For Your Benefit

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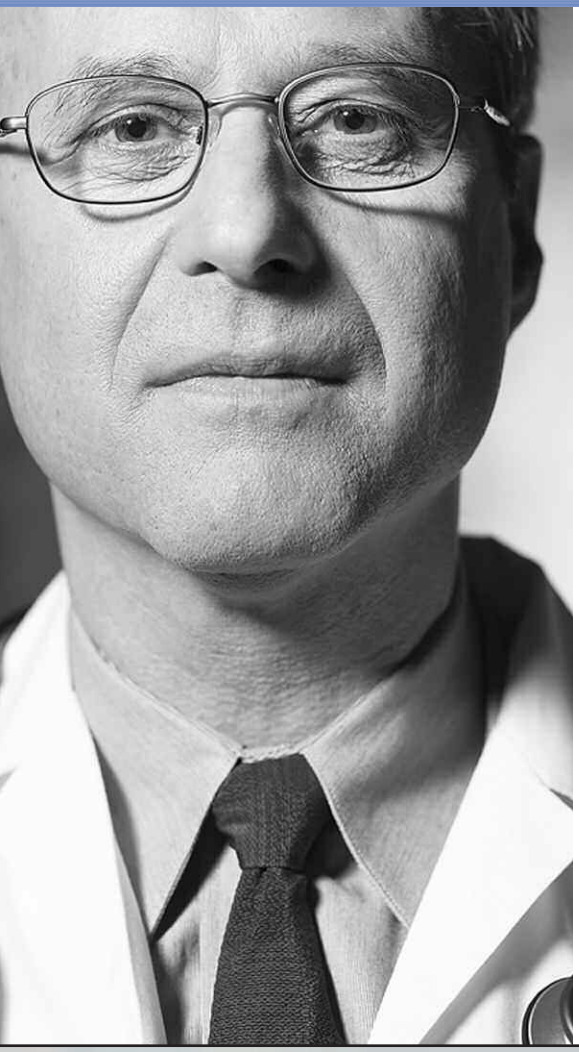

Great health benefits for our participants

Providing the best care available

Your participation in the UFCW & Employers Benefit Trust entitles you to some of the best health care benefits available.

Coverage includes preventive care — in many cases, preventive care is paid in full. For most care, you just pay your deductible and coinsurance — the Trust Fund may pay up to $2 million for the medical care you require. You can even obtain the prescription drugs you need just by paying your copay.

Our goal is to continue to provide you with the best health care benefits available today. However, not all Americans are so fortunate.

Despite spending about $1.8 trillion every year, Americans remain in the grip of a health care crisis.

In the past seven years, health insurance premiums for family coverage increased by close to 80%, compared to a 17% rate of overall inflation during the same period.

The average annual cost for family health care is now more than $12,000. Many employers state that they can no longer afford to pay for the total cost of health coverage and have shifted some of the burden to employees.

Half of Americans with health coverage said that an employer had cut back on benefits. Companies have redesigned their plans to add participant-paid premium requirements

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For Your Benefit is a quarterly newsletter designed to keep all members informed about how to use their benefits most effectively.

Members also may contact their Union's Benefit Clerks or call the nearest Trust Fund office directly:

(800) 552-2400

Phone hours for the Trust Fund's Member Services Department are 7:30 a.m. to 5:30 p.m., Monday through Friday.

Also in this issue...

UFCW-Employers Benefit Plans
of Northern California
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Great benefits for participants

(Continued from front page)

for covered dependents, multi-tiered eligibility levels with different coverage at each level, and increased deductibles, copays and coinsurance.

Other employers are encouraging their workers to go overseas for some surgeries. A hip replacement surgery that costs $40,000 in the U.S. costs about $8,000 in such countries as India, Singapore, Thailand and South Africa.

Statistics illustrate the grim scope of the problem:

- Only 60% of Americans receive employment-based health insurance.
- The percentage of companies that provide no health insurance is close to 40%.
- Some 47 million people remain uninsured, an increase of more than seven million since 2000.
- Most people who don't have health insurance are employed or are dependents of people who are employed.
- An estimated 18,000 uninsured Americans die each year because they lack access to quality health care. The reason is simple: they often skip necessary health care because they cannot afford it. This can lead to more serious illnesses that require treatment in emergency rooms or hospitals at much higher expense.

Costs keep going up

- In 2004, the United States spent $6,400 on health care for every man, woman and child. By 2014, that amount is expected to rise to $11,000.
- Health care now accounts for more than 15% of the U.S. Gross Domestic Product. In other advanced countries that figure is only 9%.
- 95% of employees with family coverage now pay an average of $3,000 a year toward premiums, deductibles, copayments and other costs. Employers who provide coverage now pay nearly $9,000 per employee for health care.
- 6.8 million Americans who have health insurance spend more than one-third of their income on health care.
- Medical debt is the most common cause of bankruptcy. Among those filing for medical bankruptcy, 76% had health insurance when they first became sick.

