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

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.

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# For Your Benefit

## Health and Welfare Coverage Payroll Deduction Increasing (Plans I, X, XX, XXX)

In accordance with your Collective Bargaining Agreement, the weekly payroll deduction will increase by $1 per week for certain Plan I, X, XX, and XXX health and welfare coverage, effective June 1, 2023 for participants employed by Giant and Safeway and November 1, 2023 for participants employed by Associated Administrators. Please note that your employer, not the Fund, handles these deductions. The new costs for coverage, payable by payroll deduction, are listed below.

### Plan I, X, and XX Full Time Participants

- **$8 per week** for individual only coverage,
- **$13 per week** for participant plus one dependent, and
- **$18 per week** for family coverage (participant plus two or more dependents).

### Plan XXX Full Time Participants

- **$13 per week** for individual only coverage,
- **$18 per week** for the participant plus dependent child(ren),
- **$23 per week** for participant plus spouse, and
- **$28 per week** for family coverage.

### Plan X Part Time Participants

- **$8 per week** for individual only coverage
- Plan X part time participants **pay 20%** of the cost of the coverage for dependent coverage and the cost for this coverage is not changing at this time. Contact the Fund Office for the exact amount of the payroll deduction.

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### Plan XX Part Time Participants

- **$8 per week** for individual only coverage,
- **$139.10 per month*** for the participant plus one dependent child,
- **$278.20 per month*** for the participant plus two dependent children, and
- **$417.30 per month*** for the participant plus three or more dependent children.

### Plan XXX Part Time Participants

- **$13 per week** for individual only coverage,
- **$146.72 per month*** for the participant plus one dependent child,
- **$293.44 per month*** for the participant plus two dependent children, and
- **$440.16 per month*** for the participant plus three or more dependent children.

*The individual $8.00 and $13.00 weekly co-payment will still apply. The dependent child co-pay rates are in addition to the $8.00 and $13.00 weekly rates.

### Spousal Surcharge

If you elect coverage under the Fund for your dependent spouse and your spouse is also **eligible** for health coverage through his or her employer, a $20 per week surcharge will apply in addition to the above-described co-premiums. This surcharge will apply even if your spouse has not elected to participate in that other coverage. However, the $20 per week surcharge is waived for any participant whose spouse is also a participant in the Plan.

# End of National Emergency Means A Return to Normal Benefit Plan Filing Deadlines

The COVID-19 National Emergency, which was originally declared in March 2020, ended on April 10, 2023. The National Emergency is separate from the COVID-19 Public Health Emergency, which ended on May 11, 2023. Under the National Emergency, the Department of Labor extended the deadlines for:

- Requesting enrollment in the Health Plan due to a HIPAA special enrollment event;
- Electing COBRA continuation coverage;
- Paying COBRA premium payments;
- Notifying the Health Plan of a COBRA qualifying event, such as a birth or adoption of a child, marriage, or determination of disability for the purposes of the COBRA disability extension;
- Filing a Pension Plan or Health Plan benefit claim;
- Filing an appeal of the denial of a Pension Plan or Health Plan benefit claim; and
- Requesting an external review of certain denied Health Plan appeals and providing information required for the external review request.

This extension, called the Outbreak Period, began on March 1, 2020 and continued until 60 days after the National Emergency ended. Therefore, the tolling period on your deadline to take any of the above actions ended when the Outbreak Period ended on June 9, 2023.

**This is to advise you that since the National Emergency ended on April 10, 2023, the Outbreak Period ended as of June 9, 2023 and the above deadlines have begun to run again as of June 9, 2023**.

The following examples explain how the ending of the Outbreak Period will affect these deadlines:

### Example: Pension Plan Appeal Deadline

Your claim for pension benefits was denied on October 1, 2022. Typically, you would have 60 days under the Pension Plan document to file your appeal of that denial. Therefore, your appeal would have been due by November 30, 2022. However, due to the Outbreak Period, the Pension Plan's 60-day deadline to file an appeal will now start to run on June 9, 2023. You will therefore have until August 8, 2023 (i.e., 60 days from June 9, 2023) to file your appeal. If your appeal is not filed by this deadline, the Fund's decision on your claim is final.



