United Food & Commercial Workers Unions
and Food Employers Benefit Fund

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Benefits+
Your Trusted Benefits Partner

November, 2019

TO: All Plan A Active Participants and Eligible Dependents

IMPORTANT CHANGES TO YOUR HEALTH PLAN BENEFITS

The following changes approved by the Board of Trustees will be implemented effective January 1, 2020 (unless stated otherwise). The changes described in this Participant notice affect the Fund's eligibility rules and health benefits provided to you and your family. This information is **VERY IMPORTANT** to you and your dependents. Please take the time to read it carefully.

CHANGES TO PAYROLL DEDUCTIONS EFFECTIVE JANUARY 1, 2020

Participants are required to pay a share of the cost for coverage through weekly payroll deductions. The standard weekly contribution to premium amount depends on which eligible family members you enroll as your dependents.

Effective January 1, 2020, employee contributions to premium for each coverage level will increase by $1.00 per week. The new weekly contributions are as follows:

- For **Employee-only coverage**: Increased from $7.00 to $8.00 per week
- For **Employee plus eligible Child(ren)**: Increased from $10.50 to $11.50 per week
- For **Family coverage (Employee plus eligible Spouse/Domestic Partner, with or without eligible Children)**: Increased from $15.00 to $16.00 per week

UNUSED DENTAL AND VISION BENEFIT CARRYOVER EFFECTIVE JANUARY 1, 2020
Dental Carryover Applicable To Indemnity Dental Plan Enrollees
Vision Carryover Applicable to All Participants with Fund Provided Vision Benefits

In the past, you may not have used all of your annual dental or vision benefits within a calendar year. Starting in 2020, your unused Indemnity Dental Plan and vision benefit amounts, up to one-half of the annual maximum, will be carried over for use in the next calendar year.

Up to $900 in unused Indemnity Dental Plan benefits (up to $500 for Plan A Silver) and up to $75 in unused vision plan benefits (up to $62.50 for Plan A Silver) each calendar year will be carried over for use in the following calendar year.

The annual maximums are unchanged.

For example: if you are in the Plan A Platinum Plus, Platinum or Gold Plan, and you used $1,000 of Indemnity Dental benefits in 2019, $800 would be carried over and available for use for your dental treatments in 2020, in addition to your $1,800 annual maximum. This means that, in 2020, you could have up to $2,600 in paid dental claims.

This change applies to both dental and vision maximums. However, unused dental benefits that are carried over to the following year can be used only for services covered by the Indemnity Dental Plan, and unused vision benefits can be used only for vision services covered by the Plan.

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Claims are paid in the order that they are processed. Payments will be made based on the benefit amount available at the time the claims are processed.

CHANGES TO WORKING SPOUSE/DOMESTIC PARTNER RULE EFFECTIVE JANUARY 1, 2020

The old Working Spouse rule required your working Spouse (hereafter the term Spouse refers to your covered Spouse or Domestic Partner) to enroll in the "best" health coverage available from his or her employer, regardless of the cost. If your Spouse did not enroll in his/her employer-provided coverage, and you enrolled your Spouse as a Dependent in this Fund's Plan, you were assessed a "working spouse penalty," which reduced the amount the Fund paid on your Spouse's claims by 60%.

Starting January 1, 2020, the new rule requires that your Spouse enroll in the employee-only health care benefits (medical, dental, orthodontic, and/or vision) available through his or her employer that are most comparable, as determined by the Board of Trustees, to the level of coverage that you have from the Fund. (For example, if you are in the Indemnity Gold Plan, your Spouse must enroll in his/her employer's plan that is most comparable to the Fund's Indemnity Gold Plan).

If your Spouse chooses not to enroll in his/her employer's most comparable coverage, the Fund will invoke the "Working Spouse Penalty" and the amount payable for your Spouse's claims will be reduced by 60%.

However, also starting January 1, 2020, if that other comparable coverage requires your Spouse to pay $200 or more per month for employee-only coverage, you may avoid the "Working Spouse Penalty" (and your Spouse may decline coverage from his/her employer) by paying a greater contribution to premium to the Fund - $48 per week (3 times the regular weekly family rate). This new premium level is described on enrollment forms as the "Working Spouse Exception (Employee & Spouse, with or without child(ren)." If you want this new "Working Spouse Exception" coverage, you must notify the Fund by completing the appropriate enrollment form, and you (and your Spouse's employer) must provide evidence as to the cost of your Spouse's employer-provided coverage. Please contact the Fund Office for assistance.

Your Spouse is subject to the "Working Spouse Rule" only if health care coverage is available through his or her employer.

KAISER OPTION FOR PLATINUM LEVEL COVERAGE

EFFECTIVE JANUARY 1, 2020

We are pleased to advise you that effective for coverage beginning January 1, 2020 through December 31, 2020, employees eligible to participate in Platinum level coverage (Platinum Participants) will be offered the option to participate in the Platinum Kaiser HMO. The Kaiser benefits for Platinum members are exactly the same as those benefits offered to Platinum Plus Participants. We are including a copy of the Kaiser plan benefits with this SMM so you will be able to easily review the benefits available to you.

