UFCW TRUST

Working For Your Benefit

SUMMER 2019
Actives & Retirees

FOR YOUR BENEFIT: OFFICIAL PUBLICATION OF THE UFCW COMPREHENSIVE BENEFITS TRUST (UCBT)

Open Enrollment 2020 is almost here!

Open Enrollment is the time each year when Active Members are required to complete certain Enrollment Steps and/or Wellness Steps **(only Active Ultra and Premier Members and their Spouses/Domestic Partners are required to complete Wellness Steps in order to be eligible to participate in the Wellness Program, sometimes referred to as "Health Care Partnership" (or "HCP"), for the 2020 Plan Year.)**

There are two parts to Open Enrollment: Completion of Enrollment Steps and completion of Wellness Steps (if applicable).

Open Enrollment for the 2020 Plan Year takes place from July 29, 2019, through September 27, 2019. All Open Enrollment materials will be mailed to you in July with your customized and detailed instructions.

(Please see page 2)

FOR YOUR BENEFIT

is a newsletter designed to keep all Members informed about how to use their benefits most effectively. Members also may contact their Union's Benefit Clerks or call the Trust Fund Office directly at (800) 552-2400.

Phone hours for the Trust Fund Office's Health and Welfare Services Department are 7:30 a.m.-5:30 p.m., Monday-Friday.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 999-1999.

TRUST FUND OFFICE CORE VALUE: RESPECT

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Open Enrollment 2020

(Continued from front page)

How to complete Open Enrollment for 2020

Enrollment Steps (for all UCBT Active Members)

All UCBT Active Members are **required** to complete their Enrollment Steps in order to be eligible to maintain coverage for themselves and their enrolled Dependents (if applicable) for the 2020 Plan Year.

If Members do not complete their required Enrollment Steps by September 27, 2019, they and their enrolled Dependents will be dropped from coverage for the 2020 Plan Year.

To complete the required Enrollment Steps, log into UFCWTRUST.COM and click on the "Shopping Cart" button located on the My Info page to get started. If you do not have any changes to your current Carriers or Dependents you can click on the "Express Enrollment Steps" button. If you have changes to your Carriers, or wish to add or remove Dependents, you will need to click the "Full Enrollment Steps" button and make the necessary changes. Using either method, you will complete an Other Insurance Information survey.

If you do not complete the required Enrollment Steps by September 27, 2019, you, your Spouse/Domestic Partner and any Dependent Children will be dropped from coverage as of January 1, 2020, and you will not be able to reenroll any Dependents until Open Enrollment for the 2021 Plan Year.

Wellness Steps (for Premier & Ultra Members plus Spouses)

All UCBT Active Members and their currently enrolled Spouses/

For Your Benefit is the official publication of the UFCW Comprehensive Benefits Trust (UCBT). Every effort has been made to provide correct and complete information regarding particular benefits, but this newsletter does not include all governing provisions, limitations and exclusions, which may vary from Plan to Plan. Refer to the Summary Plan Description, Plan Document, Evidence of Coverage and/or Disclosure Form ("Governing Documents") for governing information. In the event of any conflict between the terms of this newsletter and the Governing Documents, the Governing Documents will control. As always, the Board of Trustees for the UFCW Comprehensive Benefits Trust retains the sole and complete discretionary authority to determine eligibility and entitlement to Plan benefits and to construe the terms of the Plans. The information in these articles is for general use only and should not be taken as medical advice. In an emergency, you are advised to call 9-1-1.

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FOR YOUR BENEFIT
Your Sick Leave benefits

Share your stories and ideas with the Trust Fund Office

Would you like to share a story of how UCBT benefits made a difference in your life or for one of your loved ones? Do you have a benefit-related topic you would like to learn more about in a future issue of *For Your Benefit?*

Email your story or ideas to **MemberProfile@ufcwtrust.com**.
We may contact you for more information.

Click on the "Shopping Cart" button located on the My Info page to get started.

Domestic Partners (if applicable) are required to complete their Wellness Steps by September 27, 2019, in order to be eligible to participate in the Wellness Program (HCP) for the 2020 Plan Year.

