FELRA UFCW

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

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

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For Your Benefit

Coverage for Hospital Services

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 a CareFirst in-network provider is required, 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, contact Carewise Health at (866) 511-1462. This number is also found on your Fund medical ID card.

When the professional services described below are rendered by a physician, physician's assistant, nurse practitioner or certified surgical assistant, the Plan will provide benefit payment at 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 benefits for the following hospital services when the services are furnished and billed as hospital services, and when consistent with the diagnosis and treatment of the condition for which hospitalization is required:

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;

Continued on page 3

Summary Annual Report in This Issue!

FELRA & UFCW VEBA Fund

This issue—

Coverage for Hospital Services 1

Correction to Plan XX SPD (Open Enrollment for Part Time Participants) 2

Preparing to Retire? Follow These Tips 2

Coverage for Breast Pumps and Breastfeeding/Lactation Consultation 3

Forms of Pension Benefits 4

You Have One Year (365 Days) to File a Medical Claim (This Rule Does Not Apply to HMO Benefits) 5

CareFirst In-Network Provider Generally Is Required, With A Few Exceptions 6

Summary Annual Report 7

Reconstructive Surgery Following Mastectomy 8

Correction to Plan XX SPD (Open Enrollment for Part Time Participants)

The following correction applies to the Plan XX Summary Plan Description ("SPD") booklet. Be sure to keep this with your SPD.

On page 48, under "Part Time Participants," the first two sentences are revised to read as follows: If you do not enroll your dependent child within 30 days of the date your child becomes your dependent, you may only enroll him or her during the open enrollment period from November 1st – November 30th for coverage effective January 1st.

There is only one open enrollment period for Plan XX Part Time participants to add their children if they didn't do so when first eligible. Remember, if you are a Part Time participant who would like to add a dependent child or children for coverage, you must pay the full cost (via payroll deduction). Contact the Fund Office for information on cost and to receive an enrollment form.

Preparing To Retire? Follow These Tips

When you are planning to retire, you should notify the Fund Office and begin the process of applying for your pension at least six months before your expected retirement date. The retirement process will go smoothly for you if you ask the Fund Office any questions you have about your available options before you begin the application process. Below are some 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. You may also download the form by logging on to www.associated-admin.com. 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. Provide the Fund Office with the following documents, as applicable, when you submit your Application for Pension: birth certificate, spouse's birth certificate, spouse's death certificate, marriage certificate and divorce decree. Please send photocopies of these documents, not originals since they will not be returned.

4. 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 will 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 January, you will likely receive your first check in the first week of March. This check will include your pension benefit for February. From then on, you should receive your pension check during the first week of each month.

5. If you submit a Pension Application and later decide to change your date of retirement (before your pension payments have begun), please send a letter to the Fund Office stating your new retirement date. Depending on the new date, you may be required to complete a new pension application.

Continued from page 1

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.

Coverage for Breast Pumps and Breastfeeding/ Lactation Consultation

Breast Pumps and Lactation Consultation

- For the first 12 months following the birth of a child, coverage is provided for rental or purchase of one standard manual or standard electric breast pump (purchase price up to $400) plus necessary breast pump supplies. Coverage is available at no cost from in-network providers only. The Plan does not cover hospital grade breast pumps (heavy duty breast pumps designed for multiple users), or any other lactation supplies, such as ointments, wipes, cleaning and storage supplies, nursing bras, or lactation pillows. There is no coverage for breast pumps and supplies purchased through an out-of-network provider.
- In conjunction with birth, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider during pregnancy and/or in the postpartum period, at 100%, with no deductible, when provided by an In-Network provider. Under the Plan, a trained provider is a Breastfeeding/ Lactation Educator.

Who is a Breastfeeding/Lactation Educator?

A Breastfeeding/Lactation Educator is a provider who is currently certified as a lactation consultant by the International Board of Lactation Consultant Examiners (IBLCE). If he/she is not IBLCE certified, the provider must be a licensed, registered, or certified health care professional with referenced experience and training in lactation management. Breastfeeding/lactation educators help mothers initiate or maintain lactation and provide assessment, planning, intervention, and evaluation for optimal breastfeeding, working in conjunction with the mother's physician, midwife and/or baby's pediatrician.

