

**IMPORTANT INFORMATION
ABOUT YOUR BENEFITS!
YOUR ACTION IS REQUIRED
TO MAINTAIN YOUR COVERAGE!**

FOR YOUR BENEFIT

Special Edition for Retirees



**UEBT
RETIREE
HEALTH PLAN**

Open Enrollment January 14 - January 31

Online only — visit www.ufcwtrust.com

**FAILURE TO COMPLETE OPEN ENROLLMENT MAY RESULT
IN THE PERMANENT LOSS OF BENEFIT COVERAGE**

Announcing the UEBT Retiree Health Plan

Big changes to your benefits will be effective on March 1, 2013

Important changes are on the way for retirees served by the UFCW & Employers Benefit Trust. The plan for retirees is now known as the UEBT Retiree Health Plan.

Beginning March 1, 2013, the health benefits of retirees will have new and unique features. This special edition of *For Your Benefit* outlines how your benefits and out-of-pocket costs will change under the Plan.

The new plan for retirees reflects inescapable economic realities, including unchecked inflation in health care costs. Some out-of-pocket costs will increase and some benefits will be adjusted to reflect these realities. Nevertheless, it is important to emphasize that retirees still have a health plan they can count on, providing security and peace of mind for participants and their loved ones.

Throughout the country, Americans typically lose their employment-based health plans upon retirement and must purchase their own health insurance. The new retiree health plan is designed to preserve health coverage by improving efficiency and eliminating unnecessary costs wherever possible.

This newsletter is a Summary of Material Modifications that describes changes to the UEBT Retiree Health Plan. Please read it carefully and keep it with your Summary Plan Description and other Plan information. The Trustees reserve the right to amend, modify or terminate the Plan at any time.

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IN THIS ISSUE

- How to participate in **OPEN ENROLLMENT**
- How your **MONTHLY COSTS** are changing
- How your **MEDICAL COVERAGE** is changing
- How your **PRESCRIPTION** benefits are changing
- How coverage of **DEPENDENTS** is changing



The UEBT Retiree Health Plan

Elements of the new plan

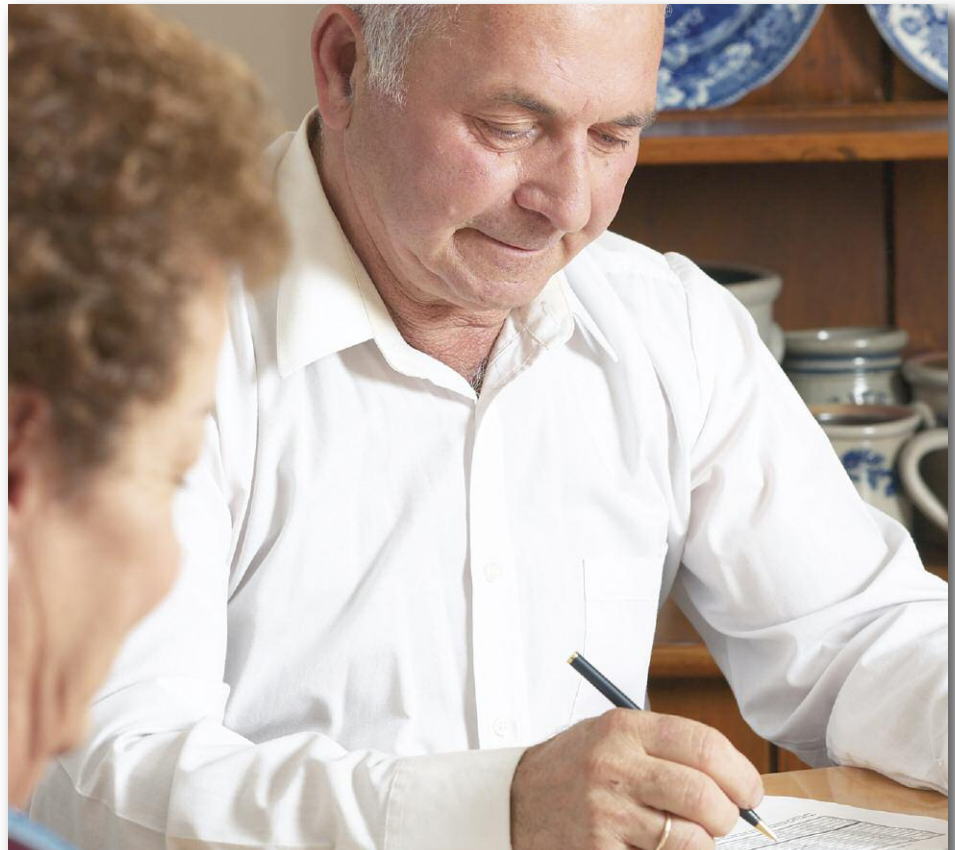
Key elements of the benefit changes include the following:

- **Monthly premiums** will be determined by how many Years of Credited Service the retiree earned towards retirement (see page 3).
- **When the Plan is the secondary payer**, Coordination of Benefits will change to calculate Plan payments on a Non-Duplication of Benefits basis (see pages 4-5).
- **Retirees, spouses, domestic partners or dependent children of covered retirees** who have access to an employment-based plan must enroll in that plan (see page 6).
- **HMO benefits will change** — Health Net and Pacificare will no longer be available for “early” (non-Medicare) retirees. All enrollees in Kaiser’s HMO will see some changes in costs and supplemental benefits (see page 7).
- **The new Market Priced Drug program** will help retirees and their covered dependents and their doctors identify and use lower-cost but therapeutically

equivalent prescription drugs for treating some common health conditions (see pages 8-9).