Non-PPO and Out-of-Area providers

Outpatient Hospital and Ambulatory Surgical Centers

The Trustees have amended the Plan to limit the amount the Plan will pay when you use a non-PPO provider, including out-of-area providers, for outpatient surgery facilities. These facilities include the outpatient department of a hospital or a freestanding surgical facility, sometimes called an ambulatory surgical facility. Some facilities specialize and perform only certain procedures, like eye surgery or colonoscopy.

Effective Jan. 1, 2009, the Plan will pay up to $1,000 for non-PPO outpatient surgery facility expenses. The surgery facility expenses are subject to the annual deductible and co-insurance. In addition, you will be responsible for all expenses charged by any non-PPO facility that exceed $1,000. Out-of-area benefits apply if you live more than 30 miles from a PPO provider, so the lower deductible and co-insurance apply. However, the new $1,000 maximum applies to out-of-area non-PPO providers. The $1,000 limit does not apply in the case of an emergency.

Due to this plan change, be sure your doctor (including PPO network providers) knows that you need to utilize a PPO outpatient surgical facility. For most people, the PPO network is Anthem Blue Cross. Visit their website at www.anthem.com/ca to verify that the facility is in the PPO. For retirees who live outside of California, the PPO network may be ppoNEXT. To find a network provider, visit their website at www.pponext.com. (Note: ppoNEXT is not available in all states. Please contact the Fund office for more information.)

Example: You use a non-PPO outpatient surgical facility. The facility charges $10,000 for your care. The deductible and coinsurance for your plan level will be applied when the claim is processed. But payment will be limited to $1,000. The Plan would pay only $1,000 of the $10,000 charge — leaving you responsible for the $9,000 balance.

The $1,000 limit applies to any non-PPO outpatient surgical facility, even if your doctor is a PPO provider.

For Your Benefit is an official publication of the
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MERGER: UFCW & Employers Benefit Trust works for you

As we informed you previously, the UFCW Bay Area Health and Welfare Trust Fund (Bay Fund) and the UFCW Northern California Health and Welfare Trust Fund (NoCA Fund) have merged, effective Jan. 1, 2009. The new name of the Fund is the UFCW & Employers Benefit Trust.

The Trustees and the Trust Fund Office (or Staff) have been working all year to implement the changes needed to make the merger as simple and seamless as possible for all participants. PPO and Health Net members will receive ID cards reflecting the new name, however, you will continue to access your benefits under the merged Fund in the same way and from the same providers as you have previously, and the Fund's administrative offices remain the same.

If you recently changed plans through open enrollment, those changes will apply to your benefits under the UFCW & Employers Benefit Trust.

If you have any questions, you may call the Trust Fund office at (925) 746-7530 or (800) 552-2400.

New combined Sick-Leave and Disability Extension Form

The Sick-Leave form and the Disability Extension application have been combined into one form.

You will no longer be required to obtain separate physician certifications for your Sick-Leave claim and Disability Extension application. One doctor's certification can be used for both. For privacy reasons, you may choose to complete the Employee's Statement section of the form *after* your employer completes its portion.

In order to receive Sick-Leave benefits on the first day of your absence, you must be seen and treated by a physician during your period of disability; otherwise benefits will begin on the second day of your disability. Telephone advice does not satisfy the requirement to be seen by a physician.

If you are disabled for more than seven calendar days (three days if the disability is caused by work), you must file for State Disability Benefits (SDI) or Workers' Compensation Benefits (WC). Any amount you can receive from State Disability or Workers' Compensation will be deducted from your Sick-Leave pay. The combined amounts will equal your straight time wages for the period you were unable to work. Attach a copy of your SDI statement of benefits or Worker's Compensation Benefit notice to your Sick-Leave Claim form.

If The Trust Fund receives your claim form without your SDI statement, the Trust Fund will expedite payment for your first week of disability based on estimated SDI benefits. When you receive your SDI or WC benefit notice, mail a copy of the notice to the Trust Fund. If the amount of SDI or WC that you actually received was less than what the Trust Fund estimated, the Trust Fund will reconsider your claim and pay any additional benefits that are due. You will be required to return any overpayments.

If you fail to file for State Disability Benefits, your Sick-Leave benefits will be reduced by the maximum State Disability benefit.

Timely filing limit

If you do not file your application by the deadline, you will be disqualified for the Sick-Leave Benefit and/or Disability Extension. The filing deadlines are:

- Disability Extensions: Must be filed within 60 days from the date you receive your COBRA/Loss of Eligibility notification for Disability Extension;
- Sick-Leave: Must be filed one year from the first day of your disability.

