FELRA & UFCW Active Health Plan

A Plan of the Food Employers Labor Relations Association
and United Food and Commercial Workers
VEBA Fund

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Plan X

Summary of Material Modifications

February 2025

This Insert is a Summary of Material Modifications (changes) to your Summary Plan Description (SPD) booklet. If there is any discrepancy between the terms of the Plan or any amendments and this document, the provisions of the Plan, as amended, will control. Please keep this Insert with your booklet so you will have it when you need to refer to it.

- Effective September 1, 2023, the Plan will not cover COVID-19 immunizations provided on an out-of-network basis. The Plan will continue to cover qualifying COVID-19 immunizations provided in-network, without cost-sharing (i.e. deductibles, co-payments, or co-premiums) and without prior authorization, under the Plan's ACA Preventive Services Benefit.

- Effective July 1, 2023, diagnostic testing by a physician or other covered provider for COVID-19, and related items and services, are no longer covered with no cost sharing. COVID-19 diagnostic testing by a physician or other covered provider, and related items and services, will be covered subject to the Plan's rules for covered medical expenses and any applicable cost-sharing and prior authorization requirements.

- Effective August 1, 2023, the Plan will cover up to 2 over-the-counter (OTC) COVID-19 diagnostic tests per covered Participant and Dependent per 30-day period, provided those tests are purchased at 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 under the applicable FDA authorization, clearance, or approval. Generally, at-home OTC tests that are available for purchase in 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 two (2) 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.

- ***Effective March 1, 2023, Beacon Health Options became Carelon Behavioral Health ("Carelon")***

  - The new name does not impact your plan or services
  - You can see all of your previous doctors and health professionals
  - All existing phone numbers, emails, websites, and apps will redirect you to the right place

The following new subsection is added before the "Definitions" section of your SPD:

1. Prohibition of Assignment of Benefits

No benefit under the Plan or right under ERISA may be assigned or transferred to another party by a participant, dependent, spouse or beneficiary. The *Fund* will not recognize any attempted assignment. Nothing in this SPD or the *Fund*'s Trust Agreement shall be construed to make the *Fund*, the *Trustees*, UFCW Locals 27 or 400, or any *Participating Employer* liable to any third-party to whom a participant, dependent, spouse or beneficiary may be liable for medical care, treatment, or services. The *Fund* may make direct payments to a medical provider. A direct payment by the *Fund* to a medical provider does not make the provider an assignee, and in no way confers upon the provider any rights that a participant has under the Plan or ERISA.

2. In the first numbered list in the Claims Filing and Review Procedure section of the SPDs for item, number 3 is revised as follows:

Benefit payments will be sent directly to the provider unless there is no payment direction and evidence of your payment is reflected. In that case, payment will be sent directly to you.

3. In the Claims Filing and Review Procedure section of the SPD, and the Retiree Plan under the "When you File a Claim" subsection, the last sentence of item number 4 is revised as follows:

Benefit payments will be sent directly to the provider unless there is no payment direction and there is evidence of your payment on the bill.

- **Effective January 1, 2022, The following changes to your Plan are designed to comply with the No Surprises Act of 2021, which was enacted to shield patients from the negative financial impacts of unexpected balance billing by non-network providers for certain medical claims such as those relating to emergency medical care.**

The following new definitions are added under the "Definitions" section of the SPD:

- **ANCILLARY SERVICES.** With respect to an in-network *Health Care Facility*, (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; and (4) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

- **CONTINUING CARE PATIENT.** An individual who is: (1) receiving a course of treatment for a *Serious and Complex Condition*; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

- **EMERGENCY SERVICES**. Any of the following, with respect to an *Emergency Medical Condition*:
  - An appropriate medical screening examination that is within the capability of the emergency department of a *Hospital* or *Independent Freestanding Emergency Department*, including *Ancillary Services* routinely available to the emergency department to evaluate such *Emergency Medical Condition*;

- Such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and
- Services provided by an out-of-network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:
  - The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;
  - The patient is supplied with a written *Notice*, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and
  - The patient gives informed *Consent* to continued treatment by the nonparticipating provider, acknowledging that she or he understands that continued treatment by the out-of-network provider may result in greater cost to the patient.

- **HEALTH CARE FACILITY**. For non-*Emergency Services*, a: (1) hospital; (2) hospital outpatient department; (3) critical access hospital; or (4) ambulatory surgical center.

- **INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT**. A facility that is geographically separate and distinct from a *Hospital* under applicable state law and provides, and is licensed under state law to provide, *Emergency Services*.

- **NO SURPRISES ACT.** The No Surprises Act enacted under the federal Consolidated Appropriations Act of 2021.

- **NO SURPRISES SERVICES.** The following services, to the extent covered under the Plan: (1) out-of-network *Emergency Services*; (2) out-of-network air ambulance services; (3) non-emergency *Ancillary Services* (such as anesthesiology, pathology, radiology, neonatology and diagnostic services and other services defined as ancillary under the *No Surprises Act* and its implementing regulations) when performed by out-of-network providers at in-network *Health Care Facilities*; and (4) other out-of-network non-*Emergency Services* performed by an out-of-network provider at in-network *Health Care Facilities* with respect to which the provider does not comply with federal *Notice and Consent* requirements.

- **NOTICE AND CONSENT.** With respect to out-of-network services provided at an in-network *Health Care Facility*, *Notice and Consent* means: (1) that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and (2) you give informed consent to continued treatment by the out-of-network provider, acknowledging that you understand that continued treatment by the out-of-network provider may result in greater cost to you.

- **SERIOUS AND COMPLEX CONDITION.** A condition, (1) in the case of an acute illness, that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

▪ **The definitions of "Co-Payment or Co-Insurance" and "Medical Emergency" under the "Definitions" Section of the SPDs are deleted and replaced with the following:**

- **CO-PAYMENT OR CO-INSURANCE.** The out-of-pocket amount of the *Allowable Charge* that a participant or dependent is responsible for paying when receiving benefits after paying any applicable *Deductible* amount for that year. Effective January 1, 2022, the *Co-insurance* or *Co-payment* applicable to *No Surprises Services* is based on the

lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider.

- **EMERGENCY MEDICAL CONDITION**. A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

- **All references to the "Usual, Customary, and Reasonable charge" or the "UCR charge" are deleted and replaced with the "Allowable Charge," and the definition of "Usual, Customary, and Reasonable or UCR" under the "Definitions Section of the SPD is deleted and replaced with the following:**

  - **ALLOWABLE CHARGE.** The fee, as determined by the *Fund*, that is the lowest of: (1) the health care provider's actual charge; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the maximum amount that the Fund has determined it will pay for the service or supply; or (4) the amount that is reasonable and customary for the locality in which incurred. Notwithstanding the above, for CareFirst in-network claims, the *Allowable Charge* is the CareFirst allowed amount.

- **The first sentence under "Hospitalization" in the SPD's "Schedule of Benefits for Full Time Participants" and "Schedule of Benefits for Part Time Participants" is deleted and replaced with the following:**

  - **All emergency *Inpatient Hospital* stays must be certified within 24 hours of admission and all non-emergency *Inpatient* stays must be pre-certified with Conifer Health Solutions, to the extent consistent with applicable law.**

- **The last sentence under "Hospitalization" in the "Schedule of Benefits for Full Time Participants" and "Schedule of Benefits for Part Time Participants" is deleted and replaced with the following:**

  - **You must use an in-network CareFirst PPO provider (with the exception of (1) *No Surprises Services* and (2) emergency *Ambulance Service*).**

- **The last three sentences under "Medical" in the "Schedule of Benefits for Full Time Participants" and "Schedule of Benefits for Part Time Participants" are deleted and replaced with the following:**

  - **You must use a CareFirst PPO participating provider (with the exception of (1) *No Surprises Services* and (2) emergency *Ambulance Service*). You must pre-certify all non- emergency *Inpatient Hospital* stays with Conifer Health Solutions. You must use LabCorp or Quest facilities** in order to be covered for laboratory services, except that laboratory services performed by out-of-network providers at in-network facilities also are covered.