SPD/PLAN DOCUMENT FOR PLAN A - CORRECTIONS TO SCHEDULE OF BENEFITS FOR PLATINUM & PLATINUM PLUS PLANS

EFFECTIVE AUGUST 1, 2019

There are three rows in the Schedule of Benefits of the recently published SPD/Plan Document for Plan A (effective August 1, 2019) where the Fund's payment percentage for the Platinum and Platinum Plus Plans is shown as 75%, when it should say 80%. The correct benefits for those three rows (and page numbers where the benefits can be located in the SPD) are as follows:

Benefit Description	Explanations and Limitations of Benefits	Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
PAGE 33 **Family Planning, Reproductive, Contraceptive Services** • Sterilization services (e.g., vasectomy, tubal ligation, implants). • Contraceptive devices. • Infertility – limited to initial exam and diagnostic services.	• No coverage for reversal of sterilization procedures. • When a generic contraceptive device is available, only the generic is covered at no cost-sharing, unless the generic is medically inappropriate. • Treatment of infertility is limited to initial exam and diagnostic services. • Contraceptive drugs, such as birth control pills, are covered under the Prescription Drug Program.	***Female sterilization and FDA-approved contraceptive devices:*** 100%, deductible waived ***All others***: 80%	50%	***Female sterilization and FDA-approved contraceptive devices:*** 100%, deductible waived ***All others:*** 80%	50%
PAGE 34: **Maternity Services** • Hospital and Birthing Center charges and Physician and Certified Nurse Midwife fees. The following maternity services are payable as Preventive Care services: • Breastfeeding equipment (breast pump) and supplies needed to operate the pump, as outlined in the Durable Medical Equipment row of this Schedule. • In conjunction with birth, the Plan pays for lactation support and counseling (including breastfeeding classes) by a trained provider during pregnancy and/or in the postpartum period, at 100%, no deductible, when provided by a PPO provider. Under this plan, a trained provider is a breastfeeding or lactation educator.	• Maternity care is covered for a female Employee or Spouse or Domestic Partner only. **No coverage is provided for maternity/ delivery expenses of Dependent children** (except for certain preventive screening services mandated by ACA). • Surrogate pregnancies and all related charges (both when the surrogacy is for a Plan Participant and when a Plan Participant is the surrogate) are not covered. • Under federal law, group health plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. The Plan may pay for a shorter stay if the attending Provider, after consultation with the mother, discharges the mother or newborn earlier. In any case, the Plan may not require that a Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).	Lactation support and counseling: 100%, Deductible waived All other: 80%	50%	Lactation support and counseling: 100%, Deductible waived All other: 80%	50%

Benefit Description	Explanations and Limitations of Benefits	Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
PAGE 35: Medical Supplies & Equipment Coverage is provided for medically necessary Durable Medical Equipment (DME): • DME must be ordered by a Health Care Practitioner, be of no further use when medical need ends, be usable only by the patient and manufactured specifically for medical use. • Diabetic supplies (e.g., a diabetic glucose meter, insulin pump and related necessary supplies) and other Medically Necessary diabetes DME. • Oxygen and its administration, blood and blood products (and their administration), medical prosthetics, splints, casts, other supplies, chemotherapy/radiation/antigens. • Infusion drugs/injectable drugs (except insulin). • For the duration of breastfeeding, coverage is provided for one standard manual or electric breast pump (plus supplies to operate the breast pump). Coverage is provided for **nondurable supplies** dispensed/used by a Health Care Practitioner, such as: • Dialysis supplies; Colostomy and ostomy supplies; • Medical supplies/devices, including sterile surgical supplies used immediately after surgery; • Supplies needed to operate or use covered medical supplies or corrective appliances; and • Supplies needed by skilled home health or home infusion personnel, but only during the course of their services.	• Equipment for exercise, environmental control or for the patient's comfort or hygiene is not covered. • Rental charges that exceed the reasonable purchase price of the equipment are not covered. ***Maximums for Silver/Gold Plans:*** • Hearing aids: During any 36-month period, there is a maximum benefit of $475 for one aid or $630 for two aids. • Orthopedic shoes are subject to a $235 annual maximum. • Orthotics: $125 annual maximum; • Health aids (except crutches) $95 annual maximum. ***Maximums for Platinum/Platinum Plus Plans:*** • Hearing aids: During any 36-month period, there is a maximum benefit of $840 for one aid or $1,050 for two aids. • Orthopedic shoes are subject to a $315 annual maximum. • Orthotics: $210 annual maximum; • Health aids (except crutches): $160 annual maximum. **Nondurable supplies:** Coverage is provided for up to a 31-day supply of home/personal use and may be refilled if Medically Necessary. • A blood glucose monitor is covered every two years. • Insulin is covered under the Prescription Drug benefit	***Breast Pump:*** 100%, deductible waived **All others:** 80%	50%	***Breast Pump:*** 100%, deductible waived ***All others:*** 80%	50%

SPD/PLAN DOCUMENT FOR PLAN A - CORRECTIONS TO INFORMATION ABOUT HIP & KNEE REPLACEMENTS AT DESIGNATED HOSPITALS EFFECTIVE AUGUST 1, 2019

On page 47 of the recently published SPD/Plan Document for Plan A the subsections entitled "Information About Hip & Knee Replacements at Designated Hospitals," should read as follows:

Information About Hip & Knee Replacements at Designated Hospitals

Upon request, HMC Healthworks will provide you with:

- A list of Designated Hospitals that keep their charges within the $30,000 Allowed Amount; and
- A list of Hospitals that will accept a negotiated price above the Allowed Amount.

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Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, contact the Fund Office at 422; if you have any questions regarding any of the Plan changes described in this notice, please contact the Fund Office at 424.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan, and we are advising you of these Plan changes.