Fund Uses Formulary List from Express Scripts

The Fund uses the Express Scripts, Inc. ("ESI") formulary list of preferred and non-preferred drugs. The formulary list changes periodically as new drugs are added and the discounts and pricing change. As a result, a particular drug may move from Preferred to Non-Preferred status, which has an impact on the co-payment for participants in Plans XX and XXX. ESI sends notifications to those participants and dependents currently taking a drug which is changing status on the formulary list so that you have an opportunity to speak with your doctor about possibly changing to a preferred drug.

FELRA & UFCW
VEBA Fund
911 Ridgebrook Rd.
Sparks, MD 21152-9451

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Plan X Part Time Participants: Open Enrollment for Dependent Coverage Is July 1 - July 31. See page 5.

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For Your Benefit

Determining Your Severance from Service Date

Your Severance from Service Date is the earlier of:

1. The date your employment with all Employers terminates (an "Employer" is an employer who is a party to a (1) Collective Bargaining Agreement or other similar arrangement with the United Food and Commercial Workers Unions, Local 27 or Local 400, or (2) Participation Agreement with the Fund, which requires contributions to the Fund) on your behalf; or

2. If you are covered by a Collective Bargaining Agreement between your Employer and the Union, the earlier of: (i) the three year anniversary of your approved leave of absence from employment because of sickness, accident, pregnancy, or military reserve or National Guard training, or (ii) the expiration of your leave of absence under the Collective Bargaining Agreement applicable to you; or

3. If you are not covered by a Collective Bargaining Agreement between your Employer and the Union, the 6 month anniversary of your leave of absence (unless you have a right to reemployment with an Employer under law or contract, in which case your Severance from Service Date will be the last date of your leave of absence if you do not immediately return to employment for an Employer).

Whether you have experienced a termination of employment for purposes of determining your Severance from Service Date will be based on whether the facts and circumstances indicate that you and/or your Employer reasonably expected that you would perform no further services for the Employer. If you file a formal grievance relating to your termination, your Severance From Service Date will not occur until the earlier of: (a) the completion of the grievance process, provided the grievance process upholds your termination; (b) the date you withdraw your grievance; or (c) six months after your termination date that is the subject of the grievance, unless you provide written evidence to the Fund that arbitration has been filed relating to the grievance, in which case the applicable date will be the date the arbitration is concluded (by settlement or a decision of the arbitrator).

Reminder: Landover Fund Office Moved to New Location

On April 1, 2017, the Landover Fund Office moved to the following address:
Fund Office, 8400 Corporate Drive, Suite 430, Landover, MD 20785-2361.
All phone and fax numbers remain the same. Participant Services is still (800) 638-2972.

Plans I, X, XX and XXX:
Open Enrollment July 15 – September 15. See page 3.

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.

MemberXG – New Online Access

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

MemberXG Benefit system

Want to check eligibility or the status of your claim? Log on to MemberXG and check your information online, available 24 hours a day, seven days a week.

The Fund is pleased to announce a new online access service called MemberXG. It replaces the NETime Benefit System mentioned in your Summary Plan Description. There is no change to your benefit Plan.

MemberXG allows you to view your benefit claim information online and through your mobile device. It provides personal benefit information to you via the Internet in a safe, secure and HIPAA compliant environment.

MemberXG Offers the Following:

- Secure internet access to benefit information with assured privacy.
- Mobile-ready access allows you to view your benefit information 24 hours a day.
- Benefit access which allows you to track your claims and view the following:
  - Accident and Sickness Claims – displays claims submitted to the Plan on your behalf.
  - Eligibility – your past and present eligibility.
  - Summary Explanation of Benefit (EOB) information concerning claims processed by the Fund.
- Dashboard – a landing page containing quick navigation to other benefit information.
- Demographics – a demographic page displaying your address, phone number, and other information.

How Does It Work?

- Log in to www.associated-admin.com, select *Your Benefits*, located at the left side of the page, and select *FELRA & UFCW Health & Welfare Plan*. Click on *MemberXG* which will take you to the Member XG site.
- Select *Create Account*, located at the upper right corner. You will be asked to create a username and password.
- If you had a password for NETime, the online access service previously offered by the *Fund*, it will **not** apply to this site. You will need to create a new username and password for MemberXG.

If you have any questions about a claim that you see on MemberXG, please call the Participant Services Department at (800) 638-2972.