- **The "Use Participating Doctors" Subsection under the "Consumer Tips" Section is deleted and replaced with the following:**

  - **Use Participating Doctors**
    When you need to see a doctor or go to a *Hospital* or other facility, you must use a CareFirst provider to have coverage, with the exception of (1) *No Surprises Services* and emergency *Ambulance Service*. To locate a CareFirst provider, contact CareFirst at the number listed on your ID card.

- **The first two paragraphs of the "CareFirst PPO" Section is deleted and replaced with the following:**

  - CareFirst PPO is a network of *Hospitals*, *Physicians*, and other health care providers which offers medical and *Hospital* services at discounted rates that are generally lower than usual provider fees. **You must use a CareFirst provider to have coverage for *Hospital*, medical, or surgical benefits under the *Fund*** (with the exception of: (1) *No Surprises Services* and (2) emergency *Ambulance Service*)**.**

  - **Exceptions**
    You are covered for *No Surprises Services* provided by non-PPO network providers. You are also covered for out-of-network emergency *Ambulance Service*.
    - **The following paragraph is added to the SPDs' "CareFirst PPO" Section:**

      - **Provider Directory**
        The provider directory listing those providers that are in-network because they participate in CareFirst's network will be updated at least every ninety (90) days and will be available through the Fund's website. If you receive services from a provider that you thought was in-network, based on inaccurate information in a current provider directory, then the services provided by that out-of-network provider will be covered as if the provider was in-network.

    - **The last paragraph of the SPD's "CareFirst PPO" Section is deleted and replaced with the following:**
      Important: For laboratory services to be covered, you must use either LabCorp or Quest Diagnostic Laboratories for all laboratory services (except those performed when you are an *Inpatient* in the *Hospital* or by out-of-network providers at in-network facilities). Lab services performed in your doctor's office or other locations generally will not be covered. To find the nearest LabCorp location, call (888) 522-2677 or log onto their website at www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220 or go to their website at www.questdiagnostics.com/appointment.

- **The following is added to the beginning of the "Comprehensive Medical Benefits" Section of the SPD:**

  - Notwithstanding anything in this Section to the contrary, no prior authorization requirement will apply to *Emergency Services*.

- **The following new sections are added under the "Comprehensive Medical Benefits" Section of the SPD:**

  - **Air Ambulance Services**
    Under applicable law, the cost-sharing requirement applicable to out-of-network air ambulance services must be no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider. In general, you cannot be balance billed for these air ambulance services.

  - **Continuing Care Patients**
    If an in-network provider leaves the CareFirst network, a *Continuing Care Patient* who is receiving care with that provider will be notified, and may elect to continue to receive such care at the same in-network *Co-Payment* and *Co-Insurance* rate for up to 90 days after the provider leaves the network.

- **The "You Must Use a CareFirst Provider" Subsection of the "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  - **You Must Use a CareFirst Provider**
    Medical benefits will be covered ***only if services are performed by an in-network provider,*** with the exception of: (1) *No Surprises Services* and (2) emergency *Ambulance Service*. When you need to use a provider (whether a *Hospital*, *Physician*, or other health care provider), be sure they are in the CareFirst network. Otherwise, your claim will be denied unless it fits into one of the specific exceptions mentioned above.

- **The "Payment of Benefits" Subsection of the SPD's "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  - **Payment of Benefits**
    When the professional services described below are rendered by a *Physician*, physician's assistant, nurse practitioner or certified surgical assistant, the Plan will provide benefit payment at the percentage shown in your Schedule of Benefits, up to the *Allowable Charge*. The annual *Deductible* applies, except as may otherwise be provided here or under applicable law. Payment by the *Fund* will constitute full and final payment, except as may otherwise be provided or limited here or under applicable law. Charges made in excess of these amounts are the responsibility of the patient, **except** in the case of No Surprises Services. Your only financial responsibility for any *No Surprises Service* is any applicable *Deductible, Co-Insurance* and/or *Co-Payment* amount, up to the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider. You will not be responsible for any other amount relating to *No Surprises Services*, even if the provider does not accept the *Allowable Charge*.

- **The "Hospital Services" Subsection of the "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  - **Hospital Services**
    Conifer Health Solutions pre-authorization is required for all Hospital admissions*, except that there is no prior authorization requirement for *Emergency Services. Contact Conifer Health Solutions at (833) 778-9806.

- **The third paragraph under the "Diagnostic X-Ray and Laboratory Services" Subsection of the SPD's "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  - **<u>Important:</u> For laboratory services to be covered, you must use either LabCorp or Quest Diagnostic Laboratories for all laboratory services (except those performed when you are an *Inpatient* in the Hospital or by out-of-network providers at in-network facilities). Lab services performed in your doctor's office or other locations generally will not be covered. To find the nearest LabCorp location, call (888) 522-2677 or log onto their website at www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220 or go to their website at www.questdiagnostics.com/appointment.**

- **The second, third, and fourth paragraphs under the "Inpatient Medical Services" Subsection of "Comprehensive Medical Benefits" Section are deleted.**

- **The "Outpatient Emergency Care" Subsection of the SPD's "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  - **<u>Outpatient Emergency Care</u>**
    Benefits are available to you or your eligible dependents for care received within 72 hours of an *Accidental Injury*, by a *Physician*, wherever it is performed, and for *Outpatient Emergency Services*.

- **The "Outpatient Treatment" Subsection of the SPD's "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

  - **<u>Outpatient Treatment</u>**
    Outpatient Hospital treatment will be covered when the treatment is for:

    - The performance by a *Physician* of minor surgical procedures required for treatment and not solely for diagnosis,
    - care rendered within 72 hours after a non-occupational *Accidental Injury*, or
    - *Emergency Services*.
    - Benefits for coverage of *Outpatient* radiation and radioactive isotope therapy will be provided when performed in the *Outpatient* department of a *Hospital* and billed as a *Hospital* service.

- **In the "Conifer Health Solutions" (formerly "Carewise Health") Section of the SPD, the last bullet point under "2. Emergency Admission (Requires Certification within 48 Hours of Admission)" is deleted and replaced with the following:**

  - Emergency room <u>visits</u> do not require certification and *Emergency Services* do not require prior authorization.

- **In the first numbered list under the SPD's "Claims Filing and Review Procedure" Section, the first sentence of number 6. is deleted and replaced with the following:**

  - **You must use a CareFirst PPO participating provider** (with the exception of (1) *No Surprises Services* and (2) emergency *Ambulance Service*).

- **The following is added to the end of the "Claims Review – Types of Claims," "4. Post-Service Claim" Subsection of the SPD's "Claims Filing and Review Procedure" Section:**

  - Notwithstanding the above, providers of *No Surprises Services* will receive payment, or a denial, of a *Post-Service Claim* for *No Surprises Services* within 30 days of the Fund's receipt of all information necessary to adjudicate the claim.

- **The second sentence under the "External Review of Claims for Uninsured Benefit – Comprehensive Medical and Prescription Drug" Subsection of the SPD's "Claims Filing and Review Procedure" Section is deleted and replaced with the following:**

  - External review is limited to claims: (a) relating to a *No Surprises Service;* (b) involving medical judgment (e.g., lack of *Medical Necessity*, or a determination that a claim is *Experimental* or cosmetic); or (c) involving a retroactive rescission of coverage.