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## Examples: Health Plan Appeal Deadline

- **Example A**: Your claim for a medical procedure was denied on September 1, 2022. Typically, you would have 180 days under the Plan document to file your appeal of that denial. Therefore, your appeal would have been due by February 27, 2023. However, due to the Outbreak Period, the Plan's 180-day deadline to file an appeal will now start to run on June 9, 2023. You will therefore have until December 9, 2023 (i.e., 180 days from June 9, 2023) to file your appeal. If your appeal is not filed by this deadline, the Fund's decision on your claim is final.

- **Example B**: Your claim for a medical procedure was denied on February 14, 2020. The deadline for you to file an appeal under the Plan would have been August 12, 2020 (180 days from February 14, 2020). However, due to the Outbreak Period, the Plan deadline was "tolled" or stopped as of March 1, 2020 and you now have 165 days from the end of the Outbreak Period to file an appeal (15 days passed between February 14, 2020 and March 1, 2020 and 165 days remain as of March 1, 2020). You will therefore have until November 12, 2023 (i.e., 165 days from Jwune 9, 2023) to file your appeal. If your appeal is not filed by this deadline, the Fund's decision on your claim is final.

## Example: COBRA Election

You terminated covered employment and your health coverage ended on September 1, 2022. Typically, you would have had until October 30, 2022 to elect to continue your coverage under COBRA (i.e., 60 days after your coverage terminated).

Due to the Outbreak Period, you now have until August 8, 2023 (i.e., 60 days from June 9, 2023) to elect to continue your coverage under COBRA. Therefore, if you want to elect COBRA coverage, you must return your COBRA election form by August 8, 2023.

## Example: COBRA Premium Payments

You elected COBRA coverage on September 15, 2022, retroactive to August 1, 2022. You timely paid your COBRA premiums for August, September and October 2022 but have not made any payments for November 2022 to June 2023. Typically, premiums were due on the 1st of the month and you had 30 days to pay, so your eligibility for COBRA coverage would have ended on November 30, 2022 if your premium payment for November 2022 was not received by that date.

Due to the Outbreak Period, your ability to pay for COBRA coverage for November 2022 through June 2023 will end on July 9, 2023 (i.e., 30 days from June 9, 2023). If you make your premium payment by July 9, 2023, the Fund will reinstate your coverage and pay any claims incurred between November 1, 2022 through June 30, 2023. If you do not make these payments by July 9, 2023, your eligibility for COBRA coverage will terminate.

**Remember, the Fund will not pay any claims until you have elected COBRA and paid all of your retroactive COBRA premiums back to your initial date of termination**.

Please be mindful that the benefit plan extensions honored by the Funds during the National Emergency will be returning to the Plan's normal filing periods and deadlines, as described in your applicable Summary Plan Description. If you have a question regarding any applicable deadlines, please contact the Fund Office.

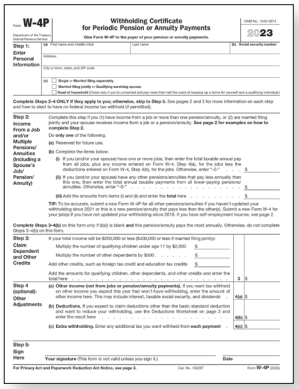
# Be Wary of Offers for Additional/Supplemental Coverage!

Retirees often receive calls from insurance companies or brokers offering health plans and supplemental coverage. Should you choose to pursue additional coverage, it is very important that you contact the Fund Office to determine whether it will have an effect on your current benefits. Enrolling in a new plan may disqualify you from using your benefits through the Fund.

If you are an active or retired participant who is already enrolled in Kaiser HMO coverage through the Fund, please be cautious if you receive an offer of additional or different coverage from Kaiser. **Enrolling in other coverage with Kaiser may disqualify you from the Fund's Kaiser Plan as well as your Optical and Dental coverage (if applicable) provided by the Fund.**

**Don't sign up for anything that you don't understand!** Call the Fund Office at (410) 683-6500 or toll-free at (800) 638-2972 to speak with a representative before enrolling in any new or additional coverage, so you know what effect it could have on your Fund health benefits.

