

United Food and Commercial Workers Union Local 1529 and Employers Health and Welfare Plan and Trust

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BOARD OF TRUSTEES

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August 14, 2006

To: All Eligible Health and Welfare Plan Participants

FROM: The Board of Trustees

RE: Plan Benefit Changes

This memo is to notify all eligible Health and Welfare Plan participants of **several benefit improvements** in your plan. **All benefit improvements will be effective on all claims dated on or after September 1, 2006.** The Board of Trustees is working hard to be certain this Plan remains solid for its participants. With the rising cost of health care, in double digits, that is not an easy task.

The Board of Trustees is pleased to announce the following benefit improvements in your health plan. All improvements will be effective September 1, 2006. These benefit improvements will be paid as any other eligible medical claim and will be subject to the \$200,000 annual medical benefit

1. Prior to September 1, 2006, Podiatry (foot care) was limited to \$750 per eligible person per year with a \$4,000 lifetime maximum. For all claims with a date of service on or after September 1, 2006, these podiatry limits will no longer apply. .
2. Prior to September 1, 2006, Chiropractic benefits were restricted to \$500 per eligible person per year. For all claims with a date of service on or after September 1, 2006, these chiropractic limits will no longer apply.
3. Prior to September 1, 2006 certain procedures were classified as routine care. Although some procedures still remain as routine care, the Board of Trustees is pleased to announce the following benefit improvements for men, women and children, including the care of all babies at time of birth.

Men's Health

Preventive Health Guidelines

Health exams, tests and immunizations are vital to preventive care. Use these general guidelines to make sure your health maintenance schedule is up-to-date. Please check your benefit plan details for information about covered services.

Men ages 19 and older

Schedule regular physical exams with your Primary Care Physician (PCP)-your PCP will determine which of the following immunizations and screenings you may need.

Immunizations

- Influenza (flu): ages 19 to 49, as your PCP advises; ages 50 and older, annually
- Pneumonia vaccine
- Tetanus-diphtheria (Td)

Screenings

- Blood pressure:
- Cholesterol (complete lipoprotein profile, fasting or nonfasting): ages 20 and older
- Colon cancer: ages 50 and older, one of the following:
- hidden blood in stool test

- flexible sigmoidoscopy
- double-contrast barium enema
- colonoscopy
- Diabetes: ages 45 and older; if history of gestational diabetes
- Hearing: ages 65 and older
- Height and weight: periodically
- Vision: ages 65 and older
- Prostate specific antigen(PSA)

These preventive health guidelines are based on recommendations from the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, U.S. Preventive Task Force, American Cancer Society and other nationally recognized authorities. These preventive health guidelines are only a general guide and are not intended to replace your doctor's best clinical judgment.

Women's Health

Preventive Health Guidelines

Health exams, tests and immunizations are vital to preventive care. Use these general guidelines to make sure your health maintenance schedule is up-to-date. Please check your benefit plan details for information about covered services. In addition to the preventive care guidelines shown here, all women ages 18 and over should perform monthly breast self-exams.

Women ages 19 and older

Schedule regular physical exams with your Primary Care Physician (PCP)—your PCP will determine which of the following immunizations and screenings you may need.

Immunizations

- Influenza (flu): ages 19 to 49, as your PCP advises; ages 50 and older
- Pneumonia vaccine: once for people ages 65 and older
- Rubella (German measles): women of childbearing age who are not immune
- Tetanus-diphtheria (Td):

Screenings

- Blood pressure: every two years, or as your PCP advises
- Chlamydia: sexually active females under age 25
- Cholesterol (complete lipoprotein profile, fasting or nonfasting): ages 20 and older
- Colon cancer: ages 50 and older, one of the following:
 - o hidden blood in stool test
 - o flexible sigmoidoscopy
 - o double-contrast barium enema
 - o colonoscopy
- Diabetes: ages 45 and older; if history of gestational diabetes
- Hearing: ages 65 and older, as your PCP advises
- Height and weight
- Mammogram: ages 40 and older
- Pap test: ages 19 to 64, at least every three years if sexually active; ages 65 and older may discontinue if prior Pap tests were consistently normal

