FOR YOUR BENEFIT

UFCW Unions & Participating Employers Health & Welfare Fund

March 2023 Vol. 39, No. 1

www.associated-admin.com

Summary of Material Modifications This Issue!

UFCW Unions & Participating Employers Active Health and Welfare Plan*

**A Benefit Plan of the UFCW Unions and Participating Employers Health & Welfare Fund*

2023 Preventive Services

The UFCW Unions and Participating Employers Active Health and Welfare Plan, Plans Y, Y20, Y30, and JSS2, 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, 2023 is available at www.associated-admin.com. Click on the "UFCW Unions & Participating Employers Active Health & Welfare Plan" link under the "Your Benefits" dropdown menu at the top of the page. The list is located under the "Important Notices" section.

IRS Form W-4 P

The IRS recently released a new version of the federal tax withholding form intended specifically for withholding taxes from monthly pension benefits:

IRS Form W-4P. The Fund Office is now using the new Form W-4P for federal tax withholding elections, replacing the form previously used. According to the IRS, the purpose of the new form is to help you accurately withhold the correct tax amount from your pension benefit, to avoid over-withholding or under-withholding. If you would like to change your federal tax withholdings at any time in the future, you must do so using the new IRS Form W-4P. You may request a copy of this form by calling the Fund Office, or you may print a copy from the Fund webpage. Note: your current withholdings will continue to be honored unless you decide to change them using the new Form W-4P.

This issue—

The purpose of this newsletter is to explain your benefits in easy, uncomplicated language. It is not as specific or detailed as the formal Plan documents. Those documents always govern.

Material Modifications

Summary of Material Modifications

Below are Summaries of Material Modifications (changes) made to your Plan during the past year. Please clip this summary and keep it with your Plan booklets so you will have it for easy reference.

The Board of Trustees of the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund ("Fund") has adopted the following changes to the UFCW Unions and Participating Employers Health and Welfare Plan. Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits and Coverage ("SBC").

1. 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 medical benefits and weekly disability 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 Weekly Disability Benefits may be satisfied by a visit with the physician through telephone conference, video conference, or similar technology.

2. **The following new subsection is added before the "Definitions" section of your SPD:**

   Prohibition of Assignment of Benefits

   No benefit under the Plan or right under ERISA may be assigned or transferred to another party by a participant or beneficiary. The Fund will not recognize any attempted assignment. Nothing in this SPD or the Fund's Trust Agreement shall be construed to make the Fund, the Trustees, UFCW Locals 27 or 400, or any Participating Employer liable to any third-party to whom a participant, dependent, or beneficiary may be liable for medical care, treatment, or services. The Fund may make direct payments to a medical provider. A direct payment by the Fund to a medical provider does not make the provider an assignee, and in no way confers upon the provider any rights that a participant has under the Plan or ERISA.

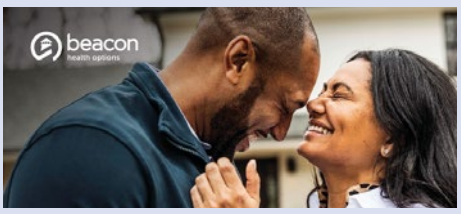
3. **In the first numbered list in the Claims Filing and Review Procedure or Claims Procedures section of the SPDs for Plans Y, Y20, Y30, T, and JSS2, item number 3 (for Plans Y, Y20, and Y30) or number 4 (for Plans JSS2 and T) is revised as follows:**
   Benefit payments will be sent directly to the provider unless there is no payment direction and evidence of your payment is reflected. In that case, payment will be sent directly to you.

4. **In the Claims Filing and Review Procedure section of the SPDs for Plans Y, Y20, Y30, T, and JSS2, under the "When you File a Claim" or "Filing a Claim" subsection, the last sentence of item number 4 (for Plans Y, Y20, and Y30), item number 13 (Plan JSS2), or item number 14 (for Plan T) is revised as follows:**

   Benefit payments will be sent directly to the provider unless there is no payment direction and there is evidence of your payment on the bill.

