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

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For Your Benefit

Material Modifications

Shingles (Shingrix) Vaccine Now Approved for Those Age 50 and Over

The following article applies to participants in the FELRA and UFCW Active Health and Welfare Plan.

A new shingles vaccine called "Shingrix" is now covered, effective March 15, 2018, 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.

This issue—

The purpose of this newsletter is to explain your benefits in easy, uncomplicated language. It is not as specific or detailed as the formal Plan documents. Nothing in this newsletter is intended to be specific medical, financial, tax, or personal guidance for you to follow. If for any reason, the information in this newsletter conflicts with the formal Plan documents, the formal Plan documents always govern.

Material Modifications

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, these drugs are no longer covered under the Plan.

Hospice Care Services

For terminally ill participants and eligible dependents whose prognosis of probable survival is six months or less and who are receiving palliative, not curative, care, below is a description of the hospice care services covered under the Plan:

- 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, and
- 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 counseling 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.

Hospice Care Services are covered as follows: Plans I and X – 80%, Plan XX – 75%, and Plan XXX – 70% of the Usual, Customary and Reasonable (UCR) cost under Comprehensive Medical Benefits.

Pre-certification is required and services must be approved by Carewise Health.

For additional information about Hospice Care, contact Carewise Health toll-free at (866) 511-1462.

Dental Coverage When Using a Non-Participating GDS Provider

Your plan of benefits provides coverage for dental benefits including exams, x-rays, cleanings, amalgam fillings, and simple extractions, when the service is provided through Group Dental Service of Maryland, Inc. ("GDS"). Except as provided below, **any service you receive from a dentist who does not participate with GDS will not be covered under the Fund.**

You may use a non-participating GDS dentist and receive coverage only:

- When referred by a participating dentist to a non-participating specialist;
- When authorized in advance by GDS;
- In the case of a dental emergency which occurs more than 50 miles from your primary dentist. If you are temporarily away from home and outside the GDS service area, GDS will reimburse you for dental expenses relating to minor procedures for the palliative relief of pain up to a limit of fifty dollars per occurrence; or
- When the participant does not live or work within 20 miles or 30 minutes of a participating dentist. Before using a non-participating dentist under this geographical exception, you should verify with GDS that it has no facilities within 20 miles or 30 minutes of your home or work, before your appointment.

You Must Use a CareFirst In-Network Provider to Receive Medical Coverage

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

You must use a CareFirst provider to have coverage for hospital, medical, or surgical benefits under the Fund, with the exception of:

1. services provided by pathologists, anesthesiologists, and radiologists at an in-network facility,
2. emergency admission,
3. emergency room services, and
4. emergency ambulance service.

Exceptions

You are covered for services provided by non-PPO network pathologists, anesthesiologists, and radiologists, **if** the services are performed at an in-network facility. You are also covered for emergency services, including emergency ambulance service, and admission to the hospital for **urgent/emergency reasons only** (not for scheduled procedures) both in-network and out-of-network. Emergency service is the care given for the sudden onset of a medical condition with severe symptoms, such as heart attack, poisoning, severe breathing difficulties, convulsions, loss of consciousness, and other acute conditions that may be considered life threatening.

CareFirst reprices claims when you use a participating provider, but **CareFirst is not your insurance carrier.** Your coverage is provided through the Fund.

To Locate a CareFirst Provider

To locate a CareFirst provider, contact CareFirst at the number listed on your ID card.

- Call (800) 235-5160 if you have a green ID card.
- Call (800) 810-2583 (800-810-BLUE) if you have a white ID card.

Note that the numbers above are only for finding a participating CareFirst provider. **No other questions (claims, eligibility, etc.) will be answered on these lines.**

Verify that the health care provider you selected participates with CareFirst when you make your appointment, as provider information is subject to change. At your appointment, show your Fund ID card and tell the physician or facility that you participate with CareFirst. You or your provider should send medical claims in the local lease area of CareFirst that are not filed electronically directly to CareFirst at:

CareFirst/Network Leasing
PO Box 981633
El Paso, TX 79998-1633

CareFirst will reprice the claim and forward it to the Fund Office for processing. A CareFirst provider should **not** require payment for covered services at the time of service unless the service provided is a non-covered benefit or if your deductible has not been met. If the provider attempts to collect payment for covered services at the time of your visit, remind the provider that payment will be made by the Fund after CareFirst reprices the claim. The amount of the reduced charge which the patient is responsible for paying will be shown on the Explanation of Benefits (EOB) which is sent to you and your provider after your claim has been processed.