Note: The information provided on the MemberXG website is not a guarantee of coverage. It is possible that the information shown is inaccurate or is not fully up to date.

Open Enrollment for Medical Coverage (Kaiser Permanente HMO or Fund Medical) Is July 15 – September 15

*The following article applies to **actively working participants** in Active Plans I, X, XX and XXX.*

Open Enrollment for choosing your medical coverage is from July 15 – September 15 for coverage effective October 1, 2017 – September 30, 2018. During open enrollment, if you live in the service area covered by Kaiser, you may choose between HMO (Kaiser Permanente) coverage and traditional Fund coverage.

How Does Open Enrollment Work?
If you live within the geographic area covered by Kaiser and you continue to be eligible for Fund coverage, you should receive a letter from the Fund Office in July, along with a packet of important information from the HMO (Kaiser Permanente). A Benefit Summary explaining the HMO benefits will be included, along with an enrollment form. ***Please read the Kaiser Permanente information carefully.***

What If I Didn't Get an Open Enrollment Letter?
You will receive an open enrollment letter only if you live in the geographic area covered by Kaiser. If you do not live in this area and you continue to be eligible for Fund coverage, your traditional Fund coverage will continue automatically. If you didn't receive an open enrollment letter and think you should have, call the Fund Office at (800) 638-2972. We will double check whether you are in Kaiser's geographic area, and if you are, we will help you get information about the HMO.

How Do I Enroll in the Kaiser HMO?
If you decide you want to enroll in the Kaiser HMO, complete the enrollment form for Kaiser Permanente and send it back to the Fund Office (**not to Kaiser**). Your Plan is the "Signature" Plan. After enrolling, you will receive an ID card from Kaiser. This should arrive on or shortly after October 1, 2017.

Please note: if you are currently enrolled in traditional Fund medical coverage and you decide to switch to Kaiser, ***the change becomes effective October 1, regardless of when your Kaiser ID card arrives.*** Starting October 1, you must use providers in the Kaiser network. Your providers for optical, dental and prescription drug benefits remain the same whether you have Kaiser or traditional Fund coverage. Participants in an HMO no longer need their Fund ID cards. If you come back to traditional Fund medical coverage in the future, we will send you a new Fund medical card.

What If I Want to Change to Traditional Fund Medical Coverage?
If you are currently in Kaiser and wish to change to traditional Fund medical coverage, call Participant Services at (800) 638-2972. ***Remember, you must make this change between July 15 and September 15!***

What If I Want to Keep the Same Coverage I Currently Have?
If you wish to remain in the Plan you are in now (Kaiser or traditional Fund medical), ***don't do anything!***

Those enrolled in Kaiser Permanente – READ THIS!
Remember, the co-pay for your benefits may change! You will be responsible for the new monthly co-pay unless you change to traditional Fund medical coverage.

Is There a Cost to Enroll in Kaiser?
There is a monthly cost to enroll in Kaiser. The amount will be shown in your open enrollment letter – be sure to read it!

What's The Difference between Traditional Fund Coverage and HMO Coverage?
Traditional Fund medical coverage varies by Plan. Fund participants pay an annual deductible, other than for preventive services, before payment from the Fund is made. For Plan XX, the deductible is $500 per person. For Plans I and X, the deductible is $300 per person.

Under traditional Fund coverage, if you are a participant in Plan I you may use any provider you wish, although you will save money if you use a CareFirst provider. **Plans X, XX and XXX *must* use a CareFirst provider in order for their treatment to be covered, except for the services of pathologists, anesthesiologists and radiologists at in-network hospitals, and for emergency room care.**

Under the Kaiser HMO, you must use a participating doctor or facility. If you do not use a participating provider for routine or follow-up care, the services rendered won't be covered. However, you are covered for emergency care worldwide.

Continued on page 4

Continued from page 3

If you don't do anything (and you remain eligible for Fund coverage), you will stay in the Plan you have now, whether that is traditional Fund medical coverage or Kaiser Permanente HMO, for the next year. If you were terminated from Kaiser for failing to pay your co-premium, you will automatically be moved back to Fund medical coverage effective October 1.