To be eligible for a Disability Extension:

- Your disability must begin during a work month in which you are eligible for benefits.
- Your total Qualifying Hours for the month in which your disability begins can be a combination of actual hours worked and hours not worked due to disability. The hours you are unable to work because of your disability plus the hours you actually worked, if any, must equal or exceed the minimum monthly Qualifying Hours required to maintain eligibility.
- If your disability lasts more than seven calendar days, you must submit proof of your disability. You can request that your doctor complete the Physician's Statement Section or attach the notification you received from State Disability or Workers' Compensation for benefits paid to you for the calendar month(s) for which the extension application is made.
- If your Disability Extension Application is granted but you remain disabled when your extension expires, you must file a new application within 60 days from the date the last Disability Extension expired.

You will receive notification from the Trust Fund office when your application is processed. To obtain a form, contact the Trust Fund office or your Union Local.

Did you return your Annual Update Form?

Each year, participants are required to confirm and/or update vital information that is needed to process their benefits by completing the Annual Update Enrollment Form.

Nov. 30, 2008 was the deadline to return your Form if you wanted to make benefit plan changes. If you missed the Nov. 30 deadline, no medical or dental coverage changes can be made; however, you are still required to review, sign and return your Form. If your Form was returned to you because it was incomplete, please follow the instructions to complete and return your Form as soon as possible. Please note that even if the information on the Form is correct and you do not want to make any changes, you are still required to sign and return the Form.

Failure to return your completed Form will result in the denial of claims payments until the Trust Fund office receives your completed Form. Additionally:

- You may not receive important notices about your benefits because the Plan may not have your correct mailing address;
- Your beneficiary information may not be current;
- Health care providers may not be able to verify your coverage;
- You and your covered dependents' claims will be denied and you may face delays when you need to use your benefits; and
- If your marital status changes and the Trust Fund office is not notified in a timely manner, claims may be paid in error and you will be responsible for repaying the Trust Fund for any claims paid because you did not provide this information in a timely manner.

In the unlikely event that you did not receive an Annual Update Enrollment Packet or if you need another Form, please contact the Trust Fund office at (800) 552-2400.

Reminder

- You must return your Annual Update Form or claims will be denied
- Anthem Blue Cross and Health Net will send new medical ID cards reflecting the new merged Fund name.
- HMC is your new EMAP Provider. You must contact HMC *before* receiving any services or treatment for mental health or chemical dependency in 2009. Call HMC at (877) 845-7440.

Protect yourself in this flu season

Flu season begins as early as October and ends as late as May. You can reduce your risk of getting the flu this winter by getting a flu shot now. It is especially important for:

- Children from 6 months through 19 years of age;
- Adults age 50 or older;
- People with certain chronic conditions; and
- Women who are pregnant or expect to be pregnant during flu season.

Since some people should not get a flu shot, talk to your doctor before receiving one — especially if you have health issues.

There is still time to protect yourself from the flu this season by getting a flu shot now.

This year, a special program for active employees covered under the new 2007 Collective Bargaining Agreement language will help make flu shots both convenient and free for many PPO participants. Many grocery stores, pharmacies and other entities offer flu shots, which makes access to flu shots convenient. However, the flu shots received at these locations are usually considered a non-PPO benefit.

This flu season, under a special program, Raley's, Safeway and Save Mart pharmacies will be considered PPO providers under the preventive care provisions of the PPO medical plan so that many participants can get their flu shots from the same pharmacy that they already use for their prescriptions.

Show your medical ID card at these pharmacies and you can get your flu shot for free. This benefit also applies to your spouse or domestic partner.

If you are in Plan C/Standard, immunizations are usually subject to the regular plan provisions. Under this special program, Plan C employees can receive a free flu shot. Remember, you must use the flu shot clinics at Raley's, Safeway or Save Mart pharmacies.

You do not need to be an employee of one of these stores or receive your shot at the store where you work to take advantage of this benefit. You must, however, be covered under a new collective bargaining agreement (CBA). These special provisions apply only to PPO enrollees in Plan A/Premier, Plan B Ultra and Plan C/Standard under a new CBA. They do not apply to HMO enrollees, retirees or active participants under an earlier CBA. If you have questions regarding your eligibility for this new program, please call the Fund Office at (800) 552-2400.

Some basic steps can also help avoid spreading or contracting a cold or the flu.

Cover your mouth when you sneeze and cough. Wash your hands well and often; use sanitizing gel if soap and water are unavailable. Avoid touching your face, eyes, nose and mouth. Get plenty of sleep, eat properly and exercise, and remind children to follow these guidelines also.

For more information on vaccine availability, call your doctor or log onto www.fluclinicslocator.org.