- **Effective June 1, 2021, Dentegra Insurance Company ("Dentegra") will provide the Fund's dental benefits, replacing Group Dental Service.**

  What Does This Mean for You?
  - **Your benefits will NOT change.** You will have the same coverage described in your Summary Plan Description ("SPD") booklet with the same co-pays, exclusions etc.
  - **For the first time, you will receive a Dental ID card.** You should receive the card around mid-May. Show the card to the dentist when you receive dental services on or after June 1, 2021. If you haven't received a dental ID card by May 31st, contact Dentegra at (877) 280-4204 to request a card. If you have an urgent dental situation before your ID card arrives, contact the Fund office and we will provide you with information to tell the dentist until your actual card arrives.

- Dentegra has a wide network of providers, so most participants will have more dentists available to them.
- Just as you did under Group Dental Service, you must use a Dentegra dentist in order to be covered. Participants who live more than 20 miles from a Dentegra dentist may use a non-Dentegra dentist, but you will be responsible for any balance owed after Dentegra makes its payment.
- You can change dentists at any time without notifying Dentegra as long as the dentist you choose is in the Dentegra network.

Finding a Participating Dentegra Dentist
Go to Dentegra.com/FELRA to find participating dentists in your area. Click on the "EPO-Collective Bargaining" tab to get to the list of covered providers. Call the dentist yourself and make your appointment. Have your Dental ID card ready when you call, and be sure to tell the provider that your insurance is through Dentegra.

Benefit and Claims Information available on Dentegra's website
Register for an online account with Dentegra to be able to view claims and eligibility status. General Plan information can be found on the website at Dentegra.com/FELRA.

- **COVID-19 Vaccination Coverage**

The following services will be covered under Comprehensive Medical Benefits and the Prescription Drug Benefit on an in-network and out-of-network basis with no cost sharing (including deductibles, co-payments and co-premiums) and no requirement of prior authorization:

- A COVID-19 immunization that has a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use), after such recommendation has been in effect for 15 business days; and

- items and services that are an integral part of furnishing the covered immunization, including vaccine administration.

Office Visit Coverage
There are limited situations in which an office visit is payable under this COVID-19 Vaccination Coverage. The following conditions apply to payment for office visits under the COVID-19 Vaccination Coverage:

- If the covered immunization, item or service is billed separately from an office visit, then the Fund will impose cost-sharing with respect to the office visit.
- If the covered immunization, item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of the immunization, then the Fund will pay for the office visit without cost-sharing.
- If the covered immunization, item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of the immunization, then the Fund will impose cost-sharing with respect to the office visit.

- **Effective January 1, 2021, the following new subsection is added under the Comprehensive Medical Benefits Section of your SPD:**

Cologuard – Colorectal Cancer Screening
Cologuard colorectal cancer screening tests are covered under the Plan, subject to the same guidelines followed by Medicare Part B for coverage of such tests. Under the current Medicare guidelines, the test is covered once every three years for participants and eligible dependents who are ages 50 to 85 years old, have no signs or symptoms of colorectal disease (i.e., lower gastrointestinal pain, blood in stool, etc.), and are at average risk of developing colorectal cancer.

- **Effective March 1, 2020 and continuing through December 31, 2020, any in-person visit requirement applicable to traditional Fund (non-Kaiser) medical benefits and accident and sickness benefits under the Plan will be waived, as follows:**

  The Plan will cover medical benefit claims for otherwise covered services provided by telephone conference, video conference, or similar technology, subject to any applicable Plan rules and cost-sharing requirements (*e.g.*, deductible, pre-authorization) that would apply to an in-person visit for the same service.

  The requirement that you be seen in-person by a physician in order to verify your eligibility for Accident and Sickness Benefits may be satisfied by a visit with the physician through telephone conference, video conference, or similar technology.

- **Effective June 1, 2020, the "Ambulance Service" Subsection of the "Comprehensive Medical Benefits" Section of the SPD for Plans I, X, XX, and XXX of the Active Plan is deleted and replaced with the following to reflect an increase in the Ambulance Service benefit under the Fund:**

  Ambulance Service
  For Participants and Dependents covered under Plan I, benefits are provided for emergency *Ambulance Service* up to the greater of $200 per trip or 80% after the annual deductible has been met. For Participants and Dependents under Plans X, XX, and XXX, benefits are provided for emergency *Ambulance Service* up to $200 per trip. The patient's condition must be such that use of any other method of transportation is not medically advisable.

- **Effective July 1, 2020, the "Quantity Limits/Prior Authorization" Subsection of the "Prescription Drug Benefit" Section of the SPD is deleted and replaced with the following:**

  Prior Authorization
  There are prior authorization requirements applicable to the coverage of certain medications under the Plan. If your prescription drug claim is denied based on the Fund's prior authorization requirements, please have your *Physician* or pharmacist contact Express Scripts and provide the appropriate documentation for review. Please go to www.express-scripts.com or contact Express Scripts by phone at (800) 903-8325 for the current list of drugs subject to prior authorization.

  Drug Quantity Management

  The Fund maintains a Drug Quantity Management program. Drug Quantity Management means that the Fund will only pay for a specific quantity at a particular strength for certain prescription drugs. Quantity limits are set in accordance with FDA approved prescribing limitations and standard medical practice. Please go to www.express-scripts.com or contact Express Scripts by phone at (800) 903-8325 for the current list of drugs subject to these rules. If your *Physician* wants to prescribe a particular strength or quantity of drug that does not fit within the limits of the Fund's Drug Quantity Management program, your *Physician* can request an exception by contacting Express Scripts.

- **Effective June 1, 2020, the following new Subsection is added at the end of the "Prescription Drug Benefit" Section of the SPD:**

  Prescription Care Management
  The Fund has adopted a prescription management program provided through Prescription Care Management, LLC ("PCM"). Under the program, PCM may contact you or your *Physician* to discuss lower cost alternatives to certain medications you are taking with the goal of achieving cost savings for both you and the Fund. Participation in the PCM program is completely voluntary and you will not be penalized if you decide not to participate.

- **Effective September 24, 2019, the following is added after the last paragraph of the "Specialty Medication/Accredo Specialty Pharmacy" Subsection of the "Prescription Drug Benefit" Section of the SPD:**

  Limited Distribution Specialty Drugs
  Certain "limited distribution" specialty drugs may not be available through the Accredo Mail Order Specialty Pharmacy. If such a specialty drug meets the Plan's requirements for coverage but is not available through Accredo or any other covered pharmacy, the Plan will cover prescriptions for the specialty drug ordered through CVS Specialty Pharmacy, subject to the same *Co-payment* that applies to specialty drugs ordered through Accredo.
- **Effective June 1, 2020 – SaveonSP – Speciality Drug Coverage** *(applicable to Active Plan Participants and Dependents in Plans I, X, XX, and XXX).*

The Active Plan is partnering with Express Scripts, Inc. and SaveonSP, to help you and the Fund save money on certain specialty medications. You should have already received, or will soon receive, a separate notice from Express Scripts regarding the SaveonSP program that includes a list of the specialty drugs that currently are subject to this program.

