FOR YOUR BENEFIT

UFCW Unions & Participating Employers Health & Welfare Fund

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Retiree Information Forms Mailed - *Return This Form or Benefits May Be Suspended*

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

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

You will notice two minor changes to the RIF form this year:

1. In order to protect your privacy and prevent potential identity theft, we have assigned each retiree or pension beneficiary a unique ID number rather than using your Social Security Number.

2. Bar coding has been added to the bottom of the form to improve our internal processing of the RIF form.

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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.

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Helpful Reminders

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

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

Moving? Keep the Fund Office Informed

It is very important that you tell the Fund Office when your address and/or telephone information changes. The Fund Office sends out important information about your benefits, coverage change notices, Plan booklets, and even this *For Your Benefit* newsletter. If we don't have the correct information, we may not reach you and that may affect your benefits.

If you are planning to move (even temporarily), or have recently moved, let the Fund Office know your new address and telephone number by calling (800) 638-2972. Remember, telling the Union or your employer is not the same as telling the Fund Office. Tell us where you live so we can send you important information regarding your benefits, claims, changes, etc.

Go Online to MemberXG for Benefit Information

MemberXG is an online access service which allows you to view your benefit claim information online and through your mobile device. It replaced NETime Benefit System. It provides personal benefit information to you via the Internet in a safe, secure and HIPAA compliant environment.

MemberXG Offers the Following:

- Secure internet access to benefit information with assured privacy.
- Mobile-ready access allows you to view your benefit information 24 hours a day.
- Benefit access which allows you to track your claims and view the following:
  - Accident and Sickness Claims – displays claims submitted to the Plan on your behalf.
  - Eligibility – your past and present eligibility.
  - Summary Explanation of Benefit (EOB) information concerning claims processed by the Fund.
- Dashboard – a landing page containing quick navigation to other benefit information.
- Demographics – a demographic page displaying your address, phone number, and other information.

How Does It Work?

- Log in to www.associated-admin.com, select *Your Benefits*, located at the left side of the page, and select *UFCW Unions and Participating Employers Health & Welfare Fund.* Click on *MemberXG* which will take you to Member XG's site.
- Select *Create Account*, located at the upper right corner. You will be asked to create a username and password.
- If you had a password for NETime, the online access service previously offered by the Fund, it will **not** apply to this site. You will need to create a new username and password for MemberXG.

If you have any questions about a claim that you see on MemberXG, please call the Participant Services Department at (800) 638-2972.

Note: The information provided on the MemberXG website is not a guarantee of coverage. It is possible that the information shown is incomplete or is not fully up to date.

You Must Use a CareFirst In-Network Provider to Receive Medical Coverage

The following article applies to participants who have Fund coverage, not HMO coverage.

You must use a CareFirst provider to have coverage for hospital, medical, or surgical benefits under the Fund, with the exception of:

1. services provided by pathologists, anesthesiologists, and radiologists at an in-network facility,
2. emergency admission,
3. emergency room services, and
4. emergency ambulance service.

Exceptions

You are covered for services provided by non-PPO network pathologists, anesthesiologists, and radiologists, **if** the services are performed at an in-network facility. You are also covered for emergency services, including emergency ambulance service, and admission to the hospital for **urgent/emergency reasons only** (not for scheduled procedures) both in-network and out-of-network. Emergency service is the care given for the sudden onset of a medical condition with severe symptoms, such as heart attack, poisoning, severe breathing difficulties, convulsions, loss of consciousness, and other acute conditions that may be considered life threatening.

CareFirst reprices claims when you use a participating provider, but **CareFirst is <u>not</u> your insurance carrier.** Your coverage is provided through the Fund.

To Locate a CareFirst Provider

To locate a CareFirst provider, contact CareFirst at the number listed on your ID card.

- If your ID card has blue writing ("Net Lease" or "Local Lease"), call (800) 235-5160.
- If your ID Card has black writing ("Flexlink"), call (800) 810-2583.