Important Reminders about Open Enrollment

- This open enrollment period applies ***ONLY*** to your ***medical coverage*** (including mental health/substance abuse). This does not affect your optical, dental, or prescription drug coverage. Those benefits continue to be provided through Advantica, Group Dental Service, Inc. and Express Scripts.
- Once you choose how you would like your medical coverage to be provided, ***you may not change again*** until open enrollment next year (July 15, 2018 – September 15, 2018).
- If you are a Plan X part time participant and you pay a monthly co-payment to have dependent ("family") coverage via payroll deduction, that will continue, regardless of which medical coverage option you choose— traditional Fund coverage or the HMO option.
- Open enrollment ends September 15. Contact the Fund Office on or before this date if you want to make a change.

If you have questions about Kaiser Permanente coverage, call Kaiser Permanente Member Services at (301) 468-6000 or toll-free at (800) 777-7902 and speak with a representative Monday through Friday between the hours of 7:30 a.m. and 5:30 p.m. Mention the FELRA & UFCW Health and Welfare Fund and ***refer to group # 6879 if you're in Plan I or X, group # 1976 for Plan XX, group # 1976-42 for Full Time Plan XXX, and group # 1976-43 for Part Time Plan XXX. This is very important.*** You can also call Kaiser's open enrollment hotline where you can leave a message requesting an enrollment kit or a return call if you have questions about Kaiser Permanente. The number is (301) 625-5377 and the line will be open during the FELRA open enrollment period (July 15th – September 15th). Messages will be checked daily.

For questions about the enrollment process or eligibility, call the Fund Office at (800) 638-2972.

You Have Separate Out-of-Pocket Maximums for Medical and Prescription Drug Benefits

The following applies to participants under the FELRA & UFCW Active Health and Welfare Plan whose medical coverage is provided through the Fund, not an HMO.

Separate out-of-pocket maximums apply for comprehensive medical benefits and prescription drug benefits. The out-of-pocket limit is the most you could be required to pay during a coverage period (usually one year) for your share of the cost of services your Plan covers. Once you have reached the out-of-pocket max, further claims for that benefit (whether medical or prescription drug) will be covered at 100% up to the usual, cutomary and reasonable (UCR) for the remainder of that calendar year.

The annual out-of-pocket maximums are:

Plan I and Plan X

- $4,000 for medical, per individual
- $8,000 for medical, per family

- $2,600 for prescription drugs, per individual
- $5,200 for prescription drugs, per family

Plan XX

- $5,000 for medical, per individual
- $10,000 for medical, per family

- $1,600 for prescription drugs, per individual
- $3,200 for prescription drugs, per family

Plan XXX

- $5,000 for medical, per individual
- $10,000 for medical, per family

- $1,600 for prescription drugs, per individual
- $3,200 for prescription drugs, per family

Plan X Part Timers: July 1 – July 31 Is Open Enrollment for Adding Dependent Coverage

The following article applies only to active Plan X part time participants.

Open Enrollment for adding dependent ("family") coverage to your benefits is July 1 to July 31. If you are eligible for dependent coverage but did not elect it when you first became eligible, you may add the coverage during July. The coverage will be effective September 1, 2017. The next open enrollment for dependent coverage will be in January for coverage effective March 1, 2018.

Is there a cost?

Yes — it is 20% of the overall cost of your health and welfare coverage, payable via payroll deduction starting in September. Contact your employer for the exact amount that applies to you. ***Do not send payment to the Fund Office.***

How Do I Add My Dependents?

To add dependent coverage, call the Fund Office at (800) 638-2972 during the open enrollment period and let us know. We'll send you an enrollment form and begin the process for starting your payroll deduction. ***We must have the completed enrollment form returned to us (along with any forms of proof which may be required, such as copies of birth certificates, etc.) before dependent coverage will begin.***

When will the coverage begin?

Coverage for your dependents will begin September 1.

How many dependents may I cover?

As long as they are eligible dependents under the Plan, you may enroll as many dependents as you have. The cost is the same regardless of the number of dependents.

What if I want to drop dependent coverage?

You may drop dependent coverage at any time throughout the year provided you notify the Fund Office ***in writing***. You may call us to request the proper form, which you must sign and return to us (it verifies that you wish to stop payroll deductions). However, please remember that if you ***do*** drop the coverage, you will not be eligible to add it again until the open enrollment period *following* a twelve-month waiting period, except in special circumstances such as a birth, adoption or marriage. Open enrollment for dependent coverage occurs twice a year: in January and in July.

What If I Don't Have Dependents Now, But I Do Later?

