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

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For Your Benefit

Material Modifications

Eligibility for Plans XX, XXX and XL Participants

The following Summary of Material Modifications (SMM) applies to actively working participants whose medical coverage is provided through the Fund, not an HMO.

The Board of Trustees of the FELRA and UFCW Health and Welfare Fund has adopted the following changes to the FELRA and UFCW Active Health and Welfare Plan ("Plan") for participants employed by Giant Food and Safeway. Please keep this document with your Summary Plan Description ("SPD").

1. If you were hired as a bargaining unit employee before January 1, 2014 and you were not yet eligible to participate under Plan XX on January 1, 2014, the paragraphs on page 17 of your Plan XX SPD entitled "Initial Eligibility – Full Timers" and "Initial Eligibility – Part Timers" are deleted and replaced with the following:

A. Plan XX—Initial Eligibility for Full-Time Employees

If you were hired as a "full-time" employee (as defined under the collective bargaining agreement applicable to your employment), you will be eligible for benefits under the Plan as follows, subject to the Fund's receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the Fund office the necessary enrollment forms, including any payroll deduction forms:

TYPE OF BENEFIT	ENROLLMENT DATE
Hospital, Medical, Prescription Drug	First of the month following 1,200 hours of service plus 60 days.
Life, Accidental Death & Dismemberment	First of the month following 12 months of continuous employment.
Accident & Sickness, Dental, Vision	First of the month following 15 months of continuous employment.

For example, if you were hired as a full-time employee on April 15, 2013 and were entitled to be paid for 1,200 hours of work as of November 30, 2013, you would become eligible for: (a) Hospital,

Continued on page 2

Plans 1, X and XX: Open Enrollment July 15 – September 15. See Page 5.

Plan X Part Time Participants: Open Enrollment for Dependent Coverage Is July 1 – July 31. See page 6.

This issue—

Continued from page 1

Medical and Prescription Drug benefits on February 1, 2014; (b) Life and Accidental Death & Dismemberment benefits on May 1, 2014; and (c) Accident & Sickness, Dental and Vision benefits on August 1, 2014.

B. Plan XX—Initial Eligibility for Part-Time Employees

If you were hired to work an undetermined number of hours per week and you were entitled to be paid for an average of at least 28 hours per week during your first 12 months of employment (your "initial measurement period"), you will be eligible for Hospital, Medical and Prescription Drug benefits on the first day of the month after you have worked for 13 months, and you will be eligible for Life and Accidental Death and Dismemberment benefits on the first day of the month after you have worked 18 months, subject to the Fund's receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the Fund office the necessary enrollment forms, including any payroll deduction forms. For example, if you start work on May 15, 2013 and you were entitled to payment for an average of 30 hours a week through May 14, 2014, you will be covered under Plan XX as of July 1, 2014.

If you were hired to work an undetermined number of hours per week, and you were entitled to be paid for an average of less than 28 hours per week, you will not be eligible for benefits under Plan XX after 13 months of Covered Employment. However, if you are entitled to be paid for an average of at least 5 hours per week during the next five (5) months of Covered Employment (your second "measurement period"), you will be eligible for Hospital, Medical, Prescription Drug, Life and Accidental Death & Dismemberment benefits on the first day of the month after your 18th month of Covered Employment, subject to the Fund's receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the Fund office the necessary enrollment forms, including any payroll deduction forms. For example, if you start work on May 15, 2013 and you were entitled to payment for an average of ten (10) hours per week through May 14, 2014, you will not be eligible for Plan XX as of July 1, 2014. However, if you continue to be entitled to payment for 10 hours per week from May 15, 2014 through October 14, 2014, you will be covered under the Plan XX as of December 1, 2014.

You will become eligible to receive Accident & Sickness benefits, Dental benefits and Vision benefits under Plan XX on the first day of the month after you have worked for 30 months. For example, if you begin work on May 15, 2013 and you continue to be entitled to payment for work in Covered Employment for an average of at least five (5) hours a week for 30 months, you will be eligible for Accident & Sickness, Dental and Vision benefits on December 1, 2015.