Note that the numbers above are <u>only</u> for finding a participating CareFirst provider. **No other questions (claims, eligibility, etc.) will be answered on these lines.**

Verify that the health care provider you selected participates with CareFirst when you make your appointment, as provider information is subject to change. At your appointment, show your *Fund* ID card and tell the *Physician* or facility that you participate with CareFirst. If you have a white ID card with blue writing ("Net Lease" or "Local Lease"), make sure your provider participates in CareFirst's Net Lease/Local Lease network. If the provider states that he/she participates with CareFirst, be sure to explain that the Plan generally only covers services provided by providers **in CareFirst's Net Lease/ Local Lease network.** If your Local Lease/Net Lease provider does not file electronically, you or the provider should send such claims to:

CareFirst/Network Leasing
PO Box 981633
El Paso, TX 79998-1633

CareFirst will reprice the claim and forward it to the Fund Office for processing. A CareFirst provider should **not** require payment for covered services at the time of service unless the service provided is a non-covered benefit or if your deductible has not been met. If the provider attempts to collect payment for covered services at the time of your visit, remind the provider that payment will be made by the Fund after CareFirst reprices the claim. The amount of the reduced charge which the patient is responsible for paying will be shown on the Explanation of Benefits (EOB) which is sent to you and your provider after your claim has been processed.

Physical Therapy Must Be Certified through Conifer Health Solutions

The Fund Office covers the cost of physical therapy under your Medical benefit up to the approved number of visits, if the physical therapy is **medically necessary** and you are covered by Fund medical coverage. This does not apply to Kaiser HMO or Plan Y40 participants. Conifer Health Solutions, will determine how many treatments are necessary. It is a good idea to submit a treatment plan to Conifer in advance so that you are aware of any treatments which would be determined not medically necessary, before you have services and incur charges.

Your physical therapist ***must* contact *Conifer Health Solutions ("Conifer")* at (866) 290-8147 to be sure your treatment is covered.**

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How Many Visits Will the Fund Cover?

The Fund generally provides benefits for two visits per week for six weeks. If you need treatment beyond six weeks, your provider must certify the additional care with Conifer.

Example

Let's say you hurt your back and, after Conifer determined that physical therapy was medically necessary, you have physical therapy twice a week for six weeks. If your doctor decides you need additional treatment, he/she must contact Conifer to certify the additional sessions. **Don't wait until your final week of therapy to re-certify, because additional visits may be denied while the new information is being reviewed.**

Remember, you are responsible for any charges not authorized by Conifer.

Your Dental Benefits through Group Dental Services

Your Plan of benefits provides coverage for dental benefits including exams, x-rays, cleanings, amalgam fillings, and simple extractions, when the service is provided through Group Dental Service of Maryland, Inc. ("GDS"). Except as provided below, **any service you receive from a dentist who does not participate with GDS will <u>not</u> be covered under the Fund.**

Coverage under the Plan is provided only for the least costly, professionally adequate procedure to treat a condition. If you elect a more costly procedure, the Plan will only cover the less costly procedure and you will be responsible for the difference in cost. Any dental expense incurred in connection with any dental procedure started prior to a participant's or eligible dependent's effective date of coverage is excluded.

Coverage for Dependents in Plans Y, Y20 and Y30

Generally, your biological children, adopted children, children placed with you for adoption, children over whom you have legal custody and your stepchildren are eligible for dental benefits until the end of the calendar year in which they turned age 19. However, if your dependent child is a full-time student at an accredited college or university, dental coverage may be continued until the end of the calendar year in which he/she turns age 23. Children under age four are not eligible for dental benefits.

Coverage for Dependents in Plan JSS2

Generally, your biological children, adopted children and children placed with you for adoption are eligible for dental coverage as your dependents if they are under age 26. Generally, stepchildren and children over whom you have legal custody are eligible for dental coverage until the end of the calendar year in which they turn age 19. Children of retirees, and all children under age four, are not eligible for dental benefits.