- **Benefits and coverage of dependents** will change (see pages 10-11).
- **Other changes** are included in the UEBT Retiree Health Plan (see pages 12-13).

This Special Edition newsletter also provides answers to some **frequently asked questions** about the UEBT Retiree Health Plan (see page 14). Instructions for participating in the **online-only Open Enrollment**, Jan. 14-Jan. 31, 2013, are listed on page 16.



Effective as of January 1, 2013, the UEBT Retiree Health Plan will be established and operated as a retiree-only plan under the Affordable Care Act. This means that it is not intended to cover any active employees (except as dependents) and will be a separate and distinct plan from the UEBT Health Plan. Retiree-only plans are exempt from many federal health benefit mandates, including, but not limited to, the Affordable Care Act, HIPAA portability rules and the Mental Health Parity Act. Other rules, like HIPAA privacy rules, still apply. For more information on benefits covered or excluded under the UEBT Retiree Health Plan, refer to the SPD and this notice regarding your benefits.



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Monthly premiums will reflect years of service earned toward retirement

Under the UEBT Retiree Health Plan, those who retired with more years of credited service will have a lower monthly premium than those with fewer years of credited service.

The chart below identifies the monthly premium amount based on “years of credited service.”

A person who retired with 35 or more years of credited service will pay lower premiums than someone who retired with between 25 and 34 years of credited service, and both will pay less than someone who retired with fewer than 25 years of credited service.

A “year of credited service” generally is defined as a year of full-time work (1,800 or more hours). Partial years are credited, provided the

participant worked at least 150 hours in a year.

The Trust Fund office will send you a letter identifying your category of credited service before Open Enrollment begins so you will know which service group level applies to you. Please do not call the Trust Fund office in advance of Open Enrollment for this information.

Eligibility

Effective Jan. 1, 2014, the eligibility requirement for the UEBT Retiree Health Plan will increase from 15 to 20 years of service. However, any participant who has satisfied the prior “15 years of service” requirement on or before the effective date of this change will **remain eligible provided all other requirements are met.**

MONTHLY PREMIUMS FOR RETIREES		
Years of Credited Service	Non-Medicare Retirees	Medicare Retirees
35 or more years	\$250 per family	\$50 per person
25-34 years	\$275 per family	\$75 per person
Less than 25 years	\$300 per family	\$100 per person

The spouse or domestic partner’s rate is determined by the retired member’s status (Non-Medicare vs. Medicare).

You will be required to complete a new Authorization to Deduct form online if you would like your monthly premiums for coverage deducted from your monthly pension payment. If your monthly pension payment is not enough to cover your monthly premiums, you may request to be billed. If you do not provide for timely payment of premiums your coverage will be terminated permanently and you will not be able to enroll in the future.



How your medical benefits will change

Coordination of Benefits (COB) with Medicare and other plans to be provided on a Non-Duplication basis

In addition to coverage under the Plan, you and/or another enrolled family member may be covered under another health care plan such as Medicare or another active/retiree health care plan through employment.

Coordination of benefits operates so that one of these plans, called the primary plan, will pay its benefits first. The other plan, called the secondary plan, may then pay additional benefits.

In no event will the combined benefits of the primary and secondary plans exceed 100% of the allowable expenses actually incurred. Sometimes, the combined benefits that are paid will be less than the total expenses.

Effective March 1, 2013, the Plan will change the way it provides secondary benefits to retirees who have primary coverage through Medicare and/or other health care plans.

Instead of using the current full coordination method of providing secondary benefits, the Plan will coordinate based on a Non-Duplication of Benefits (NDB) method.

Full coordination of benefits

Under full coordination, in most cases

the Plan paid the difference between the covered amount and the amount paid by the other plan. This meant that a very small amount, if anything, was required to be paid by the patient.

For example, if Medicare or another primary insurer paid 80% of the bill, the Plan would pay the remaining 20% if the deductible was previously satisfied.

Non-Duplication of Benefits

Under Non-Duplication of Benefits, the retiree will pay the same out-of-pocket costs as he or she would if the Plan was the only plan providing benefits.

For example, if Medicare or another plan paid 80% of the allowed amount as primary and the Plan would have paid 75% of the same allowed amount (after the retiree's deductible), the Plan will pay nothing additional. The retiree will be responsible for the 20% remaining amount due of the allowed amount.

Another example: If the primary plan pays 70% of the allowed amount and the Plan would have paid 75% of the same allowed amount as primary, the Plan would pay the 5% difference (after the retiree's deductible).

In no case will the UEBT Plan pay

for a service that is covered under a primary plan but is not a covered benefit under the UEBT Plan.

Coordination of Benefits (COB) credit banks eliminated

Previously, when this Plan was secondary and its payment was reduced in consideration of the primary plan's payment, a record was kept of the reduction (called a "credit bank"). The amount in the credit bank was used to supplement this Plan's payments on the patient's later claims in the same calendar year — to the extent that there were allowable expenses that would not otherwise be paid fully by this Plan and the other plan.

Effective March 1, 2013, the COB credit bank benefit is discontinued and all existing COB credit banks will be eliminated.

Dual coverage

If both spouses or domestic partners are enrolled in the UEBT Retiree Health Plan and both elect the same coverage and cover all of the same dependents, then the Plan will provide full Coordination of Benefits rather than Non-Duplication of Benefits.



