FELRA UFCW
FOOD EMPLOYERS LABOR RELATIONS ASSOCIATION & UNITED FOOD AND COMMERCIAL WORKERS FUNDS

Summary Plan Descriptions (SPDs), Summaries of Benefits and Coverage (SBCs) and Summaries of Material Modifications (SMMs) are available on our website, www.associated-admin.com.

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For Your Benefit

Summary of Material Modifications This Issue!

- FELRA & UFCW Active Health and Welfare Plan*
- FELRA & UFCW Retiree Health and Welfare Plan*
- FELRA & UFCW Pension Fund
- UFCW & FELRA Severance Plan**
- UFCW & FELRA Legal Benefits Plan**
- UFCW & FELRA Scholarship Plan**

** Benefit Plans of the FELRA & UFCW VEBA Fund*

*** Benefit Programs of the FELRA & UFCW Active Health and Welfare Plan*

Coverage for Virtual Doctors Office Visits Extended through Dec. 2022

The Board of Trustees of the Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund ("Fund") has adopted the following change to the FELRA & UFCW Active Health and Welfare Plan ("Active Plan") Plans I, X, XX, and XXX and the FELRA & UFCW Retiree Health and Welfare ("Retiree Plan"). Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits and Coverage ("SBC").

The Trustees are pleased to advise that the following temporary benefit enhancement has been extended through December 31, 2022. Effective March 1, 2020 and continuing through December 31, 2022, any **in-person visit** requirement applicable to traditional Fund (non-Kaiser) medical benefits and accident and sickness benefits under the Plan will be waived, as follows:

The Plan will cover medical benefit claims for otherwise covered services provided by telephone conference, video conference, or similar technology, subject to any applicable Plan rules and cost-sharing requirements (e.g., deductible, pre-authorization) that would apply to an in-person visit for the same service.

The requirement that you be seen in-person by a physician in order to verify your eligibility for Accident and Sickness Benefits may be satisfied by a visit with the physician through telephone conference, video conference, or similar technology.

This issue—

Changes to Your Dental and Prescription Benefits

The Board of Trustees of the Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund have adopted the following changes to the FELRA & UFCW Active Health and Welfare Plan ("Active Plan") and the FELRA & UFCW Retiree Health and Welfare Plan ("Retiree Plan"). Please keep this document with your Summary Plan Description ("SPD") and you Summary of Benefits and Coverage ("SBC"). Effective January 1, 2021, the following new subsection is added under the Comprehensive Medical Benefits Section of your SPD:

1. **Dentegra Insurance Company – Dental Benefits**
   Effective June 1, 2021, Dentegra Insurance Company ("Dentegra") became the Fund's provider of dental benefits, replacing Group Dental Service ("GDS"). To reflect this change, effective June 1, 2021, all references in the SPD to GDS are deleted and replaced with Dentegra, and the following changes apply to the "Dental Benefits" and "Claims Filing and Review Procedure" Sections of the SPD.

   a. **The "Claims Procedure" subsection of the "Dental Benefits" Section of the SPD is revised to read as follows:**

   ### Claims Procedure

   To request a participating provider in the Plan, call Dentegra at (877) 280-4204 between 8:00 a.m. – 8:00 p.m. EST. Monday through Friday. When calling Dentegra, please be ready to give the participant's Social Security Number and to take down the name, address, and phone number of the dentist. There are no claim forms necessary when seeing an in-network provider.

   b. **The "Grievance Procedure" and "Appeals Process" subsections of the "Dental Benefits" Section of the SPD are revised to read as follows:**

   ### Grievance Procedure

   Grievances or complaints may be directed orally or in writing to Dentegra Insurance Company, P.O. Box 1809, Alpharetta, GA 30023-1809, or telephone number (877) 280-4204 A representative will personally handle your complaint and attempt to resolve it in an equitable and fair manner. You will be told, either verbally or in writing, about the disposition of your complaint within thirty (30) days of the date the grievance is filed for a prospective denial, and within forty-five (45) days of the date the grievance is filed for retrospective denials.