Legal Custody

If you have had court-awarded legal custody of a child for at least six months, you may enroll that child as your dependent. You must submit a copy of the court-entered custody order along with the applicable enrollment form. Further, you must submit a notarized letter to the Fund Office every six months, confirming the continuation of custody.

Coverage for Stepchildren

To be eligible for coverage as your dependent, a stepchild must reside with the eligible participant.

Proof of Dependent Status

The Plan requires you to submit evidence of your dependent(s)' eligibility status – for your children: a birth certificate, adoption papers, or other proof of adoption or placement for adoption acceptable to the Trustees, and for your spouse: a marriage license. In the case of a stepchild, a copy of the divorce decree indicating custody is required as evidence.

Coverage When Using a Non-Participating GDS Dentist

You may use a non-participating GDS dentist and receive coverage only:

- When referred by a participating dentist to a non-participating specialist;
- When authorized in advance by GDS;
- In the case of a dental emergency which occurs more than 50 miles from your primary dentist if you are temporarily away from home. "Emergency" means an unforeseen situation requiring services necessary to treat a condition or illness that, without immediate dental attention, would result in unalleviated acute dental pain, dental infection, and/or dentally related bleeding; or
- When the participant does not live or work within 20 miles or 30 minutes of a participating dentist.

Tips on Retirement

Please 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 helpful tips.

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. You may also download the form from our website. 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. This form is also located on our website. After your application is processed, you'll receive a benefit election form and other information regarding the pension options available to you.

3. 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 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.

4. Electronic Funds Transfer (EFT) is the pension benefit delivery option chosen by the majority of pensioners because of its convenience. To use this option, provide the Fund Office with the bank routing number and other bank information for the account where you would like your deposit to go. A wire transfer, depositing your monthly pension into your bank account, then occurs on or about the first working day of every month. If you don't elect EFT, checks are mailed on the last working day of the month. If your mailed check is late getting to you, the Fund Office must wait 10 days before putting a "stop pay" on your check, since there is sometimes a delay in the postal service.

Hospice Care Services

For terminally ill participants and eligible dependents whose prognosis of probable survival is six months or less and who are receiving palliative, not curative, care, below is a description of the hospice care services covered under the Plan:

- 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 (subject to a separate copay depending on Plan),
- lab tests and x ray services,
- medical surgical supplies,
- oxygen,
- durable medical equipment, and
- physician home visits.

Subject to the normal limits in your Plan of benefits, 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 counseling 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.

Hospice Care Services are covered as follows: Plans Y and JSS2 – 80%, Plan Y20 – 75%, Plan Y30 – 70% of the Usual, Customary and Reasonable (UCR) cost under Comprehensive Medical Benefits.

Pre-certification is required and services must be approved by Conifer. For additional information about hospice care, contact Conifer toll free at (866) 290-8147.

Use Quest or LabCorp When Lab Work Is Needed

The following article applies to participants who have Fund medical coverage, not an HMO.

You must use either Quest Diagnostic Laboratories ("Quest") or Lab Corporation ("LabCorp") for all laboratory services in order for such services to be covered by the Plan.

Inform Your Doctor

Be sure your doctor knows before the lab work is performed that you will receive coverage for lab work only if the bill comes to the Fund directly from either a Quest or LabCorp facility. Even if your doctor has a contract with LabCorp to perform lab work in his/her office, tell him/her that only lab work performed at a Quest or LabCorp facility will be covered. Your Plan will not pay for lab work performed and billed from your doctor's office.

Locating a Lab

To find the most current list of Quest or LabCorp facilities, log on to their website or call:

- www.questdiagnostics.com/appointment or call (866) MYQUEST, (866) 697-8378
- www.labcorp.com/psc/index or call (888) 522-2677

HEALTH CORNER

Taking Your Medicine

If you take any medication on a regular basis, chances are you've forgotten to take a few pills or fudged the dosage amount. That's no big deal, right? Wrong. Medication compliance is critical, and disregarding instructions for taking medicines can have serious consequences.