# Retirees: IRS Form W-4P Will Soon Be Mailed. Your Response is Required!


Form W-4P
Withholding Certificate for Periodic Pension or Annuity Payments
2023

The IRS recently released a new mandatory federal tax withholding form intended specifically for withholding taxes from monthly pension benefits: **IRS Form W-4P**.

If you retired prior to 2023 and you are currently having a **flat-dollar amount** of federal tax withheld from your monthly pension benefit, then you will soon receive a Form W-4P in the mail to complete and return to the Fund Office. The IRS now requires your federal tax withholding to be determined using this new Form W-4P, and no longer allows for flat-dollar amount withholdings. (Note: this does not apply to your State tax withholdings.)

If you previously elected to have no withholding or $0.00 withheld for federal tax, you will not receive a Form W-4P in the mail, and the Fund will continue to honor your election to have no federal tax withheld.

If you receive this form in the mail from the Fund Office, you will have **60 days** to complete the form and return it to the Fund Office. If the form is not completed and returned within 60 days, the Fund will determine your federal withholding by applying the IRS' default election based on a filing status of single with no allowances. This could result in a higher or lower withholding from your pension checks in the future.

Although you are required to complete and return this form, you are not required to have federal tax withheld from your pension checks. You may choose to have no tax withheld from your monthly checks by writing the words "No Withholding" on Form W-4P in the designated box.

If you have any questions regarding federal tax withholdings or Form W-4P, please consult your tax advisor. If you receive this form in the mail and have any questions for the Fund Office, please contact the Fund Office. Note: The Fund Office cannot provide tax advice.

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

The Fund Office will send all retirees (and beneficiaries who are collecting a benefit) a Retiree Information Form ("RIF") within the next few months to be completed and returned to the Fund Office. The form asks questions about your current address, your beneficiary, whether you and/or your spouse have other health coverage, and current employment information, if any.

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

### Helpful Reminders

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

***The only person who can sign the RIF form is the Retiree or Beneficiary named on the RIF form, unless another individual holds legal authority to sign on the individual's behalf, such as a Power of Attorney or legal guardian. A copy of any such Power of Attorney or other legal document must be submitted to the Fund Office and verified before a RIF will be accepted with a representative's signature. If, for health reasons, the individual is unable to sign the form and there is no Power of Attorney or legal authority on file, then the individual must sign an "X" on the RIF and have it notarized by a Notary Public.***

We appreciate your cooperation!

# Kaiser Permanente Rate Changes

Each year, Actively Working participants who live within the Kaiser service area have the opportunity to enroll in the Fund's Kaiser Permanente HMO to provide medical coverage instead of traditional Fund medical coverage. Open enrollment is July 15th to September 15th, for coverage effective October 1st.

The cost to enroll in Kaiser is shown below. This amount is payable to the Fund office each month by you. Your regular payroll deduction will continue to apply. If you choose Kaiser for your Medical coverage, your Medical and Mental Health coverage will be through Kaiser. Your other health benefits (optical, dental, drug, A&S, Life Insurance) will continue to be provided through the Fund. **If you enroll in Kaiser, you MUST use a Kaiser provider in order to be covered**.

If you would like to receive an enrollment packet from Kaiser Permanente, call (301) 468-6000 or toll-free at (800) 777-7902 and request one. IMPORTANT! When you call Kaiser to request an enrollment packet, participants in Plans I and X should specify Group #6879 and participants in Plans XX and XXX should specify Group #1976. This ensures you receive the correct information for your Plan! Once you receive the packet from Kaiser, if you want to enroll, complete the enrollment form and return it to the FUND OFFICE. We will send it to Kaiser Permanente for you. If you choose Kaiser for the upcoming Plan Year, you cannot change your election until open enrollment next year for coverage effective 10/1/2024.

If you are in Kaiser currently and would like to change to Fund Medical coverage, call the Fund office at (800) 638-2972 to make the request.

The Kaiser Plan Year starts on October 1st If you have questions about eligibility, coverage or the co-pay rates, contact Participant Services at (800) 638-2972. We'll be glad to assist you.

