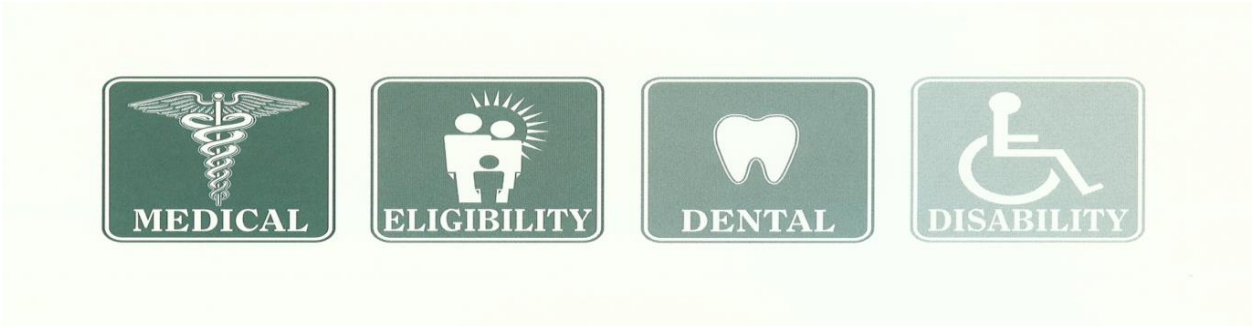
UNITED FOOD AND COMMERCIAL WORKERS
LOCAL NO. 1529 AND EMPLOYERS
HEALTH AND WELFARE
PLAN AND TRUST

BENEFITS AND ENROLLMENT BOOKLET

For Benefit Year 2019

CASTLE RETAIL GROUP

Please reference your Plan's Summary Plan Description (SPD) Booklet and Summary of Benefits and Coverage (SBC) Booklet for all of the Plan's provisions regarding your coverage. This booklet does not include Plan Exclusions and Limitations. The following are brief highlights of the major plan provisions.



Electronic Consent:
SPD's and SBC's, as well as other plan information can be found on www.bams.bz. You can access them through the website however you also have the option to request a hard copy free of charge. To request a hard copy, please send a request to the Administration Office.

Table of Contents

Important! **This benefit booklet provides an overview of your benefits; you will need to also review your SPD, SBC and Article 14 of the Plan's Collective Bargaining Agreement for all limitations and exclusions. In the event of a conflict between this benefit booklet and the terms in the Plan's SPD document, the SPD document will control.**

HEALTHCARE REFORM – Affordable Care Act

GRANDFATHERED STATUS:

This group health plan believes the United Food and Commercial Workers Union Local 1529 and Employers Health & Welfare Plan and Trust is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement to provide for external review of appeals. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 1-800-874-8499 or (901) 758-3000.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans

ELIGIBILITY CRITERIA

Who Is Eligible?

Pursuant to the Collective Bargaining Agreement by and between your employer and United Food & Commercial Workers Union, Local No. 1529:

Plan B: Full and part-time employees qualified after May 1, 2001, shall be eligible for a schedule of benefits identified as Plan B.

Known Work Employees Only: Sixty (60) days of consecutive employment. Eligible to add dependents. Note that this applies only if you are classified by your employer as a Known Work Employee

Courtesy Clerks, Fuel Clerks, and Students under age 18: Effective January 1, 2016, a courtesy clerk, fuel clerk, or student under age 18 with access to coverage through another source will become eligible for health and welfare benefits on the first day of the first calendar month immediately following nine months of employment if he/she has maintained an average of thirty hours per week (360 hours) under current eligibility rules. Coverage is for the employee only. Dependents and spouses cannot be added.

Below is an outline of the benefits you would potentially be eligible for based on your **hire date, Plan, position, period of coverage and hours worked.** *Coverage begins the first day of the first calendar month following the date of eligibility.*

Full-Time Employees Only: Three (3) months of consecutive employment working an average of 35 hours per week for a period of 12 consecutive calendar weeks (minimum of 420 hours). Eligible to add dependents. The first day of the fourth (4^{th}) month you are eligible for all of the following benefits: Medical, Prescription, Dental and Vision

Part-Time Employees Only: Eligible after **nine (9) months of consecutive employment** working on average 12 hours per week for a period of 9 consecutive months*. **Not** eligible to add dependents or spouse. **The first day of the tenth (10^{th})** month Part-Time benefits will commence on the following schedule:

Timeline	Benefits
The first day of the **tenth month** (10^{th}) from date of hire	Medical and Prescription Coverage Only
6 months later (16 months from date of hire)	Medical, Prescription + Dental
6 months later (22 months from date of hire)	Medical, Prescription, Dental + Vision

*Depending on your date of hire, the 12 hour work requirement may not apply.

