Coverage extend beyond 36 months.

  Second qualifying events include the death of the Participant, divorce or separation from the Participant or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund. The events described in this paragraph are second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. Consequently, since the Plan's eligibility rules permit active Participants and their dependents to remain covered after the Participant becomes eligible for Medicare, eligibility for Medicare is not a second qualifying event (so it does not extend COBRA coverage).

  Here are some examples of how these rules work:

  1. You and your dependents are currently receiving COBRA Continuation Coverage under the Plan for an 18-month period as a result of your termination of employment. If you and your spouse are divorced during that 18-month period, your dependents would be entitled to extend their COBRA Continuation Period for an additional 18 months.

  2. You and your dependents are receiving COBRA Continuation Coverage under the Plan for an 18-month period as a result of your termination of employment and, during that 18-month period, you become eligible for Medicare because you have attained age 65. Your dependents will not be entitled to extend their period of COBRA Continuation Coverage under the Plan, because your eligibility for Medicare would not have caused you to lose coverage under the Plan if you were still an active Participant under the Plan on your 65th birthday.

  Please remember that your spouse and dependents must notify the Fund office in writing and in accordance with the notification procedures described in your SPD in order to extend their period of COBRA Continuation Coverage upon the occurrence of a second Qualifying Event.