Have You Heard?

On March 1, 2023, Beacon Health Option became Carelon Behavioral Health.



How will this affect you?

- The new name will not impact your plan or your service.
- You do not need to take any action.
- Your benefits and plan will not change.
- You can see all of your previous doctors and health professionals.
- All phone numbers, emails, websites, and apps will redirect you to the right place.

Retiree Information Forms Will Be Sent: Return Promptly to Avoid Suspension of Pension Benefits

The Fund Office will send all retirees (and beneficiaries who are collecting a benefit) 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.

It is very important that you review all sections of this form to be certain the information is correct. Mark any corrections on the form and promptly send it back to the Fund Office. It is critical that the Fund Office timely receives your completed RIF to avoid any interruption of your monthly benefits. To assist you, the Fund Office will include a postage-paid return envelope with the RIF.

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 another individual holds legal authority to sign on the Retiree's behalf, such as a Power of Attorney or legal guardian. A copy of any such Power of Attorney or other legal document 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 or legal documentation on file, then the Retiree must sign an "X" on the RIF and have it notarized by a Notary Public.

We appreciate your cooperation!

Kaiser Permanente Open Enrollment Letters Mailed

The following article applies to active participants in Plans JSS2, Y, Y20 and Y30.

From March through May 15th is the Open Enrollment period for choosing how you would like your medical coverage provided: through the Fund office or through Kaiser Permanente HMO. You will receive a letter about the Kaiser option in March, including the cost to you to enroll. The costs vary by Plan and in some cases by Individual/Family coverage, so read carefully to be sure you understand the applicable costs. Payment for the Kaiser option must be made directly to the Fund office, by check. If you don't make the monthly co-premium payment, your medical coverage will be terminated and may not be reinstated until June 1st of the next year.

Under Kaiser, most services are covered with a required "per visit" co-pay you must pay. Check the benefit summary from Kaiser to see the required co-pay. You must see a Kaiser Permanente provider in order to be covered.

If you would like to enroll in the Kaiser option, contact Kaiser Member Services immediately at (800) 777-7902 and request a packet with an enrollment form. If you are enrolled in the Kaiser option and want to change back to the medical coverage processed by the Fund office, contact the Fund office and request a disenrollment form. You must disenroll with Kaiser in order to change to Fund coverage.

If you don't want to make a change, DON'T DO ANYTHING.

Changes in coverage are effective June 1st and remain in effect until May 31st of next year.

Advance Benefits for Workers' Compensation Claims

The Fund does not cover work-related claims because they are covered under Workers' Compensation. However, if your injury or illness is NOT work-related or if it is, and you apply for Workers' Compensation and your claim is denied by either your employer or your employer's insurance carrier, you may apply to the Fund for Weekly Disability or medical benefits.

Carrier vs. Commission

Your employer or your employer's Workers' Compensation carrier is the entity that provides work-related Injury or Sickness benefits to you and other employees of your employer. You will be sent a letter from your employer or its claims adjuster after the carrier reviews your claim, stating their decision. You must send a copy of this letter to the Fund Office.

If your employer or the carrier denies your claim for Workers' Compensation, you must appeal that denial to the Workers' Compensation Commission in order to receive benefits from the Fund related to your work-related Injury or Sickness. In order for the Fund to consider your work-related claim, your case must be heard before the Commission. When you receive a copy of the Commission's decision, you must forward it to the Fund Office.