NON-DUPLICATION EXAMPLES

(These examples assume that all deductibles have been met. They are for illustration purposes only and are not intended to reflect every possible benefit plan calculation.)

Example 1

Primary Plan (Medicare or other group health plan)		UEBT Retiree Health Plan if no other plan coverage is available	
Billed Amount	\$8,600	Billed Amount	\$8,600
Plan Allowed Amount	\$6,500	PPO Allowed Amount	\$6,500
Plan Pays 80% of allowed amount	\$5,200	UEBT Pays 75% of allowed amount	\$4,875
Member Responsible (without other coverage) for	\$1,300	Member Responsible (without other coverage) for	\$1,625

Applying Non-Duplication of Benefits

In this case, the benefit paid by the Primary Plan exceeds the benefit that would have been paid by UEBT if there was no other coverage available*. Therefore, the amount paid by UEBT is zero. The member is responsible for \$1,300.

Example 2

Primary Plan (Medicare or other group health plan)		UEBT Retiree Health Plan if no other plan coverage is available	
Billed Amount	\$8,600	Billed Amount	\$8,600
Plan Allowed Amount	\$8,100	PPO Allowed Amount	\$7,900
Primary Plan pays 70% of allowed amount	\$5,670	UEBT Pays 75% of allowed amount	\$5,925
Member Responsible (without other coverage) for	\$2,430	Member Responsible (without other coverage) for	\$1,975

Applying Non-Duplication of Benefits

In this case, the Primary Plan paid less than what would have been paid by UEBT if there was no other coverage available*. UEBT will pay \$255, which is the difference between what the Primary Plan paid and what UEBT would have paid (\$5,925 minus \$5,670). The member is responsible for \$2,175 (\$2,430 minus the \$255 that UEBT paid).

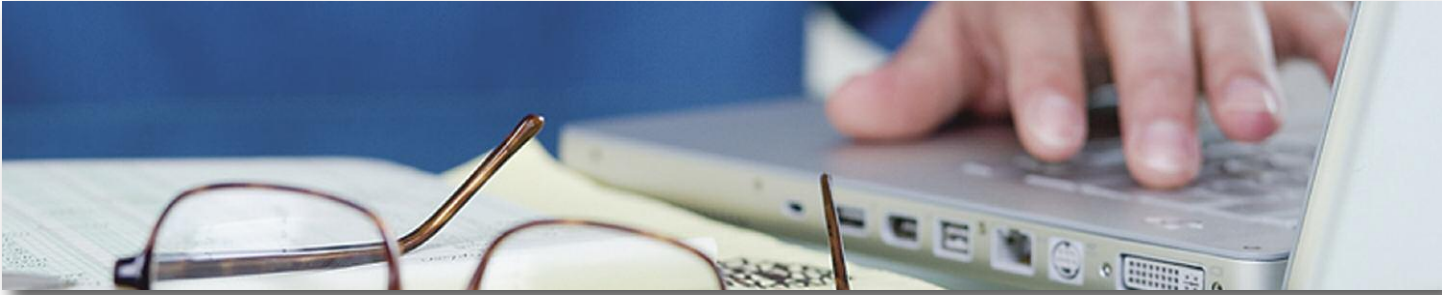
Example 3

Primary Plan (Medicare or other group health plan)		UEBT Retiree Health Plan if no other plan coverage is available	
Billed Amount	\$8,600	Billed Amount	\$8,600
Plan Allowed Amount	\$4,900	PPO Allowed Amount	\$5,500
Primary Plan pays 70% of allowed amount	\$3,430	UEBT Pays 75% of allowed amount	\$4,125
Member Responsible (without other coverage) for	\$1,470	Member Responsible (without other coverage) for	\$1,375

Applying Non-Duplication of Benefits

In this case, the Primary Plan paid less than what would have been paid by UEBT if there was no other coverage available*. UEBT will pay \$695, which is the difference between what the Primary Plan paid and what UEBT would have paid (\$4,125 minus \$3,430). The member is responsible for \$775 (\$1,470 minus the \$695 that UEBT paid).

*Note: If there is other group health plan coverage available, you are required to enroll in it or UEBT benefits will be significantly reduced.



Retirees, spouses, domestic partners and dependent children will be required to enroll in available plans

Beginning March 1, 2013, retirees, spouses, domestic partners and dependent children of retirees who have access to another employer-provided plan will be required to enroll in that plan, and must enroll in the option that is at least as comprehensive as the UEBT Retiree Health Plan in which they are currently enrolled, without regard to the cost of the plan.

- This change applies to any retiree, spouse, domestic partner or dependent child with access to either a retiree plan through a previous employer or an active plan through a current employer.
- A retiree, spouse or domestic partner who has other group coverage must enroll for coverage under the rules of the Fund, but are not required to enroll dependent children.
- The Plan will reduce benefit payments for a retiree, spouse, domestic partner or dependent child who does not enroll in a plan available through his or her employer (current or former) or who does not enroll in the plan with benefits that are at least as comprehensive as the benefits under the UEBT Retiree Health Plan.

If a retiree, spouse, domestic partner or dependent child is unable to enroll in an available group health plan until that

plan's next open enrollment, the Plan will allow a one-time grace period until that other plan's next effective date of coverage. The Plan will require documentation from that plan stating enrollment at this time is not possible and identifying the date of the next open enrollment for that plan and the effective date of coverage. During this grace period, benefit payments will not be reduced.

