FELRA UFCW

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

1099Rs Will Be Mailed in Late January. Look for Yours!

December 2020 Vol. 37 No. 3
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For Your Benefit

Summary Annual Report in This Issue!
FELRA & UFCW VEBA Fund

This issue—

Open Enrollment for Health and Welfare Coverage Is Now through December 30th

Now through December 30, 2020 is open enrollment to choose health and welfare coverage through the Fund **effective January 1, 2021 and continuing (assuming you remain eligible) through December 31, 2021.**

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 dependents (if eligible) or to drop coverage.

Not Enrolled

If you are not currently enrolled in Fund health and welfare coverage, you were sent a letter, enrollment form, payroll deduction form and, if applicable, a spousal surcharge form.

If You Are Currently Enrolled

If you are already enrolled and want to change coverage levels (from single coverage to husband/wife, for example) or to drop coverage completely, call the Fund Office by December 30, 2020. If you are not making changes, **don't do anything.**

If you are changing your coverage or enrolling for the first time, the Fund Office must receive both the enrollment form and payroll deduction form by December 30 for coverage to begin as of January 1, 2021.

Continued on Page 2

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. Nothing in this newsletter is intended to be specific medical, financial, tax, or personal guidance for you to follow. If for any reason,the information in this newsletter conflicts with the formal Plan documents, the formal Plan documents always govern.

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Cost for Coverage (All costs payable via payroll deduction)

Plans I, X and XX Full Time Participants

Single coverage	$5/Week
Participant + one dependent	$10/Week
Family coverage	$15/Week

Plans XXX Full Time Participants

Single Coverage	$10/Week
Participant + child(ren)	$15/Week
Participant + spouse	$20/Week
Family Coverage	$25/Week

Plans X Part Time Participants

Single coverage	$5/Week
Family coverage	20% of cost*

*Plan X part time participants may add dependent coverage by paying 20% of the cost of the coverage. Such dependent coverage would be effective January 1. Contact the Fund Office for the exact amount of the payroll deduction if you are interested in adding this coverage.

Plan XX Part Time Participants

Single coverage	$5/Week
Per Child Rate:	$131.53/Month
Two Children:	$263.06/Month
Three or More Children:	$394.59/Month

Plan XXX Part Time Participants

Single coverage:	$10/Week
Per Child Rate:	$138.72/Month
Two Children:	$277.44/Month
Three or More Children:	$416.16/Month

Spouses of Plan XX and Plan XXX part time participants are not eligible for coverage. Part time participants in Plans XX and XXX who enroll a child/ren will continue to pay the $5 or $10 weekly co-payment in addition to the amounts shown above.

Spousal Surcharge Applies To All Full Time Participants and Part Time Plan X Participants, As Follows:

A $20 weekly spousal surcharge will be deducted from your paycheck if you elect coverage for your spouse and:

- your spouse is eligible for coverage through his/her employer, but is not enrolled in that coverage; or
- your spouse is also enrolled in his/her employer's coverage. In this case, the Fund will provide secondary coverage to your spouse and the **non-duplication coordination of benefits rules apply.** Any secondary benefit payment will be determined by calculating 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.

Note: ***The spousal surcharge does not apply if your spouse is also employed by Giant or Safeway.***

Coordination of Benefits

When an eligible dependent under the Plan is offered a program of health, dental, drug, and/or vision benefits by another employer as a result of his or her employment, and the dependent has the option of selecting the other employer's health coverage or receiving cash or other financial incentives, this Plan coordinates its benefits as if the other employer's health coverage were applicable. It does so even when the dependent does not elect the coverage under another employer sponsored plan. Before the Fund will pay benefits to an employed dependent, he or she must provide the Fund Office with information explaining the other employer's health coverage, if any.

Part Time Participants in Plans XX and XXX

Coverage for part time participants shall be secondary if the employee is covered under another plan.

If you have questions, contact the Fund Office at (800) 638-2972. We are happy to assist you.

Summary of Material Modifications

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, XXX, and XL. Please keep this document with your Summary Plan Description ("SPD").

1. **The subsection entitled "Coverage Options Other than COBRA Coverage" or "Other Coverage Options besides COBRA Coverage" under the Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") Section of your SPD is deleted and replaced with the following:**

Coverage Options Other than COBRA Coverage

Instead of enrolling in *COBRA* coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, *Medicare*, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than *COBRA* continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Enrollment in *Medicare* Instead of COBRA Coverage after Coverage under the Plan Ends

In general, if you don't enroll in *Medicare* Part A or B when you are first eligible because you are still employed, after the *Medicare* initial enrollment period, you have an 8-month special enrollment period (https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods) to sign up for *Medicare* Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in *Medicare* and elect *COBRA* continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect *COBRA* continuation coverage and later enroll in *Medicare* Part A or B before the *COBRA* continuation coverage ends, the Plan may terminate your continuation coverage. However, if *Medicare* Part A or B is effective on or before the date of the *COBRA* election, *COBRA* coverage may not be discontinued on account of *Medicare* entitlement, even if you enroll in the other part of *Medicare* after the date of the election of *COBRA* coverage.

