FOR YOUR BENEFIT

Winter 2014 for Active Members

Know your dental benefits

The condition of your mouth is an important indicator of your overall health, so be sure to maintain your oral health by taking advantage of your dental benefits.

The dental plan options for Premier and Ultra members are:

- Premier Access DPO (Dental Provider Organization)
- Liberty Dental DMO (Dental Maintenance Organization, only available to those currently enrolled in Liberty Dental)

(Please see page 2)

For Your Benefit is a 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 Trust Fund office directly at **(800) 552-2400**. Phone hours for the Trust Fund office's Health and Welfare Services Department are 7:30 a.m.-5:30 p.m., Monday-Friday. Or visit us online at **www.ufcwtrust.com**.

¿Le gustaría una versión en Español de este boletín de noticias?
Would you like a Spanish version of this newsletter?

Visite www.ufcwtrust.com, haga clic en el menú de Recursos y seleccione formas para elegir un tema.
Visit www.ufcwtrust.com, highlight the Resources menu and select Forms to choose an issue.

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ALSO IN THIS ISSUE

Know your dental benefits

(Continued from front page)

- Delta Dental DPO (only available to those currently enrolled in Delta Dental)

The dental plan option available to Standard members is:

- Premier Access DPO

In the Premier Access DPO Network or Delta Dental options, you may select the dentist of your choice, although using a network dentist will lower your out-of-pocket costs. Liberty Dental DMO users must use a Liberty Dental DMO provider or else they will be responsible for 100 percent of charges for using a non-network provider.

Benefit details

Premier Access DPO Network and Delta Dental Network

- No calendar year deductible
- Calendar year benefit maximum: Premier, $2,500 per person; Ultra, $2,000 per person; Standard, preventive and diagnostic procedures only
- Plan payments for:
  - Preventive and diagnostic: Premier, Ultra and Standard, 100% of covered expense
  - Basic restorative: Premier, 80% of covered expense; Ultra, 60% of covered expense; Standard, not covered
  - Major restorative: Premier, 70% of covered expense; Ultra, 50% of covered expense; Standard, not covered
- Orthodontic plan payment is 75% of covered expense, up to $2,000 per person lifetime benefit (Premier and Ultra only); Standard, not covered

Liberty Dental DMO

- No calendar year deductible
- No calendar year benefit maximum
- Plan payments: Network provider services provided after you pay the applicable copayment
- Orthodontic benefits provided through the Premier Access DPO Plan

Note: When a spouse/domestic partner has other group coverage based on their own current or former employment that is a Dental DMO, the individual is required to use that DMO benefit first.

For more details on your dental benefits, including limitations and exclusions, refer to your Summary Plan Description.

UFCW & EMPLOYERS TRUST LLC
Health and Retirement Benefits

For Your Benefit is the official publication of the UFCW & Employers Benefit Trust. Every effort has been made to provide correct and complete information regarding particular benefits, but this newsletter does not include all governing provisions, limitations and exclusions, which may vary from plan to plan. Refer to the Summary Plan Description, Plan Document, Evidence of Coverage and/or Disclosure Form ("Governing Documents") for governing information. In the event of any conflict between the terms of this newsletter and the Governing Documents, the Governing Documents will control. As always, the Board of Trustees for the UFCW & Employers Benefit Trust retains the sole and complete discretionary authority to determine eligibility and entitlement to plan benefits and to construe the terms of the plans. The information in these articles is for general use only and should not be taken as medical advice. In an emergency, you are advised to call 9-1-1.

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Glossary

A **copayment** is a fixed dollar amount you pay each time you use certain services, such as when you fill a prescription.

Coinsurance is a percentage of covered expenses that you pay after the deductible is satisfied and until your coinsurance out-of-pocket maximum is reached. For example, assuming your deductible was met, if you receive a service with covered expenses of $100 and your coinsurance is 20%, you would pay $20, unless you have reached your out-of-pocket maximum. The Trust Fund pays the balance of the covered expenses.

The **primary payer** is the health insurance carrier that is responsible for providing benefits before any other insurer makes payment.

A **participant** in the Trust Fund is someone who is covered under the current Collective Bargaining Agreement between the unions and employers. He or she has access to health care benefits through the Trust Fund.