ENROLLMENT REQUIREMENTS

From the date of eligibility to any Plan, you have 60 calendar days to elect coverage. If you fail to enroll within 60 days from your eligibility date, you will have to wait until the next Open Enrollment period, unless you have a qualifying life event. Each year there will be an Annual Open Enrollment period. Any changes outside of a qualifying life event must be done during the Annual Open Enrollment period.

TO ENROLL:

- ✓ **New Hires: new hires enrolling for the first time are required to complete a paper application and submit ALL REQUIRED DOCUMENTS. (see Enrollment Matrix)**
- ✓ **Re-Enrollees: during Annual Open Enrollment can be completed online via www.bams.bz or by phone if no changes are being made**

QUALIFYING LIFE EVENT: A qualifying life event change is a personal change in status which may allow you to change your benefit elections. You have **30 calendar days from the date of the event** to notify the Plan Administrator in writing if you experience a qualifying life event. *For example, if your divorce is finalized on August 1st you must submit an Enrollment Application/Change Form along with a copy of the finalized divorce decree by August 31st.*

If you do not request the change within 30 calendar days, the next opportunity you will have to make changes to your benefits will be during the next Annual Open Enrollment period. You will not be reimbursed for deducted Health Coverage Premiums if you fail to notify the Plan of ineligible dependents.

Examples of some life changing events include, but are not limited to, the following:

1. Change in legal marital status – marriage, divorce, legal separation, annulment, or death of a spouse
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status– switching from part-time to full-time employment status or from full-time to part-time
4. Dependent satisfies or ceases to satisfy eligibility requirement – Dependent that is over the age of 26

SPECIAL ENROLLMENT RIGHTS: When the employee or dependent of an employee loses other health coverage, a special enrollment opportunity in the group health plan may be triggered.

To have a special enrollment opportunity in this situation, the employee or dependent must have had other health coverage when coverage under the group health plan was previously declined. If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted. If the other coverage was not COBRA continuation coverage, special enrollment can be requested when the individual loses eligibility for the other coverage.

ENROLLMENT MATRIX

You may enroll your dependents for coverage under the plan only if you are classified in an eligible full-time position. If dependents become ineligible, you are responsible for notifying the Plan Administrator within 30 days of loss of eligibility. Recovery of claims paid to ineligible dependents may be requested. Employees who add a *dependent as a result of Open Enrollment, New Hire, or Qualifying Life Event during the year will must provide proof of their eligibility by providing the Required Documents listed in the Enrollment Matrix which begins on the following page.

Enrollment/Change Type	Eligibility Criteria	Documents Required For Verification	Effective Dates
NEW HIRES: Elect Coverage for yourself (the Employee	See Health Plan Overview and Eligibility Criteria	Enrollment Application/Change Form Other Coverage Questionnaire PHI Form Beneficiary Card	The first of the month that a contribution is made for you by your employer. Coverage and premiums will back date regardless of when you submit your application.
Re-Enrollees With NO Changes	Annual Open Enrollment	If no changes, no documents are required. You can confirm "no changes" via phone or online at www.bams.bz	
Re-Enrollees WITH Changes	Annual Open Enrollment	Changes require an Enrollment Application/Change Form to be completed and any applicable Required Documentation submitted	The first of the following benefit calendar year.
Natural Born Child	Your Natural Born Child AND Under age 26	Enrollment Application/Change Form Other Coverage Questionnaire PHI Form Birth Certificate (listing you or your spouse as parent) If applicable: court order/parenting plan	A newborn dependent child who is born after the Employee becomes eligible for coverage shall become eligible on the newborn dependent child's date of birth. Otherwise the first of the new benefit calendar year.
Stepchild	Your Stepchild AND Under age 26	Enrollment Application/Change Form Other Coverage Questionnaire PHI Form Birth Certificate (listing you or your spouse as parent) Verification of Spouse (Marriage License) If applicable: court order/parenting plan	New Hire: dependent child will be effective on the employee's effective date. Re-Enrollees: the first of the following benefit calendar year. Qualifying Life Event: the date of the qualifying event.

