FOR YOUR BENEFIT

UFCW Unions & Participating Employers Health & Welfare Fund

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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.

Open Enrollment for Health and Welfare Coverage Is December 1st – December 31st

December 1st through December 31st is open enrollment to choose health and welfare coverage through the Fund **effective January 1, 2022** and continuing through December 31, 2022 (assuming you remain eligible).

If you don't currently have health coverage through the Fund, this is your opportunity to enroll. If you do have coverage, this is your chance to add or drop dependents or to drop coverage. If you are already enrolled and don't want to make any changes to your coverage, don't do anything.

Open Enrollment Letter

You will receive an open enrollment letter, along with an enrollment form and, for all except Plan Y40, a payroll deduction form from the Fund Office. If a spousal surcharge applies to your Plan of benefits, you will also receive a spousal surcharge form. ***If you are changing your coverage or enrolling for the first time, the Fund Office must receive both the enrollment form and applicable payroll deduction form.*** For example, if you are already enrolled with single coverage and want to add coverage for your spouse, note the change on the payroll deduction form, complete the enrollment form and return both to the Fund Office. If you don't want to make changes, there is no need to return the forms. You will remain in your current coverage (assuming you are still eligible for the same Plan).

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.

IMPORTANT!

All Health Benefits Terminate When You Drop Fund Coverage

If you wish to disenroll from Fund health coverage, call the Fund Office to request a disenrollment form. Complete and return the form. **Note: when you disenroll, all health benefits terminate.** You will no longer have Medical, Weekly Disability, Life Insurance, Accidental Death & Dismemberment, Prescription Drug, Optical or Dental benefits from the Fund. You will, if eligible, still have Legal and Pension benefits.

What Is The Cost? (All Costs Are Payable Via Payroll Deduction)

Plan JSS2 Full-Time and Part-Time Participants

- Individual coverage - $5 per week
- Participant plus one dependent - $10 per week
- Family coverage - $15 per week
- An additional spousal surcharge - $20 per week if applicable. See description below.

Plans Y and Y20 Full-Time Participants

- Individual coverage - $5 per week
- Participant plus one dependent - $10 per week
- Family coverage - $15 per week
- An additional spousal surcharge - $20 per week if applicable. See description below.

Plan Y30 Full-Time Participants

- Individual coverage - $10 per week
- Participant plus child/ren - $15 per week
- Participant plus spouse - $20 per week
- Family coverage - $25 per week
- An additional spousal surcharge - $20 per week per applicable. See description below.

Plan Y Part-Time Participants – Individual Only Coverage

If you are a part-time participant and you would like to enroll yourself for coverage, the cost deducted from your payroll for individual only coverage is $5 per week.

Plan Y Part-Time Participants - Dependent Coverage

If you are a **Local 400 Plan Y part-time participant hired after September 4, 1996 or a Local 27 Plan Y part-time participant hired after May 27, 1997** and you elect dependent coverage, you must pay part of the cost for dependent coverage. Your employer pays 80% of the cost and you pay 20% (via payroll deduction with your employer). Contact your employer to see how much the payroll deduction will be. ***A $20 per week spousal surcharge may also apply.***

If you are a **Local 27 Plan Y part-time participant hired on or before May 27, 1997** and you elect dependent coverage, the amount below is the cost for such dependent coverage that must be deducted from your payroll.

- $10 per week for the participant plus one dependent,
- $15 per week for family coverage,
- An additional spousal surcharge of $20 per week, if applicable. See description below.

Plan Y20 and Y30 Part-Time Participants – Dependent Child Coverage

If you are a Plan Y20 or Y30 part-time participant and you elect coverage for dependent child(ren), you must pay the full cost for that coverage. Your open enrollment material will specify the costs for dependent child(ren) coverage.

Spousal Surcharge

Full-time participants in Plans Y, Y20, Y30 and JSS2, and part-time participants in Plan Y, must pay an additional $20 per week deduction for dependent spouse coverage if one of the following conditions is applicable (note: the spousal surcharge does not apply if your spouse also is a participant in the Plan, rather than a dependent):

1. Your spouse is eligible for coverage through his/her employer, but elects not to enroll, or
2. Your spouse is enrolled in his/her employer's coverage *and* also elects Fund coverage on a secondary basis. In this case, the ***non-duplication coordination of benefits rules apply.*** Any secondary benefit payment will be determined by calculating the primary payment, subtracting it from what the Fund's payment would have been, and paying the remaining amount, if any. For example, if your spouse's primary coverage paid 80% for a certain service and the Fund's payment would also have been 80%, no additional payment would be payable under the Fund.

