FELRA & UFCW Retiree Health Plan
A Plan of the Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund

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Plan I Retiree

Summary of Material Modifications

July 2021

This Insert is a Summary of Material Modifications (changes) to your Summary Plan Description ("SPD") booklet. If there is any discrepancy between the terms of the Plan or any amendments and this document, the provisions of the Plan, as amended, will control.

- **Effective June 1, 2021, Dentegra Insurance Company ("Dentegra") will provide the Fund's dental benefits, replacing Group Dental Service.**

  What Does This Mean for You?
  - **Your benefits will NOT change.** You will have the same coverage described in your Summary Plan Description ("SPD") booklet with the same co-pays, exclusions etc.
  - **For the first time, you will receive a Dental ID card.** You should receive the card around mid-May. Show the card to the dentist when you receive dental services on or after June 1, 2021. If you haven't received a dental ID card by May 31st, contact Dentegra at (877) 280-4204 to request a card. If you have an urgent dental situation before your ID card arrives, contact the Fund office and we will provide you with information to tell the dentist until your actual card arrives.
  - Dentegra has a wide network of providers, so most participants will have more dentists available to them.
  - Just as you did under Group Dental Service, you must use a Dentegra dentist in order to be covered. Participants who live more than 20 miles from a Dentegra dentist may use a non-Dentegra dentist, but you will be responsible for any balance owed after Dentegra makes its payment.
  - You can change dentists at any time without notifying Dentegra as long as the dentist you choose is in the Dentegra network.

  Finding a Participating Dentegra Dentist
  Go to Dentegra.com/FELRA to find participating dentists in your area. Click on the "EPO-Collective Bargaining" tab to get to the list of covered providers. Call the dentist yourself and make your appointment. Have your Dental ID card ready when you call, and be sure to tell the provider that your insurance is through Dentegra.

Benefit and Claims Information available on Dentegra's website
Register for an online account with Dentegra to be able to view claims and eligibility status. General Plan information can be found on the website at Dentegra.com/FELRA.

- **COVID-19 Vaccination Coverage**

  The following services will be covered under Comprehensive Medical Benefits and the Prescription Drug Benefit on an in-network and out-of-network basis with no cost sharing (including deductibles, co-payments and co-premiums) and no requirement of prior authorization:

  - A COVID-19 immunization that has a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use), after such recommendation has been in effect for 15 business days; and

  - items and services that are an integral part of furnishing the covered immunization, including vaccine administration.

    Office Visit Coverage
    There are limited situations in which an office visit is payable under this COVID-19 Vaccination Coverage. The following conditions apply to payment for office visits under the COVID-19 Vaccination Coverage:

  - If the covered immunization, item or service is billed separately from an office visit, then the Fund will impose cost-sharing with respect to the office visit.
  - If the covered immunization, item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of the immunization, then the Fund will pay for the office visit without cost-sharing.
  - If the covered immunization, item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of the immunization, then the Fund will impose cost-sharing with respect to the office visit.

- **Effective January 1, 2021 - Employer Group Waiver Plan ("EGWP")**

  - Medicare-eligible retirees in the FELRA and UFCW VEBA Fund who are enrolled in Fund Medical benefits (not Kaiser Medicare Advantage HMO) will begin a new Express Scripts Medicare (PDP) prescription program under Express Scripts, Inc. ("ESI"). The program is called an "Employer Group Waiver Plan" or "EGWP."

  - There will be some changes in how retirees obtain certain drugs and how they are classified (for example all drugs costing over $675 will be classified as specialty drugs under the EGWP program). The drug formulary list under the EGWP is slightly different from the formulary list that is currently in effect for Medicare-eligible retirees. The applicable co-pay percentages will remain the same.

  - All Medicare-eligible retirees who are enrolled in Fund Medical benefits have been automatically enrolled in the EGWP program unless they notified the Fund Office that they wanted to opt out, in which case Fund prescription coverage for that retiree will terminate on December 31, 2020.

  - Retirees receiving drugs affected by the change to the EGWP program received a letter in November notifying them of the changes to their coverage for the drugs, giving them time to work

with their doctors and the ESI EGWP team to make any necessary change. You can see the list of 2021 approved formulary drugs on the ESI website which is: express-scripts.com/documents.

Retiree "Hotline" Number Available

ESI has a special customer service number for retirees enrolled in the EGWP program, which is (800) 856-4695. Call this number for questions about drug delivery method, co-pay amount, locating a pharmacy, and more. If your questions concern your eligibility for the program, enrollment, or other "administrative" questions, contact the Fund office.

- **Effective January 1, 2021, the following new subsection is added under the Comprehensive Medical Benefits Section of your SPD:**

Cologuard – Colorectal Cancer Screening

Cologuard colorectal cancer screening tests are covered under the Plan, subject to the same guidelines followed by Medicare Part B for coverage of such tests. Under the current Medicare guidelines, the test is covered once every three years for participants and eligible dependents who are ages 50 to 85 years old, have no signs or symptoms of colorectal disease (i.e., lower gastrointestinal pain, blood in stool, etc.), and are at average risk of developing colorectal cancer.

- **Effective July 1, 2020, the "Quantity Limits/Prior Authorization" Subsection of the "Prescription Drug Benefit" Section of the SPD is deleted and replaced with the following:**

Prior Authorization

There are prior authorization requirements applicable to the coverage of certain medications under the Plan. If your prescription drug claim is denied based on the Fund's prior authorization requirements, please have your *Physician* or pharmacist contact Express Scripts and provide the appropriate documentation for review. Please go to www.express-scripts.com or contact Express Scripts by phone at (800) 903-8325 for the current list of drugs subject to prior authorization.