Enrollment/Change Type	Eligibility Criteria	Documents Required For Verification	Effective Dates
Natural Born or Step Child, At least 26, AND Disabled	Your Natural Born Child AND The child is 26 years old or older AND The child is physically or mentally incapable of self-support	A copy of the child's birth certificate naming you as the child's parent Other Coverage Questionnaire Statement of Disability Disability documentation proving disability occurred before the dependent reached the maximum age of 26 and documentation that dependent was enrolled in the plan immediately prior to attaining age 26.	New Hire: dependent child will be effective on the employee's effective date. Re-Enrollees: the first of the following benefit calendar year. Qualifying Life Event (marriage or disability): the date of the qualifying event.
Grandchild	Your Grandchild AND Under age 26 AND Is claimed as a dependent on your federal tax return	A copy of the Grandchild's birth certificate naming your child as the grandchild's parent A copy of your child's birth certificate showing you as the parent A copy of your most recent federal tax return showing the grandchild as your claimed dependent. Along with a Temporary Certificate of Tax Dependency for the current Plan year.	New Hire: dependent child will be effective on the employee's effective date. Re-Enrollees: the first of the following benefit calendar year.
A Child covered by a Qualified Medical Support Order (QMSO)	A child covered under a QMSO	A copy of the QMCSO	Date of court order
Legally Adopted Child OR Child Placed for Adoption OR Legal Guardianship	Your Legally Adopted Child OR Child Placed for Adoption OR Legal Guardianship And Under age 26	Enrollment Application Other Coverage Questionnaire Amended birth certificate showing you as the child's parent OR Copy of the adoption decree or court order naming you as the Child's adoptive parent or legal guardian AND a copy of a legal document showing child's age. OR Copy of Qualified Medical Court Support Order (QMCSO) and For non-biological dependents, a copy of the Employees or Spouse's most recent IRS Income Tax Statement reflecting the dependent as "claimed" in their household.	A child legally adopted by an Employee after the Employee becomes eligible shall become eligible on the earlier of (i) the date the child is placed for adoption with the Employee or (ii) the date the child is legally adopted by the Employee. If a child is placed for adoption with an Employee and the adoption does not become final, coverage for that child will terminate as of the date the Employee no longer has an obligation to support the child.
Add a Lawful Spouse, including same sex spouse:		Enrollment Application Other Coverage Questionnaire Copy of Marriage License	A new Spouse shall become eligible on the first day of the first calendar month following the date this Plan receives a request for enrollment via paper application of the new Spouse.

Enrollment/Change Type	Eligibility Criteria	Documents Required For Verification	Effective Dates
Qualifying Life Event: Change in Marital Status	Marriage, Divorce, Legal Separation, Annulment, or death of a spouse	Final Divorce Decree OR Death Certificate	The date of qualifying event
Qualifying Life Event: Change in Dependents Covered	Birth, Death, Adoption, Placement for adoption, Award of Legal Guardianship	See above for required documents for adding dependents. For removing due to death, a death certificate is required.	The date of qualifying event

Claims will not be paid for any new dependent unless the Plan Office has received ***all*** required enrollment forms and documents. ***Note***: Social Security numbers are required on the application for yourself and all dependents. Social Security numbers for newborns should be submitted to the Plan as soon as available, not to exceed 90 days.

***See SPD for the definition of an eligible dependent**

HEALTH PLAN EMPLOYEE PREMIUMS

Premiums are for applicable Collective Bargaining Agreements only. Premiums date back to your date of eligibility NOT the date you submit your enrollment application. The contribution amount for the Coverage Type you select will be taken out pre-tax from your weekly payroll check. Appropriate arrears will also be deducted should you delay enrollment. **It is your responsibility to notify the Plan Administrator timely of any qualifying event that would impact your deduction amount. You will not be reimbursed for deducted Health Coverage Premiums if you fail to notify the Plan of these events. Rates are subject to change.**

Weekly Employee Premiums

Coverage Type	2019 Premium Rates
Part Time Employee Only	$9.00
Full Time Employee Only	$11.00
Full Time Employee with Children	$17.00
Full Time Employee with Spouse	$21.00
Full Time Employee Family	$24.00

MEDICAL HEALTH PLAN HIGHLIGHTS

You must refer to the SPD and SBC for applicable benefit limits and details regarding the plans

Medical Services Only Highlights	Plan B	
	In Network	**Out of Network**
Calendar Year Deductible	**$175**/person **$350**/family $60.00/visit *Emergency Room Deductible	
*Office Visit Copayment	$20 copayment	N/A
Coinsurance (Hospital and Specialty Services)	You Pay: 20% Plan Pays: 80%	You Pay: 50% Plan Pays: 50%
	Note: A 10% penalty applies if prior-authorization is not obtained for required services.	
*Calendar Year Out of Pocket Limit	$5,000/person	None
Preventive Services: Pays at 100% when care is from an in-network doctor. See SPD for specific covered services. **This benefit is only for services that indicate primary diagnosis of preventative or wellness.**		

* **Emergency Room Deductible:** Waived if the patient is (1) admitted to the Hospital directly from the emergency room; (2) the emergency room visit is for the treatment of a life-threatening or limb-threatening Accidental Injury; or (3) had the emergency room visit not occurred, the patient's life could have been placed in danger or serious impairment of the patient's bodily functions could have occurred.