PPO and HMO Members and their currently enrolled Spouses/Domestic Partners currently participating in the Wellness Program who completed all Wellness Steps last year:

For Members and their currently enrolled Spouses/Domestic Partners (if applicable) who are currently participating in the Wellness Program (HCP) for the 2019 Plan Year, and completed their Biometric Screenings in 2018 for the 2019 Plan Year, only two Wellness Steps are required to be completed. Specifically, Members and their Spouses/Domestic Partners who are currently participating in the Wellness Program in 2019 each must:

1. Complete the Health Risk Questionnaire (HRQ), and,
2. Complete the GINA Agreement (for currently enrolled Spouses/Domestic Partners only).

PPO and HMO Members and their currently enrolled Spouses/Domestic Partners not currently participating in the Wellness Program:

For Members and their currently enrolled Spouses/Domestic Partners (if applicable) who are <u>**not**</u> currently participating in the Wellness Program (HCP), the Wellness Steps that are required to be completed (if applicable) by September 27, 2019, are:

1. Complete the Wellness Program (HCP) Agreement,
2. Complete the GINA Agreement (for currently enrolled Spouses/Domestic Partners only),
3. Complete the Health Risk Questionnaire (HRQ), and,
4. Complete Biometric Screenings
   PPO: Total Cholesterol (non-fasting), blood glucose (fasting), Body Mass Index (BMI), blood pressure and nicotine (cotinine)
   HMO: If you have not had the Biometric Screenings listed below completed after the date shown you are required to complete those biometric Screenings by September 27, 2019:
   HMO Biometrics: (earliest allowed date shown)
   Total Cholesterol (non-fasting): 7/1/2014
   Blood Glucose (fasting): 7/1/2014
   Body Mass Index (BMI): 7/1/2017
   Blood Pressure: 7/1/2017

Members and/or Spouses/Domestic Partners currently participating in the Wellness Program who did not complete Wellness Steps last year:

If you graduated from Standard to Ultra Plan between 7/1/2018 and 6/30/2019, and were provisionally participating in the Wellness Program in 2019, or if you are in the Premier or Ultra Plan Level and work at Yosemite Wholesale or Yosemite Management, you and your currently enrolled Spouse/Domestic Partner must complete all four of the above Wellness Steps required during Open Enrollment in order to continue your participation in the Wellness Program (HCP) for the 2020 Plan Year.

In addition, if you are currently participating in the Wellness Program (HCP) for the 2019 Plan Year, and you added a Spouse/Domestic Partner to your UCBT Plan after July 1, 2018 – meaning your Spouse/Domestic Partner did not complete Wellness Steps in 2018 for the 2019 Plan Year – your Spouse/Domestic Partner **will be required** to complete all four Wellness Steps even though you, the Member, only have to complete the Health Risk Questionnaire (HRQ) in order for your family unit to be able to participate in the Wellness Program (HCP) for the 2020 Plan Year.

To complete your required Wellness Steps, log into **UFCWTRUST.COM** and click on your "Shopping Cart" button located on your My Info page to get started. If you have a currently enrolled Spouse/Domestic Partner, he or she must first register on **UFCWTRUST.COM** before beginning his/her Wellness Steps.

Biometric Screening information

(for Premier and Ultra Members only)

For PPO Members

You can schedule your Biometric Screenings during a regular office visit with your physician or during your annual physical before September 27, 2019; just remember your physician must complete the PPO HM7 Form and fax to MedExpert at (650) 326-6700 no later than September 27, 2019.

Biometric Screenings are also available at Quest Diagnostics Patient Service Centers. Log into **UFCWTRUST.COM** to schedule your Biometrics Screening appointment at a Quest Diagnostics Patient Service Center.

For HMO Members

If you have not had your 2019 Annual Physical you can have any outstanding Biometric Screening (tests or labs) completed during your Annual Physical prior to September 27, 2019. For Members who have previously had a 2019 Annual Physical you may visit a Kaiser Clinician for assistance in completing your HM7 Form. (A Kaiser Clinician is any of the following: Primary Physician, Registered Nurse, Medical Assistant, Medical Secretary, or simply go to a Nurse's Station.)