C. Plan XX—Continued Eligibility for Full-Time and Part-Time Employees

As long as you continue to work in Covered Employment, you will continue to be eligible for benefits under Plan XX for a period of 12 months from the date that your coverage begins. For example, if you first become covered on June 1, 2014, you will continue to be covered under Plan XX at least until May 31, 2015, provided you continue to work in Covered Employment. (There is a limited exception to the above described rule for participants who were hired between October 16, 2013 – November 1, 2013 and first become eligible for coverage under Plan XX on December 1, 2014. If this applies to you, your initial eligibility period will continue for 13 months, until December 31, 2015, provided you continue in Covered Employment).

After your first period of coverage ends, your continuing eligibility for benefits under Plan XX in each calendar year will depend on whether you were entitled to payment for an average of at least five (5) hours per week in Covered Employment in each 12-month period ending October 14 of the prior year. For example, if your first coverage period ends on May 31, 2015, your eligibility for coverage for the balance of 2015 will depend on whether you were entitled to payment for an average of at least 5 hours per week during the period of October 15, 2013 – October 14, 2014. If you were entitled to payment for an average of 5 hours per week during this period, your eligibility for benefits under Plan XX will continue until at least December 31, 2015.

2. If you were hired as a bargaining unit employee on or after January 1, 2014, you will become eligible to participate in Plan XXX or Plan XL, based on the following eligibility rules:

A. Plan XXX—Initial Eligibility for Full-Time Employees

If you were hired as a "full-time" employee (as defined under the collective bargaining agreement applicable to your employment), you will be eligible for benefits under Plan XXX as follows, subject to the Fund's receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the Fund

office the necessary enrollment forms, including any payroll deduction forms:

TYPE OF BENEFIT	ENROLLMENT DATE
Hospital, Medical, Prescription Drug	First of the month following 1,200 hours of service plus 60 days.
Life, Accidental Death & Dismemberment	First of the month following 12 months of continuous employment.
Accident & Sickness, Dental, Vision	First of the month following 15 months of continuous employment.

For example, if you were hired as a full-time employee on April 15, 2014 and were entitled to payment for 1,200 hours of work as of November 30, 2014, you would become eligible for: (a) Hospital, Medical and Prescription Drug benefits on February 1, 2015; (b) Life and Accidental Death & Dismemberment benefits on May 1, 2015; and (c) Accident & Sickness, Dental and Vision benefits on August 1, 2015.

B. Plan XXX and Plan XL—Initial Eligibility for Part-Time Employees

If you were hired to work an undetermined number of hours per week, and you were entitled to payment for an average of at least 28 hours per week during your first 12 months of employment, you will be eligible for Hospital, Medical and Prescription Drug benefits under Plan XXX on the first day of the month after you have worked for 13 months, and you will be eligible for Life and Accidental Death and Dismemberment benefits on the first day of the month after you have worked 18 months, subject to the Fund's receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the Fund office the necessary enrollment forms, including any payroll deduction forms. For example, if you start work on May 15, 2014 and you are entitled to payment for an average of 30 hours a week through May 14, 2015, you will be covered under the Plan XXX as of July 1, 2015.

If you were hired to work an undetermined number of hours per week and you were entitled to payment for an average of less than 28 hours per week during your first 12 months of employment, you will be eligible for Life and Accidental Death & Dismemberment benefits under Plan XL on the first day of the month after you have worked for 18 months, subject to the Fund's receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the Fund office the necessary enrollment forms, including any payroll deduction forms. For example, if you start work on May 15, 2014 and you are entitled to payment for an average of 10 hours a week through May 14, 2015, you will be covered under the Plan XL as of December 1, 2015.

If you are covered under Plan XXX or Plan XL, you will become eligible to receive Accident & Sickness benefits, Dental benefits and Vision benefits on the first day of the month after you have worked in Covered Employment for 30 months. For example, if you begin work on May 15, 2014 and you continue to be eligible for payment for Covered Employment for 30 months, you will be eligible for Accident & Sickness, Dental and Vision benefits on December 1, 2016.