Forms of Pension Benefits

Under the FELRA & UFCW Pension Fund and the Mid-Atlantic UFCW and Participating Employers Pension Fund, you may elect to receive your pension in one of the following benefit forms:

- **Single Life Annuity** – This is the automatic form of benefit if you are not married at the time of your retirement. You will receive a monthly benefit for your lifetime.
- **50% Joint and Survivor Pension** (if married) - This is the automatic form of benefit if you are married at the time of your retirement. Your monthly benefit is reduced and one half of that reduced pension will be payable to your spouse after your death. The amount of reduction depends on your age and your spouse's age at the time of your retirement.

You and your spouse can elect to waive this form of benefit within 90 days before the starting date of your pension. A Final Pension Election Form is provided by the Fund Office during the application process. At that time, you may reject this automatic form of benefit and elect one of the other available optional forms of benefit. **This form must be notarized before it is returned to the Fund Office.**

- **66$^{2}/_{3}$% Joint and Survivor Pension** (if married) – Under this option, your monthly pension amount would be actuarially reduced so that 66$^{2}/_{3}$% of the monthly pension amount you were receiving during your lifetime can continue to your spouse after your death.
- **75% Joint and Survivor Pension** (if married) – Under this option, your pension amount would be actuarially reduced so that 75% of the monthly pension amount you were receiving during your lifetime can continue to your *Spouse* after your death.
- **100% Joint and Survivor Pension** (if married) – Under this option, your pension amount would be actuarially reduced so that 100% of the amount you were receiving during your lifetime can continue to your spouse after your death.
    - You do not need your spouse's consent to choose any of the Joint and Survivor Pension forms.
    - If you elect to receive your pension in any Joint and Survivor Pension form and your spouse dies before you, your pension benefit will not increase and no further benefits will be payable on your behalf after your death.

Lump Sum Amount – If the total value of your pension benefit is $5,000 or less when you elect to receive your benefit, you will receive one lump sum payment in lieu of monthly benefit payments. If such a benefit is payable to your spouse as a survivor benefit, he or she may choose to receive the benefit as a lump sum or in monthly payments.

Once you elect your form of benefit, you have 14 days after you receive your first benefit payment to change your mind regarding the form of benefit you elected, provided you have not changed your marital status or had a significant change in health during those 14 days.

Remember, you must be married to your spouse on your benefit commencement date and you also must be married to your spouse for at least 12 months as of the date of your death.

You Have One Year (365 Days) to File a Medical Claim (This Rule Does Not Apply to HMO Benefits)

Claims must be filed within one year from the date of service. If a claim is not filed within that time period, benefits will be denied. You have 45 days from the post mark date on a request from the Fund Office for additional information to return the information to the Fund Office. If your provider agrees to file the claim on your behalf but fails to submit the claim to the appropriate entity within the one-year deadline, causing the claim to be denied, the Fund will defend you against any attempts by the provider to collect payment from you if you notify the Fund Office within two weeks of receiving a bill from the provider for those services or within two weeks of the provider taking any other action against you. If you do not timely notify the Fund, you can be held responsible by the provider and the Fund will not defend you.

In order for the Fund to defend you, the following requirements must be satisfied:

- If you receive a bill or lawsuit from the provider for services that were provided to you, and you believe the above "hold harmless" rules apply, you must contact the Fund Office within the two week deadline described above to notify us that the provider is pursuing you and to request that the Fund defend you against attempts by the provider to collect payment for these services. If you don't notify the Fund Office within this two-week period, the Fund will not defend you and the provider can hold you responsible for the bill.

- If you receive a bill from a provider, it could be because the Fund Office has not received, or paid, that bill yet. The hold harmless protection applies when the Fund has denied the claim based on its untimely submission by the provider and the provider then attempts to collect the claim amount from you. Therefore, don't automatically apply for hold harmless protection when you receive a bill from a provider. Contact the Fund Office to make sure we've received it.

Finally, please note that the Fund will not defend you against a provider's collection attempts if the reason for the provider's late filing of the claim was *your failure* to inform the provider of your Fund coverage.

