FELRA UFCW

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

1099Rs Will Be Mailed in Late January. Look for Yours!

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For Your Benefit

Summary Annual Report in This Issue!

FELRA & UFCW VEBA Fund

This issue—

Kaiser Medicare Retirees in DC and Many Maryland Counties Will Change to Kaiser "Advantage" Plan on January 1, 2019

Medicare-eligible retirees in the FELRA and UFCW VEBA Fund who live in the Maryland and DC areas are currently enrolled in a "Medicare Cost" Plan with Kaiser Permanente. Effective January 1, 2019, retirees (and dependents if applicable) who live in Maryland (except those in Calvert, Carroll and Frederick counties) and those who live in DC will remain in Kaiser, but the Plan type will change to a **"Medicare Advantage"** plan. Retirees in the Northern Virginia area and the Maryland counties mentioned above will remain in the Kaiser "Medicare Cost" Plan in 2019 and will transition to a Kaiser Advantage Plan effective January 1, 2020 (Kaiser is building its provider network in the northern Virginia area before making the change for that group).

Basically, the difference between the two types of plans is this: under the current Kaiser Medicare Plan (Medicare Cost), you have the option of NOT using a Kaiser provider and simply sending the bill through Medicare. The Fund does not supplement Medicare's payment if you choose to do that, but you can see any provider that accepts Medicare.

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Under a Medicare Advantage plan, which is what will be in place for DC participants and most Maryland participants starting January 1, 2019, you **must use a Kaiser Medicare provider in order to be covered**. If you don't use a Kaiser provider, the bill will be denied by Medicare and the Fund will not cover any portion of the service. Kaiser has added a number of individual providers to the service area as well as two new Kaiser Centers to make it more convenient to use Kaiser providers.

You will automatically be changed over to the new Kaiser Plan. Kaiser will be sending mailings directly to you with additional information. There is nothing you have to do -- simply read what is sent and be sure to use a Kaiser Medicare provider starting January 1, 2019.

If you have questions about the changeover, contact Kaiser Member Services at (888) 777-9909. Helpful information is available online at KP.ORG/Medicareadvantage2019.

Don't Send Medicare EOBs Unless Requested

The following applies to Medicare-eligible participants and dependents whose medical coverage is provided through the Fund, not through a Medicare HMO.

Unless you received a notice from the Fund Office requesting a Medicare Explanation of Benefits ("EOB") for a specific provider and date of service, it is not necessary to send any of the EOBs you may receive from Medicare to the Fund Office.

An itemized bill is required to process your medical claim. The EOB is not considered an itemized bill and does not contain all the information needed to accurately process your claim.

Your service providers – doctors, hospitals, etc. – will submit both an itemized bill and the Medicare EOB for secondary payment for any services rendered.

Your Life Insurance

The following article applies to active eligible participants in Plans I, X, XX, XXX and XL.

If you die while covered under the Plan, the amount of your life insurance (a.k.a. life benefit) is payable to the person you have named as your beneficiary.

There are different benefit amounts (see below) depending on your status (full time or part time) and your plan (Plan I, X, XX, XXX and XL). A part time participant who has satisfied the initial eligibility requirement and is later promoted to full time will continue to be eligible for the part time life benefit until eligible for full time benefits. A participant is never eligible for both a part time and a full time life benefit.

Benefits *(Participant Only)*

Plan I	Full Time Part Time	$17,500 $7,500
Plan X	Full Time Part Time	$7,500 $5,000
Plan XX	Full Time Part Time	$5,000 $2,500
Plan XXX	Full Time Part Time	$5,000 $2,500
Plan XL	Part Time	$2,500

Beneficiary

You may name any person you choose to be your beneficiary.

You may change the named beneficiary at any time.

1. Contact the Fund Office for an enrollment form or print it from our website www.associated-admin.com.
2. Complete and sign the form.
3. Return the form to the Fund Office.

Only enrollment forms which are properly completed, signed, and received by the Fund Office prior to a participant's death will be honored.

Open Enrollment for Health and Welfare Coverage Is Now through December 28th

Now through December 28, 2018 is open enrollment to choose health and welfare coverage through the Fund **effective January 1, 2019 and continuing (assuming you remain eligible) through December 31, 2019**.

If you don't currently have health coverage through the Fund, this is your opportunity to enroll. If you do have coverage, this is your chance to add dependents (if eligible) or to drop coverage.