C. Plan XXX and Plan XL—Continued Eligibility for Full-Time and Part-Time Employees

As long as you continue to work in Covered Employment, you will continue to be eligible for the above-described benefits under Plan XXX or Plan XL for a period of 12 months from the date that your coverage begins. For example, if you first become covered on April 1, 2015, you will continue to be covered at least until March 31, 2016, provided you continue to work in Covered Employment. (There is a limited exception to the above described rule for participants who are hired between October 16 – November 1 of any calendar year and first become eligible for coverage under Plan XXX or XL on December 1 of the following year. If this applies to you, your initial eligibility period will continue for 13 months, until the next December 31, provided you continue in Covered Employment. For example, if you first become covered on December 1, 2015, you will continue to be covered until at least December 31, 2016).

After your first period of coverage ends, your continuing eligibility for benefits under Plan XXX or Plan XL each calendar year will depend on the average number of hours per week for which you were entitled to payment for Covered Employment in each 12-month period ending October 14 of the prior year. For example, if your first coverage period ends on March 31, 2016, your eligibility for continued coverage through December 31, 2016 will depend on the average number of hours per week for which you were entitled to payment during the period of October 15, 2014 – October 14, 2015. If you were entitled to payment for an average of at least 28 hours per week during this period, you will be eligible for benefits under Plan XXX until at least December 31, 2016. If you continued to be employed in Covered Employment but were entitled to payment for an average of less than 28 hours per week during this period, you will be eligible for benefits under Plan XL until at least December 31, 2016.

Material Modifications

Coverage for Breastfeeding/Lactation Consultation and Breast Pumps

The following Summary of Material Modifications (SMM) applies to actively working participants whose medical coverage is provided through the Fund, not an HMO.

Effective April 10, 2015, the Board of Trustees approved the below clarification of the preventive services language regarding coverage for comprehensive breastfeeding (lactation) support and counseling.

Lactation Consultation and Breast Pumps

- In conjunction with birth, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider during pregnancy and/or in the postpartum period, at 100%, no deductible, when provided by an In-Network provider. Under this Plan, a trained provider is a Breastfeeding/Lactation Educator.
- For the first 12 months following the birth of a child, coverage is provided for rental or purchase of one standard manual or standard electric breast pump (purchase price up to $400) plus necessary breast pump supplies. Coverage is available at no cost from in-network providers only. The Plan does not cover hospital grade breast pumps (heavy duty breast pumps designed for multiple users), or any other lactation supplies, such as ointments, wipes, cleaning and storage supplies, nursing bras, or lactation pillows. There is no coverage for breast pumps and supplies purchases through an out-of-network provider.

Lactation Educator

A Breastfeeding/Lactation Educator is a provider who is currently certified as a lactation consultant by the International Board of Lactation Consultant Examiners (IBLCE). If he/she is not IBLCE certified, the provider **must** be a licensed, registered, or certified health care professional with referenced experience and training in lactation management. Breastfeeding/lactation educators help mothers initiate or maintain lactation and provide assessment, planning, intervention, and evaluation for optimal breastfeeding, working in conjunction with the mother's physician, midwife and/or baby's pediatrician.

A Prescription Is Required for Coverage Of Over-the-Counter Drugs

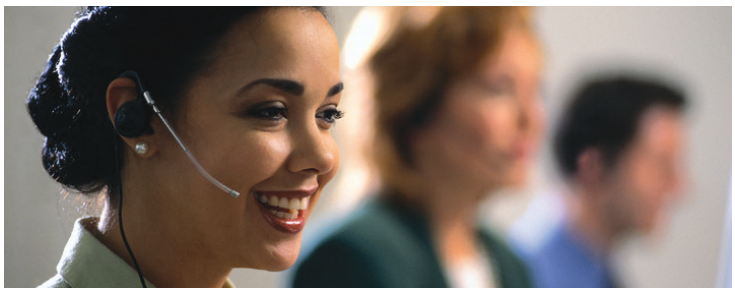
To receive coverage for Preventive over-the-counter (OTC) medications that are included under the Health & Welfare Plan (for example, aspirin to prevent heart attacks, or Vitamin D) you must have a prescription for such medications. Also, you need to pay for the prescription at the pharmacy and not the regular checkout line, in order to receive coverage under the Plan.

ValueOptions Name Change Not In Effect Yet

The March 2015 ***For Your Benefit*** newsletter reported that ValueOptions changed its name to Beacon Health Options. However, the name change has not yet been made official and the company will continue to be called ValueOptions for the coming months.