   ### Appeals Process

   If your dental claim is denied by Dentegra and you, your representative, or your provider want to appeal the denied claim, you, your Representative or the provider must write to Dentegra or call Dentegra at (800) 932-0783 within one hundred eighty (180) days of receipt of the adverse decision. The request for appeal should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim should accompany the request for review. Written acknowledgement of the filing of the appeal will be provided to you, your representative, or the attending dentist within five (5) days of the filing of the appeal. You, your representative or the provider are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

The review of the appeal shall be conducted on behalf of Dentegra by a person who is neither the individual who made the coverage decision that is the subject of the review, nor the subordinate of such individual. Dentegra will render a final decision in writing to you, your representative, and/or provider acting on your behalf within 60 working days after the date on which the appeal is filed. Within 30 days after the Appeal Decision has been made, Dentegra will send you, your representative, and the provider a written notice of the Appeal Decision.

If in your opinion, or the opinion of your representative or the provider, the matter warrants further consideration, you, your representative, or the provider should advise Dentegra in writing as soon as possible. The matter shall then be immediately referred to Dentegra's Dental Affairs Committee. This stage can include a hearing before Dentegra's Dental Affairs Committee if requested by you, your representative, or the provider. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The notice of decision will state the specific factual bases for the decision. The decision of the Dental Affairs Committee shall be final insofar as Dentegra is concerned. Recourse thereafter would be to the Maryland Insurance Commissioner, or to the courts with an ERISA or other civil action.

You, your representative, or the provider has a right to file a complaint with the Maryland Insurance Commissioner within four (4) months after receipt of Dentegra's grievance or appeal decision. When filing a complaint with the Commissioner, you or your representative will be required to authorize the release of any of your medical records that may be required to be reviewed for the purpose of reaching a decision on the complaint.

Please refer to your Dentegra Evidence of Coverage document for additional information on Dentegra's internal appeal and grievance procedures.

c. **The "Special Rule Regarding Appeals of Dental Benefit Claims" subsection of the "Claims Filing and Review Procedure" Section of the SPD is deleted.**

2. **SaveOnSP – Change in Co-Payment When You Decline Participation (Applicable to Active Plan Participants and Dependents in Plans I, X, XX and XXX)**

The Fund's SaveonSP program saves you and the Fund money through manufacturer copay assistance programs. If you are prescribed a specialty drug that is part of the SaveonSP program and you enroll in the program, your full Co-payment for the specialty drug will be paid through the drug manufacturer's copay assistance program and you will pay nothing ($0). However, effective January 1, 2022, the Co-payment that you must pay for the specialty drug if you elect not to participate in the SaveonSP program is changing, from the Co-payment listed on the SaveonSP program's current Non-Essential Health Benefit Specialty Drug List to a flat 30% Copayment. To reflect this change, effective January 1, 2022, the following changes apply to your SPD.

a. **The last two sentences at the end of the Prescription Drug Section of your Active Plan SPD's Schedules of Benefits for Full Time and Part Time Participants are revised to read as follows:**

If you do not participate in the SaveonSP program, the specialty drug will be subject to a 30% Co-payment for any specialty drug listed on the SaveonSP program's current Non-Essential Health Benefit Specialty Drug List, and the Co-payment will not count towards your deductible or out-of-pocket maximums. See the "Prescription Drug Benefit" Section of the SPD for more information.

b. **The second paragraph of the "Cost for Certain Specialty Drugs Under SaveonSP Program" subsection of the "Prescription Drug Benefit" Section of your Active Plan SPD is revised to read as follows:**

If you choose not to enroll and participate in the SaveonSP program, you will be charged a 30% Co-payment for any specialty drug listed on the SaveonSP program's current Non-Essential Health Benefit Specialty Drug List for a Participating Specialty Drug. The Co-payment will not count towards your deductible or out-of-pocket maximums.

c. **Your Active Plan SBC includes a section describing what you will pay "[i]f you need drugs to treat your illness or condition." The following is added to the end of the "Limitations, Exceptions, & Other Important Information" for that section of your SBC:**

If a specialty drug is covered by the Fund's SaveonSP program and you enroll in the program, your coinsurance will be paid through the drug manufacturer's copay assistance program and you will pay nothing ($0). If you do not participate in the SaveonSP program, the specialty drug will be subject to a 30% coinsurance for any specialty drug listed on the SaveonSP program's current Non-Essential Health Benefit Specialty Drug List. Contact SaveonSP at (800) 683-1074 for a copy of the List.