HMO Participants must be current with their Biometrics based on Kaiser's Clinical Guidelines.

For Retirees

This year, **Open Enrollment is not required for Retirees; meaning no action is necessary during the Open Enrollment time period if you do not have changes to your current Medical Carriers, Dependents, and/or Other Insurance Information.**

If you do not complete Open Enrollment within the specified period (July 29, 2019, through September 27, 2019), your current Carriers, enrolled Dependents, and Other Insurance Information provided previously will remain the same for the 2020 Plan Year.

Members requiring assistance can visit the Trust Fund Office (TFO) in Roseville or Concord Monday–Friday, from 8:30 a.m. to 4:30 p.m. Pacific Time, or call the TFO at (800) 552-2400 Monday–Friday, between the hours of 7:30 a.m. to 5:30 p.m. Pacific Time.

Kaiser HMO Members

Something new and exciting is coming for Active Kaiser HMO Members in 2020! Be on the lookout for your customized Open Enrollment Materials in the mail!

Bag your benefits for 2020!

The entire process is as easy as 1-2-3:

1. Log into **UFCWTRUST.COM** and click on the shopping cart icon to get started.
2. Complete the "My Customized Checklist" of Enrollment Steps and Wellness Steps.
3. Enjoy comprehensive, affordable benefits for 2020!

Retirees: Medicare and Coordination of Benefits

The article on page 4 titled "Retirees: Medicare and Coordination of Benefits" of this newsletter describes changes to the UCBT Retiree Health Plan. This information is VERY IMPORTANT to you and your eligible Dependents. Please take the time to read this article and share it with your Dependent.

Please read the article titled "Retirees: Medicare and Coordination of Benefits" on page 4 of this newsletter carefully and keep it with your other Plan information. If there is any discrepancy between the Plan Information previously provided to you and the changes described in this article,the rules described in this article will govern. The Trustees reserve the right to amend, modify or terminate the Plan at any time. For further information regarding changes to the Plan's eligibility rules, please contact the Trust Fund Office (TFO) at (800) 552-2400.

Starting January 1, 2019, the UCBT Retiree Health Plan changed the way your Medicare claims are processed. Prior to January 1, 2019, all Medicare claims were processed by Blue Shield before being sent to the Trust Fund Office (TFO) for review and adjudication (payment/denial). However, as of January 1, 2019, the UCBT Retiree Health Plan ("Retiree Plan") receives claims electronically directly from Medicare. This change was enacted by the Retiree Plan to reduce processing costs and to reduce the amount of time it takes to process Medicare claims.

As part of this change, Medicare Retirees no longer need to go to a Blue Shield provider to qualify for the Retiree Plan's in-network level of benefits. Medicare Retirees instead receive the Retiree Plan's in-network level of benefits when they go to any provider who accepts Medicare. In addition, since the Retiree Plan no longer uses Blue Shield to process claims for its Medicare Retiree Participants, the Retiree Plan also no longer uses Blue Shield's contract pricing as the Retiree Plan's allowed amount for payment of Medicare claims. The Retiree Plan now uses Medicare's contracted rates as the Retiree Plan's allowed amount.

When Medicare is your primary coverage, the Retiree Plan pays as secondary on almost all claims. The Retiree Plan continues to use the Non-Duplication of Benefits payment methodology for all claims where the Retiree Plan is secondary.

Under the Non-Duplication payment methodology, the Retiree Plan does not issue payment for a claim when the allowed amount under the primary plan (Medicare) exceeds the Retiree Plan's allowed amount. In addition, the Retiree Plan does not issue payment on a claim if the amount the Retiree Plan would have paid if it had been primary is less than the amount that has already been paid by the primary plan.

The Retiree Plan determines how much it would have paid if the Retiree Plan had been the primary plan by starting with the Retiree Plan's allowed amount (which is the Medicare rate) for the services and then subtracting out any remaining deductible amounts and/or co-insurance amounts (up to the Participant's out-of-pocket maximum). If the amount the Retiree Plan would have paid if it was the primary plan, after deducting any applicable deductible and co-insurance, is less than what Medicare has already paid on the claim, the Retiree Plan will not make any payment on the claim.