This notice describes the SaveonSP program and serves as a summary of material modification to your SPD and a notice of modifications to your Summary of Benefits and Change (SBC) previously provided to you when you enrolled in coverage.

a. The following is added to the end of the Prescription Drug Section of your Active Plan SPD's Schedules of Benefits for Full Time and Part Time Participants:

However, if a specialty drug is covered by the Fund's SaveonSP program and you enroll and participate in the program, your *Co-payment* will be paid through the drug manufacturer's copay assistance program and you will pay nothing ($0). **If you do not participate in the SaveonSP program, the specialty drug will be subject to an increased *Co-payment* listed on the SaveonSP program's current Non-Essential Health Benefit Specialty Drug List, and the *Co-payment* will <u>not</u> count towards your deductible or out-of-pocket maximums**. See the "Prescription Drug Benefit" Section of the SPD for more information.

b. The following is added after the second bullet point under the "Cost of Prescription Drugs" Subsection of the "Prescription Drug Benefit" Section of your Active Plan SPD:

<u>Cost for Certain Specialty Drugs under SaveonSP Program</u>
Certain specialty drugs are subject to the Fund's program through SaveonSP. The SaveonSP program saves you and the Fund money through manufacturer copayment assistance programs. If you are prescribed a specialty drug that is part of the SaveonSP program (a "Participating Specialty Drug") and you have not yet enrolled in this program, SaveonSP will contact you with educational and enrollment information after your prescription is presented to Accredo Specialty Pharmacy. Enrollment in the SaveonSP program is voluntary, but if you do not enroll, your co-payment for any Participating Specialty Drug will increase significantly.

If you choose <u>not</u> to enroll and participate in the SaveonSP program, you will be charged the full *Co-payment* listed on the SaveonSP program's current Non-Essential Health Benefit Specialty Drug List for a Participating Specialty Drug. The *Co-payment* will <u>not</u> count towards your deductible or out-of-pocket maximums.

However, if you enroll in the SaveonSP program, your full *Co-payment* for the Participating Specialty Drug will be paid through the drug manufacturer's copay assistance program and you will pay nothing ($0), for as long as that Participating Specialty Drug is part of the program.

For a copy of the current Non-Essential Health Benefit Specialty Drug List of Participating Specialty Drugs, or if you have any questions regarding the SaveonSP program, please contact SaveonSP at (800) 683-1074.

c. Your Active Plan SBC includes a section describing what you will pay "[i]f you need drugs to treat your illness or condition." The following is added to the end of the "Limitations, Exceptions, & Other Important Information" for that section of your SBC:

If a specialty drug is covered by the Fund's SaveonSP program and you enroll in the program, your coinsurance will be paid through the drug manufacturer's copay assistance program and you will pay nothing ($0). If you do not participate in the SaveonSP program, the specialty drug will be subject to an increased coinsurance listed on the SaveonSP program's current Non-Essential Health Benefit Specialty Drug List. Contact SaveonSP at (800) 683-1074 for a copy of the List.

- Effective March 1, 2020, any in-person visit requirement applicable to traditional Fund (non-Kaiser) medical benefits and accident and sickness benefits under the Plan will be waived, as follows:

  - The Plan will cover medical benefit claims for otherwise covered services provided by telephone conference, video conference, or similar technology, subject to any applicable Plan rules and cost-sharing requirements (e.g., deductible, pre-authorization) that would apply to an in-person visit for the same service.

  - The requirement that you be seen in-person by a physician in order to verify your eligibility for Accident and Sickness Benefits may be satisfied by a visit with the physician through telephone conference, video conference, or similar technology.

- **Effective March 18, 2020 – COVID-19 Testing**

  The following services will be covered with no cost sharing (including deductibles, co-payments and co-premiums) and no requirement for prior authorization:

  - Diagnostic products for the detection of SARS-CoV-2 or the diagnosis of COVID-19 and the administration of such diagnostic products. The types of tests that will be covered include:

    1. Diagnostic testing authorized by the FDA or the Secretary of HHS;
    2. Diagnostic testing that is under review, or will be submitted for review, by the FDA for emergency use; and
    3. Diagnostic testing authorized by a State, if that State has notified the Secretary of HHS.

  - Items and services furnished to a Participant or Dependent during health care provider office visits, urgent care visits, and emergency room visits that result in an order for, or administration of, a diagnostic product, but only to the extent that the item or service relates to the furnishing or administration of the diagnostic test or the evaluation of whether an individual needs a diagnostic test.

- **Effective January 1, 2020 – Conifer Health Solutions Replaced SHPS/Carewise Health and Health Dialog**

  The Board of Trustees is pleased to announce a new utilization, case management and disease management provider. **Effective January 1, 2020,** Conifer Health Solutions ("Conifer") replaced SHPS/Carewise Health as the Fund's utilization and case management provider. Conifer also replaced Health Dialog Coaching Program as the Fund's disease management provider.

  How Do Conifer's Case Management and Disease Management Programs Benefit Me?

  Conifer's nurse case managers will assess any individual medical needs you or your covered dependents may have and provide education and resources to manage your health. They can also help coordinate care and advocate for services on your behalf that will assist you in achieving an optimal level of health and wellbeing.

  For those with **acute or chronic** medical issues, a Conifer Personal Health Nurse (or "PHN") can work with you to structure a disease management program with the goal of better managing your ongoing care needs and thereby improving your quality of life.

Starting January 1, 2020, you must contact Conifer (not SHPS/Carewise Health) to pre-certify ALL non-emergency or elective hospital stays and within 48 hours after an emergency admission. To pre-certify, call Conifer toll-free at (833) 778-9806. Remember, you must certify all hospital stays in order for the Fund to pay benefits.

The telephone number for case management and disease management is (800) 459-2110.

Beacon Health Options still handles your mental health benefits.

- **Effective September 1, 2019 – Advantica Purchased by Superior Vision**
  You should have received a new ID card from Superior Vision during the month of September 2019. Please show the new card to your optical provider when you go for care. If you need to see a vision provider and have not yet received your new ID card from Superior Vision, contact the Fund Office. We'll make sure the provider knows what benefits are available to you and that you are covered under the Fund.

  Superior Vision has an expanded network with providers located in major malls and other convenient locations, including Lens Crafters (this is new – Advantica did not have Lens Crafters in its network), Pearl Vision, Sears, and JCPenney, as well as many individual providers. For a current list of providers, log on to www.superiorvision.com. There are some limited benefits available if you use a non-participating provider. The new telephone number for customer service is (800) 507-3800. We think you will be pleased with the added convenience of additional providers.

- **Open Enrollment and Eligibility Changes**
  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 and clarifications to Fund's Summary Plan Descriptions ("SPDs") for Plans I, X, XX, XXX, and XL. Please keep this document with your SPD.

1. The following new "Open Enrollment Periods" Subsection is added before the Subsection entitled "Enrollment Form" under the "Employee Eligibility" Section of the SPDs for Plans I, X, XX, XXX, and XL:

   Annual Open Enrollment
   If you do not timely enroll yourself and/or your dependent(s) upon initial eligibility for coverage, you generally must wait until the next applicable Open Enrollment period to enroll or make changes to coverage for yourself and/or your dependent(s), as described below. There is an exception to this rule if you qualify for a special enrollment period, as described in the section entitled "Special Enrollment Provisions" under "Employee Eligibility."

   Enrolling in Coverage under the *Fund* and Adding or Dropping Dependents. The *Fund* has a single annual Open Enrollment period during which you may enroll in or drop coverage as a participant under the Plan and add or drop coverage for your eligible dependents. This annual Open Enrollment period is during the month of December each year, for coverage effective January 1.

   Enrolling in Medical Benefit Coverage through the Fund's HMO Option. If you are a participant in Plan I, X, XX, or XXX and you live in the geographic area of the HMO offered by the *Fund*, there is a separate annual opportunity to choose whether you want to receive your, and your enrolled dependents' (if any), medical coverage under an HMO offered by the *Fund* instead of receiving traditional *Fund* medical coverage. This period is from July 15 – September 15 for coverage effective October 1 each year. For more information, please refer to the "HMO Option" section of your SPD.
   Other Enrollment Changes. You may also drop coverage for your dependent children if the cost for dependent child coverage that must be deducted from your paycheck increases significantly, as determined in the sole discretion of the *Fund*'s Trustees, provided you timely drop the dependent child coverage by submitting a new enrollment form within 30 days from the date you receive notice of the new rates.

