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 XL

Summary of Material Modifications

May 2021

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 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 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 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 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.

- 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 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.

- **Effective April 1, 2018 – Disability Benefits**
  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," page 89 in the Plan XL 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," page 92 of the Plan XL 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.