Signed certification on the employer's letterhead will be required to certify that a retiree, spouse, domestic partner or dependent child does not have access to other group health insurance or that changes are not allowed outside of the open enrollment period. Benefits will be reduced for dates of service on or after April 1, 2013, until this documentation is received.

Take action now.

You can send the certification, on the employer's letterhead, to the Trust Fund office at:

UEBT Retiree Health Plan
Employer Certification
P.O. Box 8086
Walnut Creek, CA 94596-8086

- Retirees will be required to certify, under penalty of perjury, whether they or their spouse, domestic partner

and/or dependent children have access to other health coverage. In addition, retirees will be responsible for reimbursing the Plan for any amounts paid by the Plan for them or on behalf of a spouse, domestic partner or dependent child that should not have been paid.

- A retiree who is not enrolled in the UEBT Retiree Health Plan but who is covered under his or her spouse's active or retiree plan may **only** enroll in the UEBT Retiree Health Plan within 60 days of losing coverage under his or her spouse's plan or the next UEBT Retiree Health Plan open enrollment after that, so long as proof of creditable coverage from the other plan is provided, and the retiree is otherwise eligible for benefits under the UEBT Retiree Health Plan.

These will be the ONLY opportunities to enroll under this circumstance.

- A surviving spouse's coverage will be permanently terminated under the UEBT Retiree Health Plan, without the ability to re-enroll, if he or she becomes covered under another plan or remarries.

Note for working retirees:
A retiree who has access to coverage through another employer-provided plan is required to enroll in that plan, according to the same rules that apply to a spouse/ domestic partner and dependent child.

How HMO benefits will change

Health Net not available to early retirees; some supplemental benefits for HMO participants ending

Retirees who are enrolled in health maintenance organizations (HMOs) will see changes in their benefits as of March 1, 2013:

- Health Net HMO will no longer be available to “early” retirees who do not yet qualify for Medicare. Health Net will *only* be available to a retiree whose spouse/domestic partner **and** eligible dependent children are Medicare-eligible.
- The Pacificare early retiree option will no longer be offered.
- The Medicare HMO hospital co-payment will increase to \$500 per admission.
- In the past, the Plan provided some supplemental benefits, such as EMAP, MedExpert, mental health, chemical dependency, acupuncture, chiropractic and hearing aid services, to HMO participants. Beginning March 1, 2013, these supplemental benefits will end. These services are generally available under your HMO plan. Review your Open Enrollment benefit comparisons and consider the best plan to meet your needs if you require these services.

Note: If a retiree does not complete Open Enrollment, benefits will be terminated. There is no longer a default option for a retiree who does not complete Open Enrollment.



Changes for non-Medicare retirees at Kaiser Permanente

Effective March 1, 2013, the following out-of-pocket costs will apply to retirees who are enrolled in Kaiser and do not have Medicare:

Annual deductible: \$500 individual, \$1,000 family, not applicable to doctor’s office and preventive visits

Out of pocket limits: \$3,000 per person/\$6,000 per family

Hospital inpatient: 20% per admission (all services)

Outpatient care (specialty, routine, eye/hearing): \$20 per visit

Outpatient surgery: 20% per procedure

X-rays and lab tests: \$10 per encounter

Ambulance: \$150 per trip

Emergency room: 20% per visit

Mental health: Inpatient psychiatric (20% per admission), outpatient individual therapy (\$20 per visit), outpatient group therapy (\$10 per visit)

Chemical dependency: Inpatient detox (20% per admission), outpatient individual therapy (\$20 per visit), outpatient group therapy (\$5 per visit)

Supplemental durable medical equipment: 20% of the cost of equipment

Skilled nursing: 20% per admission



How your prescription benefits will change

Catamaran and MPD can help you save money on prescription drugs

On March 1, 2013, the UEBT Retiree Health Plan will implement a Market Priced Drug (MPD) program for prescription drugs.

In most cases, you and your covered dependents will continue to pay the same amount for prescription drugs that you are paying now.

If you are enrolled in Kaiser Senior Advantage, the MPD program does not apply to you at this time because Kaiser physicians already prescribe medications using comparable guidelines.

About the MPD program

The new MPD program will help you and your doctor identify lower-cost prescription drugs with the same clinical effectiveness for treating some common health conditions. These drugs are called Preferred Drugs under the MPD program.

When you use a Preferred Drug to treat a condition included in the MPD program, you will pay your current co-payment. However, if you use a drug that is not on the Preferred Drug list (known as a Non-Preferred Drug), your out-of-pocket cost will be much higher.

When ordering a Non-Preferred Drug, you pay the price difference between the Non-Preferred and Preferred Drugs — **plus** the applicable brand or generic co-payment for the Non-Preferred Drug. In some cases, that difference can be hundreds of dollars.

What you need to do

If you take a prescription drug, be sure to tell your doctor about the MPD program right away. Remind him or her about the program whenever a new prescription is written.

If you are using a Non-Preferred Drug, you will receive a special letter from Catamaran, the UEBT Retiree Health Plan's pharmacy benefit manager. It will provide you with the alternative Preferred Drug, its estimated cost

MPD categories

The MPD program can help you save on prescription drug costs. Some of the most common drugs and health conditions included in the MPD program are:

- Acid reflux, heartburn and stomach ulcer
- Antidepressants
- Blood thinners
- Cardiac medications
- Diabetes
- High blood pressure
- High cholesterol
- Hypnotics and anti-anxiety drugs
- Nasal steroids and allergy medications
- Overactive bladder
- Pain, inflammation and arthritis
- Parkinson's disease

This list will be continually updated by Catamaran.

and your cost for continuing to use the Non-Preferred Drug. It will also explain how to get a new prescription for a Preferred Drug.