2. Effective November 1, 2017, as a result of collective bargaining, the following changes in eligibility apply to participants employed by Associated Administrators, LLC ("Associated Participants"). Associated Participants covered under Plans XXX or XL as of November 1, 2017 became covered under Plan XX on that date. Further, Associated Participants enrolled in

Plan XX will be eligible for Plan X as of the first (1st) day of the month after at least five (5) years of continuous participation in Plan XX, provided they otherwise meet the eligibility requirements under the Plan. Associated Participants who were enrolled in Plan XX and had at least 5 years of service under Plan XX as of November 1, 2017 became covered under Plan X effective November 1, 2017. Associated Participants who first become eligible for coverage under the Plan on or after November 1, 2017 will become covered under Plan XX after the applicable waiting period.

To reflect the above, the following changes have been made to the SPDs for Plans X, XX, XXX, and XL:

- Line 5 under the "UFCW Local 27" Subsection, and Line 6 under the "UFCW Local 400" Subsection, of the "Covered Employment with Participating Employers" Section of the Plan X SPD are revised to read as follows:

  Associated Administrators, LLC – Employees hired through October 31, 2005 or who have at least five (5) years of continuous participation in Plan XX as of the first day of the month.

- Line 5 under the "UFCW Local 27" Subsection, and Line 6 under the "UFCW Local 400" Subsection, of the Section entitled "Covered Employment with Participating Employers" on page 8 of the Plan XX SPD are revised to read as follows:

  Associated Administrators, LLC – Employees hired after October 31, 2005 with less than five (5) years of continuous participation in Plan XX as of the first day of the month.

- The "Covered Employment with Participating Employers" Section of the Plan XXX and XL SPDs is revised by deleting Associated Administrators, LLC from the list of Participating Employers.

- **Effective December 12, 2018 – Change in Open Enrollment for Part-Time Plan X Participants**
  Starting in December 2019, Part Time Plan X participants will have a single annual Open Enrollment Period each year, during which participants may enroll in or drop coverage under the Plan and add or drop dependents, if they are eligible for dependent coverage. Coverage will be effective each January. Previously, Open Enrollment was each January, for coverage effective March 1.

- **Effective July 1, 2018 - Life Insurance and AD&D Benefits Now through Symetra**
  Your life insurance benefits and Accidental Death and Dismemberment benefits under the Plan are insured under an insurance policy between the Fund and Symetra. Your benefits remain the same.

- **Open Enrollment Rule Clarification**
  Participants may disenroll from Fund Health and Welfare coverage in the event of a substantial increase in their co-premium payroll deduction, as determined by the Trustees.
  The disenrollment request must be received by the Fund office within thirty days from the date you were notified of the co-premium increase.

- **Effective March 15, 2018 – Shingles (Shingrix) Vaccine Now Approved for Those Age 50 and Over**
  A new shingles vaccine called "Shingrix" is now covered to treat Shingles. The Shingrix vaccine is a two-part vaccine. The second dose is administered between two and six months after the first dose. It is covered at no cost for participants age 50 and over when obtained at a Giant or Safeway participating pharmacy.

  The Zoster shingles vaccine also is still covered under the ACA Preventive Services Benefit to participants and their dependent(s) who are age 60 or over at no cost when you present your Express Scripts ID card at any Giant or Safeway pharmacy.

Note: if either of the above vaccines are administered at the doctor's office instead of a pharmacy, the doctor must be a participating provider. The shot is covered at 100% up to the UCR amount. If there is an office visit charge, it is covered under Comprehensive benefits at 80% for participants in Plans I or X, 75% for Plan XX and 70% for Plan XXX. Participants in Plans X, XX and XXX must use a participating CareFirst provider in order for this benefit to be covered.

- **Effective July 1, 2018 – Formulary Drug Changes**

  Beginning July 1, 2018, Express Scripts, the Fund's pharmacy benefit manager, will exclude 33 additional products from its formulary list, including 30 brand name drugs that have generic equivalents. The remaining three drugs to be excluded are high-cost combination drugs with lower-cost generic or over-the-counter options, and are delineated with an asterisk in the table below. If you currently have a prescription for any of the drugs listed below, you should have received a notice about this change from Express Scripts.

NEW FORMULARY EXCLUSIONS		
ARIMIDEX	AVALIDE, AVAPRO	AVODART
CELEBREX	CELEXA	COREG
COSOPT	COZAAR, HYZAAR	CRESTOR
DETROL, DETROL LA	DIOVAN, DIOVAN HCT	EXFORGE, EXFORGE HCT
GLEEVEC	GLUCOPHAGE, GLUCOPHAGE XR	KEPPRA, KEPPRA XR
LAMICTAL, LAMICTAL ODT, LAMICTAL XR	LIPITOR	LOESTRIN, LOESTIN FE
LOTREL	MAXALT, MAXALT MLT	MEBOLIC*
MICARDIS, MICARDIS HCT	NEURONTIN	NORVASC
ORTHO TRI-CYCLEN, ORTHO TRI-CYCLEN LO	TOPAMAX	TRICOR
TRILEPTAL	XALATAN	XYZBAC*
ZOCOR	ZOMIG TABLETS, ZOMIG ZMT	ZYVIT*

Effective July 1, 2018, the above drugs are no longer covered under the Plan.

- **Effective April 1, 2018 – Disability Benefits**

  The Board of Trustees of the FELRA and UFCW VEBA Fund ("Fund") has adopted the following changes to the FELRA & UFCW Active Health and Welfare Plan ("Active Plan") and FELRA & UFCW 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.

1. Effective for claims for disability benefits filed on or after April 1, 2018, the following language is added after the "If Your Accident & Sickness Claim is Denied" Subsection of the Section entitled "Claims Filing and Review Procedure" in the Active Plan SPDs and after the Section entitled "Denial of a Claim" in the Retiree Plan 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 – Accident & Sickness Claims" Subsection of the Section entitled "Claims Filing and Review Procedure" in the Active Plan SPDs and at the end of the Section entitled "Review of a Denied Claim" in the Retiree Plan 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 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" in the Active Plan SPD; (b) the second paragraph of the "If Your Accident & Sickness Claim is Denied" Subsection of the Section entitled "Claims Filing and Review Procedure" in the Active Plan SPD; and (c) the Section entitled "Denial of a Claim" in the Retiree Plan SPD:

   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.

- **Effective January 10, 2018 - Change in Open Enrollment And Enrolling New Dependents**
  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 and clarifications to the Fund's Summary Plan Descriptions ("SPDs") for Plans I, X, XX, and XXX.

1. Plan X now has a single annual Open Enrollment Period, from January 1-31 each year, when Participants may enroll in or drop coverage under the Plan and add or drop dependents, if they are eligible for dependent coverage. The July 1-31 Open Enrollment Period for Plan X Part Time Participants is eliminated.
2. The subsection entitled "Enrolling New Dependents" under the Section entitled "Dependent Eligibility" in Plans I, X, XX, and XXX is deleted and replaced with the following:

Enrolling <u>New</u> Dependents
Once you have satisfied the waiting period for dependent coverage, if any, a newly eligible dependent can be included for benefit coverage by notifying the Fund Office and completing an enrollment form. You must apply for dependent coverage **<u>within 30 days</u>** of the date your family member becomes your dependent.

If you apply for dependent coverage within 30 days from your date of marriage, your eligible spouse may be included for benefit coverage on the first day of the calendar month following the date of marriage. When you apply within 30 days of the date of a child's birth, the biological child(ren) and/or newborn child(ren) adopted or placed for adoption with you may be added as of the date of birth. For adopted children or children placed with you for adoption other than newborns, when you apply within 30 days of the date of adoption or placement with you for adoption, the child(ren) may be added as of the date of adoption or placement for adoption. When you apply within 30 days of the date of your marriage, stepchildren may be added on the first of the month following your date of marriage.