Your Over-the Counter COVID-19 Test Coverage

The Board of Trustees of the Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund ("Fund") has adopted the following changes to the FELRA & UFCW Active Health and Welfare Plan ("Active Plan") Plans I, X, XX, and XXX. Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits and Coverage ("SBC").

Over-the-Counter COVID-19 Test Coverage

Effective January 15, 2022 and continuing through the end of the federally-declared public health emergency, certain at-home COVID-19 diagnostic tests purchased without a prescription ("over-the-counter" or "OTC Tests") are now covered under the Plan's Prescription Drug Benefit.

The types of OTC Tests that are covered include at-home diagnostic tests approved, cleared, or authorized by the FDA for use without an order or individualized clinical assessment from a health care provider or the involvement of a laboratory under the applicable FDA authorization, clearance, or approval. Generally, at-home OTC tests that are available for purchase in pharmacies will meet this standard. Currently, these OTC Tests are covered with no cost sharing (including deductibles, co-payments, and co-premiums) and no requirement of prior authorization.

At participating pharmacies, you and your covered dependents will be able to present your Express Scripts ID card at the Pharmacy and obtain up to eight (8) OTC Tests per person, every thirty (30) days, with no out-of-pocket cost. You may be asked to complete an attestation form prior to receiving the tests, to confirm that the test is for personal use, is not for employment purposes, and will not be reimbursed by another source or placed for resale.

To obtain your OTC Tests from a Participating Pharmacy, first call the pharmacy to see if they have OTC Tests available. When you go to the pharmacy, take your Express Scripts ID Card with you and bring the COVID-19 test to the pharmacy counter, not the regular checkout lane. When you check out at the pharmacy counter with your Express Scripts ID card, your test should automatically ring up at no cost to you. To find a retail pharmacy in your network, visit www.express-scripts.com and click "Find a Pharmacy" or use the Express Scripts mobile app. If you prefer to order your OTC Tests online at $0 copay and have them delivered to your home, visit www.express-scripts.com/covid-19/resource-center to log in at the Express Scripts Pharmacy and place your order.

If you or your covered dependents purchase OTC Tests at non-participating pharmacies, or other retailers, you may submit a request for reimbursement of up to eight (8) FDA-approved OTC Tests per covered person per 30-day period. Be sure to obtain a receipt when you purchase the OTC Tests. To see a list of FDA-authorized tests that are eligible for reimbursement, visit https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/home-otc-covid-19-diagnostic-tests. For purchases made after January 28, 2022, reimbursement will be capped at $12 per test. A testing kit containing two tests in one box will count as two tests toward this limit. To request reimbursement for the cost of OTC Tests, go to www.express-scripts.com/covid-19/resource-center and log in for instructions on how to submit an online reimbursement claim form or download and print a paper claim form that you can mail in to the address on the form for reimbursement. You may also call Express Scripts at (866) 290-8147 to request a paper claim form. You must include a receipt for the purchase of the OTC Test with your claim form, and you will be required to submit an attestation that the test is for personal use, is not for employment purposes, and will not be reimbursed by another source or placed for resale.

Regardless of whether you obtain the tests at a participating pharmacy, from Express Scripts online, or out-of-network, coverage is limited to eight (8) tests per covered participant or dependent per 30-day period. Please note, COVID-19 diagnostic tests performed at a provider's office, hospital, or clinic do not count toward this limit.

Important Notes:

- The Fund is continuing to work with its prescription benefit manager, Express Scripts, on the development of this program to provide coverage for OTC COVID tests. As this program develops, the Fund will inform you of any important changes to the scope of coverage of OTC COVID tests. You can also visit www.express-scripts.com/covid-19/resource-center for the latest information on the OTC Test coverage available through Express Scripts.
- OTC COVID tests may be in high demand. As an alternative to obtaining these tests at a pharmacy or retailer, you also can visit www.COVIDtests.gov to order 2 sets of 4 free at-home tests that will be mailed to you from the federal government. If you already ordered your first set, you can order a second set now. There also may be additional options in your local area for obtaining OTC COVID tests at no cost.

If you have any questions, please contact the Fund Office at (800) 638-2972.

Summary of Material Modifications

Material Modifications

Below are Summaries of Material Modifications (changes) made to the Food Employers Labor Relations Association and United Food and Commercial Workers Pension Plan ("Pension Plan") during the past year. Please clip this summary and keep it with your Summary Plan Description ("SPD") booklet so you will have it for easy reference.