What **Non-Duplication of Benefits** means for you

The term "Non-Duplication of Benefits" applies to participants who have other insurance. It means that, if a participant's or dependent's other insurance is the primary payer, the UEBT Plan will only provide additional payment if the other insurance pays less than what the UEBT Plan would have paid if it was the primary plan.

For example, if Ralph (a UEBT Plan participant) had a medical procedure and a non-UEBT Plan was going to be the primary payer for that procedure, the claim would be processed as follows:

Example 1

Amount billed for Ralph's procedure: $8,500

Primary Plan allowed amount: $8,100

UEBT Plan allowed amount: $7,500

Primary Plan payable at 70%: $5,670

UEBT Plan payable at 85%: $6,375

In this example, because the UEBT Plan would have covered more of the cost of Ralph's procedure (85% versus 70%), the UEBT Plan will pay the difference.

UEBT Plan payable amount:	$6,375
Minus primary plan payable amount:	-$5,670
Equals (UEBT Plan will pay):	$705

Ralph's remaining responsibility is $1,725.

Primary Plan allowed amount:	$8,100
Minus primary plan's payment:	-$5,670
Minus UEBT plan payment:	-$705
Equals (Ralph's responsibility):	$1,725

If the UEBT payable amount was lower than the primary plan's payable amount then the UEBT Plan would pay zero as shown in the following example.

Example 2

If Rosalyn had a medical procedure and another non-UEBT Plan was going to be the primary payer for that procedure, the claim would be processed as follows:

Billed amount: $8,600

Primary Plan allowed amount: $6,500

UEBT Plan allowed amount: $6,500

Primary Plan payable at 80%: $5,200

UEBT Plan payable at 75%: $4,875

In this case, the UEBT Plan would have paid 75% of the allowed amount. Because the primary plan offers coverage greater than what the UEBT Plan offers (80% versus 75%), the UEBT Plan will pay nothing additional toward Rosalyn's procedure.

Rosalyn will be responsible for the 20% remaining amount due of the Primary Plan's allowed amount.

Notes and reminders

- In no case will the UEBT Plan pay for a service that is covered under a non-UEBT primary plan but is not a covered benefit under the UEBT Plan.
- Deductibles, coinsurance and out-of-pocket maximums vary for each plan (Premier, Ultra, Standard, or Retiree), so refer to your Summary of Benefits and Coverage.
- Your out-of-pocket maximum, based on your UEBT plan, remains the same regardless of whether another plan is primary under Non-Duplication of Benefits.

Does your spouse/domestic partner have other insurance available? **Contact the Trust Fund.**

If you have a spouse/domestic partner who has coverage as your dependent under the UEBT Plan, it is your responsibility to notify the Trust Fund office (TFO) if other insurance is available through his or her current or previous employer. You must provide the Trust Fund with his or her other carrier information within 30 days so benefits can be coordinated properly.

Penalties may occur

For example, Peter is a UEBT Plan member and his wife, Beth, is also covered under the Plan. Since Beth works at an employer where health insurance is offered, she must enroll in her employer's plan and choose the option that is most comparable to the UEBT Plan.

If Beth is unemployed but is still able to enroll in health insurance through a former employer, she must do so and choose the option that is most comparable to the UEBT Plan.

If Beth's employer does not offer health insurance, she must submit a letter (on letterhead from her employer) to the Trust Fund office stating there is no other coverage "offered" for Medical, Dental and/or Vision.

If Beth does not submit the letter on letterhead from her employer, or if she chooses not to take the other coverage that is available, the UEBT Plan will pay 60% less on her claims going forward. Beth will also not be reimbursed for any out-of-pocket expenses she incurs as part of any claims she submits to the UEBT Plan.

Please note: Only Beth needs to enroll in the health insurance her employer offers – she does not have to enroll anyone else in the family.

Note: If the spouse/domestic partner's employer letter is received after claims have been processed under the 60% reduced benefit, the claims will not be reprocessed.

When a participant's spouse/domestic partner has other group coverage that is an HMO, the spouse/domestic partner is required to use that HMO benefit first.

Phone calls and your benefits: What is your responsibility?