***Office Visit Copayment**: Not subject to the Deductible. An Office Visit consists of the professional services rendered by a Physician in the Physician's office and the procedures performed in a Physician's office directly related to such professional services, as determined from time to time by the Trustees in their sole discretion. All other labs, x-rays, procedures, and tests performed in the Physician's office will be subject to the Deductible and applicable Coinsurance. Examples are specialist office visits and Durable Medical Equipment.

***Calendar Year Out of Pocket Limit**: See SPD for services that apply to your out of pocket limit

Organ Transplant Benefits (all Plans)

Organ Transplant Performed at a Center of Excellence

Your Plan's Coinsurance percentage and Deductible apply to Eligible Expenses of the organ recipient.

Mileage Reimbursement for travel to and from a Center of Excellence that is at least 100 miles from the Eligible Person's primary residence by the Eligible Person and one Immediate Relative of the Eligible Person (or one person living in the Eligible Person's household)……**$.36 per mile.**

Room and Board for one Immediate Relative of the Eligible Person (or one person living in the Eligible Person's household) if the Center of Excellence is at least 100 miles from the Eligible Person's primary residence **……..$75.00 per day not to exceed 30 days.**

Organ Transplant Not Performed at a Center of Excellence

The Plan pays 60% of Eligible Expenses of the organ recipient not to exceed 60% of the lowest fee that would be charged by a Center of Excellence.

Mileage and Room & Board reimbursement is NOT available for services performed at a non-Center of Excellence

DENTAL & ORTHODONTICS BENEFITS

DENTAL GENERAL

Deductible amount per Calendar Year per Eligible Person ……..$50.00
Maximum deductible amount per family per Calendar Year……$150.00
Maximum dental benefits per Calendar Year per Eligible Person…..$1,500.00

ORTHODONTICS GENERAL

Eligibility: Coverage for dependent children under the age of 19 of full-time employees. **Spouses and employees are not covered for this benefit.**

Diagnosis and treatment planning for Class II malocclusion……$37.50
Initial appliances, fixes or removable, Class I-II malocclusion, including follow-up care, initial…. $500.00
Monthly statements per month thereafter…. $31.25
Total amount allowable for a lifetime maximum, no deductible …. $1,250.00

DENTAL FEE SCHEDULE

This Plan pays on a Dental Fee Schedule; each covered service (code) has a set allotted amount payable under the Plan. The fee schedule pays at the 80th percentile (NOT 80%). This means that 80% of local dentists will accept this payment as payment in full. To know what your patient responsibility will be after your co-pay of $50 has been met, you will subtract the billed amount for each service from the allowed amount. A copy of the Dental Fee Schedule is available at www.bams.bz. Participants of the Plan can request a copy by calling the benefits office.

DENTAL NETWORK – Shared Administration with Cigna

The Fund will be participates in the **Shared Administration,** Preferred Provider Network (PPO), through **Cigna Dental. You can go to any dentist you choose however you can realize better savings which will extend the life of your benefit if you go to dental provider that is in network with Cigna.**

To locate a participating network dentist – you may call 1-800-797-3381 or go to www.cignadentalnetworksolutions.com

VISION PLAN BENEFITS

Vision care benefits are provided through Group Vision Services / EyeMed

Customer Service at 1-866-265-4626, to view benefits or locate a provider

Important! Members will be responsible to pay the provider at the time of service for any applicable copayment /costs that exceed the plan coverage.

Benefits from a GVS/EyeMed Network Provider*		Copayment
Vision Examination – includes dilation as indicated	**Once Every 12 Months***	**$ 0.00**
Eyeglass Lenses - single vision, bifocal, or trifocal in standard/basic plastic **w/Standard Scratch Resistance**	**Once Every 12 Months***	**$ 0.00**
Frame –covered in full up to a **$ 135.00 retail value**. Members receive 20% off balance for selection costing more than the plan allowance	**Once Every 12 Months***	**N/A**
Contact Lenses - in lieu of spectacle lenses (does not include fitting and follow-up) • **Elective** – Disposable or Conventional, covered in full up to **$ 130.00 A**llowance. Conventional lenses: members receive 15% discount off balance over plan allowance. • **Medically Necessary** – Covered in full up to **$ 250.00**	**Once Every 12 Months***	**N/A**

Out of Network Benefits – If you choose to go to a non-network provider, you must pay the provider his or her full charges at the time of service. Members will be responsible for submitting a claim for reimbursement for the amount indicated in the member reimbursement schedule.