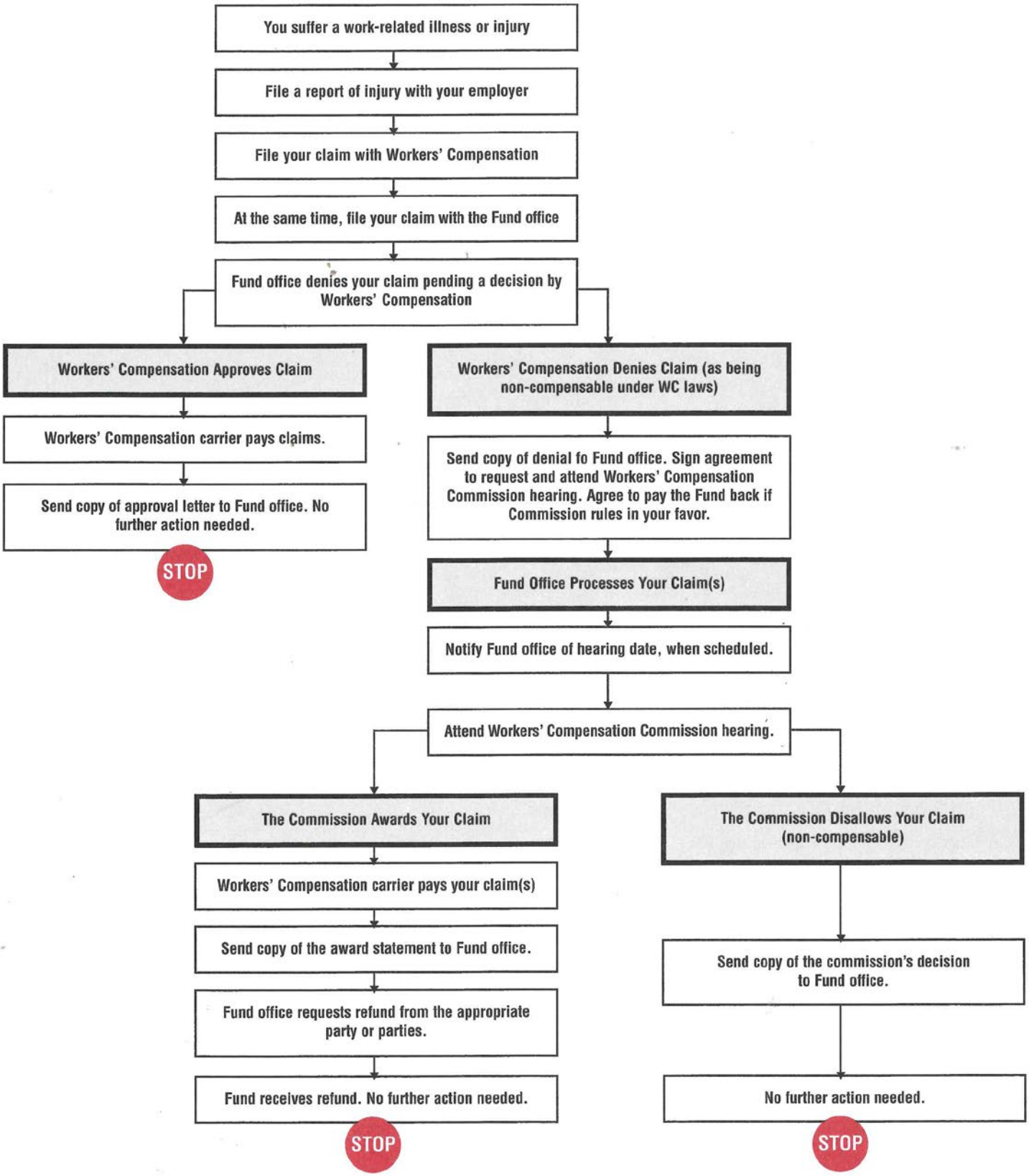
The Fund will pay benefits provided that:

1. You file a claim with the Fund on time.
2. You submit a copy of the written denial from your employer or your employer's Workers' Compensation carrier. The denial must state that the claim is denied because it is not compensable, meaning that it is not work-related. If the claim is denied for any other reason, the Fund will not cover it.
3. You appeal the denial of your Workers' Compensation claim to the Workers' Compensation Commission for final adjudication within 30 days from the date the claim is denied by your employer.
4. You take all procedural action necessary to pursue your appeal with the Workers' Compensation Commission.
5. If you fail to file an appeal with the Commission within 30 days from the date the claim is denied by your employer, all benefits terminate and you must immediately repay to the Fund payments made by the Fund to you and/or your provider relating to your Injury or Sickness.
6. You notify the Fund Office of the date of your Workers' Compensation Commission hearing (when scheduled), and you attend the hearing.
7. You obtain approval from the Fund prior to any settlement of your appeal. If you accept a settlement in connection with your Workers' Compensation claim, the Fund will consider this an indication that your claim is work-related and will require that you reimburse the Fund, in full, for any benefits it has paid on your behalf relating to your Workers' Compensation claim.
8. If the Workers' Compensation Commission determines that your claim is compensable, all Fund benefits terminate and you must immediately repay to the Fund payments made by the Fund to you and/or your provider relating to your Injury or Sickness.
9. If the Workers' Compensation Commission denies your claim for ***any reason OTHER than being non-compensable under the Workers' Compensation laws of that state, you must immediately repay to the Fund payments made by the Fund to you and/or your provider relating to your Injury or Sickness***. If the Commission denies your claim as being non-compensable and you don't appeal that denial, you may keep any payments the Fund has advanced to you. However, if you decide to pursue your claim after that denial and you receive any recovery, whether by judgment, settlement, or compromise, you must repay the Fund the payments advanced to you.
10. You must sign the Fund's forms agreeing to comply with these procedures.

Please refer to your Summary Plan Description for more information on the benefits described in this article, including the Fund's rights and your obligations with respect to any amounts that are due to the Fund as described above.

The helpful chart to the right shows the steps to follow when filing a work-related claim.

Claims Process for Work-Related Incidents



Accident and Sickness Benefits are Taxable

Tax season is here and participants who have utilized Weekly Disability, also known as Accident and Sickness ("A&S"), benefits should know that these benefits are taxable and must be reported on IRS tax returns. Unless requested, income tax is not automatically withheld from your A&S payments.

If you do want taxes withheld from your Weekly Disability check, you will need to complete IRS Form W-4S. This form is available at www.associated-admin.com. Go to "Your Benefits" located both at the top of the page as a drop down box and on the left side of the page. Under the "Downloads" heading, select "Request for Federal Income Tax Withholding from Sick Pay". You may also call the Fund Office at (800) 638-2972 and ask to have the form mailed to you. IRS has a few simple rules to follow when filling out Form W-4S. Withholding amounts must:

- Be in whole dollars (for example, $25, not $25.50);
- Be at least $4 per day, $20 per week, or $88 per month based on your payroll period; and
- Not reduce the net amount of each sick pay payment that you receive to less than $10.

Weekly Disability Benefits: Helpful Reminders

Before scheduling a surgery or going out on sick leave, make sure that you have satisfied your Plan's waiting period for Weekly Disability (sometimes called "accident and sickness", or "A&S") benefits. Check your Summary Plan Description ("SPD") or call the Fund Office to confirm that you're eligible for these benefits.

A&S Claim Form

Be sure that your Accident & Sickness claim form is completed ***in full*** before you submit it to the Fund Office. If you don't answer all the questions on the form, it will be returned to you and will delay the processing of your claim.

Mental Health Related Claims

If your disability is due to a mental health condition, call **Carelon Behavioral Health** ("Carelon") at 800 353-3572 for a referral. You must be seen by a **Carelon Behavioral Health** provider for payment of the disability claim.

Benefit Exhaustion

Your eligibility status for other benefits will be maintained while you are receiving Weekly Disability benefits, but if you exhaust your Weekly Disability benefits and don't return to active employment, you will lose eligibility, and all health benefits (medical, optical, dental and prescription drug) under the Fund will terminate.