Remember, ValueOptions reviews your treatment plan while you use your mental health and substance abuse benefit to make sure your care is medically necessary and appropriate. Services are completely confidential. No one has access to your clinical medical records without your written permission unless access is required by law.

Access to the ValueOptions panel of therapists is available by calling the ValueOptions' 24-hours, 7-days-a-week referral service at (800) 454-8329. Referrals are available for both emergency/hospital care and for non-emergency/outpatient referrals. In an emergency, you or your therapist must call ValueOptions within 24 hours after admission to the hospital.



Open Enrollment for Medical Coverage Is July 15 – September 15

*The following article applies to **actively working participants** in Active Plans I, X and XX.*

Open Enrollment for choosing how your medical coverage will be provided is from July 15 – September 15 for coverage effective October 1, 2015 – September 30, 2016. During open enrollment, you may choose between HMO (Kaiser Permanente) coverage and traditional Fund coverage.

How Does Open Enrollment Work?

If you live within the geographic area covered by Kaiser and you continue to be eligible for Fund coverage, you should receive a letter from the Fund Office in July, along with a packet of important information from the HMO (Kaiser Permanente). A Benefit Summary explaining the HMO benefits will be included, along with an enrollment form. ***Please read the Kaiser Permanente information carefully.***

What If I Didn't Get an Open Enrollment Letter?

You will receive an open enrollment letter only if you live in the geographic area covered by Kaiser. If you do not live in this area and you continue to be eligible for Fund coverage, your traditional Fund coverage will continue automatically. If you didn't receive an open enrollment letter and think you should have, call the Fund Office at (800) 638-2972. We will double check whether you are in Kaiser's geographic area, and if you are, we will help you get information about the HMO.

How Do I Enroll in the Kaiser HMO?

If you decide you want to enroll in the Kaiser HMO, complete the enrollment form for Kaiser Permanente and send it back to the Fund Office (NOT to Kaiser)! Your Plan is the "Signature" Plan. After enrolling, you will receive an ID card from Kaiser. This should arrive on or shortly after October 1, 2015.

Please note: if you are currently enrolled in traditional Fund medical coverage and you decide to switch to Kaiser, ***the change becomes effective October 1, regardless of when your Kaiser ID card arrives.*** Starting October 1, you must use providers in the Kaiser network. Your providers for optical, dental and prescription drug benefits remain the same whether you have Kaiser or traditional Fund coverage. Participants in an HMO no longer need their Fund ID cards. If you come back to traditional Fund medical coverage in the future, we will send you a new Fund medical card.

What If I Want to Change to Traditional Fund Medical Coverage?

If you are currently in Kaiser and wish to change to traditional Fund medical coverage, call Participant Services at (800) 638-2972. Remember, ***you must make this change between July 15 and September 15!***

What If I Want to Keep the Same Coverage I Currently Have?

If you wish to remain in the Plan you are in now (Kaiser or traditional Fund medical), ***don't do anything!***

Those enrolled in Kaiser Permanente—READ THIS!

Remember, the co-pay for your benefits may change! You will be responsible for the new monthly co-pay unless you change to traditional Fund medical coverage.

Is There a Cost to Enroll in Kaiser?

There is a monthly cost to enroll in Kaiser. The amount will be shown in your open enrollment letter—be sure to read it!

What's The Difference between Traditional Fund Coverage and HMO Coverage?

If Traditional Fund medical coverage varies by Plan. Fund participants pay an annual deductible, other than for preventive services, before payment from the Fund is made. For Plan XX, the deductible is $500 per person. For Plans I and X, the deductible is $300 per person.

Under traditional Fund coverage, if you are a participant in Plan I you may use any provider, you wish, although you will save money if you use a CareFirst provider. **Plans X and XX *must* use a CareFirst provider in order for their treatment to be covered, except for the services of pathologists, anesthesiologists, radiologists at in-network hospitals, and emergency room care.**

Under the Kaiser HMO, you must use a participating doctor or facility. If you do not use a participating provider for routine or follow-up care, the services rendered won't be covered. However, you are covered for emergency care worldwide.