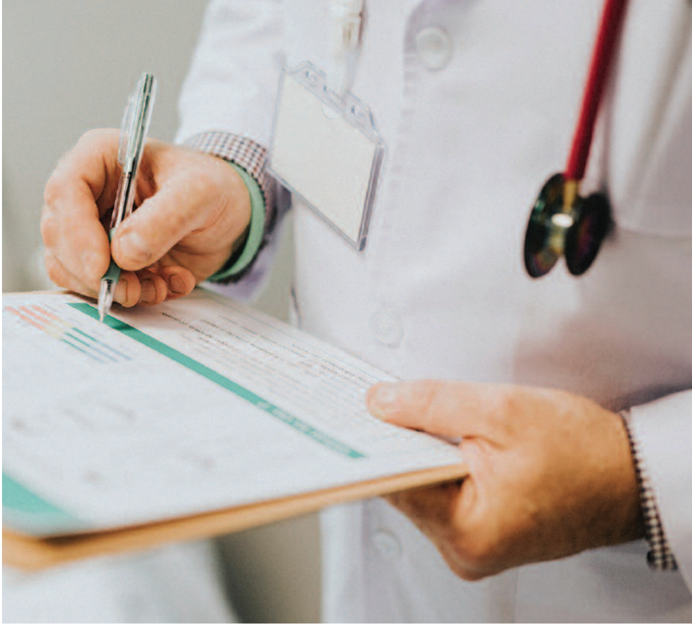
Since the Retiree Plan now uses Medicare's contracted rates as the Retiree Plan's allowed amount (instead of Blue Shield rates), the amount the Retiree Plan pays as a secondary plan may differ from what the Retiree Plan previously paid when it was using Blue Shield's rates. This also means the amount of patient responsibility (or the amount you are required to pay) for services received from a provider may be different (more or less) than the patient liability amount was prior to January 1, 2019, for those same services. You may also meet your annual out-of-pocket maximum sooner or later in the year now than you would have previously.

Generally, this means that if a Medicare Participant has not yet met his/her deductible and co-insurance maximum for the year under the Retiree Plan, the amount the Retiree Plan would pay if it was primary will likely be less than the amount that Medicare has already paid on the claim. Therefore, in those instances, a Medicare Participant will likely be required to pay out-of-pocket on the claim. However, the deductible and/or coinsurance amounts that the Retiree Plan determined you would have paid if the Retiree Plan was primary do count toward your required deductible and out-of-pocket maximums under the Retiree Plan.

Please see the following examples of when the Retiree Plan pays secondary to Medicare:

Example 1

Janice Price is a Medicare Retiree covered under the UCBT Retiree Health Plan (the "Retiree Plan"). On March 1, 2019, Janice receives services from a Medicare provider. The Medicare contracted rate for those services is $1,500. Medicare processes the claim and pays 80% of the



contracted rate, or $1,200, leaving a patient responsibility of $300.

Medicare Contracted Rate with Provider	$1,500
Medicare Payment of 80%	-$1,200
Medicare Patient Co-insurance of 20% (Patient Liability)	$300

The Retiree Plan's allowed amount for the services Janice received is $1,500 (the Medicare rate). If the Retiree Plan was primary, it would generally pay 75% of the Retiree Plan's allowed amount for services received from an in-network (Medicare) provider, once a Participant's deductible was met. As of March 1, 2019, Janice has $400 remaining for her deductible under the Retiree Plan. This means that if the Retiree Plan was primary, Janice would be required to pay $675 on this claim ($400 for the deductible plus 25% of the remaining allowable amount, or an additional $275). As a result, on Janice's claim, the maximum the Retiree Plan would pay if it were the primary plan (assuming the participant had not reached his/her out-of-pocket maximum) would be $825 (or $1,500 minus the $675 Janice would be required to pay).