If you do not enroll your dependent spouse or child within 30 days of the applicable date described above, you must wait until the next Open Enrollment period to add him or her, unless you qualify for a special enrollment event as described in this SPD.

- **Clarification: Send Your Monthly Payments to the Fund Office, Not to Kaiser Permanente**

  If you are an actively working participant who has chosen the Kaiser Permanente HMO to provide your Medical/Mental Health benefits, send your monthly premium payments directly to the Fund Office and not to Kaiser. Under the "HMO Option" section and the subsection "Costs," of the Plans X, XX, and XXX SPDs, please replace with the following:

  There may be a monthly co-premium for coverage through an HMO which you must submit directly to the Fund Office (not the HMO). You will receive a letter each year explaining the Open Enrollment options and the monthly cost, if any, for each choice. Missed co-premium payments will result in a loss of coverage.

  Payments sent directly to Kaiser may be lost or misapplied. Please send your Kaiser co-payments/premiums to the Fund Office. For your convenience, the Fund Office provides payment coupons and return envelopes pre-printed with the Fund Office's address to all actively working participants enrolled in the Kaiser Permanente HMO.

- **Clarification to Hospice Care Services**

  For terminally ill participants or eligible dependents whose prognosis of probable survival is six months or less and who are receiving palliative, not curative, care, covered services include 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, lab tests and x-ray services, medical-surgical supplies, oxygen, Durable Medical Equipment, 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 visits 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.

- **Effective January 1, 2018 – Revised ACA Preventive Services**

  The Patient Protection and Affordable Care Act of 2010 ("ACA") requires 100% coverage for certain preventive medical services **as long as the patient is seen by an in-network provider.** This means you will have no deductible, co-payment or co-insurance for your wellness exam and related tests as long as you see a participating provider.

  Shown below are some of the new services.

  - Depression screening for pregnant and postpartum women.
  - Syphilis screening for adolescents who are at increased risk for infection.
  - Screening and counseling for adolescents for interpersonal and domestic violence.
  - Aspirin (low dose) as a preventive medication after 12 weeks of gestation in women who are at high risk of preeclampsia.
  - Aspirin preventive medication for adults aged 50 to 59 years having a more than 10 percent 10-year cardiovascular risk.
  - Statin preventive medication for adults aged 40 to 75 years with no history of cardiovascular disease (CVD), one or more cardiovascular disease risk factors, and a calculated 10-year CVD event risk of 10 percent or greater.

  Complete List on the Fund's Website

  A complete list of the 2018 ACA Preventive Services can be found on the Fund's website at www.associated-admin.com.

- **Beacon Health Options – New Address**
  Beacon Health Options, your mental health/substance abuse provider, recently changed its mailing address. Send all correspondence to the new mailing address: Beacon Health Options, PO Box 1854, Hicksville, NY 11802.

- **On April 1, 2017, the Landover Fund Office relocated to the following location:**

  Fund Office
  8400 Corporate Drive, Suite 430
  Landover, MD 20785-2361

  All phone and fax numbers remain the same. Participant Services is still toll-free (800) 638-2972.

- **Add the Following –** On page 12 of your SPD ("Full Time Group B benefits include Accident and Sickness, Prescription Drug, Dental and Optical") please add the following after "Dental":

Optical Participant and Eligible Dependent(s).	Exam, frames, and lenses once every two years, through Advantica.

- **New Address for Beacon Health Options –** For all correspondence to Beacon Health Options, please note the following address change:

Old Mailing Address	New Mailing Address
PO Box 930321 Wixom, MI 48393	PO Box 1854 Hicksville, NY 11802

- **<u>Page 31 – Transfer</u>**
  Please remove "VEBA" from the second paragraph. The sentence should read: If you are re-employed by a Participating Employer within 30 days of termination of coverage under this Fund or the UFCW Unions and Participating Employers Health and Welfare Fund ("UFCW Unions Fund"), you will be eligible for benefits under this Fund according to your total length of covered employment under both Plans.
- **<u>Pages 38 – 40 -- Dental Benefit Eligibility</u>**
  Subject to the requirements described in the Dental Benefit section of this SPD, your biological children, adopted children, and children placed with you for adoption are eligible for dental benefit coverage as your dependents through the end of the Calendar Year in which the dependent turns age 19 if they are:
  - Not married,
  - Not employed on a regular full-time basis, and
  - Dependent on you for financial support.

  Children under age four are not eligible for dental benefits.

  The Fund will provide dependent coverage for a child who is placed for adoption with a full time participant regardless of whether the adoption is finalized. A child will be considered to be placed for adoption with a participant if the participant assumes a legal obligation for the total or partial support of a child in anticipation of the adoption of that child. The child's placement with the participant will be considered terminated when the participant no longer has a legal obligation to support the child.

- **<u>Page 39 - Full Time Student Coverage</u>**
  Dependent stepchildren and children for whom you have legal custody may continue to receive **medical and optical benefits** under the *Fund* on and after their 19th birthday, if they are a full-time student at an accredited college or university, and they elect to waive any rights to elect *COBRA* that they may have. In such case the above-referenced coverage may be continued until the earliest of the last day of the calendar month in which he/she marries, ceases to

be financially dependent on you for support, ceases to be a full-time student, or the end of the *Calendar Year* in which he/she turns age 23.

- **Pages 95 - 97 – Accident & Sickness Benefits**
  - **Benefit Amount - Full Time Participants**

    Maximum Benefit – 66 2/3% of gross straight time pay for first 24 weeks plus 50% of gross straight time pay for the next 12 weeks.

    Example of benefit amount computation (Full Time Participants):

    First 24 weeks:

Hourly rate	= $10.00
$10.00 X 40	= $400.00 gross straight time pay
$400.00 X .666666 (66 2/3%)	= $266.67 weekly benefit amount
$266.67 ÷ 5	= $53.33 daily benefit amount

    Next 12 weeks:

$10.00 X 40	= $400.00 gross straight time pay
$400.00 X .5 (50%)	= $200.00 weekly benefit amount
$200.00 ÷ 5	= $40.00 daily benefit amount

  - **Part Time Participants**

    Maximum Benefit – 60% of average weekly straight time pay for first 16 weeks plus 50% of average weekly straight time pay for the next 8 weeks.

    Example of benefit amount computation (Part Time Participants):

    First 16 weeks:

Hourly rate	= $10.00
Average hours worked	= 25
$10.00 x 25	= $250.00 gross straight time pay
$250.00 x .60 (60%)	= $150.00 weekly benefit amount
$150.00 ÷ 7	= $21.43 daily benefit amount

    Next 8 weeks:

$10.00 x 25	= $250.00 gross straight time pay
$250.00 x .50 (50%)	= $125.00 weekly benefit amount
$125.00 ÷ 7	= $17.86 daily benefit amount

- **Pages 166-168 Dental Services and Fees**

Procedure Code	Description	Member Co-Pay
Diagnostic & Preventive		
00120	Periodic Oral Exam	N/C
00140	Limited Oral Evaluation – Problem Focused	N/C
00150	Comprehensive Oral Evaluation	N/C
00170	Re-evaluation – Limited, Problem Focused	N/C
00210	Intraoral – Complete Series. Including Bitewings (once per 3 years)	N/C
00220	Intraoral-Periapical-First Film	N/C
00230	Intraoral-Periapical-Each Additional Film	N/C
00240	Intraoral – Occlusal Film	N/C
00270	Bitewings – Single Film	N/C
00272	Bitewings – Two Films	N/C
00274	Bitewings – Four Films	N/C
00277	Vertical Bitewings – 7 to 8 Films	N/C
00330	Panoramic Film (once per 3 years)	N/C