Member Reimbursement for services/materials obtained from an Non-Network Provider	
Vision Examination	Up to $ 32.00
Lenses	
Single Vision	Up to $ 30.00
Bifocal	Up to $ 45.00
Trifocal	Up to $ 75.00
STD. Scratch Resistance	Up to $ 12.00
Frame	Up to $ 57.00
Elective Contact Lenses (in lieu of spectacle lenses)	Up to $105.00
Medically Necessary Contact Lenses	Up to $200.00

Additional Savings Program

Pricing available in conjunction with funded benefits

Lens Options	Member Pricing	Other Options/Services	Member Pricing
Tint (solid & gradient)	$15.00	Other Lens Add-Ons and Services	20% off Retail
UV Coating	$15.00	Additional Complete Pair Purchases ***	40% off Retail
Standard Scratch Resistance*	**Covered**	Conventional Contact Lenses	15% off Retail
Standard Polycarbonate Adult	$40.00	Premium Contact Lens Fitting and Follow-up	10% discount
Children	$40.00		
Standard Anti-Reflective	$45.00	Standard Contact Lens Fitting and Follow-up	$40.00
Standard Progressive Lens**	$65.00	Retinal Imaging	$39.00
Premium Progressive Lens**	20% off Retail	EPIC Hearing Aid Savings Program	Fixed fee schedule

** Standard/Premium Progressive lenses are not covered benefits – however when upgrading in conjunction with your funded benefit the bifocal lens amount will be applied. Members are responsible for the lens copayment and any additional charges.

*In-network services and materials may be subject to a copayment at the time of service. **Out-of-Network amounts are maximum reimbursable amounts paid to members after the claim is filed. Amounts may vary by state.

LensCrafters
Sears Optical
Pearle Vision
JCPenney jcp.com
Target Optical
Private Practitioners

To access the Hearing aid savings plan contact:
EPIC Hearing Healthcare
877-606-3742
Website is located at: www.epichearing.com

epic HEARING HEALTH CARE

VISION PLAN LIMITATIONS AND EXCLUSIONS

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseiikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures
- Any corrective eyewear, required by a policyholder as a condition of employment, safety eyewear, services provided as a result of any Worker's Compensation law, or similar legislation or required by any governmental agency or program whether federal, state or subdivision thereof
- Plano (non-prescription) lenses; non-prescription sunglasses
- Two pair of glasses in lieu of bifocal
- Services or materials provided by another group benefit plan providing vision care
- Services rendered after the date an insured ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered and the services rendered to the insured are within 31 days from the date of such order
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.
- Certain frame brands in which the manufacturer imposes a no-discount policy
- Covered benefits may not be used in conjunction with coupons or other provider discount offers
- If an Insured and the Insured Spouse are both Insured by the plan, one Insured party may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Out-of-Network Providers

1. Visit non network provider
2. Members are required to pay the entire amount for exam and eyewear at the time of service.
3. Members must obtain an OON claim form from the GVS website at www.gvsmd.com. (click "Members" click "Forms").
4. Members must submit OON claim form and provider receipt to the Claims Address indicated on the form.
5. Member will be reimbursed based on OON benefits indicated in their benefit summary.

PRESCRIPTION DRUG PLAN

The prescription drug plan vendor is Envision Rx

Copays, the portion of the drug cost that you are responsible to pay, are listed in the table below. Please note that you will only be able to receive 90 Day fills at Retail at Kroger pharmacy only.

	30-Day Retail			90-Day Retail/Mail Order		
	Generic	**Brand**	**Brand with Generic**	**Generic**	**Brand**	**Brand with Generic**
Plan B Copay	$0	$25	$30	$0	$50	$60

Your benefit plan may have certain restrictions regarding refills. Please refer to the Summary Plan Description Booklet provided by your plan or contact your Plan Administrator. You may also call our Customer Service Help Desk at 1-800-361-4542.

Orchard Pharmaceutical Services

Mail order services are provided through Envision Rx's affiliate company, Orchard Pharmaceutical Services, located in North Canton, Ohio.

Mail order is an excellent way to receive prescriptions you will be taking for a long time with no worries about weather or availability of supply at the local pharmacy. For individuals who are taking maintenance medications, you may want to consider utilizing the mail order service for the convenience of home or office delivery.

Before you mail in a new prescription, you must REGISTER your information with Orchard Mail Order Pharmacy. You may use any of the following 3 easy registration options:

1. **Online: (Recommended method)** Visit www.orchardrx.com to register**.** Your account will activate within 24 hours. By registering online, members can also track the progress of their orders.
2. **Phone:** Call Orchard Pharmaceutical Services Customer Service at 1-866-909-5170 to speak with a representative.
3. **Mail:** Complete the Registration and Prescription Order Form enclosed in this packet.