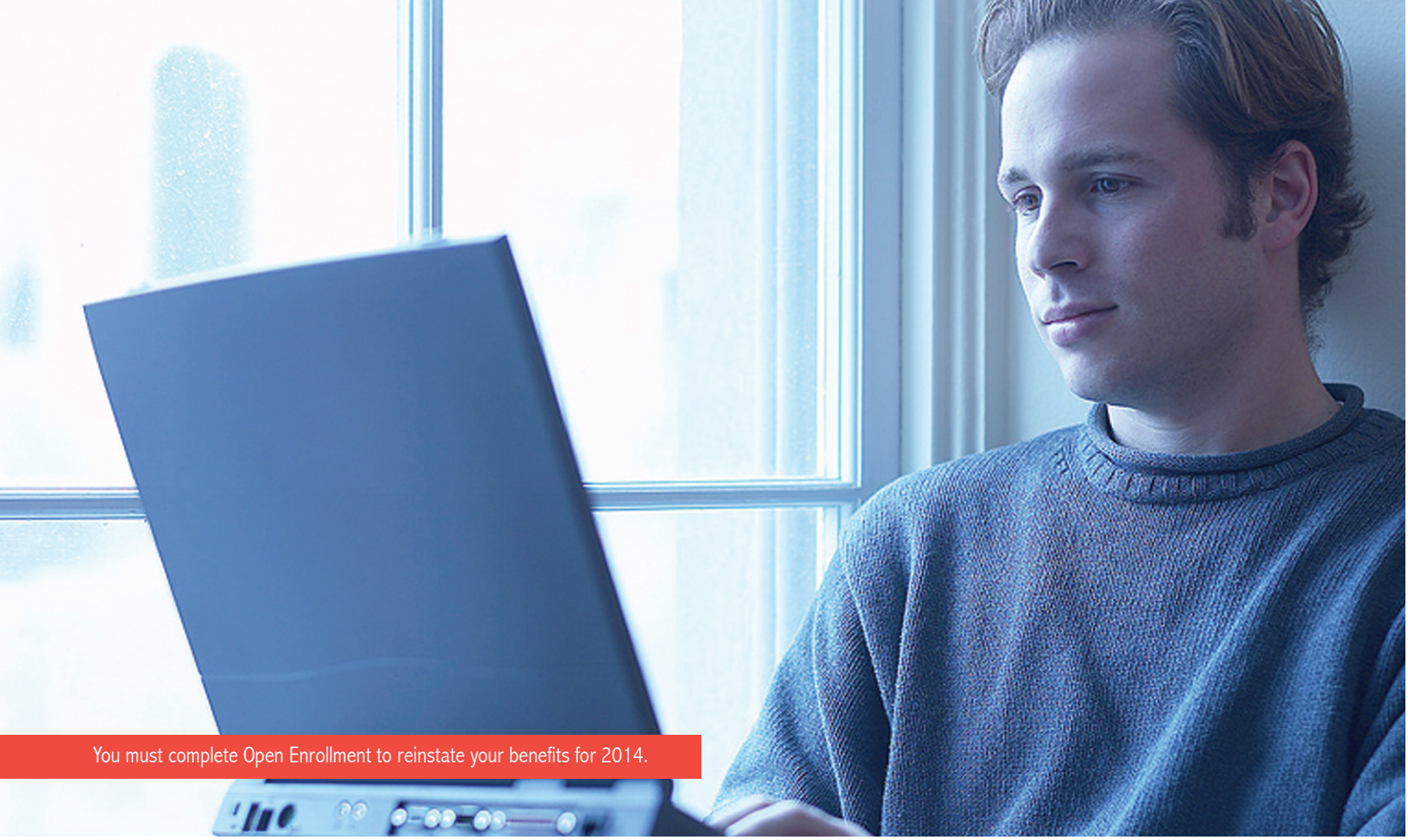
The Trust Fund contacts participants in many ways to keep them up to date on their benefits and to help them maintain their health. Some participants may receive or be required to make phone calls as part of this outreach.

Coaching calls are phone calls that members and enrolled spouses/domestic partners in the PPO Health Care Partnership (HCP) Plan are encouraged to complete for the 2014 Plan year. The health professionals from MedExpert on these calls will take the time to answer your medical questions and help you navigate your health plan.

Disease Management calls are phone calls that a small group of members and spouses/domestic partners receive to help them manage a chronic disease such as diabetes, coronary artery disease, and asthma. The Disease Management program is by invitation only. These members and spouses/domestic partners will receive calls periodically from a health care professional to assist them with prescriptions, follow-up appointments and other aspects of their care.