Pregnant Women

If you're pregnant, you should visit your PCP or OB/GYN during your first trimester for an initial evaluation and to establish a prenatal care schedule. Your doctor will check your health and the health of your baby. Based on your medical history, your doctor may recommend additional tests and care, which may include the following:

- Vitamins and supplements: Talk with your doctor about taking a prenatal multivitamin with folic acid. Taking 0.4 mg of folic acid a day can help reduce the risk of neural tube defects.
- Blood tests: These should be taken during your first prenatal care visit to detect anemia, hepatitis B, rubella and sexually transmitted diseases, such as syphilis and HIV.
- Chlamydia culture: during your first prenatal care visit
- Urine tests: as recommended by your doctor
- Diabetes screening: between weeks 24 and 28
- Culture for Group B strep: between weeks 35 and 37 to check for Group B streptococcal infection

Child Immunizations

Protect your child from serious childhood illnesses

Use these general guidelines to make sure your child's health maintenance schedule is up-to-date. Please check your benefit plan details for information about covered services.

Birth to 2 years Immunizations

- Diphtheria, tetanus and acellular pertussis (DTaP): at 2, 4 and 6 months and between 15 and 18 months
- Haemophilus influenzae b (Hib): at 2, 4 and 6 months and between 12 and 15 months
- Hepatitis B virus (HBV): at birth, 1 to 4 months and 6 to 18 months; or at 1 month, 2 to 4 months and 6 to 18 months
- Measles-mumps-rubella (MMR): between 12 and 15 months
- Pneumococcal conjugate (PCV): at 2, 4 and 6 months and between 12 and 15 months
- Poliovirus (IPV): at 2 and 4 months and between 6 and 18 months
- Varicella (chickenpox): between 12 and 18 months

Ages 3 to 10 Immunizations

- Diphtheria, tetanus and acellular pertussis (DTaP): between ages 4 and 6
- Measles-mumps-rubella (MMR): between ages 4 and 6, or 11 and 12 (if not already immunized)
- Poliovirus (IPV) between ages 4 and 6
- Varicella (chickenpox): anytime if no evidence of prior immunization or chickenpox

Ages 11 to 18 Immunizations

- Hepatitis B virus (HBV): between ages 11 and 12, if not previously immunized
- Measles-mumps-rubella (MMR): if not already immunized
- Tetanus-diphtheria (Td) booster: every 10 years
- Varicella (chickenpox): if not already immunized

These preventive health guidelines are based on recommendations from the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, U.S. Preventive Task Force, American Cancer Society and other nationally recognized authorities. These preventive health guidelines are only a general guide and are not intended to replace your doctor's best clinical judgment.

As you know, the Board of Trustees has retained a Preferred Provider Organization ("PPO"), which provides for discounted charges for hospitals and physicians who are part of the PPO's network. These health care providers are referred to as "in-network providers." The use of in-network providers by eligible employees and dependents not only helps in reducing the costs incurred for health services by your plan, but also reduces your costs associated with deductibles and co-insurance payments. To encourage the use of in-network providers, the Board of Trustees has adopted the following changes in benefits paid for providers not in the PPO network ("out-of-network services") effective September 1, 2006.

The out of pocket limits/maximum for **out of network** claims has been removed. For example;

Prior to September 1, 2006, Plan A out of network paid 60% up to an out of pocket maximum of \$8,000. That out of pocket maximum of \$8,000 has been removed. Plan A will pay 60%. The participant will be responsible for the remaining 40% for **out of network services**. That 40% is usually based on the retail cost.

Prior to September 1, 2006 Plan B out of network paid 50% up to an out of pocket maximum of \$10,000. Again, that out of pocket maximum of \$10,000 has been removed. The Plan B will now pay 50%. The participant will be responsible for the remaining 50% for **out of network services**. That 50% is usually based on the retail cost.

The out of pocket limits are removed for all out of network claims that have a date of service on or after September 1, 2006.

These out of network/out of pocket benefit changes DOES NOT apply to **out of area**. Out of area remains the same.

The Board of Trustees will continue to closely monitor these Plans and implement changes that are in the best interest of the participants. Should you have any questions feel free to contact the Administrative Office at the above listed phone numbers or address.