UFCW TRUST
Working For Your Benefit

Summer 2019
for Retired Members

For Your Benefit: Official Publication of the UEBT Retiree Health Plan

Open Enrollment 2020 is here!

Open Enrollment is the time each year when Retirees can make Medical Carrier changes, add or drop Dependents, and complete Other Insurance Information (OII) for the upcoming Plan Year.

Open Enrollment 2020 takes place from July 29, 2019, through September 27, 2019. During this time, visit **UFCWTRUST.COM** to complete your enrollment.

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 Other Insurance Information.**

(Please see page 3)

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For Your Benefit

is a newsletter designed to keep all Members and Retirees informed about how to use their benefits most effectively. They 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. Or visit us online at **UFCWTRUST.COM**.

¿Le gustaría una versión en Español de este boletín de noticias? Would you like a Spanish version of this newsletter?

Visite UFCWTRUST.COM, haga clic en el menú de Recursos y seleccione "*For Your Benefit* **Newsletter" para elegir una edicion.** Visit **UFCWTRUST.COM**, highlight the Resources menu and select *For Your Benefit* Newsletter to choose an issue.

Trust Fund Office Core Value: Respect
We are thoughtful in our behavior and treat others with dignity and kindness

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UEBT Retiree Health Plan

UFCW & Employers Trust, LLC, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UFCW & Employers Trust does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

UFCW & Employers Trust:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
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If you need these services, contact the Compliance Manager.

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UFCW & Employers Trust
Attn: Compliance Manager
P.O. Box 4100
Concord, CA 94524-4100

Phone: (800) 552-2400
Fax: (925) 746-7549

You may file a grievance in person or by mail or fax. If you need help writing a grievance, the Compliance Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at http://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone: (800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-999-1999.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-999-1999.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-999-1999.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-999-1999 번으로 전화해 주십시오.

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-999-1999.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-999-1999.

Kreyòl Ayisyen (French Creole, Haitian Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-999-1999.

Français (French)
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-999-1999.

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-999-1999.

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-999-1999.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-999-1999.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-999-1999 まで、お電話にてご連絡ください。

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-999-1999.

(Persian, Farsi)
فارسی توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-800-999-1999

(Arabic)
اللغوية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-999-1999

UFCW TRUST
Working For Your Benefit

For Your Benefit is the official publication of the UEBT Retiree Health Plan. 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 UEBT Retiree Health Plan 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.

1000 Burnett Avenue, Suite 110
Concord, CA 94520

2200 Professional Drive, Suite 200
Roseville, CA 95661

(800) 552-2400 • UFCWTRUST.COM

Open Enrollment 2020 is here!

(Continued from front page)

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

Open Enrollment materials will be mailed to you in July with your customized and detailed instructions.

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

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.
3. Enjoy comprehensive, affordable benefits for 2020!

Non-Medicare Blue Shield PPO lifetime maximum benefits

As a Participant in the UEBT 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 UEBT 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.

Medicare and Coordination of Benefits

The article titled, "Medicare and Coordination of Benefits," on page 4 of this newsletter constitutes a Summary of Material Modification that describes changes to the UEBT 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 Dependents.

In accordance with ERISA reporting requirements, this Summary of Material Modification modifies the information contained in the Summary Plan Description regarding Medicare and coordination of benefits in the Medicare Coverage section beginning on page 8 of the current Summary Plan Description. Please read the article titled "Medicare and Coordination of Benefits" on page 4 of this newsletter carefully and keep it with your Summary Plan Description and other Plan information. If there is any discrepancy between the Summary Plan Description and this Summary of Material Modification, the provisions of this Summary of Material Modification 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 UEBT 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 UEBT 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 UEBT 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

Medicare coverage for 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 amount allowed by the Plan 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.

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, adoption, etc.) and date to proceed with the Special Enrollment. Please refer to your Summary Plan Description for needed enrollment documentation and rules. **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 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 Other Insurance Information and upload enrollment documentation.

Retiree preventive care benefits

As a Member of the UEBT Retiree Health Plan, 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%

Your diabetes benefits

A variety of benefits are available to Retirees who are dealing with diabetes. Please refer to your Summary Plan Description for coverage amounts for the UEBT Retiree Health Plan.

- 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.