If you are enrolled in both *COBRA* continuation coverage and *Medicare*, *Medicare* will generally pay first (primary payer) and *COBRA* continuation coverage will pay second.

For more information visit: https://www.medicare.gov/medicare-and-you.

2. **The following new subsection is added after the subsection "*Medicare* – Coordination of Benefits for Participants Who are 'Actively Working'" under the Coordination of Benefits Section of your SPD:**

Medicare – Coordination of Benefits for Participants Who Are on COBRA

If you or your eligible dependent is eligible for *Medicare* and then elects *COBRA* continuation coverage, *Medicare* will be primary to the Fund's benefits (except in the case of End Stage Renal Disease ("ESRD") as set forth below).

3. **The subsection "3. End Stage Renal Disease (ESRD)" under the Coordination of Benefits Section of your SPD is deleted and replaced with the following:**

End Stage Renal Disease (ESRD)

If you or your eligible dependent(s) are entitled to *Medicare* on the basis of age or disability and you become entitled to *Medicare* based on ESRD, and the Plan is currently paying benefits as primary or you or your eligible dependent(s) are receiving *COBRA* continuation coverage under the Plan, the Plan will remain primary for the first 30 months of your entitlement to *Medicare* due to ESRD. If the Plan is currently paying benefits secondary to *Medicare*, the Plan will remain secondary upon your entitlement to *Medicare* due to ESRD (unless you are receiving *COBRA* continuation coverage).

New Prescription Program for *Medicare* Retirees Who Have Express Scripts Rx Coverage

Starting January 1, 2021, 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.

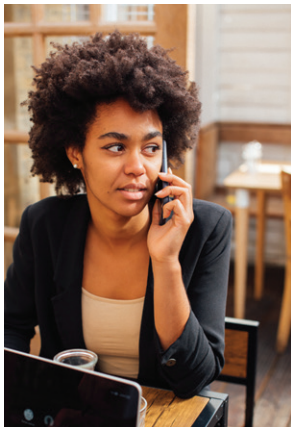
Retirees receiving drugs affected by the change to the EGWP program received a letter in November notifying them of the changes to their coverage for the drugs, giving them time to work with their doctors and the ESI EGWP team to make any necessary change.

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.

Welcome to the new program.

Be Wary of Offers for Additional/Supplemental Coverage!



It is common to receive calls from insurance companies offering health plans and supplemental coverage during this time of year. Should you choose to pursue additional coverage, it is very important that you contact the Fund Office to determine whether or not it will have an effect on your current benefits before proceeding. Enrolling in a new plan may disqualify you from using your benefits through the Fund.

Don't sign up for anything you do not understand. Call the Fund Office at (410) 683-6500 or toll-free (800) 638-2972 to speak with a representative before electing new coverage.

EXPRESS SCRIPTS®

Express Scripts Formulary Drug Change

The Express Scripts formulary will change effective January 1, 2021. To view the list, log on to www.associated-admin.com, click on "Your Benefits" and select FELRA & UFCW Health and Welfare Plan. Under "Downloads," you can view the "2021 Express Scripts National Preferred Formulary List."

If a prescription you are currently taking is affected, you will receive a letter notifying you of the change and a list of alternative medications will be provided.

Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund

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Summary Annual Report for FELRA and UFCW VEBA Fund

This is a Summary of the Annual Report for the FELRA and UFCW VEBA Fund (Employer Identification No. 52-1036978, Plan No. 501) for the period January 1, 2019 to December 31, 2019. The Annual Report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $42,172,810 as of December 31, 2019 compared to $40,098,226 as of January 1, 2019. During the plan year, the plan experienced an increase in its net assets of $2,074,584. This increase includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year. During the plan year, the plan had total income of $136,538,233. This income included employer contributions of $129,563,089, employee contributions of $4,614,989, realized gains of $29,085 from the sale of assets and earnings from investments of $2,329,415, and other income of $1,655. Plan expenses were $134,463,649. These expenses included $9,151,533 in administrative expenses and $125,312,116 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full Annual Report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report;
2. Assets held for investment;
3. Financial information and information on payments to service providers;
4. Transactions in excess of 5 percent of the Plan assets; and
5. Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full Annual Report, or any part thereof, write or call the office of:

Board of Trustees of the FELRA & UFCW VEBA Fund
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
52-1036978 (Employer Identification Number)
410-683-6500

The charge to cover copying costs will be $7.50 for the full report, or $0.25 per page for any part thereof.
You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full Annual Report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report.
The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the Annual Report at the main office of the Plan:

Board of Trustees of the FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

And at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.

Additional Explanation

Dental Claims - Group Dental Services, Inc. - Premiums Paid $6,083,830.
Medical Claims - Kaiser Foundation Health Plan - Premiums Paid $8,534,907.
Life Insurance/Accidental Death & Dismemberment Claims – Symetra - Premiums Paid $223,113.
Vision Claims - Advantica - Premiums Paid $510,478.
EAP Program – Beacon Health – Premiums Paid $70,155.