Once registered, your physician can fax your prescription(s) to Orchard at 1-866-909-5171. Please be sure that your prescriber includes your date of birth and contact information on the fax. Only faxes sent from a physician's office will be valid.

Glucometer Replacement

Envision Rx has a program available to members that allows them to receive a free glucometer. Call **1-866-224-8892** for an Abbott Diabetes Care Glucometer (FreeStyle and the Precision Xtra® Blood Glucose & Ketone Monitoring Systems) or **1-877-229-3777** for a Bayer HealthCare, Diabetes Care Glucometer (Ascensia® CONTOUR® and Ascensia® BREEZE®).

Please identify EnvisionRxOptions as your pharmacy benefits administrator, and Abbott or Bayer will take care of the rest. There is a limit of one glucometer per member.

Complaints and Appeals

If you have a complaint or need assistance, please call our Customer Service Help Desk. Please refer to the Summary Benefit Plan provided by your plan or contact your Plan Administrator for instructions on how to file a grievance with your plan or appeal a coverage determination. If you have any questions regarding your prescription drug benefit, please call the Envision Rx Customer Service Help Desk at 1-800-361-4542.

SHORT TERM DISABILITY INCOME BENEFIT

Loss of Time Benefit for Full-Time Employees

Purpose: *Weekly Disability Income Benefits provide a partial replacement of Eligible Employee's take-home pay as a result of accident or illness.

Amount of Weekly Benefit……..66 – 2/3% of weekly earnings up to a maximum of $160 per week
Waiting Period for Accident ……..None, benefit accrues from the first full day of absence due to accident
Waiting Period for Sickness…….7 days, benefit accrues beginning on the 8th full day of absence due to illness.

*Maximum Period of Benefit during Disability…….. 26 weeks in any consecutive 12-month period. Must return to work for six consecutive months before this benefit is renewed.

The Plan will pay a Weekly Benefit if you become sick or injured and unable to work provided:

- ✓ You are a full-time Eligible Employee on the date the disability commences;
- ✓ You are Totally Disabled from illness or accident (whether occupational or non-occupational so as to be unable to perform the duties of your employment;
- ✓ You are under the direct and continuing care of a Physician;
- ✓ The Disability is continuously and
- ✓ The Disability extends beyond the expiration of the waiting period, if any. The Eligible Person's Disability must be certified by a Physician, and the Eligible Person must be under the direct and continuing care of a Physician.

SUCCESSIVE DISABILITIES

- If you again become Totally Disabled after a period for which a Weekly Benefit was paid, the Plan will treat the new Disability period as part of the first one if:
- The new period is due to the same or related cause and you have not been actively at work for more than two consecutive weeks between the two periods: or
- The new period is due to an unrelated cause, and you have not been actively at work at all between the two periods.
- When the second period is treated as part of the first, you will receive payments without another waiting period. When the second period is treated as a new Disability, you must start a new waiting period.

WORKERS' COMPENSATION

- For occupational accidents or sickness, Weekly Disability Income Benefits offset the difference between the amount of the stated benefits and the amount paid by Workers' Compensation.

DEATH BENEFIT (For Employees Only)

Amount of Death Benefit $10,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (For Employees Only)

Amount of Principal Sum Benefit $10,000

IMPORTANT FORMS!!!

COMPLETE THE REMAINING PAGES

AND

RETURN TO THE ADMINISTRATIVE OFFICE

661 North Ericson Rd.
Cordova, TN 38018
Fax: (901) 758-3021

TIME SENSITIVE

Forms to include any "Required Documents" will not be returned to sender. Do not mail originals.

ENROLLMENT APPLICATION/CHANGE FORM

Applications are accepted for the following three events:

1. **New Hire – 60 days from eligibility date to complete**
2. **Qualifying Life Event – 30 days from the event**
3. **Plans Open Enrollment Period**

Section 1: ENROLLMENT TYPE – Check All That Apply	**Section 2: WAIVING COVERAGE**
□ New Enrollee □ Add Dependent □ Open Enrollment □ Re-Enrollment □ Other **Are you applying due to a Qualifying Life Event?** □ No □ Yes, Date of Event __/__/___ Event Type: □ Marriage □ Birth □ Court Order □Adoption □ Loss of Other Coverage □ Other (Explain):_____ □ Waiving Coverage, Complete Section 2	I would like to waive Medical Coverage Only □ YES I would like to waive Dental Coverage Only □ YES I would like to waive Medical and Dental Coverage □ YES **If you elect to waive coverage you cannot re-enroll until the next Annual Open Enrollment period unless you experience a Qualifying Life Event.**

