IMPORTANT: PLEASE READ THIS NOTICE CAREFULLY. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE FUND OFFICE AT (800) 882-5556.

This notice is a Summary of Material Modifications (SMM) for the Local 371 United Food and Commercial Workers Union Amalgamated Welfare Trust Fund (the "Fund") as required by the Employee Retirement Income Security Act of 1974 (ERISA). It describes changes to the information presented in your Summary Plan Description (SPD), other plan communications and any previous SMMs. Please share this SMM with your family and keep it with your SPD booklet so you have it when you need to refer to it.

I. Benefit Improvements to Comply With Mental Heath Parity and Addiction Equity Act

Effective January 1, 2012, the Plan has been amended to comply with the requirements of the Mental Health Parity and Addiction Equity Act ("MHPAEA"). As a result, effective January 1, 2012, your Plan benefits have been improved in the following ways:

- All day limits on inpatient hospital stays associated with substance use disorders have been eliminated. However, all treatment that you receive remains subject to verification by the Fund for medical necessity.

- Your coverage for in-network, outpatient office visits for mental health and substance use disorders will now be equal to your coverage for in-network outpatient office visits for medical/surgical benefits. Thus, all services will be covered at 80% of Allowable Charges subject to a co-payment of $200.00

- Your coverage for out of network, outpatient office visits for mental health and substance use disorders will now be equal to your coverage for out of network outpatient office visits for medical/surgical benefits. Thus, all services will be covered at 60% of Allowable Charges subject to a co-payment of $200.00

- All lifetime and annual limits associated with mental health office visits have been eliminated. However, all treatment that you receive remains subject to verification by the Fund for medical necessity.

II. Coverage Added to Full-Time Plan for Same Sex Spouses

Effective February 1, 2012, your same-sex spouse is eligible to be covered if you are a participant in the Full-Time Plan. Thus, same-sex spouses who did not have access to coverage under the Full-Time Plan previously, or who were not eligible for coverage, because they did not meet the Plan's definition of "spouse" may be eligible for coverage under the Plan beginning February 1, 2012.

To be eligible for coverage as a spouse under this Plan, a person must be your opposite-sex or same-sex spouse as determined under applicable state law at the time and location that the marriage was entered into. In order for your spouse to be covered under the Plan, you must also be enrolled for coverage.

To request coverage for a same-sex spouse as of February 1, 2012, you must complete all sections on the appropriate enrollment form making certain to add the spouse in the Dependent Profile section. The enrollment form must be returned to the Fund Office along with a photocopy of the marriage certificate.

Note: Coverage of a non-dependent same-sex spouse implicates federal tax obligations. Accordingly, such coverage is being offered subject to compliance with federal income tax laws, including withholding requirements.

III. Overall Annual Dollar Limit Scheduled to Increase for Full-time Plan

Effective January 1, 2012, the Fund's overall annual dollar limit for the Full-time Plan that will be applied to "essential health benefits" (currently $1,000,000) will increase to $1,250,000.

In addition, for the Plan Year beginning January 1, 2013, the overall annual dollar limit on essential health benefits provided under the Fund's Full-time Plan will increase to $2,000,000. The overall dollar limit will be eliminated effective January 1, 2014.

The following are considered "essential health benefits" under this Fund: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Otherwise, until further federal guidance is released, the Trustees can determine whether a specific benefit is an "essential health benefit."

IV. The Fund is "Grandfathered" Under the ACA

The Amalgamated Welfare Trust Fund Local 371 (the "Fund") believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (i.e., the Affordable Care Act). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Fund may not include certain consumer protections of the Affordable Care Act that apply to other health plans, for example, the requirement that certain preventive health services be provided without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at (800) 882-5556.