Flu Shots Are Covered

This article applies to participants in Active Plans I, X, XX and XXX who have Fund medical and/or prescription coverage.

Participants with Fund Coverage

Active participants in Plans I, X, XX and XXX, and Plan I Retirees who have medical or prescription coverage through the Fund, can receive the flu vaccine at any Giant or Safeway pharmacy at no cost, using their Express Scripts prescription drug ID card.

Flu Shot at Doctor's Office

Participants in one of the above Plans also may receive the flu shot at their doctor's office. If the primary reason for the office visit is preventive and a flu shot is administered, then the office visit and flu shot will be paid at 100%. If the flu shot is administered and there is a medical reason for the office visit other than just the flu shot, the flu shot will be paid at 100% and the office visit will be paid at 80% for Plans I and X, 75% for Plan XX and 70% for Plan XXX, based on the diagnosis for the visit. If there has been a previous preventive visit and there is not a medical diagnosis listed, the office visit will be denied and only the flu shot will be paid at 100%. Members are only entitled to 100% coverage for one routine preventive office visit per year. Participants in Plans X, XX and XXX **must** use a participating CareFirst provider in order to be covered.

Participants with Kaiser Permanente HMO Coverage

For participants in the Kaiser Permanente HMO who prefer to get a flu shot from their doctor, the flu shot is covered in full, with no co-pay, as long as you use a Kaiser physician. Members can get a flu shot at no cost – no appointment needed – at any Kaiser Permanente medical center. To find the nearest Kaiser Permanente medical center, go to kp.org/flu or contact Member Services at (800) 777-7902, Monday through Friday (except holidays), 7:30 a.m. to 5:30 p.m. Actively working participants covered by Kaiser who use Express Scripts for their prescription benefit may also choose to get a flu shot at a Giant or Safeway pharmacy using the Express Scripts ID card, at no cost.

Reconstructive Surgery Following Mastectomy

The following article applies to you if your medical benefits are provided through the Fund, not an HMO. If you have coverage through an HMO, you should receive a similar notice directly from the HMO.

The Women's Health and Cancer Rights Act ("WHCRA") provides protections for individuals who elect breast reconstruction after a mastectomy. Under federal law related to mastectomy benefits, the Plan is required to provide coverage for the following:

- All stages of reconstruction of the breast on which a mastectomy is performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of all stages of mastectomy, including lymphedema.

Such benefits are subject to the Plan's annual deductibles and co-insurance provisions. Federal law requires that all participants be notified of this coverage annually.

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 January 1, 2021, the four-month waiting period will expire on May 1, 2021, and your severance payment deadline will be December 31, 2021.

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."

Be Sure Your Beneficiary Designation Is Current

Under the FELRA and UFCW Pension Fund and the Mid Atlantic Pension ("MAP") Fund, upon the death of any eligible pensioner except a pensioner receiving a deferred vested pension, the pensioner's beneficiary will receive a death benefit. To be sure the benefit is paid to the person you intended, make sure that your beneficiary designation form is up to date.

Print this form from your computer by logging onto our website (see instructions on left) and printing the "Change in Beneficiary" form. You can also call the Fund Office at (410) 683-6500 or toll-free (800) 638-2972 to request a copy of the form. Completed forms must be mailed to the Fund Office and will not be effective until received by the Fund Office.

Availability of Pension Estimate

The following article applies to active participants in the FELRA & UFCW Pension Fund and the Mid-Atlantic UFCW and Participating Employers Pension ("MAP") Fund only. It does not apply to those already collecting a Pension Benefit.

You have the right to request a pension benefit estimate annually. To receive your pension estimate, please complete a Benefit Service Request form. To get this form, you can:

- Log on to www.associated-admin.com. Click on "Your Benefits" located at the left of the screen. Select either FELRA & UFCW Pension Fund or Mid-Atlantic Pension Fund "MAP" and print the "Benefit Service Request" form, or
- Call the Fund Office at (410) 683-6500 or toll-free (800) 638-2972.

Complete all the information on the form and return it to the Fund Office. It may take approximately 8 – 12 weeks for us to prepare your estimate. It takes time because we verify work history in our records with your employer(s). There is no charge for a Benefit Statement.

Does Your Eligible Dependent Live Outside the Baltimore/Washington/Northern Virginia Area?

The following article applies to actively-working participants and their eligible dependent(s) who have traditional Fund medical coverage, not Kaiser Permanente HMO.

If your eligible dependent resides outside the Baltimore, Washington or Northern Virginia area, and you and your dependent(s) have a green Fund ID card (what CareFirst calls a "Local Lease" card), your dependent's claims will not be covered if he/she sees a "Non-Local Lease" provider outside of the Baltimore, Washington or Northern Virginia area. Medical claims outside of this area will only be covered when your dependent uses a white ID card (what CareFirst calls a "Flexlink" card).

To solve this problem, contact the Fund Office. Your whole family will be re-coded for the Flexlink network and you will be sent new Flexlink ID cards. That way, your dependent can show the card to any CareFirst provider outside of the Baltimore, Washington or Northern Virginia area and his/her claims will be processed.

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