Questions about Kaiser benefits and coverage should be directed to Kaiser Member Services at (800) 777-7902.

| Plan | Co-Pay Rates |
|---|---|
| Plan I Full Time | $1,711.89 |
| Plan I Part Time | $2,080.29 |
| Plan X Full Time | $1,009.12 |
| Plan X Part Time Individual | $810.65 |
| Plan X Part Time Family | $1,203.68 |
| Plan XX Full Time | $92.53 |
| Plan XX Part Time | $81.90 |
| Plan XXX Full Time | $199.93 |
| Plan XXX Part Time | $181.58 |

# Over-the-Counter COVID-19 Test Coverage

*Below is a Summary of Material Modification (change) made to the FELRA & UFCW Active Health and Welfare Plan. Please keep it with your Summary Plan Description ("SPD") booklet so you will have it for easy reference.*

*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, and XXX. Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits and Coverage ("SBC").*

Effective May 11, 2023, the Plan will cover up to 4 over-the-counter (OTC) COVID-19 diagnostic tests per covered Participant and Dependent per 30-day period, provided that those tests are purchased from an in-network participating pharmacy covered under the Plan's Prescription Drug Benefit. These tests will be covered with no cost sharing (including deductibles, co-payments, and co-premiums) and no requirement of prior authorization.

The types of OTC Tests that are covered include at-home diagnostic tests approved, cleared, or authorized by the FDA for use without an order or individualized clinical assessment from a health care provider. Generally, at-home OTC tests that are available for purchase from participating pharmacies will meet this standard.

To find a retail pharmacy in your network, visit www.express-scripts.com and click "Find a Pharmacy" or use the Express Scripts mobile app. If you prefer to order your OTC Tests online at $0 copay and have them delivered to your home, visit www.express-scripts.com/covid-19/resource-center to log in at the Express Scripts Pharmacy and place your order.

Regardless of whether you obtain the tests at a participating pharmacy or from Express Scripts online, coverage is limited to four (4) tests per covered participant or dependent, per 30-day period. Please note, COVID-19 diagnostic tests performed at a provider's office, hospital, or clinic do not count toward this limit.

If you have any questions, please contact the Fund Office at (800) 638-2972.

# Send Note from Physician and Paid Receipt to Fund Office for Reimbursement of Diabetic Supplies

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

If you or a covered dependent have Diabetes Mellitus, you may be eligible for reimbursement for the cost of blood sugar monitors (like Glucometer and Accu-Check) and other supplies, such as Chemstrips, after you have satisfied your annual deductible. Send your paid, itemized receipt to the Fund Office, along with a note from your physician, verifying that you (or your eligible dependent) have Diabetes Mellitus, and that the supplies are related to the treatment of your illness. Be sure that the itemized receipt shows the diabetic supply purchased.

### Buying at a Pharmacy

**Plans X, XX, and XXX**: Participants in these Plans must purchase diabetic supplies from a Giant or Safeway pharmacy in order to be reimbursed. The Fund will not cover supplies purchased from CVS, Walmart, Walgreens or Rite Aid pharmacies.

**Plan I**: Plan I participants may purchase supplies from any pharmacy they choose.

All participants must pay **in full** for the supplies up front, but you can be reimbursed by the Fund if you send the Fund Office your paid, itemized receipt and a note from your physician verifying that you (or your eligible dependent) have Diabetes Mellitus, and that the supplies are related to the treatment of your illness. Be sure to include your name (or patient's name, if supplies are for a covered dependent), the participant's ID Number, the name of the store or pharmacy where the diabetic supply was purchased, and the date supplies were purchased, since this information is not always on the receipt.

You will be reimbursed under your medical benefit at 80% for Plans I and X, at 75% for Plan XX, and at 70% for Plan XXX, after satisfying the annual deductible.

### Buying Online

The Fund Office will accept receipts for diabetic supplies purchased online provided that you purchase from a medical supply or diabetic supply company and, for participants in Plans X, XX and XXX, the supply company is in the CareFirst network. The Fund does not accept receipts from Amazon or other online "shopping" sites such as eBay. The purchase must be from an actual pharmacy or medical supply company. Shipping is not covered for online purchases. If you would like to verify whether a certain pharmacy or medical supply retailer is eligible for reimbursement prior to purchasing supplies, please contact the Fund Office.