1. Make sure your bills are fully itemized and on the letterhead stationery of the provider of service. Bills must show: Participant's name and alternate ID number (important), patient's name, type of service, diagnosis, date(s) of service, and charge per service. Cancelled checks, cash register receipts, and personal itemizations are not acceptable.

2. If you or your eligible dependent is enrolled in another group health plan, and that plan provides your primary coverage, include the "Explanation of Benefits" from your primary coverage along with copies of the itemized bills.

3. Benefit payments will be sent directly to the provider unless they are "unassigned" and evidence of your payment is reflected. In that case, payment will be sent directly to you.

4. An Explanation of Benefits ("EOB") will be sent when your claim is processed or with the benefit payment. Please keep the EOB and refer to it if you have questions about your claim and how it was processed.

5. Always keep copies of bills for your records—originals will not be returned.

6. With the exception of Plan I participants, you must use a CareFirst PPO participating provider, unless you are receiving (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. If you used a CareFirst PPO participating provider, mail your claim for benefits/itemized bills to:

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

If you did not use a CareFirst PPO participating provider, send your claim to the *Fund Office* at:

FELRA & UFCW VEBA Fund
Attn: Medical Claims Department
911 Ridgebrook Road
Sparks, MD 21152-9451

CareFirst In-Network Provider Generally Is Required, With A Few Exceptions

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, except as described below.

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.

Please note: CareFirst re-prices 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.

When you make your appointment, you should verify that the health care provider you selected participates with CareFirst, since 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. If the provider does not send your medical claims forms to CareFirst electronically, and you are in the local lease area of CareFirst, you or your provider should send your medical claims 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 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.

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

Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund

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4301 Garden City Drive, Suite 201
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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, 2015 to December 31, 2015. The annual report has been filed with the employee benefits security administration, as required under the Employee Benefits Security Administration of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $64,468,392 as of December 31, 2015 compared to $69,626,409 as of January 1, 2015. During the plan year the plan experienced a decrease in its net assets of $5,158,017. 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 $149,083,543. This income included employer contributions of $140,740,563, employee contributions of $7,417,356, realized losses of $214,930 from the sale of assets and earnings from investments of $1,089,971. Plan expenses were $154,241,560. These expenses included $11,694,844 in administrative expenses and $142,546,716 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.

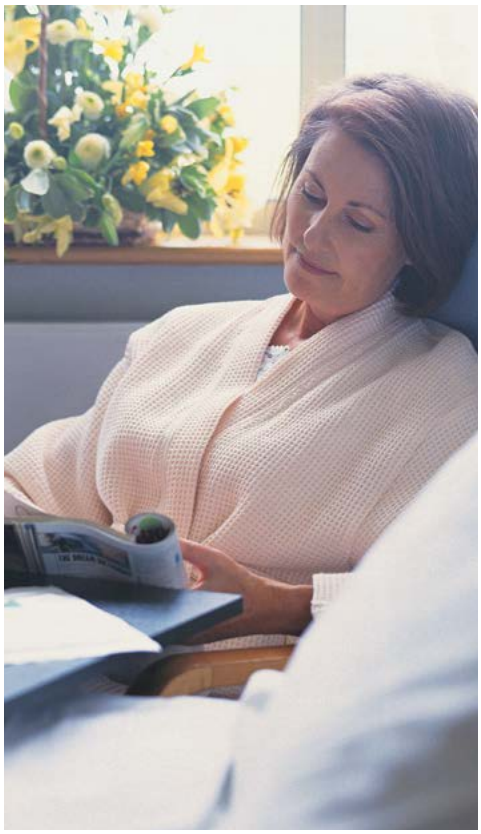
You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report 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, D.C., 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, D.C. 20210.

Additional Explanation

Dental claims- Group Dental Service, Inc. - premiums paid $8,247,315.
Medical claims - Kaiser Foundation Health Plan premiums paid $10,999,133.
Life insurance claims – Reliastar - premiums paid $181,515
Vision claims - Advantica - premiums paid $1,054,792
Accidental Death & Dismemberment - Reliastar - premiums paid $9,820



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.

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