Open Enrollment Letter

You should have received an open enrollment letter, along with payroll deduction and enrollment forms, from the Fund Office. If you are already enrolled and want to change coverage levels (from single coverage to husband/wife, for example) or to drop coverage completely, note the change on the payroll deduction form and complete the enrollment form and return both to the Fund Office. If you don't want to make changes, there is no need to return the form(s). You will remain in your current coverage (assuming you are still eligible for the same Plan).

If you are changing your coverage or enrolling for the first time, the Fund Office must receive both the enrollment form and payroll deduction form. **Forms must be returned by December 28 for coverage to begin as of January 1, 2019**. However, if you're already enrolled and are not making changes, don't do anything.

Cost for Coverage (All costs payable via payroll deduction)

Plans I, X and XX Full Time Participants

• Single coverage	$5 per week
• Participant + one dependent	$10 per week
• Family coverage	$15 per week

Plan XXX Full Time Participants

• Single Coverage	$10 per week
• Participant + child(ren)	$15 per week
• Participant + spouse	$20 per week
• Family Coverage	$25 per week

Plan X Part Time Participants

• Single coverage	$5 per week
• Family coverage	20% of cost*

*Plan X part time participants may add dependent coverage at a co-premium of 20% of the overall cost of such coverage. Such dependent coverage would be effective March 1. Contact the Fund Office for the exact amount of the payroll deduction if you are interested in adding this coverage.

Plan XX Part Time Participants

Single coverage:	$5 per week
Per Child Rate:	$117.05
Two Children:	$234.10
Three or More Children:	$351.15

Plan XXX Part Time Participants

Single coverage:	$10 per week
Per Child Rate:	$115.34
Two Children:	$230.68
Three or More Children:	$346.02

Spouses of Plan XX and Plan XXX part time participants are not eligible for coverage.

The rates for part time Dependent Children are current at this time. However, **when the 2019 rates are determined**, you will be notified and you will have the opportunity to keep or drop your dependent coverage at that time. Part time participants in Plans XX and XXX who enroll a child/ren will continue to pay the $10 weekly co-payment in addition to the amounts shown above.

Spousal Surcharge Applies to both Full Time and Part Time Participants in Plan X, As Follows:

A $20 weekly spousal surcharge will be deducted from your paycheck if you have elected coverage for your spouse and:

- your spouse is eligible for coverage through his/her employer, but elects not to enroll for that coverage; or
- your spouse also is enrolled in his/her employer's coverage. In this case, the Fund will provide secondary coverage to your spouse and the ***non-duplication coordination of benefits rules apply***. Any secondary benefit payment will be determined by calculating primary payment, subtracting it from what the Fund's payment would have been, and paying the remaining amount, if any. For example, if your spouse's primary coverage paid 80% for a certain service and the Fund's payment would also have been 80%, no

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additional payment would be payable under the Fund. Note: The spousal surcharge does not apply if your spouse is also a participant in the FELRA VEBA Fund.

Coordination of Benefits

When an eligible dependent under the Plan is offered a program of health, dental, drug, and/or vision benefits by another employer as a result of his or her employment, and the dependent has the option of selecting the other employer's health coverage or receiving cash or other financial incentive, this Plan coordinates its benefits as if the other employer's health coverage were applicable. It does so even when the dependent does not elect the coverage under another employer sponsored plan. Before the Fund will pay benefits to an employed dependent, he or she must provide the Fund Office with information explaining the other employer's health coverage, if any.

Part Time Participants in Plans XX and XXX

Coverage for part time participants shall be secondary if the employee is covered under another plan.

If you have questions, contact the Fund Office at (800) 638-2972. We are happy to assist you.

Your Coverage When Admitted to The Hospital

The following article applies to participants in Plans X, XX and XXX who have Fund coverage, not HMO coverage.

In order to be covered for most hospital services, remember that you must see a CareFirst in-network provider, and you must certify your stay with Carewise Health – before your stay for elective or pre-scheduled procedures, and within 24 hours of your admission for an emergency. To certify admissions, call Carewise Health at (866) 511-1462. This number is also on your Fund medical ID card.

When the services described below are rendered by a physician, physician's assistant, nurse practitioner or certified surgical assistant, the Plan will make payment at 80% for a Plan X participant, 75% for a Plan XX participant, and 70% for a Plan XXX participant, up to the PPO allowed amount. The annual deductible applies. Charges made in excess of these amounts are the responsibility of the patient.