If you are eligible for dependent spouse coverage, a Spousal Surcharge form will be included with your open enrollment packet. It must be completed and signed in order to add your spouse.

Your Life Insurance Benefit

The following article applies to active eligible Participants enrolled in Plans Y, Y20, Y30, Y40, JS and JSS2 who have submitted a completed beneficiary enrollment form.

If you die while covered under the Plan, the amount of your life insurance (a.k.a. life benefit) is payable to the person you have named as your beneficiary.

There are different benefit amounts depending on your Plan and status (full time or part time). A part-time participant who has satisfied the initial eligibility requirement and is later promoted to full-time will continue to be eligible for the part-time life benefit until he/she becomes eligible for full-time benefits under the Plan. A participant is never eligible for both a part-time and a full-time life benefit.

Benefits *(Participant Only)*

Plans Y, Y20 and Y30	Full-Time	$20,000
	Part-Time	$10,000
Plan Y40	Part-Time	$10,000
Plan JS	Full-Time	$5,000
Plan JSS2	Full-Time	$20,000
	Part-Time	$10,000

Beneficiary

You may name any person you choose to be your beneficiary. You may change the named beneficiary at any time.

1. Contact the Fund Office for an enrollment form.
2. Complete and sign the form.
3. Return the form to the Fund Office.

Only enrollment forms designating a beneficiary which are properly completed, signed, and received by the Fund Office prior to a participant's death will be honored.

If the beneficiary you designate dies before you and/or you fail to designate a beneficiary, the life benefits will be paid to the first survivor in the following order:

1. Your spouse
2. Your children
3. Your parents
4. Your brothers and sisters
5. Your estate

If you and your spouse or designated beneficiary die at the same time, or simultaneously as determined by relevant state law, as a result of injuries sustained or resulting from the same accident or event, your spouse or designated beneficiary will be deemed to have pre-deceased you for purposes of this life benefit.

Coordination of Benefits: When Benefits Are Available Outside Fund Coverage

Coordination of Benefits applies when a **participant or eligible dependent** is entitled to benefits under any other kind of group health coverage in addition to the Fund. When duplicate coverage exists, the primary plan normally pays benefits according to its Schedule of Benefits, and the secondary plan pays a reduced amount. **The Fund will never pay, either as the primary or secondary plan, benefits which, when added to the benefits payable by the other plan for the same service, exceed 100% of the Usual, Customary, and Reasonable (UCR) charge under the Plan.**

Example: Suppose your spouse has a medical claim of $500, and your spouse's primary carrier paid 70% of the claim ($350). If the Fund had paid this medical claim as primary, the payment would have been 70% of approved charges, meaning the Fund would have paid a maximum of $350. The Fund would not make any payment on this claim as secondary because the primary coverage already has paid the maximum amount the Fund would have paid as primary.

These provisions apply whether or not a claim is filed under Medicare or another plan. The Fund is authorized to obtain information about benefits and services available from Medicare or other plans to implement this rule.

If one plan does not have a coordination of benefits rule, it will be primary. Otherwise, the plan which covers the person as an employee is the primary plan. The plan which covers the person as a dependent is the secondary plan.

Please consult the "*Coordination of Benefits*" section of your Summary Plan Description for a more detailed explanation of the Fund's coordination of benefits rules.

Advance Benefits for Workers' Compensation Claims

The Fund does not cover claims arising from a work-related Injury or Sickness. If you suffer an Injury or Sickness that is work-related, you must file a claim for Workers' Compensation benefits with your employer. If 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 <u>OTHER</u> 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.

Know the Type of Claim You Are Filing

Are you preparing to file a claim? Have you already filed a claim? It is important not only to understand the claims process, but also the different types of claims and the procedures that apply to them.

What are the types of claims?