If you receive one of these letters from Catamaran, share it with your doctor and ask if a less costly Preferred Drug is right for you.

Your doctor knows your full medical history and which drug therapies he or she prefers, but the cost for prescriptions is determined by Catamaran and the MPD program.

If you and your doctor decide a Preferred Drug is not right for you, you may call Catamaran at (866) 635-6906, 24 hours a day, seven days a week, to request an exception. Your doctor must provide evidence of a recognized medical reason for the exception. If approved, you will pay the applicable co-payment for the medication according to the UEBT Retiree Health Plan.

For a list of medications affected by the MPD program, please visit the Catamaran website at www.mycatamaranrx.com on or after March 1, 2013.

Frequently asked questions about the Market Priced Drug Program (MPD)

Q: Why does the UEBT Retiree Health Plan have a Market Priced Drug (MPD) program?

A: The Plan is committed to providing access to the most affordable and highest quality health care possible. Prescription drugs are often an expensive part of your health care, but there are often many different drugs available to treat the same medical conditions. The MPD program helps save money that can be used more effectively in providing benefits for plan participants.

Q: How is a Preferred Drug different from a generic equivalent?

A: A generic equivalent contains the same active ingredient as a brand drug. A Preferred Drug may not have the same active ingredient as the Non-Preferred Drug, but both treat the same health condition. Preferred Drugs can be either brand-name or generic.

Q: When will my costs change?

A: The new MPD program will start on March 1, 2013. If you use a Non-Preferred Drug, you might pay more for it when you fill the prescription. You may avoid cost increases by taking action and talking with your doctor about Preferred Drugs as alternatives to Non-Preferred Drugs.

Q: How can I file a request for an exception?

A: On or after March 1, 2013, call Catamaran at (866) 635-6906, 24 hours a day, seven days a week, and ask for a MPD exception request form. Your doctor must complete and submit the form to Catamaran using the fax number on the form. Catamaran will perform a detailed clinical review and then notify you and your doctor of its decision. If you disagree with the decision, you have the right to file an appeal.

How your dependents' coverage will change

New dependent eligibility rules

The rules for qualifying dependents of retirees will change under the UEBT Retiree Health Plan as of March 1, 2013.

Some important aspects of the Plan, as it relates to dependents, include:



***Required documentation:** UEBT Full-Time Student Certification form. This form can be downloaded from the Trust website at www.ufcwtrust.com. Highlight the Resources tab on the home page and select Forms from the pulldown menu.

- A dependent child will be covered up to the age of 19 unless documentation* is provided that he or she is a full-time unmarried student or became totally and permanently disabled while covered under the UEBT Retiree Health Plan before age 19.

- Coverage is extended for full-time unmarried students until age 24.

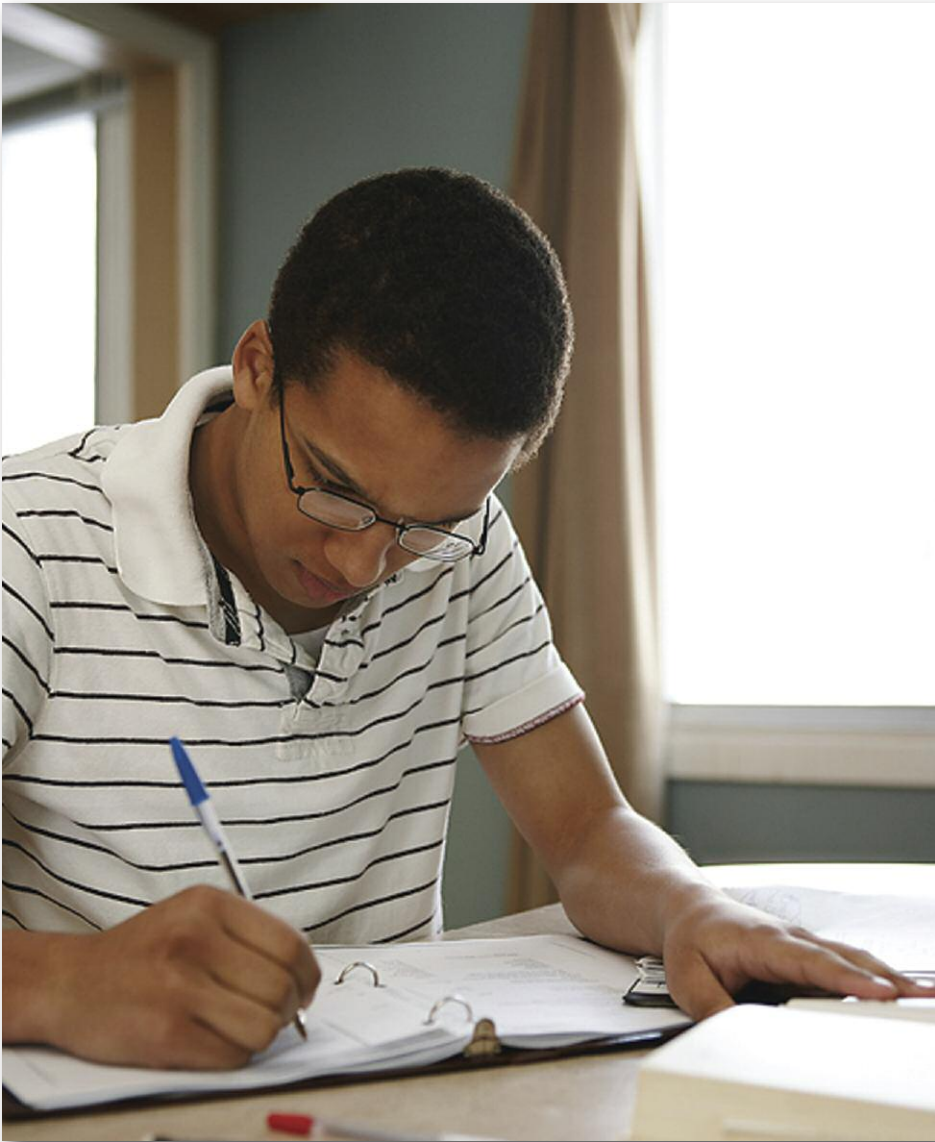
- **There is no age limit for totally and permanently disabled dependents who meet the eligibility requirements.**