If you don't have any dependents and you then get married, have a child, adopt a child, etc., you may add dependent coverage no matter what time of year, as long as you add the dependent within 30 days from the date he/she first became your dependent (for example, within 30 days from the date of marriage, 30 days from the date of birth, etc.).

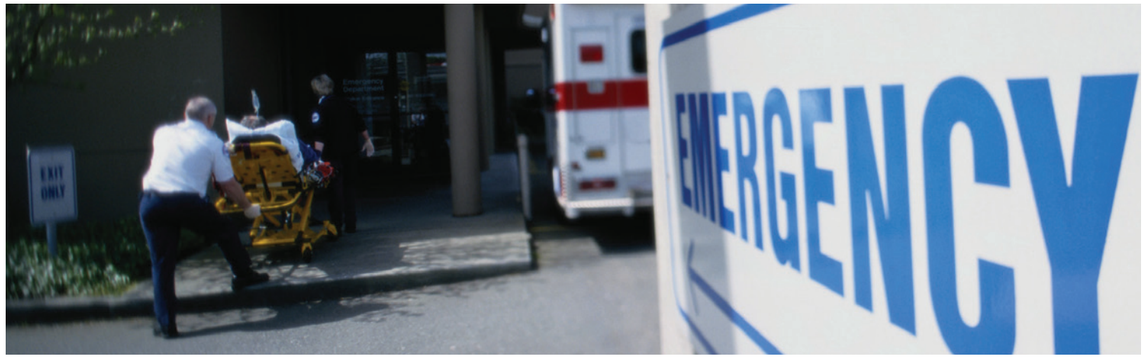
Contact Participant Services

If you have questions, contact Participant Services at (800) 638-2972.

Your Spouse Loses Coverage upon Divorce or Legal Separation

Your spouse will not be eligible for dependent coverage under the Fund if you become divorced or legally separated. If you and your spouse are physically separated, but not legally separated, your spouse may remain a dependent until the earlier of three years from the date of physical separation or the date of divorce or legal separation.

Please notify the Fund Office immediately if your spouse is covered under the Plan and you have become divorced, legally separated or physically separated from your spouse. If you do not notify the Fund and the Fund continues to pay benefits to your spouse after the date of divorce or legal separation, or after three years of physical separation, you and your spouse/former spouse will be responsible for paying such amounts back to the Fund.



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.

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.

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.

HEALTH CORNER

Prescription Drug Abuse Has Reached Epidemic Proportions Across The U.S.

According to the National Survey on Drug Use and Health, more than 6 million Americans abuse prescription drugs, and much of the abuse begins at home. In fact, more than 70% of those who illegally use prescription pain relievers obtained them through friends or family, including surreptitiously raiding the home medicine cabinet.

The most commonly abused prescription drugs are opioids. The Centers for Disease Control and Prevention estimates that about half of all overdose deaths include opioids. Data show that abuse accounts for 84% of patient-related prescription-drug fraud.

Properly storing and disposing of these and all other medications can help reduce the risk of abuse and help limit the national epidemic of addiction, overdose and death from prescription drugs by not letting them fall into the wrong hands.

Reduce the risk of drug fraud and abuse

- **Keep drugs out of reach.** Store your medications in a locked area out of children's reach. Ask your pharmacist if they can provide medication bottles with child-resistant caps.
- **Keep track of your treatments:** Keep a list of the medications in your home, especially those prone to abuse. Periodically count the medications remaining in the container.
- **Dispose properly:** If specific disposal instructions are provided on the label, follow them. Otherwise, remove the medication from its original container or vial, mix them with an undesirable substance such as used coffee grounds, kitty litter or saw dust, and place them in a sealable bag that can be disposed in the trash.
- **Don't make it easy:** Don't store narcotics or potentially addictive drugs in a medicine cabinet. If that is the only option, add a lock to the cabinet and hide the key.
- **Don't save for "next time":** Once your condition has been treated and your prescription regimen is complete, properly dispose of the drugs. Never keep extra medication for potential use in the future.
- **Don't share your medication:** The specific drug and dosage was selected specifically for the person it was prescribed for and could lead to dangerous drug interactions and serious side effects if used by someone else.

The above article was obtained with permission from Express Scripts, Inc. This information is general and not intended to replace the advice of your doctor. Consult your personal physician about your own medical condition.