When you or your eligible dependent are admitted to a hospital as a registered inpatient, you are eligible for coverage for services furnished and billed as hospital services consistent with the diagnosis and treatment of the condition for which hospitalization is required. Included services are:

1. Room and board in semi private accommodations and special care units is covered at 80% for a Plan X participant, 75% for a Plan XX participant, and 70% for a Plan XXX participant, up to the semi-private room rate;
2. General nursing care;
3. Use of the operating, delivery, recovery, or treatment room;
4. Anesthesia, radiation, and x ray therapy when administered by an employee of the Hospital;
5. Dressings, plaster casts, and splints provided by the Hospital;
6. Laboratory examinations;
7. Basal metabolism tests;
8. X ray examinations;
9. Electrocardiograms and electroencephalograms;
10. Physiotherapy and hydrotherapy;
11. Oxygen provided by the Hospital;
12. Drugs and medicines in general use;
13. Administration of blood and blood plasma and intravenous injections and solutions; and
14. Special Care Units.

If you request a private room, you are eligible for all the benefits above, but you must pay the hospital the difference between its actual charge for the private room and its average charge for semi private rooms.

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and United Food and Commercial Workers VEBA Fund

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Summary Annual Report for FELRA and UFCW VEBA Fund

This is a Summary of the Annual Report for the FELRA and UFCW VEBA Fund, (Employer Identification No. 52-1036978, Plan No. 501) for the period January 1, 2017, to December 31, 2017. The Annual Report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the Plan, was $37,360,977 as of December 31, 2017 compared to $58,210,974 as of January 1, 2017. During the plan year the Plan experienced a decrease in its net assets of $20,849,997. This decrease includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year. During the plan year, the Plan had total income of $114,883,558. This income included employer contributions of $105,296,359, employee contributions of $4,683,721, realized gains of $871,544 from the sale of assets and earnings from investments of $1,712,577. Plan expenses were $135,733,555. These expenses included $8,560,756 in administrative expenses and $127,172,799 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full Annual Report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report;
2. Financial information and information on payments to service providers;
3. Assets held for investment;
4. Transactions in excess of 5 percent of the Plan assets; and
5. Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full Annual Report, or any part thereof, write or call the office of:

Board of Trustees of the FELRA & UFCW VEBA Fund
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
52-1036978 (Employer Identification Number)
410-683-6500

The charge to cover copying costs will be $7.50 for the full report, or $0.25 per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the Plan and accompanying notes, or both. If you request a copy of the full Annual Report from the Plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the Annual Report at the main office of the Plan:

Board of Trustees of the FELRA & UFCW VEBA Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

And at the U.S. Department of Labor in Washington, DC, or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: U.S. Department of Labor, Employee Benefits Security Administration, Public Disclosure Room, 200 Constitution Avenue, NW, Suite N-1513, Washington, DC 20210.

Additional Explanation

Dental claims- Group Dental Services, Inc. - Premiums Paid $6,449,632
Medical claims – Kaiser Foundation Health Plan - Premiums Paid $7,918,313
Life insurance claims – Voya Financial - Premiums Paid $228,806
Vision claims - Advantica - Premiums Paid $916,765
Accidental Death & Dismemberment – Voya Financial - Premiums Paid $9,293

Flu Shots Are Covered

This article applies to participants in Active Plans I, X, XX and XXX.

Participants with Fund Coverage

Participants in Active Plans I, X, XX and XXX, as well as retirees who have Medicare Supplement coverage with prescription benefits through Express Scripts, can receive a flu shot at any Giant or Safeway pharmacy at **no cost,** using their Express Scripts Prescription Drug ID card. Note: Plan XL participants do not have prescription drug coverage.

Flu Shot at Doctor's Office

Participants in one of the above Plans also may receive flu shots at their doctor's office. If the primary reason for the office visit is preventive and a flu shot is administered, then the office visit and flu shot will be paid at 100%. If the flu shot is administered and there is a medical reason for the office visit other than just the flu shot, the flu shot will be paid at 100% and the office visit will be paid at 80% for Plans I and X, 75% for Plan XX and 70% for Plan XXX, based on the diagnosis for the visit. If there has been a previous preventive visit and there is not a medical diagnosis listed, the office visit will be denied and only the flu shot will be paid at 100%. Members are only entitled to 100% coverage for one routine preventive office visit per year. Participants in Plans X, XX and XXX **must** use a participating CareFirst provider in order to be covered.

Participants with Kaiser Permanente HMO Coverage

For participants in the Kaiser Permanente HMO who prefer to get a flu shot from their doctor, the flu shot is covered in full, with no co-pay, as long as you use a Kaiser physician. Members can get a flu shot at no cost – no appointment needed – at any of Kaiser Permanente medical centers. To find the nearest Kaiser Permanente medical center, go to kp.org/flu or contact Member Services at (800) 777-7902, Monday through Friday (except holidays), 7:30 a.m. to 5:30 p.m. Actively working participants covered by Kaiser who use Express Scripts for their prescription benefit may also choose to get a flu shot at a Giant or Safeway pharmacy using the Express Scripts ID card, at no cost.