Coverage will be terminated for currently enrolled dependents 19 or older who do not provide the required documentation. Coverage for any currently enrolled dependent child age 24 and older will be dropped effective March 1, 2013.

- Dependents who lose coverage because of the change in age limit are eligible to elect COBRA for up to 36 months.

Dropping coverage and re-enrolling

- If documentation certifying your dependent is a full-time student is not received by the Trust Fund office on or before March 1, 2013, the dependent's coverage will be terminated, effective March 1, 2013. If the Trust Fund



office does not receive the required documentation before April 1, 2013, the dependent cannot be reenrolled in the Plan until the next Open Enrollment period.

If the Trust Fund office terminates coverage of a dependent child of a retiree because he or she doesn't meet the requirements of a full-time unmarried student, the dependent will be allowed to re-enroll if he or she meets eligibility requirements at a later date but prior to aging out.

- A retiree and/or spouse or domestic

partner can opt out of coverage if they are covered by other group coverage from employment and provide evidence of such coverage to the Trust Fund office. Other coverage does not include Medicare (see page 13 for additional details). **In addition, if a retiree and/or spouse or domestic partner drops coverage for any reason other than because they have other group health coverage, they will be prohibited from ever enrolling again in the Plan.**

A retiree and/or spouse or domestic partner can enroll in the UEBT Retiree Health Plan due to loss of other cover-

age but must provide proof (evidence of other group coverage) within 60 days of loss of coverage.

If proof of loss of coverage and a request to enroll is not provided within 60 days of losing coverage, the next opportunity to re-enroll will be the first Open Enrollment after losing coverage. **If you do not request re-enrollment at this time, you are prohibited from ever enrolling again.**

- Effective March 1, 2013, "total and permanent disability" will be determined based on being awarded Social Security disability benefits. Dependents who have already been granted extended eligibility by the Trust Fund office will be given a reasonable amount of time to submit a Social Security disability award.

Notes about dependent children

- Effective March 1, 2013, a retiree must have at least 25 years of credited service upon retirement to enroll an unmarried dependent child, subject to the child's age and full-time student or disability status.

Dependent children of retirees with less than 25 years of credited service who are already covered by the UEBT Retiree Health Plan as of February 28, 2013, and who otherwise meet the other new eligibility requirements for dependent children, will be "grandfathered" (meaning they will remain eligible for coverage) as long as they are continuously covered by the Plan.

- A retiree's eligible dependent child may only enroll for the same coverage, including dental, as the retiree parent.



Other changes to benefits

Note: Changes will be effective March 1, 2013.

Indemnity Plan out-of-pocket maximum

The annual out-of-pocket maximum for the UEBT Retiree Indemnity (non-HMO) plan will be \$3,000 per person for in-network services. There will be no out-of-pocket limit for out-of-network services.

PPO service area

The area for Preferred Provider Organization (PPO) services will increase from a 30-mile radius of the participant's residence to within a 40-mile radius.

Surviving spouse

A surviving spouse can continue coverage until he or she remarries or becomes covered by another group health plan. A surviving spouse who remarries on or

after March 1, 2013, or who becomes covered by another group health plan, will have his or her coverage terminated under the Plan. This was an existing rule for former Valley retirees but it now will apply to all retirees.

Surrogacy pregnancy

The UEBT Retiree Health Plan excludes expenses related to surrogacy pregnancy, including child birth and expenses for the child following birth.

Future retirees of employers that leave the Plan

If you retire on or after January 1, 2013 and you worked for an employer that ceases participation in the Plan, you will be required to pay additional premiums for your coverage. You will be informed of the details of this new policy through a separate notice in the future.



Opting out

Retirees who have other group health coverage must formally opt out of the UEBT Retiree Health Plan to be able to re-enroll when the other coverage ends. To opt out while still preserving the right to re-enroll in the future, the retiree must submit proof of the other coverage at the time he or she is electing to opt out of coverage under this Plan. If the other coverage ends, the retiree must re-enroll in the UEBT Retiree Health Plan within 60 days of the date the other coverage ends or during the next Open Enrollment period with proof of other group medical coverage. Retirees who do not request re-enrollment during one of these periods will forfeit participation in this plan forever.

Vision care benefit

The retiree vision care benefit, previously available in some areas on a self-pay basis, will now be included as part of the medical and prescription benefits at no additional cost.