Section 3: EMPLOYEE'S INFORMATION

First Name	**Last Name**	**Social Security #**	**Date of Birth**

Mailing Address (Street) **City** **State** **Zip Code**

Gender (Male/Female)	**Phone Number**	**Email Address:**	**Name of Employer(s)**	**Are you Retired from any Employer**? □ Yes, Date of Retirement___/__/____ □ No

Section 4: WHO ARE YOU ADDING OR REMOVING? ***Only Full-Time Employees Can Add Dependents**

First Name	Last Name	Relationship (Spouse/Child…)	Social Security #	Date of Birth	Gender	Are you Adding or Removing?	Date of Event

Section 5: OTHER COVERAGE INFORMATION

Do you or anyone you are adding to this plan have other health insurance? □ Yes, Complete the "Other Coverage Questionnaire" form □ No

Section 6: ACKNOWLEDEMENT AND AUTHORIZATION

By signing I hereby certify under penalty of perjury that the information I have provided is true and correct.

I understand any material misrepresentation will result in the cancellation of my coverage and the denial of claims plus reimbursement to the health plan of any benefit payments. I understand my weekly premium cost, including potential arrears (back-pay) will not be reimbursed if I fail to complete the proper forms within the required timelines.

- I agree it is my responsibility to check my earnings statement each month to verify my benefit deductions and alert the Administration office immediately of errors. Further, I understand I will not be refunded deductions if I fail to provide this notification.
- I understand that my benefits can only be changed during open enrollment or a qualifying life event.
- I understand it is my responsibility to notify the plan of dependents that are no longer eligible within the required timelines

Signature: _____ Date: _____

OTHER INSURANCE COVERAGE QUESTIONNAIRE FORM

Employee Name: _____ Employee Social Security /Insured ID: _____

Do you or ANY of your dependents have any other medical or dental coverage? This includes any state plans, Veteran plans, Medicare or Medicaid: □ Yes OR □ No. If you marked **YES**, which indicates you or a dependent has other coverage, complete the section below and submit the supporting documentation outlined at the bottom of this page:

Name of the Policy Holder (the person who has the other insurance):_____

Benefits Included in Other Coverage: Medical ☐ Dental ☐ Vision ☐
Policy Holder's Relationship to covered persons: Spouse ☐ Parent ☐ Other ☐ Policy Holder's Date of Birth: ____/____/_____
Name of Dependent(s) covered by other insurance carrier: _____
Name of Other Insurance Carrier (Example: MS Medicaid/Aetna):_____
Name of Employer the insurance is provided by (Example: FedEx, Nike Corp., McDonald's)_____ Date of Hire with this Employer_____
Policy Number: _____ Policy Effective Date ____/____/_____Policy Termination Date ____/____/_____

Is there a court order regarding health care coverage for your children? □ Yes □ No

If the answer is "Yes" please supply us with a copy of the Medical Child Support Order/Parenting Plan.
If there is not a court order, who has custody of children? _____
Has the custody parent remarried? □ Yes □ No
Father's Date of Birth: _____ Mother's Date of Birth: _____
List the children the above information applies: _____

If Medicare ☐ Part A ☐ Part B ☐ Part D Medicare Effect Date: ____/____/_____ Medicare HICN: _____

Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ End Stage Renal Disease

Are you or any of your dependents covered under Medicare due to kidney failure? □ Yes □ No
If yes, when did kidney dialysis begin? ____/____/_____

Additional Supporting Documentation You Must Submit: If you or your dependents have had other insurance coverage with another carrier within 12 months of this application, you must contact that carrier and request a "**Certificate of Credible Coverage**" and submit that to our office. Additionally, if we have on file that you do have other coverage and you no longer have it, you will also need to submit a Certificate of Credible Coverage that reflects the termination date under the other policy. Lastly, please attach a copy of that carriers "Coordination of Benefits Rules."

Attest: I have read the above and attest that statements made by me on this form are complete and true. I understand that if any of the above information changes it is my responsibility to notify the Plan Administrator in writing immediately. I understand the definition of Fraud and know that if I willingly falsify this document that I can be prosecuted for Health Care Fraud.

Signature: _____ Date: _____

BENEFICIARY FORM for DEATH BENEFIT

- This form will be used to pay the employee's life benefits to the beneficiary assigned on the card.
- This form must be completed in full by the employee. Employee must sign and date the card for it to be considered valid.
- The employee may elect to change his or her beneficiary by completing and mailing to the Administrative Office another beneficiary form.
- Mail this form to the Administrative Office
- See your SPD for all terms related to the Death Benefit and Accidental Death and Dismemberment Benefit

Employee Name: (First) _____ (Middle Initial) _____ (Last Name) _____
Social Security No._____-_____-_____ Telephone # (___) _____--_____
Address: (No. and Street) _____, (City) _____, (State and Zip Code) _____
Date of Birth: _____/_____/_____ Gender: _____
Marital Status (circle one): Single Married Widowed Divorced
Spouse Name: (First) _____ (Middle Initial) _____ (Last Name) _____
Primary Beneficiary (ies):

Name	Address	Date of Birth	Telephone #	Relationship

Unless otherwise provided where two or more beneficiaries are named the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.

