FELRA & UFCW Active Health Plan

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

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

Plan XXX

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 not 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:

Cost for Certain Specialty Drugs under SaveonSP Program
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 not 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 not 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.

- **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.

- 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 March 1, 2019 – Cost to Add Dependent Children for Part-Time Plans XX and XXX**
  The cost for dependent coverage for children of part-time participants in Plans XX and XXX has changed.

Plan	Per Child Rate	3 or More Children Rate
Plan XX Part Time	$126.20 per month	$378.60
Plan XXX Part Time	$124.37 per month	$373.11

The 2019 amount will automatically be deducted from your paycheck beginning in March ***unless you contact the Fund Office*** within 30 days of the date you first receive notice of the new rates to advise that you want to drop the coverage. If you don't contact the Fund Office, you will remain enrolled for Dependent Child coverage at the same level you have currently, and the new rate will apply to you starting in March.

- **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 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."

   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 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 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 March 1, 2018 – Cost to Add Dependent Children for Part-Time Plans XXX Participants.** The cost for dependent coverage for children of Part-Time participants in Plan XXX changed.

The cost for the coverage, effective March 1, 2018, is:

Plan	Per Child Rate	3 or More Children
Plan XXX Part Time	$115.34 per month	$346.02 per month

The new amount will automatically be deducted from your paycheck ***unless you contact the Fund Office*** to advise that you want to drop the coverage. If you don't contact the Fund Office, you will remain enrolled for Dependent Child coverage at the same level you have currently, and the new rate will apply to you starting in March.

- **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.

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.

<u>Plan XX and Plan XXX Part Time Participants:</u>
You may enroll eligible dependent children as described above, but you are required to pay the full cost of the dependent coverage via payroll deduction. If you enroll your child/ren, your employer will set up payroll deductions to begin with the first month you are eligible for dependent coverage. Dependent coverage will not begin until the month in which your first payroll deductions are made.

- **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 <u>Fund Office</u> 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.

- **Effective February 17, 2017 –** Beacon Health Options transitioned content from their ValueOptions website to www.beaconhealthoptions.com.

- **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 will still be toll-free (800) 638-2972.

- **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.

- **Effective February 17, 2017 –** Beacon Health Options transitioned content from their ValueOptions website to www.beaconhealthoptions.com.

- **Effective January 27, 2017 – Change in Initial Eligibility Rule for Participants Employed by Giant.** As a result of the most recent collective bargaining, effective January 27, 2017, the Board of Trustees approved a change in eligibility for Giant employees hired November 17, 2016 or after. Such employees must have been entitled to payment for an average of at least 30 hours per week during the initial measurement period to be eligible for Plan XXX benefits.

Plan XXX Insert (SMMs) dps 05.2021