1. ***Pre-Service Claim.*** A Pre-Service Claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or part, on the Fund's approval of the benefit before you receive the medical care. For example, a request for services for which pre-certification is required, as described in your Summary Plan Description, would be a Pre-Service Claim.
2. ***Urgent Care Claim.*** An Urgent Care Claim is a Pre-Service Claim that requires shortened time periods for making a determination where the longer time periods for making non-Urgent Care determinations 1) could seriously jeopardize your life or health or your ability to regain maximum function or 2) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. It is important to note that the rules for an Urgent Care Claim apply only when the Plan requires approval of the benefit before you receive the services; these rules do not apply if approval is not required before health care is provided, for example in the case of an emergency.
3. ***Concurrent Care Claim.*** A Concurrent Care Claim is a request for the Fund to approve, or to extend, an ongoing course of treatment over a period of time or number of treatments, when such approval is required by the Plan. If you have been approved by the Fund for Concurrent Care treatment, any reduction or termination of such treatment (other than by Plan amendment or termination of the Plan) before the end of the period of time or number of treatments will be considered denial of a claim. The Fund will notify you of the denial of the claim at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on review of the denial of the claim before the benefit is reduced or terminated.
4. ***Urgent Concurrent Care Claim.*** Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care Claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care Claims (see above), except the Fund will notify you of the decision (whether approved or denied) within 24 hours after the Fund's receipt of the claim, provided that the claim is made to the Fund at least 24 hours before the end of the previously approved period of time or number of treatments.
5. ***Post-Service Claim.*** A Post-Service Claim is any claim under the Plan that is not a Pre-Service Claim. Typically, a Post-Service Claim is a request for payment by the Fund after you have received the services.

For a more detailed explanation of the procedures that apply to the types of claims listed above, including the procedures that apply when a claim is improperly filed or denied, please consult the "*Claims Filing and Review Procedure*" section of your Summary Plan Description.

It's Our Business to Care about Your Vision

Those who don't think they need vision insurance should keep in mind one number: 196.

That's the average national cost, in dollars, of a pair of eyeglasses. But that's not the entire cost of getting glasses. It doesn't include the expense of the eye exam or features such as anti-reflective or glare-free lenses.

Here are a few more numbers to remember: Almost 21 million adult Americans experience vision loss, and 75 percent require vision correction, according to the Vision Council. Yet roughly 3.4 million Americans are uninsured and receive no vision benefits. Multiply that by a pair of glasses, and you've got nearly $7 million in uninsured frames annually – and that is a lot of money!

When looking at these numbers, it's easy to see why vision care is important, but a lot of us still tend to be shortsighted when it comes to vision insurance. Instead we focus on major medical coverage, possibly dental, and eye care gets missed.

It's understandable since some of the most common eye conditions don't become evident until middle age. However, many vision issues are unexpected and can go undetected for far too long. A regular eye exam is important and can detect other health problems such as diabetes. Exams are included in the Fund's vision benefits at no cost to you.

"Eyeglasses Cost," Cost Helper Health, http://health.costhelper.com/eyeglasses.html

Facts and Figures on Adults with Vision Loss," American Foundation for the Blind, May 2014, http://www.afb.org/info/blindness-statistics/adults/facts-and-figures/235

The above article was provided by Group Vision Service.

CONIFER HEALTH SOLUTIONS®

Conifer Corner

Fueling your body right!

Healthy eating starts with adding more fruits, vegetables, and whole grains to your diet. It also means cutting back on foods that have a lot of fat, salt and sugar. Listening to your body, eating in moderation and varying your food choices can help you to get the nutrients your body needs.

Need more motivation?

Conifer Health Solutions and its Personal Health Nurses (PHNs) are available to help you to set simple and manageable goals. 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

Weekly Disability Benefits: Helpful Reminders

Eligibility

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. Consult your Summary Plan Description ("SPD") or call the Fund Office to determine if you are currently eligible.

A&S Claim Forms

Be sure that your Accident & Sickness claim form is completed in full before you submit it to the Fund Office. If you fail to answer all 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 Beacon Health Options ("Beacon") at 800 353-3572 for a referral. You must be seen by a Beacon Health Options 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 do not return to active employment, you will lose eligibility and all of your benefits will terminate.

HEALTH CORNER

Pets: A Prescription for Your Good Health

Any pet owner will tell you animals are good for people's health. Who hasn't heard about an elderly or homebound person whose "reason to live" is a companion animal? Anyone who regularly walks is certainly reaping some heart-healthy aerobic benefits.

Over the past several decades, studies and surveys have found that having a pet can help you in ways such as these:

- Comfort and emotional support.
- Companionship, guarding against loneliness and depression.
- Social facilitators, aiding in a person's ability to meet and interact with others.
- May have lower cholesterol levels and blood pressure.
- Decreased anxiety and stress response.
- Protect against illness and chronic disease.
- Positively influence childhood development.

Is it time for a pet?

Only you can decide if pet ownership is right for you and your family. While the benefits of pet ownership are undeniable, pet ownership also involves a great deal of responsibility. Take time to consider if pet ownership is right for you, and avoid spontaneous decision-making.

The above article was obtained with permission from Beacon Health Options. This information is general and not intended to replace the advice of your doctor. Consult your personal physician about your own medical condition.

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