Retiree Plan Allowed Amount	$1,500
Member Deductible	-$400
Member 25% Co-Insurance	-$275
Retiree Plan Benefit Amount (if Retiree Plan was Primary)	$825

Therefore, since the amount the Retiree Plan would pay on this claim if the Retiree Plan had been primary ($825) is less than Medicare paid on the claim ($1,200), the Retiree Plan will pay nothing on this claim, and Janice will be responsible for the $300 remaining after Medicare made its $1,200 payment. In addition, even though Janice is only required to pay $300 on this claim, the Retiree Plan will take into account the deductible and co-insurance amounts that Janice would have been required to pay if the Retiree Plan had been primary (the $400 deductible and the $275 co-insurance amount) toward Janice's deductible and out-of-pocket maximum under the Retiree Plan for the year.

Example 2

Assume that Janice receives the same medical services as in Example 1, but this time she has the services performed on September 14, 2019, when Janice had already met her deductible and out-of-pocket maximum for the year.

The same as in Example 1, Medicare processes the claim and pays $1,200 (or 80% of the contracted rate of $1,500), leaving a patient responsibility of $300.

Medicare Contracted Rate with Provider	$1,500
Medicare Payment of 80%	-$1,200
Medicare Patient Co-insurance of 20% (Patient Liability)	$300

If the Retiree Plan was primary, the Retiree Plan would be required to pay the Retiree Plan's allowed amount for these services in full ($1,500) since Janice had already met her deductible and out-of-pocket maximum for the year.

Retiree Plan Allowed Amount	$1,500
Member Deductible	-$0
Member 25% Co-Insurance	-$0
Retiree Plan Benefit Amount (if Retiree Plan was Primary)	$1,500

Therefore, since the amount the Retiree Plan would have paid if it were primary ($1,500) is more than Medicare paid ($1,200), the Retiree Plan will pay $300 and Janice will have no out-of-pocket expense for this claim.

Amount Retiree Plan would have Paid (if Primary)	$1,500
Medicare Payment of 80%	-$1,200
Amount Retiree Plan Pays	-$300
Patient Responsibility	$0

For Retirees: Medicare chiropractic services

Medicare coverage for services rendered by a chiropractor is limited to spinal manipulations that are considered medically necessary.

If Medicare denies a spinal manipulation service as not medically necessary or as maintenance only, the Plan will follow suit and the patient will be liable for the billed amount of the service. Therefore, it is important to ask your doctor if the treatment will meet the Medicare guidelines for medical necessity before beginning treatment to avoid an unwanted personal expense.

How claims are processed

As the secondary payer, the Plan's allowed amount will be the same as Medicare's allowed amount and benefits will be paid per Plan procedures and guidelines. The patient will be responsible for a $25 copayment for each date of treatment and the Plan will pay any remaining balance up to a calendar year maximum of $500 once the calendar year deductible is met. (Note: This means the Member will pay the full cost until their deductible is met).

If the provider accepts Medicare's assignment (in the Medicare network), the patient liability will be limited to the Medicare allowed amount for the service.

If the provider does not accept Medicare's assignment (out of the Medicare network), the patient liability will be limited to 115% of the Medicare allowed amount for the service.

For services never covered by Medicare when performed by a chiropractor (including office visits and physical therapy modalities), the Plan will assume primary payer status.

In this case, the Plan's allowed amount will be paid, minus any remaining patient per day copayment amount, up to a calendar year maximum of $500 once the calendar year deductible is met.

For all Medicare claims: How does Medicare Crossover pay and what does it mean for me?

As the secondary payer, the Plan will use Medicare's allowed amount as its own allowed amount. From that point, the Plan will apply the Member's deductible and co-insurance (which will be added to the Member's out-of-pocket maximum) and the resulting figure will be the Plan benefit. Since this benefit is usually less than the amount paid by Medicare, the Plan will not make a payment until your out-of-pocket maximum has been met. This means the Member will pay the Medicare patient liability up until their out-of-pocket maximum has been met. There are several exceptions as the Plan will pay for a benefit offered which Medicare does not cover.