00340	Cephalometric Film	N/C*
00460	Pulp Vitality Tests	N/C*
01110	Prophylaxis – Adult (6 months)	N/C
01120	Prophylaxis – Child (6 months)	N/C
01201	Top Application of Fluoride (Incl. Prophy), Child	N/C
01510	Space Maintainer – Fixed – Unilateral	$10
01515	Space Mainainer. – Fixed – Bilateral	$20
01550	Re-cementation of Space Maintainer	N/C

*** Not benefited separately. Fee is included in another procedure's fee being performed.**

Procedure Code	**Description**	**Member Co-Pay**
Basic Restorative		
D2140	Amalgam – One Surface, Primary or Permanent	N/C
D2150	Amalgam – Two Surfaces, Primary or Permanent	N/C
D2160	Amalgam – Three Surfaces, Primary or Permanent	N/C
D2161	Amalgam – Four or More Surfaces, Primary or Permanent	N/C
D2330	Resin – One Surface, Anterior	N/C
D2331	Resin - Two Surfaces, Anterior	N/C
D2332	Resin - Three Surfaces, Anterior	N/C
D2335	Resin - Four or More Surfaces or Incisal Angle	N/C
D2390	Resin – Crown, Anterior	N/C
D2391	Resin – One Surface, Posterior	N/C*
D2392	Resin – Two Surfaces, Posterior	N/C*
D2393	Resin – Three Surfaces, Posterior	N/C*
D2394	Resin – Four or More Surfaces, Posterior	N/C*

***GDS-MD pays up to the cost of Amalgam, patient pays the difference.**

Crowns (Single Restorations)		
02740	Crown – Porcelain/Ceramic Substrate	$125
02750	Crown – Porcelain fused to High Noble Metal	$125 + gold
02751	Crown – Porcelain Fused to Predominately Base Metal	$125
02752	Crown – Porcelain Fused to Noble Metal	$125
02790	Crown – Full Cast High Noble Metal	$125+ gold
02791	Crown – Full Cast Predominately Base Metal	$125
02792	Crown – Full Cast Noble Metal	$125
02920	Re-cement Crown	N/C
02930	Prefabricated Stainless Steel Crown – Primary Tooth	$30
02931	Prefabricated Stainless Steel Crown – Perm. Tooth	$30
02932	Prefabricated Resin Crown	$30
02940	Sedative Filling	N/C
02950	Core Buildup, Including Any Pins	N/C
02951	Pin Retention – Per Tooth, in Addition to Restoration	N/C
02952	Cast Post & Core in Addition to Crown	N/C
02954	Prefabricated Post & Core in Addition to Crown	N/C
02980	Crown Repair, by Report	N/C

Procedure Code	**Description**	**Member Co-Pay**
Endodontics		
D3110	Pulp Cap Direct (excluding final restoration)	N/C
D3120	Pulp Cap Indirect (excluding final restoration)	N/C
D3310	Endodontic Therapy – Anterior Tooth (Excl Final Rest)	$125*
D3320	Endodontic Therapy – Bicuspid Tooth (Excl Final Rest)	$125*
D3330	Endodontic Therapy – Anterior Tooth (Excl Final Rest)	$250*

**If the procedure is performed by a GDS in-network endodontic specialist, the participant is responsible for an additional $100 specialist fee.*

Periodontics

D0150	Comprehensive Oral Evaluation Performed by Periodontist	$30
D0210	Intraoral Complete Series, Including Bitewings (one per 3 years)	$30
D0220	Intraoral – Periapical First Film	$4
D0470	Diagnostic Casts	$20
D3920	Hemisection, Including Root Removal (not w/root canal)	$110
D4210	Gingivectomy/Gingivoplasty, Four or more Contiguous Teeth or Bounded Teeth Spaces per Quad	$200
D4211	Gingivectomy/Gingivoplasty, One to Three Teeth Per Quad	$55 per Tooth, Max. $100
D4240	Gingival Flap Procedure, Including Root Planing, Four or more Contiguous Teeth or Bounded Teeth Spaces per Quad	$200
D4241	Gingival Flap Procedure, Including Root Planing, One to Three Teeth per Quad	$55 per Tooth, Max. $100
D4260	Osseous Surgery, Including Flap Entry/Closure, Four or more Contiguous Teeth or Bounded Teeth Spaces per Quad	$325
D4261	Osseous Surgery, Including Flap, Entry/Closure One to Three Teeth per Quad	$100 per Tooth, Max.$200
D4271	Free Soft Tissue Graft Procedure	$200
D4341	Periodontal Scaling & Root Planing, Four or More Contiguous Teeth or Bounded Spaces per Quad	$70
D4342	Periodontal Scaling & Root Planing, One to Three Teeth per Quad	$35
D4355	Full Mouth Debridement	N/C
D4910	Periodontal Maintenance Procedures	$35

Procedure Code	**Description**	**Member Co-Pay**
Removable Prosthetics		
D5110	Complete Upper Denture (Includes adjustments)	$30
D5120	Complete Lower Denture (Includes adjustments)	$30
D5130	Immediate Upper Denture (Includes adjustments)	$30
D5140	Immediate Lower Denture (Includes adjustments)	$30
D5211	Upper Partial Resin Base (Includes adjustments)	$30
D5213	Upper Partial – Cast Metal Frame w/Resin Base	$30
D5214	Lower Partial – Cast Metal Frame w/Resin Base	$30
D5410	Adjust Complete Denture – Upper	N/C
D5411	Adjust Complete Denture – Lower	N/C
D5421	Adjust Partial Denture – Upper	N/C
D5422	Adjust Partial Denture – Lower	N/C
D5510	Repair Broken Complete Denture Base	N/C
D5520	Replace Missing/Broken Tooth – Complete Denture – Each Tooth	N/C
D5610	Partial Denture – Repair Resin Sole/Base	N/C
D5620	Partial Denture – Repair Cast Framework	N/C
D5630	Repair or Replace Broken Clasp	N/C
D5640	Partial Denture – Replace Broken Tooth – Per Tooth	N/C
D5650	Add Tooth to Existing Partial Denture	N/C
D5660	Add Clasp to Existing Partial Denture	N/C
D5670	Replace All Teeth & Acrylic on Cast Metal Frame (Upper) Four or More	N/C
D5671	Replace All Teeth & Acrylic on Cast Metal Frame (Lower) Four or More	N/C
D5730	Reline Complete Upper Denture (Chairside)	N/C
D5731	Reline Complete Lower Denture (Chairside)	N/C

D5740	Reline Upper Partial (Chairside)	N/C
D5741	Reline Lower Partial (Chairside)	N/C
D5750	Reline Complete Upper Denture (Lab)	N/C
D5751	Reline Complete Lower Denture (Lab)	N/C
D5760	Reline Upper Partial (Lab)	N/C
D5761	Reline Lower Partial (Lab)	N/C