What can you do to be compliant?

- Before starting a new prescription, ask your doctor about the name of the drug, any potential side effects, the condition it will treat, how it works, when and how you should take it, how long the regimen will last, if it will interact with other drugs or foods, what to do if you forget a dose, and if you can take home printed information about the medicine.
- Tell your doctor if you are or might become pregnant, and if you have any drug allergies.
- Work with your doctor while you're taking meds. Ask about results of tests that show how the meds are working for you, and be sure to bring up any problems you have with them. Talk about how you have felt since you started taking the drug.
- Keep a record of all meds (including over-the-counter and herbal) you take and discuss them often with your doctor and pharmacist. Drug interactions can be fatal.

- Read all dosage instructions—whether the drug is a prescription or over-the-counter—and follow them exactly, including using precise measurements. Heed warning labels. Make sure you understand the directions, and ask your doctor or pharmacist if you have any questions. Post any printed instructions in an obvious place.
- Don't use meds after the expiration date. Throw them out in a place where children or pets can't find them.
- If needed, use special tools to help you remember your drug regimens, such as pillboxes, beepers, alarms, or timers.

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 questions.

Material Modifications

When Disability Benefits Are Denied

The Board of Trustees of the UFCW Unions and Participating Employers Health & Welfare Fund ("Fund") has adopted the following changes to the UFCW Unions and Participating Employers Active Health and Welfare Plan ("Active Plan") and UFCW Unions and Participating Employers Retiree Health and Welfare Plan ("Retiree Plan") effective April 1, 2018. These changes provide you with more information on how the *Fund* reviews certain disability benefit claims and appeals. Please keep this document with your Summary Plan Description ("SPD").

1. **Effective for claims for disability benefits filed on or after April 1, 2018, the following language is added after the "If Your Weekly Disability Claim is Denied" Subsection of the Section entitled "Claims Filing and Review Procedure" in your SPD:**

   Initial Disability Claim Denial Involving Discretionary Determination of Disability by the *Fund*

   In the case of a denial of your claim for disability benefits that is based on a determination by the *Fund* (and not by a third party acting independent of the *Fund* such as the Social Security Administration ("SSA")) that you are not disabled under the Plan rules, the written notice of the denial also will include the following:

   1. A discussion of the decision, including, if applicable, an explanation of the *Fund's* basis for disagreeing with or not following:
      a. The views you presented to the *Fund* of health care professionals treating you and vocational professionals who evaluated you (if any);
      b. The views of any medical or vocational experts whose advice was obtained on behalf of the *Fund* in connection with the denial of your claim, even if the advice was not relied upon in making the determination; and
      c. A disability determination made by the SSA, if you provided it to the *Fund.*
   2. A copy of the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and
   3. A statement that you are entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

2. **Effective for claims for disability benefits filed on or after April 1, 2018, the following language is added after the "Appeals Procedures – Weekly Disability Claims" Subsection of the Section entitled "Claims Filing and Review Procedure" in the SPD:**

   Disability Decision on Appeal Involving Discretionary Determination of Disability by the *Fund*

   In the case of a denial of your appeal involving a claim for a disability benefit that is based on a determination by the *Fund* (and not by a third party acting independent of the *Fund* such as the SSA) that you are not disabled under the Plan rules, the written notice of denial also will include all of the information in the "Initial Disability Claim Denial Involving Discretionary Determination of Disability by the *Fund*" section above, as well as

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the calendar date on which the contractual limitations period expires for the claim.

3. **Effective April 1, 2018, the following is added at the end of: (a) the first paragraph of the "Denial of a Claim" Subsection of the Section entitled "Claims Filing and Review Procedure;" and (b) the second paragraph of the "If Your Weekly Disability Claim is Denied" Subsection of the Section entitled "Claims Filing and Review Procedure":**

The written notice of denial also will include a description of any contractual limitations period that applies to your right to bring an action under ERISA if your appeal is denied.

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