Medicare Part B

Effective March 1, 2013 under the UEBT Retiree Health Plan, Medicare Part B premiums will no longer be reimbursed for any retirees. Note: Not all retirees were previously eligible to receive reimbursement for Medicare Part B.

Dental

Current retirees who, while employed, were enrolled in Delta Dental will continue to have Delta Dental as an option. All other retirees, including new retirees who retire on or after March 1, 2013, will only be able to enroll in the indemnity dental plan.

Dependent children will not have dental coverage unless the retired member is enrolled in dental coverage.

If a retiree does not elect dental coverage during Open Enrollment, their dental coverage will terminate effective March 1, 2013.

Retiree dental coverage rates (updated annually)

- Retiree only: \$42 per month
- Retiree and spouse/domestic partner (and dependent children if applicable): \$84 per month

Changes to lifetime maximum benefit, physicals

Other aspects of the UEBT Retiree Health Plan, effective March 1, 2013, that retirees should be aware of include:

For PPO participants

Lifetime maximum benefit

The lifetime maximum benefit is \$2 million per participant.

Chemical dependency benefits

Inpatient chemical dependency

There is a lifetime maximum benefit of \$25,000, or two episodes. Outpatient chemical dependency benefits are counted toward this lifetime maximum.

Outpatient chemical dependency

There is a lifetime maximum benefit of \$25,000, or two episodes. Inpatient chemical dependency benefits are counted toward this lifetime maximum.

Annual physical

PPO and out-of-area

Retirees must pay a \$25 copayment for the exam. After your deductible has been met, the Plan pays 75% for lab and x-ray costs up to a maximum benefit of \$75 for the exam and \$100 for related lab and x-ray costs.

Non-PPO

After a participant's deductible has been met, the Plan pays for 50% of costs up to a maximum benefit of \$75 for the exam and \$100 for related lab and x-ray costs.

For HMO participants

Injectables (except insulin)

If the costs are not covered by your HMO, the Plan will pay 80% of injectables costs (except insulin). After a \$3,000 out-of-pocket maximum — per person, per calendar year — has been met, the Plan will pay 100% of costs for injectables (except insulin).

Chiropractic and acupuncture benefits

These services are no longer available. Please contact your HMO provider for coverage options.

Frequently asked questions about your benefits

**Q: I don't have online access —
how do I complete
Open Enrollment?**

A: Check with your local library or senior center — many offer free online access.

You can also ask a family member, friend or neighbor to assist you with online access and completion of Open Enrollment. If you are online and having difficulty completing Open Enrollment, there will be a toll-free number to call for assistance.

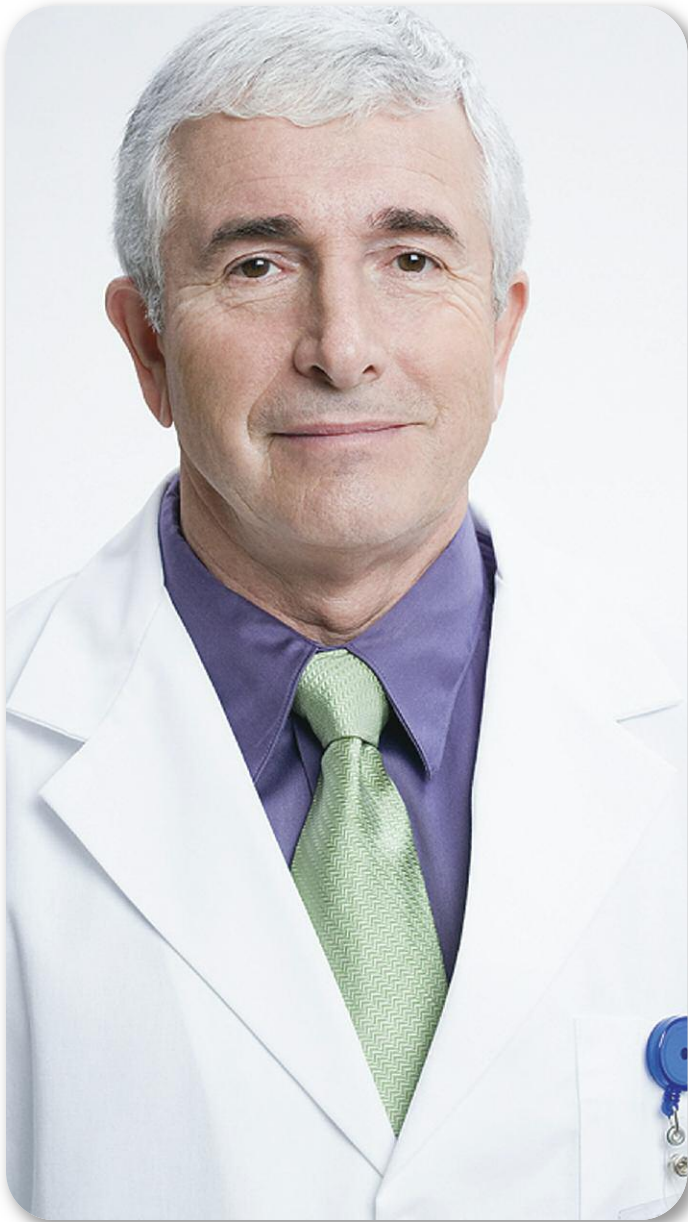


Q: I have regular chiropractic adjustments to manage osteopathic pain and flexibility. Will the Plan continue to supplement my HMO's coverage of these services?