Retiree Information Forms Mailed - *Return This Form or Benefits May Be Suspended*

The Fund Office recently sent all retirees a Retiree Information Form (RIF) to be completed and returned to the Fund Office. The form asks questions about your current address, your beneficiary, whether you and/or your spouse have other health coverage, and whether you are employed.

This form must be completed and returned every year, even if nothing has changed. It is very important that the retiree complete all sections of this form and promptly send it back to the Fund Office. If we don't receive your RIF, your benefits may be suspended until it is received. To assist you, the Fund Office included a postage-paid return envelope with the first mailing.

You will notice two minor changes to the RIF form this year:

1. In order to protect your privacy and prevent potential identity theft, we have assigned each retiree or pension beneficiary a unique ID number rather than using your Social Security Number.
2. Bar coding has been added to the bottom of the form to improve our internal processing of the RIF form.

Helpful Reminders

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

No one but the Retiree can sign the RIF, unless an individual holds a Power of Attorney for the Retiree. A copy of any such Power of Attorney must be on file with the Fund Office. If, for health reasons, the Retiree is unable to sign the form and there is no Power of Attorney on file, then the Retiree must sign an "X" on the RIF and have it notarized by a Notary Public.

Complete Pension Applications for Each Fund under Which Earned Benefit Service

If you are a Giant or Safeway participant and plan to retire, you must complete a pension application for both the FELRA and UFCW Pension Fund and the Mid-Atlantic UFCW & Participating Employers Pension Fund ("MAP"), if you earned benefit service under each Fund.

If you became a participant before December 31, 2012, you accrued benefits under the FELRA and UFCW Pension Fund through that date. Effective January 1, 2013, you stopped earning a benefit under the FELRA Fund and began earning benefits under the MAP Fund.

If this applies to you, you must complete both a FELRA pension application and a MAP pension application. Likewise, if you accrued credited service under the UFCW Unions & Participating Employers Pension Fund, you will also need to complete a pension application for that Fund.

If you have any questions you can contact the Fund Office at (410) 683-6500 or (800) 638-2972.

Moving? Keep the Fund Office Informed

It is very important that you tell the Fund Office when your address and/or telephone information changes. The Fund Office sends out important information about your benefits, coverage change notices, Plan booklets, and even this ***For Your Benefit*** newsletter. If we don't have the correct information, we may not reach you and that may affect your benefits.

If you are planning to move (even temporarily), or have recently moved, let the Fund Office know your new address and telephone number by calling (800) 638-2972. Remember, telling the Union or your employer is not the same as telling the Fund Office. Tell us where you live so we can send you important information regarding your benefits, claims, changes, etc.

Tips on Retirement

Please notify the Fund Office and begin the process of applying for your pension at least six months before you plan to retire. The retirement process will go smoothly for you if you have thought carefully about your retirement date and asked any questions you have about your available options before you begin the application process. Below are some helpful tips.

1. About six months before you would like to retire, call the Fund Office at (800) 638-2972 and ask for a Benefit Service Request Form. Tell the Fund Office the approximate date you would like to retire. The Fund Office will research your service and send you an estimate within approximately 6 - 8 weeks.
2. Upon request, the Fund Office will send you a pension application. After your application is processed, you'll receive a benefit election form and other information regarding the pension options available to you.
3. While the Fund has 90 days to make a determination with respect to your pension application, it usually takes about a month from the date you stop working to process your application, as all available Benefit Service through the date of your retirement must be included in the benefit calculation, and your service must be confirmed with your participating employer(s). Usually, you will receive your first pension check in the first week of the second month after you retire.

   Example: If you retire in August, you will likely receive your first check in the first week of October. This check will include your pension benefit for September. From then on, you should receive your pension check during the first week of each month.
4. Electronic Funds Transfer (EFT) is the pension benefit delivery option chosen by the majority of pensioners because of its convenience. To use this option, provide the Fund Office with the bank routing number and other bank information for the account where you would like your deposit to go. A wire transfer then occurs on or about the first working day of every month. If you don't elect EFT, checks are mailed on the last working day of the month. If your mailed check is late getting to you, the Fund Office must wait 10 days before putting a "stop pay" on your check, since there is sometimes a delay in the postal service.