If you don't do anything and you continue to be eligible for Fund coverage, you will remain in the Plan you have now, whether that is traditional Fund medical coverage or Kaiser Permanente HMO, for the next year. If you were terminated from Kaiser for failing to pay your co-premium, you will automatically be moved back to Fund medical coverage effective October 1.

Important Reminders about Open Enrollment

- This open enrollment period applies ***ONLY*** to your ***medical coverage*** (including mental health/substance abuse). This does not affect your optical, dental, or prescription drug coverage. Those benefits continue to be provided through Advantica, Group Dental Service, Inc. and Express Scripts.

Continued on page 8

Plan X Part Timers: July 1 – July 31 Is Open Enrollment For Adding Dependent Coverage

The following article applies only to active Plan X part time participants.

Open Enrollment for adding dependent ("family") coverage to your benefits will be held July 1 to July 31. If you are eligible for dependent coverage but did not elect it when you first became eligible, you may add the coverage during July. The coverage will be effective September 1, 2015. The next open enrollment will be in January for coverage effective March 1, 2016.

Is there a cost?

Yes—it is 20% of the overall cost of your health and welfare coverage, payable via payroll deduction starting in September. Contact your employer for the exact amount that applies to you. ***Do not send payment to the Fund Office.***

When will the coverage begin?

Coverage for your dependents will begin September 1.

How many dependents may I cover?

As long as they are eligible dependents under the Plan, you may enroll as many dependents as you have. The cost is the same regardless of the number of dependents.

What if I want to drop dependent coverage?

You may drop dependent coverage at any time throughout the year provided you notify the Fund Office ***in writing***. You may call us to request the proper form, which you must sign and return to us (it verifies that you wish to stop payroll deductions). However, please remember that if you ***do*** drop the coverage, you will not be eligible to add it again until the open enrollment period following a twelve-month waiting period, except in special circumstances such as a birth, adoption or marriage. Open enrollment for dependent coverage occurs twice a year: in January and in July.

How Do I Add My Dependents?

To add dependent coverage, call the Fund Office at (800) 638-2972 during the open enrollment period and let us know. We'll send you an enrollment form and begin the process for starting your payroll deduction. ***We must have the completed enrollment form returned to us (along with any forms of proof which may be required, such as copies of birth certificates, etc.) before dependent coverage will begin.***

What If I Don't Have Dependents Now, But I Do Later?

If you don't have any dependents and you then get married, have a child, adopt a child, etc., you may add dependent coverage no matter what time of year, as long as you add the dependent within 30 days from the date he/she first became your dependent (for example, within 30 days from the date of marriage, 30 days from the date of birth, etc.).

Contact Participant Services

If you have questions, contact Participant Services at (800) 638-2972.

PENSION CORNER

Reminder to Participants Currently Employed by Giant or Safeway

After December 31, 2012 you stopped accruing future benefits under the FELRA and UFCW Pension Fund ("FELRA") and began earning benefits under the Mid-Atlantic UFCW & Participating Employers Pension Fund ("MAP") for covered employment performed on or after January 1, 2013.

Your Covered Employment with Giant or Safeway on and after January 1, 2013 is still taken into account in determining your vesting and eligibility for retirement and/or disability benefits under FELRA. However, this does not affect the benefits you accrued under FELRA as of December 31, 2012.

If you accrued credited service under FELRA before January 1, 2013 and you accrued credited service under MAP on and after January 1, 2013, upon retirement, you will receive monthly pension checks from both the MAP Fund and the FELRA Fund.

If you have any questions you can contact the Fund Office at (410) 683-6500 or (800) 638-2972.

PENSION CORNER

Forms of Pension Benefits

Under the FELRA & UFCW Pension Fund, you may elect to receive your pension in one of the following benefit forms:

- Single Life Annuity – This is the automatic form of benefit if you are not married at the time of your retirement. You will receive a benefit monthly for your lifetime.
- 50% Joint and Survivor Pension (if married) - Your monthly benefit is reduced and one half of that reduced pension will be payable to your spouse after your death. The amount of reduction depends on your age and your spouse's age at the time of your retirement. This is the automatic form of benefit if you are married at the time of your retirement.
  - ◊ You and your spouse can elect to waive this form of benefit within 90 days before the starting date of your pension by completing a Final Pension Election Form, provided by the Fund Office. **This form must be notarized before returning to the Fund Office.**
- 66 $^{2}/_{3}$% Joint and Survivor Pension (if married) – This means that your monthly pension amount will be actuarially reduced so that 66 2/3% of the pension amount you were receiving can continue to your spouse after your death.
- 75% Joint and Survivor Pension (if married) – Your pension amount will be actuarially reduced so that 75% of the pension amount you were receiving can continue to your *Spouse* after your death.
- 100% Joint and Survivor Pension (if married) – Your pension is reduced so that your spouse can receive the same amount you were receiving before your death.
  - ◊ You do not need your spouse's consent to choose a Joint and Survivor Pension form other than the 50% Joint and Survivor Form.
  - ◊ If you elect to receive your pension in any Joint and Survivor Pension form and your spouse dies before you, your pension benefit will not increase and no further benefits will be payable on your behalf after your death.

Lump Sum Amount – If the total value of your pension benefit is $5,000 or less when you elect to receive your benefit, you will receive one lump sum payment in lieu of monthly benefit payments. If such a benefit is payable to your spouse as a survivor benefit, he or she may choose to receive the benefit as a lump sum or in monthly payments.

Once you elect your form of benefit, you have 14 days after you receive your first benefit payment to change your mind regarding the form of benefit you elected, provided you have not changed your marital status or had a significant change in health during those 14 days.

Remember, you must be married to your spouse on your benefit commencement date and you also must be married to your spouse for at least 12 months as of the date of your death.

Helpful Reminders When You Plan to Retire

When you are planning to retire, you should notify the Fund Office and begin the process of applying for your pension at least six months before you plan to retire. The retirement process will go smoothly for you if you have thought carefully about your retirement date and asked any questions you have about your available options before you begin the application process. Below are some tips to help your retirement go smoothly.

1. About six months before you would like to retire, call the Fund Office at (800) 638-2972 and ask for a Benefit Service Request Form. Tell the Fund Office the approximate date you would like to retire. The Fund Office will research your service and send you an estimate within approximately 6 – 8 weeks.
2. Upon request, the Fund Office will send you a Pension Application. After your application is processed, you'll receive a Benefit Election Form and other information regarding the pension options available to you.
3. Provide the Fund Office with the following documents, as applicable, when you submit your Application for Pension: birth certificate, spouse's birth certificate, spouse's death certificate, marriage certificate and divorce decree. Please send photocopies of these documents, not the originals.
4. While the Fund has 90 days to make a determination with respect to your Pension Application, it usually takes about a month from the date you stop working to process your application, as all available Benefit Service up through the date of your retirement must be included in the benefit calculation, and your service must be confirmed with your participating employer(s). Usually, you will receive your first pension check in the first week of the second month after you retire.
   Example: If you retire in August, you will likely receive your first check in the first week of October. This check will include your pension benefit for September. From then on, you should receive your pension check during the first week of each month.
5. If you submit a Pension Application and later decide to change your date of retirement (before your pension payments have begun), please send a letter to the Fund Office stating your new retirement date.

Continued from page 5

- Once you choose how you would like your medical coverage to be provided, ***you may not change again*** until open enrollment next year (July 15, 2016 – September 15, 2016).
- If you are a Plan X Part Timer and you pay a monthly co-payment to have dependent ("family") coverage via payroll deduction, that will continue, regardless of which medical coverage option you choose— traditional Fund coverage or the HMO option.
- Open enrollment ends September 15. Contact the Fund Office on or before this date if you want to make a change.

If you have questions about Kaiser Permanente coverage, call Kaiser Permanente Member Services at (301) 468-6000 or toll-free at (800) 777-7902 and speak with a representative Monday through Friday between the hours of 7:30 a.m. and 5:30 p.m. Mention the FELRA & UFCW Health and Welfare Fund and ***refer to group # 6879 if you're in Plan I or X or group # 1976 for Plan XX. This is very important.*** You can also call Kaiser's open enrollment hotline where you can leave a message requesting an enrollment kit or a return call if you have questions about Kaiser Permanente. The number is (301) 625-5377 and the line will be open during the FELRA open enrollment period (July 15th – September 15th). Messages will be checked daily.

For questions about the enrollment process or eligibility, call the Fund Office at (800) 638-2972.

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