# Apply for Your Severance Benefit on Time

If you are eligible for severance benefits, you should apply immediately after your Severance from Service date. This is usually your employment termination date, but there are special rules for participants on a leave of absence. See page 12 of your Severance Plan Summary Plan Description 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 July 1, 2023, the four-month waiting period will expire on November 1, 2023, and your severance payment deadline will be February 15, 2024.

**If you do not apply for and receive your severance benefit by the deadline under the Plan, you may forfeit 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." It is also a good idea to make sure your named beneficiary is up to date and on file with the Fund Office for any payable Severance Plan death benefits.

# What Happens to Your Health Benefits During a Leave of Absence

If your employer grants you an approved leave of absence (in writing), you have two options concerning your health benefits:

1. If you are eligible, you may choose to continue your benefits under COBRA or USERRA, as explained in your SPD booklet.
2. If you elect to waive your COBRA or USERRA rights, you may choose to continue your eligibility status by making self-payments directly to the Fund.

## Self-Payments

You have 30 days after you lose eligibility to decide if you want to make self-payments. **Self-payments must be made monthly in an amount determined by the Board of Trustees, and must be received by the Fund Office on or before the first of each month**. If the monthly payment is not received on time, you will no longer be eligible for benefits (as of the end of the month for which the last self-payment was received).

Timely self-payments will be accepted until you return to active employment covered by the Plan or until your leave of absence expires, but in no case more than 18 months following your loss of eligibility.

## What Benefits Would I Have?

If you choose to self-pay, you may continue:

- Medical benefits only;
- Life and Accidental Death and Dismemberment benefits only;
- Drug, Optical and Dental benefits only; or
- Any combination of these three groups.

You may make self-payments only for those benefits ***for which you were eligible as of the last day prior to your loss of eligibility***.

## Getting Started

Call the Fund Office (800-638-2972) to find out the amount of the monthly self-payments.

Mail your check or money order and a copy of your written leave of absence, if applicable, to:

FELRA & UFCW VEBA Fund
Attn: Eligibility Dept.
8400 Corporate Drive, Suite 430
Landover, MD 20785-2361

You will not be billed. It is your responsibility to send your self-payment to the above address each month and to ensure it is received prior to the first of the month.

CONIFER HEALTH SOLUTIONS® | Conifer Corner

### Don't let allergies keep you indoors.

Sneezing, congestion and a runny nose are common symptoms of seasonal allergies. You can reduce your symptoms by avoiding the outdoors when pollen counts are high and keeping your lawn mowed. If symptoms persist, talk to your provider or pharmacist about medications that can help.

**Want to learn more ways to stay healthy?**

Call a Personal Health Nurse (PHN) with Conifer Health Solutions and take charge of your overall health. Your PHNs can help you to learn ways of staying as healthy as possible. Call:

- Lea, at 800.459.2110, ext. 2917
- Renee, at 800.459.2110, ext. 2552, or
- Michelle, at 800.459.2110, ext. 2061

# Giant Associates – New Procedures for Filing Health Plan Disability and Leave of Absence Claims

When you are disabled or ill and unable to work OR if you are taking a Leave of Absence, there are new steps to follow for Giant Associates. First, contact Retail Business Services ("RBS")/Associate Business Center ("ABS") by calling (866) 789-4748. Notify them of your absence (whether due to disability or Leave of Absence). They will send you a "leave of absence" packet, which contains the Fund Office's Disability Claim form. You and your physician should complete your sections as usual, but "RBS" has to complete the Employer Section of the Disability Claim form. **This can no longer be handled at the store level! Once you and your doctor have completed your sections, the form has to be sent to "RBS/ASC" for them to complete. This can take up to five days**.

Once RBS/ASC has completed the employer portion of the form, they will forward it to the Fund Office via fax. The Fund Office cannot process your disability claim until it receives the completed form with all the information. Contact RBS/ABS directly for questions about your form. Contact the Fund office or Giant Retail Business Services if you have questions.



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