Drug Quantity Management

The Fund maintains a Drug Quantity Management program. Drug Quantity Management means that the Fund will only pay for a specific quantity at a particular strength for certain prescription drugs. Quantity limits are set in accordance with FDA approved prescribing limitations and standard medical practice. Please go to www.express-scripts.com or contact Express Scripts by phone at (800) 903-8325 for the current list of drugs subject to these rules. If your *Physician* wants to prescribe a particular strength or quantity of drug that does not fit within the limits of the Fund's Drug Quantity Management program, your *Physician* can request an exception by contacting Express Scripts.

- **Effective June 1, 2020, the following new Subsection is added at the end of the "Prescription Drug Benefit" Section of the SPD:**

Prescription Care Management

The Fund has adopted a prescription management program provided through Prescription Care Management, LLC ("PCM"). Under the program, PCM may contact you or your *Physician* to discuss lower cost alternatives to certain medications you are taking with the goal of achieving cost savings for both you and the Fund. Participation in the PCM program is completely voluntary and you will not be penalized if you decide not to participate.

- **Effective September 24, 2019, the following is added after the last paragraph of the "Specialty Medication/Accredo Specialty Pharmacy" Subsection of the "Prescription Drug Benefit" Section of the SPD:**

Limited Distribution Specialty Drugs
Certain "limited distribution" specialty drugs may not be available through the Accredo Mail Order Specialty Pharmacy. If such a specialty drug meets the Plan's requirements for coverage but is not available through Accredo or any other covered pharmacy, the Plan will cover prescriptions for the specialty drug ordered through CVS Specialty Pharmacy, subject to the same *Co-payment* that applies to specialty drugs ordered through Accredo.

- **Effective March 18, 2020 – COVID-19 Testing**
The following services will be covered with no cost sharing (including deductibles, co-payments and co-premiums) and no requirement for prior authorization:

    - Diagnostic products for the detection of SARS-CoV-2 or the diagnosis of COVID-19 and the administration of such diagnostic products. The types of tests that will be covered include:

        1. Diagnostic testing authorized by the FDA or the Secretary of HHS;
        2. Diagnostic testing that is under review, or will be submitted for review, by the FDA for emergency use; and
        3. Diagnostic testing authorized by a State, if that State has notified the Secretary of HHS.

    - Items and services furnished to a Participant or Dependent during health care provider office visits, urgent care visits, and emergency room visits that result in an order for, or administration of, a diagnostic product, but only to the extent that the item or service relates to the furnishing or administration of the diagnostic test or the evaluation of whether an individual needs a diagnostic test.

- **Effective September 1, 2019 – Advantica Purchased by Superior Vision**
You should have received a new ID card from Superior Vision during the month of September 2019. Please show the new card to your optical provider when you go for care. If you need to see a vision provider and have not yet received your new ID card from Superior Vision, contact the Fund Office. We'll make sure the provider knows what benefits are available to you and that you are covered under the Fund.

    Superior Vision has an expanded network with providers located in major malls and other convenient locations, including Lens Crafters (this is new – Advantica did not have Lens Crafters in its network), Pearl Vision, Sears, and JCPenney, as well as many individual providers. For a current list of providers, log on to www.superiorvision.com. There are some limited benefits available if you use a non-participating provider. The new telephone number for customer service is (800) 507-3800. We think you will be pleased with the added convenience of additional providers.

Please note the following clarifications to the FELRA & UFCW Plan I Retiree SPD:

- Page 15. The prescription drug benefit is for the Retiree only. **Retiree Spouses of Part Time Comprehensive Retirees are not eligible for Prescription benefits.** Please note this on "Schedule 2" printed on page 15.

- Page 39. Item #6 at bottom of page. This item **should** read as follows: Oral contraceptives are covered for the retiree or the retiree's spouse only if the retiree was Full Time or if the Retiree was Part Time and retired before October 1, 1992 (provided the spouse is an eligible dependent). Oral contraceptives are limited to a three-month supply per prescription. Oral contraceptives for dependent daughters will not be covered unless they are *Medically Necessary* for reasons other than

contraception. For approval of oral contraceptives for dependent daughters, the participant should contact Express Scripts, Inc. ("ESI") to start the prior authorization process.

- Page 39. Where it states, "The Prescription Drug Co-Payment for a Spouse is 25% of the cost of the drug after the initial $200 deductible has been paid," add the following: **Eligible Spouses are spouses of Full Time Retirees and Spouses of Part Time Retirees who retired before October 1, 1992.**

- The following replaces the chart on page 18 of the FELRA & UFCW Plan I Retiree Health and Welfare Summary Plan Description booklet:

FELRA & UFCW RETIREE HEALTH AND WELFARE PLAN
RETIREE CO-PAY RATE CHART JANUARY 1, 2019

	STATUS AT RETIREMENT			FAMILY OR	OUT OF AREA	HMO
CATEGORY	AGE	SERVICE	COVERAGE	INDIVIDUAL	RATE	RATE
A	At Least 60	At Least 30 Years	Medicare	Individual	61	21
			Medicare	Family	92	43
B	Less Than 60	At Least 30 Years	Medicare	Individual	118	70
			Medicare	Family	186	115
C	At Least 60	At Least 25 Years	Medicare	Individual	118	70
			Medicare	Family	186	115
D	At Least 55	At Least 20 Years	Medicare	Individual	242	90
			Medicare	Family	372	129
E	Retired @ 9/1/92	Less Than 20 Years	Medicare	Individual	298	106
			Medicare	Family	464	148
F	Disability	At Least 10 Years	Medicare	Individual	118	70
	Retiree		Medicare	Family	186	115