The Board of Trustees of the Food Employers Labor Relations Association and United Food and Commercial Workers Pension Fund ("Fund") has adopted the following changes to the Pension Plan.

1. **Effective December 31, 2020, the second paragraph in the "Pre-Retirement Spouse's Pension" subsection on page 36 of your SPD is replaced with the following paragraph:**

   If your death occurs after you have met the requirements to start receiving a pension under the Plan, your *Spouse's* pension will be payable immediately following your death; otherwise, it will be payable beginning at the age when you would have met the requirements for an immediate pension. Payments to your *Spouse* may be deferred if your *Spouse* so requests. However, they cannot defer payment past the later of: (1) December 31st of the calendar year immediately following the calendar year in which you died; or (2) December 31st of the calendar year in which you would have attained age 72, if you would have reached age 70½ on or after January 1, 2020. If payments are deferred, the amount of the benefit will be actuarially adjusted to reflect the later age of the *Spouse* at the time the benefit commences.

2. **Effective January 1, 2021, the last sentence of the second paragraph in the "Commencement of Benefits" subsection on page 39 of your SPD is replaced with the following sentence:**

   You may elect to defer the commencement of benefits; however, benefit payments must begin by April 1 of the calendar year following the later of: (1) the calendar year in which you attain age 72; or (2) the calendar year in which you terminate *Covered Employment*.

Medicare Supplement Increased to Cover 2022 Medicare Co-Payments and Deductibles

The following applies to Medicare-eligible participants and dependents whose medical coverage is provided through the Fund, not through a Medicare HMO.

The Board of Trustees is pleased to announce that the Medicare Supplemental benefit has increased to cover the 2022 Medicare co-payment and deductible amounts.

New Co-Pays and Deductibles for 2022

Medicare Part A pays for inpatient hospital, skilled nursing facility, hospice and some home health care services. The Part A hospital inpatient deductible for 2022 is $1,556 for each benefit period.

For each benefit period, the Fund's Medicare Supplemental benefit will cover:

- A total of $1,556 for a hospital stay of 1-60 days.
- $389 per day for days 61-90 of a hospital stay.
- $778 per day for hospital stays longer than 90 days.

For Skilled Nursing Facility Coinsurance, the Fund's Medicare Supplemental benefit will cover:

- $194.50 per day for days 21 through 100 of each benefit period.

Medicare Part B covers physician services, outpatient hospital services, certain home health services, and durable medical equipment and other items. The annual deductible for all Part B beneficiaries in 2022 is $223, and the Fund's Medicare Supplemental benefit will cover this amount.

You Are Protected from Surprise Billing for Certain Services Rendered After January 1, 2022

When you receive emergency care or receive treatment by an out-of-network provider at certain in-network facilities, you are protected from surprise medical billing.

Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance-billing." "Surprise billing" is an unexpected balance bill you receive when you can't control who is involved in your care—such as when you have an emergency, or when you visit an in-network facility but you are unexpectedly treated by an out-of-network provider.

Out-of-network providers are prohibited from balance-billing you for certain emergency services (including post-stabilization services unless you give written consent to the higher charges), as well as certain ancillary services at an in-network hospital or ambulatory surgical center by out-of-network providers, including anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers may not ask you to give up your protection not to be balance-billed. In addition, if you receive other non-ancillary services at these in-network facilities, out-of-network providers can't balance-bill you unless you give written consent.

When balance-billing isn't allowed, your health plan generally may only bill you for your share of the in-network cost of this service. The Fund Office recently mailed participants in the Active Health and Welfare Plan a notice regarding the changes to the Plan to comply with these protections from surprise billing. For more information about surprise billing protections, please refer to that notice, or visit www.cms.gov/nosurprises/consumers.

Retiree Information Forms Will Be Mailed Soon. *Complete and Return This Form!*

The Fund Office will send all retirees a Retiree Information Form (RIF) within the next few months to be completed and returned to the Fund Office. The form asks questions about your current address, your beneficiary, whether you and/or your spouse have other health coverage, and whether you are employed.

This form must be completed and returned every year, even if nothing has changed. It is very important that the retiree complete all sections of this form and promptly send it back to the Fund Office. If we don't receive your RIF, your benefits may be suspended until it is received. To assist you, the Fund Office will include a postage-paid return envelope with the first mailing.