A: No. Acupuncture, chiropractic and other alternative services for HMO participants will no longer be supplemented by the Plan. Please contact your HMO to discuss options.

Q: My spouse's company paid for health insurance while he was an active employee, but now that he's retired, the company no longer covers him. Is he eligible to share my health benefits?

A: Yes, provided he timely enrolls in this Plan after the other coverage ends (see page 6). But if his previous employer still offers a benefit plan, he must enroll in that plan.



Q: My daughter is turning 25 in a few months, but she is still in college to get an advanced degree. Can she still remain on my plan until graduating?

A: No. She may enroll in COBRA for up to 36 months to continue coverage (see pages 10-11).

Q: I found the less expensive version of my medication doesn't work as well treating my symptoms. Will I still have to pay extra if I insist on using the more expensive version?

A: An exception may be made if you obtain approval from Catamaran. You can obtain an MPD exception request from Catamaran (see contact information on page 9). Your doctor must complete and submit the form to Catamaran and then you and your doctor will be notified of its decision. Decisions are made on a case-by-case basis.

Q: I'm not sure of my credited years of service and therefore my premium, how will I know?

A: The Trust Fund office will send you a letter before Open Enrollment identifying your category of credited service.

Q: In the past, I haven't had to do anything for Open Enrollment to stay covered. Has that changed?

A: **YES.** This year, all participants must enroll and update their information online at www.ufcwtrust.com during the Open Enrollment period to maintain coverage.

Open Enrollment is being held Jan. 14-31, 2013. Failure to participate may result in the permanent loss of benefit coverage.



Open Enrollment Jan. 14-Jan. 31, 2013

Don't risk losing your coverage. Visit www.ufcwtrust.com and complete it online!

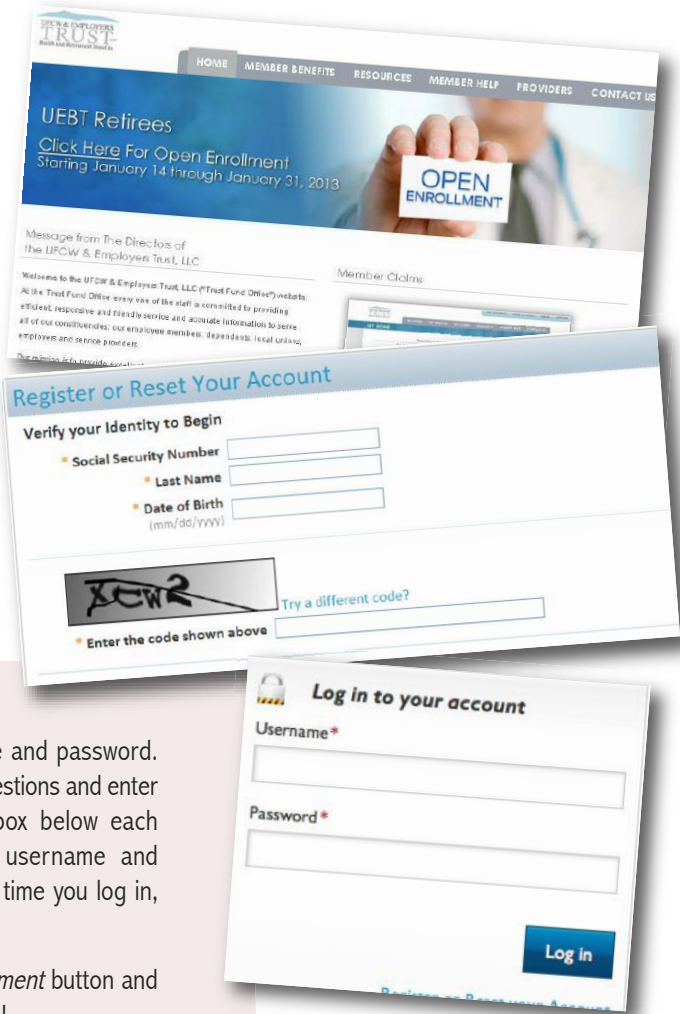
Open Enrollment will take place online beginning January 14 through January 31, 2013.

Be informed about your benefits and coverage before you start Open Enrollment for you and your dependents by reading this newsletter carefully.

This year, it will be necessary to complete the process online. **Action will be required whether you are seeking changes in coverage or not. Failure to complete Open Enrollment may result in the permanent loss of benefit coverage.**

The Trust Fund is working with the UFCW Union Locals and has organized several meetings to review these benefits and answer any questions you may have. These meetings will be held in mid-January.

You will receive a phone message with specific times and locations. Please make sure your phone number is current with the Trust Fund office. You can view your contact information on the Trust Fund website at www.ufcwtrust.com once you have registered. You can update any of your contact information directly online.



To complete Open Enrollment

1. Visit www.ufcwtrust.com beginning Jan. 14 until Jan. 31.
2. Click on the CLICK HERE text at the top of the home page.
3. Log on to the benefits portal by selecting *Register or Reset Your Account*.
4. Verify your identity by providing your Social Security Number, last name, date of birth and the code displayed on the screen.
5. Create your username and password. Choose your secret questions and enter the answers in the box below each question. Note your username and password for the next time you log in, and click Save.
6. Select the *Open Enrollment* button and you are ready to begin!

Open Enrollment January 14 - January 31, 2013

Online only — visit www.ufcwtrust.com

FAILURE TO COMPLETE OPEN ENROLLMENT MAY RESULT IN THE PERMANENT LOSS OF BENEFIT COVERAGE