Procedure Code	**Description**	**Member Co-Pay**
Fixed Prosthetics, per Unit (each retainer and each pontic constitutes a unit in a fixed partial denture)		
06210	Pontic – Cast High Noble Metal	$125
06211	Pontic – Cast Predominately Base Metal	$125
06212	Pontic – Cast Noble Metal	$125
06240	Pontic – Porcelain to High Noble Metal	$125
06241	Pontic – Porcelain to Predominately Base Metal	$125
06242	Pontic – Porcelain Fused to Noble Metal	$125
06245	Pontic – Porcelain/Ceramic	$125
06545	Retainer – Cast Metal Resin Bonded Bridge	$50
06740	Crown – Porcelain/Ceramic	$125
06750	Bridge Crown – Porcelain to High Noble Metal	$125
06751	Bridge Crown – Porcelain to Predominately Base Metal	$125
06752	Bridge Crown – Porcelain Fused to Noble Metal	$125
06783	Bridge Crown – Porcelain/Ceramic	$125
06790	Bridge Crown – Full Cast High Noble Metal	$125
06791	Bridge Crown – Full Cast Predominately Base Metal	$125
06792	Bridge Crown – Full Cast Noble Metal	$125
06930	Re-cement Bridge	N/C
Oral Surgery		
D7111	Coronal Remants – Deciduous Tooth	N/C
D7140	Extraction, Erupted Tooth or Exposed Rood	N/C
D7210	Surgical Removal of Erupted Tooth (including removal of bone and/or section of tooth)	N/C
D7220	Remove Impacted Tooth – Soft Tissue	N/C
D7230	Remove Impacted Tooth – Partially Bony	N/C
D7240	Remove Impacted Tooth – Completely Bony	N/C
D7241	Remove Impacted Tooth – Completely Bony, Unusual	N/C
D7250	Surgical Removal of Residual Roots	N/C
D7310	Alveoplasty in Conjunction w/Extractions, per Quad	N/C
D7510	Incision & Drainage of Abscess – Intraoral Soft Tissue	N/C

Procedure Code	**Description**	**Member Co-Pay**
Orthodontics		
08070	Comp. Orthodontic Treatment – Transitional Dentition 2 year program $425 per year, plus $75 on completion	
08080	Comp. Orthodontic Treatment – Adolescent Dentition 2 year program $425 per year, plus $75 on completion	
08090	Comp. Orthodontic Treatment – Adult Dentition 2 year program $425 per year, plus $75 on completion	
Miscellaneous		
09110	Palliative (Emergency) Treatment of Dental Plan – Minor Procedure	N/C
09215	Local Anesthesia	N/C
09220	General Anesthesia – 1st 30 Min. (Extractions Only)	N/C*
09221	General Anesthesia – Each Addl. 15 Min. (Extractions Only)	N/C*
09230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide (Extractions Only)	N/C*

09241	I.V. Sedation/Analgesia – 1st 30 Min. (Extractions Only)	N/C*
09242	I.V. Sedation/Analgesia – Each Addl. 15 Min (Extractions Only)	N/C*
09248	Non-Intravenous Conscious Sedation	N/C
09310	Consultation (by dentist other than attending dentist) – per Session	N/C
09999	Broken Appointment Charge (per ½ hour)	$10

Anesthesia and/or general anesthesia is covered only when administered in an oral surgeon's office for extractions and other related services.

- **N/C – No Charge**
- **Procedures not shown are not covered by Dental Plan**
- **Pedodontists are covered for Local 27 Enrollees only.**
- When gold is used, a gold surcharge will be charged. Patient will be advised of the surcharge prior to performance of procedure.
- If a condition can be treated by more than one procedure, GDS will only cover the least costly professionally adequate service.

Surcharges

If gold is used in any of the procedures listed, surcharges will depend on the market price. The patient will be advised of the surcharge **before** the procedure is performed. There is a replacement limit of one every five years for crowns, bridges, and dentures.

Exclusions and Limitations

The following exclusions and limitations apply to the Dental Benefit:

1. Prophylaxis (cleaning), including scaling and polishing, is limited to once every six months.
2. Dentures are limited to one partial or complete denture per arch within a five-year period.
3. Orthodontia coverage, when provided, is limited to:
   a) Diagnosis, including models, photographs, x-rays, and tracings.
   b) Active fully banded treatment, including necessary appliances and progress x-rays.
   c) Retention treatment following active treatment (not to exceed ten visits in any 18-month period).
   d) Phase I (interceptive orthodontic treatment) is not covered.
   e) Benefits will not be provided beyond a period of 24-consecutive months of active treatment, nor beyond a period of 18-consecutive months of retention treatment.
   f) The Plan will not be liable for the replacement and/or repair of any appliance which was not initially furnished by GDS.
   g) Benefits will be provided to a participant or eligible dependent(s) not more than once within a five-year period.
   h) Patients must be age 11 or older.
4. Covered services are limited to services provided by a participating dentist except under the following circumstances:
   a) when authorized by GDS; or
   b) in the case of a *dental emergency* which occurs more than 50 miles from the participant's primary dentist if the participant or eligible dependent is temporarily away from home and outside the GDS service area.
5. Any service or treatment begun while the participant or eligible dependent(s) was not covered by GDS will not be covered.
6. Cosmetic services are excluded. Cosmetic services are those which are elective and which are not necessary for good health. Cosmetic services include, but are not limited to:
   a) alteration or extraction and replacement of sound teeth;
   b) any treatment of the teeth to remove or lessen discoloration except in connection with endodontic treatment.
7. Examination, evaluation, and treatment of temporomandibular joint (TMJ) pain dysfunction are excluded. Evaluation of TMJ is covered when it is incidental to another appointment.
8. Replacement of dentures, bridgework, or any other dental appliances previously supplied by GDS due to loss or theft is not covered unless the participant or eligible dependent(s) received such appliance prior to the immediately preceding five year period.
9. Hospitalization for any dental procedure is not covered.
10. Drugs, whether prescribed or over-the-counter, are not covered through GDS.
11. Dental implants are excluded.
12. Appliances or treatment related to bite correction are not covered.
13. Services rendered by prosthodontic specialists which are necessary for complete oral rehabilitation or reconstruction are excluded.
14. Services for injuries or conditions which are covered under Workers' Compensation or employer's liability laws are not covered;

services which are provided by any municipality, country, or other political subdivision without cost to the participant or eligible dependent(s) are not covered.

- **Page 224 – NETime Benefit System**
  NETime Benefit System has been replaced with MemberXG.

MEMBER XG

MemberXG is an online access service that allows you to view your benefit claim information online and through your mobile device. 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
- 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 FELRA & UFCW Health & Welfare Plan. 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 inaccurate or is not fully up to date.

- *The following was erroneously omitted from Plan X SPD:*

EMPLOYEE ASSISTANCE PROGRAM

Benefits are provided through the *Fund*, not insured.
Benefit claims are processed by Beacon Health Options

If You Have Chosen One of the HMO Options for Providing Your Medial Benefits, the Employee Assistance Program Does Not Apply To You—Contact Your HMO to Determine Your Coverage

Beacon Health Options, which administers your Mental Health and Substance Abuse Benefits, also administers the *Fund's* Employee Assistance Program (EAP). EAP helps employees in areas not addressed by their medical or mental health benefits. It provides early detection and intervention for problems before your health, family, or job is seriously affected. You will be eligible to receive up to **a total of six EAP sessions in your lifetime. Only** Beacon Health Options **therapists can provide EAP services.**

The EAP provides counseling for the problems outlined below:

- Short Term Behavioral Health Problems -- Up to 6 visits*
- Marriage Problems -- Up to 2 visits
- Gambling Problems -- Up to 2 visits
- Obesity -- Up to 2 visits
- Retirement Planning -- Up to 2 visits
- Financial Planning -- 1 visit
- Sexual Dysfunction -- Up to 2 visits

- Stress Management -- Up to 2 visits
- Smoking Cessation -- Up to 2 visits
- Child Care Referrals -- Up to 2 visits

* Except for short-term behavioral health problems, after the EAP visits, the Beacon Health Options affiliated EAP counselor may make a referral to a healthcare provider, community resource, or self-pay program, if necessary. For behavioral health problems, if you continue to need treatment after the visits, the Beacon Health Options affiliated EAP counselor may direct you to a Beacon Health Options affiliated behavioral health therapist for additional visits under your Mental Health Benefit at 50% coverage.

EAP benefits are available to you and your eligible dependant(s) at no cost. Access the EAP services through Beacon Health Options by calling (800) 353-3572, 24 hours a day, seven days a week.