You Must Use Quest Or LabCorp When Lab Work Is Needed

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

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

Tell Your Doctor Up Front

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

Locating Labs

To find the most current list of Quest or LabCorp facilities, log onto their websites or call them:

- www.questdiagnostics.com/appointment or by telephone at (866) 697-8378, or
- www.labcorp.com/psc/index.html or (888) 522-2677

Remember to Claim Severance Benefits When Eligible

You should apply for your severance benefit immediately after your Severance from Service date. Usually this is your employment termination date, but there are special rules for participants on a leave of absence. See page 12 of your Severance SPD for more information.

There is a four-month waiting period between your Severance from Service Date and the date that you may receive your Payable Severance Benefit. Your payable Severance Benefit may only be paid to you between the expiration of this four-month waiting period and the later of (1) the last day of the calendar year in which the four-month waiting period expires; or (2) the 15th day of the third calendar month following the expiration of the four-month waiting period.

For example, if you terminate covered employment on January 1, 2019, the four-month waiting period will expire on May 1, 2019, and your severance payment deadline will be December 31, 2019.

If you do not apply for and receive your severance benefit by the deadline under the Plan, you will lose your benefit.

HEALTH CORNER

Thriving During the Holidays

Everyone knows that kids tend to get excited and adults tend to get stressed over the holidays. After all, the potential sources of stress are many—family feuds, time crunches, the "perfectionism" syndrome, travel, work, and school schedules, and of course money. But steps can be taken to remove the excess and get down to what most people really want—fun, companionship, and a break from the routine.

- **First, take care of yourself**, because your mood, good or bad, will trickle down to the rest of the family.
- **Accept that the holidays** will be busy. The same things that stressed you out last year will likely appear again.
- **Make a plan.** Jot down what you expect from the holidays and then what you think your family expects.
- **Manage time**. Shop in advance, stock up on goodies, throw out the junk mail. Plan for at least one activity that you know you'll enjoy and be prepared to say no to the things you don't enjoy.
- **Cut down on cards and gifts**. Maybe the best gift you can give a friend is to let each other off the present-go-round.
- **Build relaxing time** into every day and know when to go to bed.

Prepare your children

Keep a limit on gift giving and receiving when children are young. If you know you can't buy them that pony or puppy, tell them. Practice with them how to accept a gift graciously.

Travel expectations

Expectations for family to all be together can lead to feelings of guilt and pressure, especially when travel is involved.

- Accept that you can't be everywhere. Many couples face the dilemma of whose family to visit. If possible, consider visiting one family for one holiday and the other family for another holiday each year.
- Make travel plans well in advance, and let your family know of your plans.
- Pack ahead of time and allow extra time for traffic or long security lines at the airport.

All in the family

Having agreements will avoid a lot of undue stress, and will prevent assumptions, expectations, and misunderstandings ahead of time. Family arguments still erupt over the holidays despite everyone's wish for peace, love, and understanding. Try to let the little things go and focus on a relative's good points. Also, learn to respect other people's choices even if you disagree. Remember, holidays are especially difficult for new relatives and stepfamilies. Be prepared to accept new traditions and let others fade away.

The above article was provided by Beacon Health Options/Achieve Solutions. This is for informational purposes only and should not be treated as medical, health care, psychiatric, psychological or behavioral health care advice. If you have concerns about your health, please contact your health care provider.

Reconstructive Surgery Following Mastectomy

The following article applies to you if your medical benefits are provided through the Fund, not an HMO. If you have coverage through an HMO, you should receive a similar notice directly from the HMO.

The Women's Health and Cancer Rights Act ("WHCRA") provides protections for individuals who elect breast reconstruction after a mastectomy. Under federal law related to mastectomy benefits, the Plan is required to provide coverage for the following:

- All stages of reconstruction of the breast on which a mastectomy is performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of all stages of mastectomy, including lymphedema.

Such benefits are subject to the Plan's annual deductibles and co-insurance provisions. Federal law requires that all participants be notified of this coverage annually.

Clarification to Plan I SPD

On page 7 of the Plan I Summary Plan Description (SPD), the section "Covered Employment with Participating Employers for UFCW Local 27, Part Time Participants" should read as follows:

Safeway – Grocery employees hired before May 1, 1983; Meat employees hired before October 9, 1983; Non-food employees hired before August 28, 1977.

FELRA & UFCW
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