The Fund office can tell you the maximum amount of leave available to you under your Plan. This information is also stated in your Summary Plan Description ("SPD") booklet.

Understanding the "Hold Harmless" Provision

As you may know, under certain circumstances, the Fund will defend participants and dependents who are being pursued by a provider for payment of a claim if the reason for the Fund's denial was that the provider was late in submitting it. However, in order for the Fund to defend you, the following requirements must be met:

1. If you receive a bill or lawsuit from the provider for services that were provided to you, and you believe these "hold harmless" rules apply, contact the Fund Office within two weeks of when you receive the bill to notify us that the provider is pursuing you and to request that the Fund defend you against attempts by the provider to collect payment. **If you don't notify the Fund Office within this two-week period, the Fund will not defend you** and the provider can hold you responsible. Notify the Fund Office upon the first collection attempt by the provider, as well as any follow-up attempts

2. If you receive a bill from a provider, it could be because the Fund Office has not received or paid it yet. The hold harmless protection applies when the Fund has denied the claim for lateness and the provider then attempts to collect the amount from you. In other words, just because you receive a bill, don't automatically apply for hold harmless protection. Contact the Fund Office to make sure we've received it.

Finally, please note that the Fund will not defend you against a provider's collection attempts if the reason for the provider's late filing of the claim was your failure to inform the provider of your Fund coverage.

Call Conifer for Hospice Care

The following article applies to active participants with Fund medical coverage. It does not apply to Kaiser HMO participants or retirees.

Hospice care benefits are provided through the Fund for terminally ill participants or eligible dependents whose prognosis of probable survival is six months or less and who are receiving palliative, not curative, care. Covered hospice care services include intermittent nursing care by a registered or licensed practical nurse, physical therapy, speech therapy, occupational therapy, services of a licensed medical social worker, home health aide visits, prescription drugs, lab tests and x ray services, medical surgical supplies, oxygen, Durable Medical Equipment, Physician home visits, ambulance and wheelchair transportation to or from the Hospital for palliative treatment and admission as an Inpatient. Your family may receive counseling and submit a claim to the Fund Office. The Fund pays up to $500 for family counseling prior to the participant's death and up to $100 for bereavement visits to the family (parents, spouse, brothers, sisters, or children) within three months after the death of a participant or eligible dependent who received Plan approved hospice benefits.

Pre-certification is required and services must be approved by Conifer Health Solutions by calling toll free (866) 290-8147.

CONIFER HEALTH SOLUTIONS® | Conifer Corner

Stress Awareness

Recognizing and managing daily stressors is an important aspect of your health plan. Try to include a few stress relievers every day – choose healthy meals and snacks, take a walk outside or engage in exercise, try a few breathing exercises or yoga, and be sure to get a good night's sleep.

Good health can be stress free?

Conifer Health Solutions and its Personal Health Nurses (PHNs) are the perfect option for you and your family's health needs. To get started, call Elizabeth Woodrow, BSN, RN, CCM at 410-919-0488.

Dentists Can Help Diagnose Diabetes

Because the symptoms of diabetes may be subtle, many people with the disease aren't aware they have it. About a third of people with diabetes have not been tested or diagnosed with the disease. Dentists could play an important role in helping correct this, according to an article in the Journal of Periodontal Research. Because of high glucose levels, people with diabetes often have problems with their teeth and gums – increased glucose helps bacteria thrive.

Asking patients with serious periodontal (gum) disease about their family and personal medical history could help dentists steer individuals likely to have diabetes to their regular doctor for help.

In addition to gum disease, diabetes also makes people more susceptible to:

- Sore or loose teeth
- Fungal mouth infections
- Mouth ulcers
- Dry mouth
- Cavities

People with diabetes who have good control of their blood sugar are less apt to develop these problems.

*** Article provided by Dentegra/Delta Dental.*

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