Retiree preventive care benefits

If you take Retiree Health & Welfare benefits upon your retirement, the following are covered as preventive care benefits:

Routine mammograms
Benefit maximum:
$200 per calendar year

Routine preventive laboratory
Subject to deductible/coinsurance
Benefit maximum:
$100 per calendar year

Routine cancer screenings
One per calendar year
Subject to deductible/coinsurance

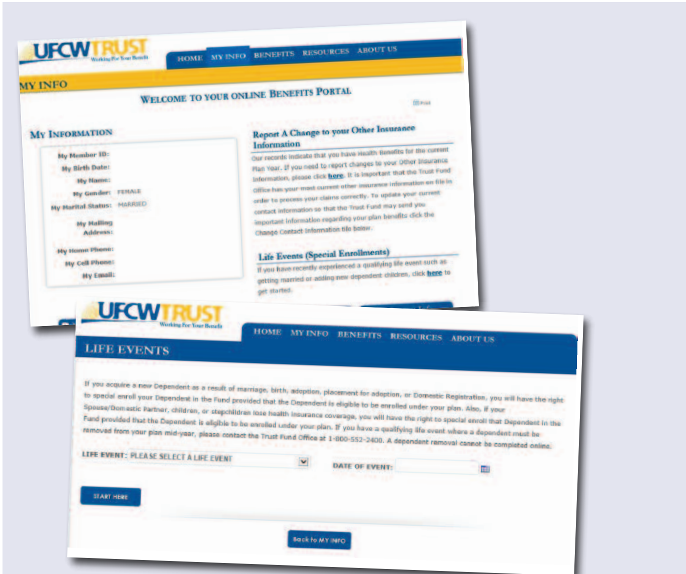
Routine immunizations
Subject to deductible/coinsurance
PPO: 75%, Non-PPO: 50%

Routine physical exam
Benefit maximum:
$75 per calendar year

Colonoscopy/sigmoidoscopy
Once every five years
Subject to deductible/coinsurance

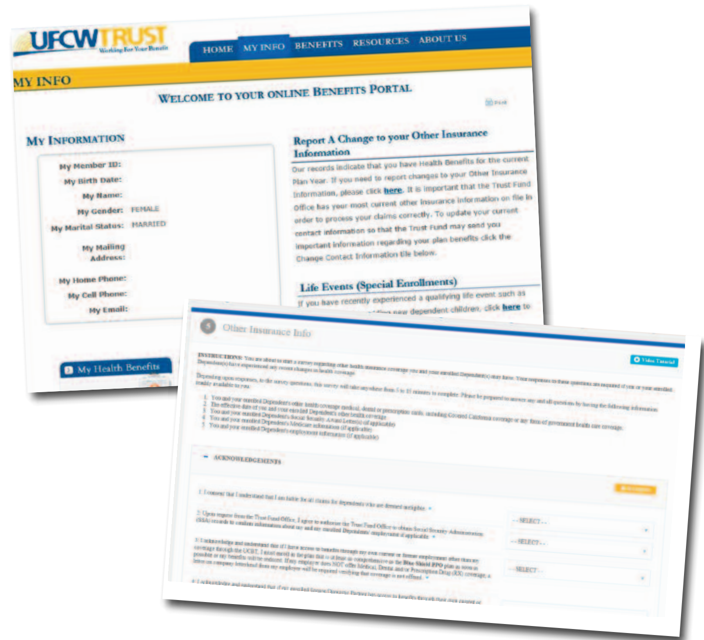
Administration of immunization
PPO: 100% after $25 copayment,
Non-PPO: 50%

Enroll dependents and update your benefits online!



Special Enrollments (Qualifying Life Events)

To enroll new Dependents outside of Open Enrollment, log into your account on UFCWTRUST.COM. At your customized Benefits Portal, follow the instructions under "Life Events (Special Enrollments)" to proceed to the Life Events page. Here you will be able to select the type of Life Event (marriage, birth, adoption, etc.) and date to proceed with the Special Enrollment. **Most Special Enrollments need to be complete, with all paperwork submitted to the TFO, within 30 days of the event.**



Report a change to your Other Insurance Information

The fastest way to update your Other Insurance Information is to log into UFCWTRUST.COM. You will land on your My Info page and follow the instructions under "Report a Change to Your Other Insurance Information" to proceed to the Enrollment Platform. Here you will be able to make changes to your Other Insurance Information and upload enrollment documentation.