Please note some members and spouses/domestic partners may be active with both coaching calls and Disease Management calls. These calls are separate, but both are important parts of maintaining your wellness.

If you are a participant who is active with these calls, please be sure to keep up with your responsibilities by completing the requirements for each of the calls.



You must complete Open Enrollment to reinstate your benefits for 2014.

Complete Open Enrollment to reinstate your benefits

UEBT Open Enrollment for Active Members took place Oct. 1, 2013 through Nov. 15, 2013. If you failed to complete Open Enrollment during this period, coverage for you and any covered dependents **was terminated effective Jan. 1, 2014**.

You will not have health coverage for 2014 unless you complete your enrollment. Our online enrollment system is available now.

Complete your Open Enrollment to reinstate your 2014 benefits by logging into the Trust Fund website at **www.ufcwtrust.com**. If you complete Open Enrollment after March 31, 2014, you will be able to enroll **yourself only** in the Personal Direction plan option.

Important notes:

1. When you see the Open Enrollment message, click on the "Start Here" button and follow the online step-by-step process.
2. For Premier and Ultra Members, you will be limited to the Personal Direction (PD) PPO Plan level option.
3. Your online Open Enrollment is complete when you see a Green Checkmark and receive a "Congratulations" line with a confirmation number. You will also receive a Confirmation Statement in the mail within 10 days of your completion.
4. Alternatively, you can enroll over the phone. Please call (866) 827-2116 for assistance. Hours of operation are Monday-Friday, 5am-5pm PST.
5. If you complete Open Enrollment after Dec. 31, 2013, you will be billed each month by the Trust Fund Office for your dependent premiums, if applicable. You must submit premium payments to the Trust Fund office by the due date on each monthly invoice. Please note: If you complete Open Enrollment after March 31, 2014, you will be able to enroll **yourself only** in the Personal Direction plan option.
6. Login at **www.ufcwtrust.com** and visit the My Health Benefits page to confirm that your benefit details have been updated.

Review and update your personal information at www.ufcwtrust.com

In order to receive the latest information from the Trust Fund, you must keep the Trust Fund office updated with your current address and phone number. It is your responsibility to stay informed and keep the benefits information you receive for reference.

The easiest way to do this is to login at **www.ufcwtrust.com** to view your profile. Select the "My Contact Info" icon to make changes directly online. Your contact information will be updated within five business days.

Keeping your information current and staying informed will help you better manage your benefits and can assist in reducing health care costs for you and the Trust Fund.

While you're on the website, you can also select the "My Health Benefits" icon to review the benefit details for you and any eligible dependents.

Thank you for your patience

The Trust Fund thanks all participants for their patience during the Open Enrollment 2014 process last fall. The Trust Fund office staff worked very hard to reduce phone wait times and address all questions and concerns as quickly as possible.

Trust Fund **101**

A message of thanks

The Trust Fund's Board of Trustees extends a heartfelt thanks to all Retirees and Active Members.

We realize 2013 was a year filled with changes and you have taken them in stride.

Open Enrollment moved to the Internet, where more than 50,000 users registered at www.ufcwtrust.com. The numbers of Retirees and Actives who completed Open Enrollment were the highest ever.

Our phone lines stayed busy and we hired additional help. Our Health and Welfare Services representatives are dedicated to helping each and every person.

Visits were high at Trust Fund and Union offices. Attendance at our Open Enrollment Fairs was fantastic. Many members and retirees got answers to their questions and completed their enrollments.

We listen to your suggestions. We're already preparing for the next Open Enrollment, coming this summer and fall, and are making every effort to make your next enrollment even easier.

Thanks again for your patience and understanding, and for participating in Open Enrollment for 2014.

We are making every effort to make your next Open Enrollment even easier.

Reminders for Health Care Partnership participants

Kaiser members

If you are enrolled in Kaiser HCP for 2014, you and your enrolled spouse/domestic Partner are encouraged to continue participation in the Kaiser Healthy Lifestyle program during 2014.

Blue Shield PPO members

If you elected the Blue Shield PPO HCP plan, you and your enrolled spouse/domestic Partner are encouraged to continue with your coaching calls through MedExpert.

Action steps requirements for 2015 HCP Plan level placement will be shared with the membership in Open Enrollment 2015 materials later on this year.