Be Aware of Deadline To Apply for Severance Benefits

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 your 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 August 1, 2018, the 4-month waiting period will expire on November 30, 2018, and your severance payment deadline will be February 15, 2019.

IF YOU DO NOT APPLY FOR AND RECEIVE YOUR SEVERANCE BENEFIT BY THE DEADLINE UNDER THE PLAN, YOU WILL LOSE YOUR BENEFIT.

A Prescription Is Needed for Over-the-Counter Drugs

To receive coverage for preventive over-the-counter (OTC) medications that are included under the Health and Welfare Plan (for example, aspirin to prevent heart attacks, or Vitamin D) you must have a prescription for such medications. Also, you need to pay for the prescription at the pharmacy and not the regular checkout line, in order to receive coverage under the Plan.

Use Quest or LabCorp When Lab Work Is Needed

The following article applies to participants in the FELRA and UFCW Active Health and Welfare Plan who have Fund medical coverage, not an HMO.

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

Inform Your Doctor

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 Quest or LabCorp 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 a Lab

To find the most current list of Quest or LabCorp facilities, log on to their website or call:

- www.questdiagnostics.com/appointment or call (866) MYQUEST, (866) 697-8378
- www.labcorp.com/psc/index or call (888) 522-2677

HEALTH CORNER

Taking Your Medicine

If you take any medication on a regular basis, chances are you've forgotten to take a few pills or fudged the dosage amount. That's no big deal, right? Wrong. Medication compliance is critical, and disregarding instructions for taking medicines can have serious consequences.

What can you do to be compliant?

- Before starting a new prescription, ask your doctor about the name of the drug, any potential side effects, the condition it will treat, how it works, when and how you should take it, how long the regimen will last, if it will interact with other drugs or foods, what to do if you forget a dose, and if you can take home printed information about the medicine.
- Tell your doctor if you are or might become pregnant, and if you have any drug allergies.
- Work with your doctor while you're taking meds. Ask about results of tests that show how the meds are working for you, and be sure to bring up any problems you have with them. Talk about how you have felt since you started taking the drug.
- Keep a record of all meds (including over-the-counter and herbal) you take and discuss them often with your doctor and pharmacist. Drug interactions can be fatal.
- Read all dosage instructions—whether the drug is a prescription or over-the-counter—and follow them exactly, including using precise measurements. Heed warning labels. Make sure you understand the directions, and ask your doctor or pharmacist if you have any questions. Post any printed instructions in an obvious place.
- Don't use meds after the expiration date. Throw them out in a place where children or pets can't find them.
- If needed, use special tools to help you remember your drug regimens, such as pillboxes, beepers, alarms, or timers.
- Express Scripts has a mobile app which may help you monitor your medication.

The above article was obtained with permission from Beacon Health Options. This information is general and not intended to replace the advice of your doctor. Consult your personal physician about your own medical questions.

When Disability Benefits Are Denied

Material Modifications

FELRA Pension Fund and MAP Fund

Effective April 1, 2018, the Board of Trustees of the FELRA and UFCW Pension Fund and Mid-Atlantic UFCW and Participating Employers Pension Fund adopted the following changes:

1. **Effective for claims filed on or after April 1, 2018, the following language is added at the end of the Denial of a Claim subsection of the Claims Filing and Appeals Procedures section of your Summary Plan Description ("SPD") book:**

   If your claim for disability benefits is denied based on a determination by the *Fund*, and not by a third party acting independently of the *Fund* such as the Social Security Administration (SSA), that you are not disabled under the Plan rules, the *Fund* will notify you of your additional rights in the denial letter.

2. **Effective for claims filed on or after April 1, 2018, the following language is added at the end of the Claims Filing and Appeals Procedures section of your SPD:**

   If your appeal for disability benefits is denied based on a determination by the *Fund*, and not by a third party acting independently of the *Fund* such as the Social Security Administration (SSA), that you are not disabled under the Plan rules, the *Fund* will notify you of your additional rights in the appeal denial letter.

VEBA Fund

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

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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.

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