Retirees: Your diabetes benefits

A variety of benefits are available to Retirees who are dealing with diabetes:

- Diabetic education and materials
- Diabetic equipment and supplies (medically necessary)
- Blood glucose monitors (limitations for non-insulin dependent diabetics)
- Blood glucose monitors designed to assist the visually impaired
- Insulin pumps and related necessary supplies
- Podiatric devices to prevent or treat diabetes-related complications (as approved by PPOC for non-Medicare Retirees and Active Members in PPO Medical Plans)
- Visual aids, excluding eyewear, to assist the visually impaired with proper insulin dosing
- Medically necessary nondurable supplies dispensed by a physician or health care professional
- Maintenance drugs for diabetes (and related supplies which require a prescription)
- Insulin and other diabetic supplies (including blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices and insulin syringes and injection kits). Please note this is covered only under the Prescription Drug Program.

Your podiatry benefits

A healthy lifestyle includes taking care of one's entire body, including a part which is often overlooked—the feet.

Here are some ways you can improve your foot health:

- **Wear comfortable shoes at work.** Proper footwear is especially important if your job requires you to stand. Buy shoes with moldable insoles and be sure they aren't too tight on your feet. Tight-fitting shoes can worsen bunions, distort toe shape and cause painful growths.
- **Avoid foot fatigue.** Take frequent breaks from standing at work, if possible, and use anti-fatigue mats. Inquire with your employer if they aren't readily available. Also, avoid flip-flops or other footwear without proper arch support.
- **Practice good foot hygiene.** Dedicate a few minutes of your shower to cleaning your feet, including the spaces between your toes. If you like to soak your feet, do so with warm water and avoid Epsom salts because they may dry out your feet. Be sure your feet are dry before putting on socks.
- **Visit a podiatrist.** The Plan provides coverage for podiatry care. To receive the PPO level of benefits you must use a Podiatry Plan of California (PPOC) provider. All PPO podiatry services must be approved by PPOC. Kaiser HMO Participants have podiatry benefits through Kaiser.

  For Retirees: Non-Medicare PPO Retirees living in California use the Podiatry Plan of California (PPOC) network of podiatrists to receive the PPO level of benefits. Retirees living out-of-state or out-of-area of a PPOC provider may use a Blue Shield podiatrist to receive the PPO level of benefits. All PPO podiatry services must be approved by PPOC.

  Kaiser HMO Retirees have podiatry benefits through Kaiser. Health Net Retirees have podiatry benefits through Health Net. **Medicare Members must use Medicare Preferred physicians to receive maximum benefits.**

Your feet should not hurt, but if they do, it could be a sign of a greater health problem, such as diabetes. Visit your primary doctor if you feel concerned.

Sources:
- **Livestrong.com**
- **HealthyWomen.org**

Retirees: Non-Medicare Blue Shield PPO lifetime maximum benefits

As a Participant in the UCBT Retiree Health Plan, you qualify for up to $2 million in benefits as an individual lifetime maximum.

The limit is applied per individual and is combined with any benefits paid under the UCBT Active Plan for that individual. This means the amounts paid on claims for medical services (dental and vision claims are excluded) provided on behalf of an individual under the Active Plan and the Retiree Plan, either as the Member or a Dependent, are added together to determine whether the $2 million maximum has been reached.

'You qualify for up to $2 million in benefits'

The same is true with regard to any claims made by the Member's Dependents. Each Dependent is subject to a $2 million maximum lifetime benefit, independent of the Member's claims, based on the amount paid on claims for services provided to the Dependent under the Active and Retiree Plans, regardless of whether he or she was a Member or Dependent when the claims were incurred.

Dual coverage

Retirees with dual coverage receive $2 million of coverage under each Retiree Plan (taking into account what was already paid under the Active Plan), totaling $4 million in coverage per individual between the two Retiree Plans.

Dual coverage determines how and whether the Plan applies the standard Coordination of Benefits rules to claims for you and your Dependents. If one of the covered Participants reaches the $2 million maximum lifetime limit, this could affect the amount of out-of-pocket expenses you and your family are required to pay, but it does not have any impact on the application of the Retiree Plan's $2 million maximum lifetime limit, as described above.