List the name and date of birth of spouse and legal dependents under the age of 19

Name	Address	Date of Birth	Telephone #	Relationship

Signature of Employee_____ Date _____

TEMPORARY CERTIFICATION OF TAX-DEPENDENCY FORM

(COMPLETE THIS FORM IF APPLICABLE)

For non-biological dependents (court ordered, grandchild, etc.) a copy of the Employees or Spouse's most recent Federal Income Tax Statement reflecting the dependent as a minor tax-dependent.

Submit this document as certification and proof of tax-dependency for the current Plan year. This document will hold in place until you have filed your taxes in the following calendar year. At that time you must then submit a copy of your filed IRS tax return no later than April 15th.

Employee Name: _____ Employee SSN/ID: _____

Employee Phone Number: _____

TAX DEPENDENT INFORMATION:

Dependent's Name	Relationship	Age	Date of Birth	Social Security #	Tax Year(s) Claimed

CERTIFICATION: By signing you certify you will claim the named dependent on your taxes for the "Tax Year(s)" you certify to and that you AGREE to submit a copy of your IRS return no later than April 15th of each year.

I UNDERSTAND that if you do not claim the listed dependents for the identified tax years and do not provide proof of tax dependency as stated, then you will be fully responsible to repay any and all health care cost paid for the dependents named and you will not be reimbursed for any premiums paid through the ineligible period.

Employee Signature_____ Date _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Policy Holder's Name:_____ Policy Holder's ID or SSN:_____

Authorizing Party (Print Name of Person Completing Authorization):_____

IMPORTANT! Without this form on file, completed by you we cannot disclose any of your personal health information (PHI) to any party.The undersigned (or his or her Personal Representative identified below), hereby authorizes the use or disclosure of my health information or the health information of my minor dependent child (identified below) as described in this authorization. Name specific person/organization authorized to provide information: **ACST, Inc. on behalf of UFCW and Employers H&W Plan and Trust**

Name specific person/organization **authorized to receive** and use this information; (You must list each person by name. In example, possible persons would include your spouse, parent, employer, attorney).

Authorized Person (s)	Relationship (spouse/employer/attorney/parent…)

INFORMATION TYPES: INITIAL below to indicate the information to be disclosed:

___Provider/Facility Name
___Explanation of Benefit Payment Details
___Diagnosis & Procedure Codes
___Nature of Injury or Illness
Date Services Rendered
___Performed Procedure
___Lack of Claim Payment
___Benefit Eligibility
___Medical Records (If applicable)
___Other, please list_____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____/_____/_____. (Must be valid date ex: 12/31/2030) **OR Initial Box ☐ for the date to be UPON TERMINATION OF ENROLLMENT IN THIS HEALTH PLAN**

REVOCATION: I understand that I have the right to revoke this authorization at any time by notifying ACST, Inc. in writing. I understand that the revocation is only effective after it is received and logged by ACST, Inc. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information has been disclosed, federal law might not protect it and the recipient might disclose it again. I understand that I am entitled to receive a copy of this authorization, a copy shall be considered as valid as the original.

Signature of Individual _____Date_____/_____/_____.
Name of Minor Dependent, if applicable_____ _____
Name of *Personal Representative, if applicable_____ _____
Signature of Personal Representative_____Date_____/_____/_____.

*If a Personal Representative executes this form, that representative warrants that he/she has the authority to sign the form and a copy of the written document that legally authorizes them to act in your behalf must be attached to this form.

Without a valid Authorization, none of your Protected Health Information can be released to anyone outside of a Covered Entity, not even to a spouse. NO EXCEPTIONS.

Plan Sponsored by:
United Food and Commercial Workers Union
Local 1529 and Employers Health and Welfare
Plan and Trust

Plan Administered by:
Administrative Consulting Services of Tennessee, Inc.
661 North Ericson Rd.
Cordova, TN 38018
1-800-874-8499. (901) 758-3000
www.bams.bz

The Trustees retain the right to amend, revise, or terminate this program at any time by action duly taken by them and the design of the Plan and its operations are subject to the express terms, conditions and provisions of the agreements between the Trustees and to all provisions of the Plan Document, rules and regulations duly promulgated by the Trustees to implement the same and other Plan documents.