Helpful Reminders

- Do not attach checks or claims to the RIF.
- Report any earnings from all employers.
- Let us know if you or your spouse has other health coverage.
- Be sure to sign the RIF.

No one but the Retiree can sign the RIF, unless an individual holds a Power of Attorney for the Retiree. A copy of any such Power of Attorney must be on file with the Fund Office. If, for health reasons, the Retiree is unable to sign the form and there is no Power of Attorney on file, then the Retiree must sign an "X" on the RIF and have it notarized by a Notary Public.

2022 Coordination of Benefits Forms ("COB") Sent

If you are a participant in the Health & Welfare Fund, you should have received a Coordination of Benefits form in the mail, requesting information about other group health coverage you have (or have been offered). There are Coordination of Benefits rules which may apply if you or your covered dependents have, or your dependents have been offered, coverage under another group health plan. The purpose of the form is to update the Fund Office's records on group health coverage available to you and your dependents.

Please complete the form and return it to the Fund Office as soon as possible. If you misplaced your form or did not receive it earlier this month, please call the Fund Office at (800) 638-2972 to request another one. You can also download a COB form from our website, www.associated-admin.com. Click on the "FELRA & UFCW Health & Welfare" link under the "Your Benefits" dropdown menu at the top of the page. The form is located under the "Downloads" section.

Notice of Scholarship Fund Termination

This notice is to advise you that the Board of Trustees of the VEBA Fund is terminating the Scholarship Fund. This notice also serves as the formal Summary of Material Modification to the Summary Plan Description.

Applicants who timely submitted Preliminary Scholarship Application forms and met the initial scholarship award requirements for a 2021 Annual Scholarship were contacted and mailed full Formal Scholarship Applications in January 2021. Those applicants who timely submitted their Formal Scholarship Applications and provided all documentation required by the Fund were awarded Scholarship Awards for the 2021 calendar year.

Once the 2021 Scholarship Awards have been paid, the Scholarship Fund will terminate and no further Scholarship Awards will be payable.

Please contact the Fund office if you have any questions.

CONIFER HEALTH SOLUTIONS® | Conifer Corner

Staying Active

Fitness means being able to perform physical activity. It also means having the energy and strength to feel as good as possible. Getting more fit, even a little bit, can improve your health. A brisk half-hour walk every day can help you reach a good level of fitness.

Want to be more active?

Conifer Health Solutions and its Personal Health Nurses (PHNs) can help you with those first steps. To get started, call any of your PHNs:

- Lea, at 800.459.2110, ext. 2917
- Renee, at 800.459.2110, ext. 2552, or
- Michelle, at 800.459.2110, ext. 2061

Remember to Claim Severance Benefits When Eligible

If you are eligible for severance benefits, you should apply for your severance benefit immediately after your Severance from Service date. Usually, this is your employment termination date, but there are special rules for participants on a leave of absence. See page 12 of your Severance SPD for more information.

There is a four-month waiting period between your Severance from Service Date and the date that you may receive your Payable Severance Benefit. Your payable Severance Benefit may only be paid to you between the expiration of this four-month waiting period and the later of (1) the last day of the calendar year in which the four-month waiting period expires; or (2) the 15th day of the third calendar month following the expiration of the four-month waiting period.

For example, if you terminate covered employment on April 1, 2022, the four-month waiting period will expire on August 1, 2022, and your severance payment deadline will be December 31, 2022.

If you do not apply for and receive your severance benefit by the deadline under the Plan, you will lose your benefit. Protect your benefit by submitting the application on time! You can print the Severance Application by logging on to www.associated-admin.com, select "Your Benefits," and then "UFCW & FELRA Severance Plan." The Severance Application is located under "Downloads."

2022 Preventive Services Benefits

The FELRA & UFCW Active Health and Welfare Plan, Plans I, X, XX, and XXX, provides coverage for certain preventive services with no cost-sharing, as required by the Patient Protection and Affordable Care Act (ACA). A list of covered preventive services as of January 1, 2022 is available at www.associated-admin.com. To view the list, click on the "FELRA & UFCW Health & Welfare" link under the "Your Benefits" dropdown menu at the top of the page. The list is located under the "Important Notices" section.

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