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

Enrollment Booklet

For Benefit Year 2020

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.

TO THE EXTENT THAT THIS BOOKLET CONFLICTS WITH THE SPD OR SBC, THE TERMS OF THE SPD OR SBC, AS APPLICABLE, CONTROL.

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.

The Trustees retain the right to amend, revise, or terminate this program at any time. 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.

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
Fax: (901) 758-3021
www.bams.bz

ENROLLMENT REQUIREMENTS

From the date of eligibility, you have 60 calendar days to elect coverage and enroll. If you fail to enroll within 60 days from your eligibility date, you will have to wait until the next Annual Open Enrollment period to enroll, unless you have a qualifying life event.

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: re-enroll during Annual Open Enrollment. Re-enrollment can be completed online via www.bams.bz or by phone if no changes are being made. If changes are being made, re-enrollees must complete a paper application and submit all required documents.**

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.* **Refer to the SPD for a list of qualifying events to include special enrollment rights.**

You will not be reimbursed for deducted Health Coverage Premiums if you fail to notify the Plan of ineligible dependents. In addition, you may be responsible to re-pay the Plan for any benefits paid on behalf of ineligible dependents if you fail to timely notify the Plan of the dependent's ineligibility.

IMPORTANT! Unless it is due to an employee qualifying for Plan B after 36 months on Plan C (See "Eligibility Criteria"), you cannot change Plans (A, B, C) due to a Qualifying Life Event, you can only change plans during Annual Open Enrollment.

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 Plan of Benefits 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.**

2020 Weekly Employee Premiums

Coverage Type	Plan A Premium	Plan B Premium	Plan C Premium
Part Time Employee Only	$11.00	$9.00	$7.00
Full Time Employee Only	$13.00	$11.00	$9.00
Full Time Employee Plus Spouse	$27.00	$21.00	$18.00
Full Time Employee Plus Child(ren) Only	$22.00	$17.00	$14.00
Full Time Employee and Family (includes spouse and child(ren)	$34.00	$24.00	$21.00

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 must provide proof of their eligibility by providing the Required Documents listed in the Enrollment Matrix. **See SPD for the definition of an eligible dependent**

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 Certified 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 Certified Birth Certificate (listing your spouse as parent) Verification of Spouse (Certified 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.
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	Enrollment Application / Change Form A copy of the child's Certified Birth Certificate naming you or your spouse 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.

Enrollment/Change Type	Eligibility Criteria	Documents Required for Verification	Effective Dates
Grandchild	Your Grandchild AND Under age 26 AND Is claimed as a dependent on your federal tax return AND Dependent on you for support at least 9 months a year	Enrollment Application / Change Form A copy of the Grandchild's Certified Birth Certificate naming your child as the grandchild's parent A copy of your child's Certified Birth Certificate showing you as the parent A copy of your Income Tax Statement 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	Enrollment Application / Change Form 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 Certified 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	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 Certified Marriage Certificate	The first day of the first calendar month following the date the Plan receives a request for enrollment via paper application of the new Spouse. Plan must receive request for enrollment within 30 days of marriage.
Qualifying Life Event: Change in Marital Status	Marriage, Divorce, Legal Separation, Annulment, or death of a spouse	Enrollment Application 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.
Note: Newborn dependents can be enrolled with the "Mother's Copy" birth certificate with a Certified Birth Certificate required as soon as available, not to exceed 90 days.

Time Sensitive Important Forms!

COMPLETE THE REMAINING PAGES AND RETURN TO:

Mail: 661 North Ericson Rd. Cordova, TN 38018
Fax: (901) 758-3021
Upload: www.bams.bz

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

Application to Enroll – Election Changes

Important Timelines: Applications received past 60 days from new hire eligibility, 30 days from qualifying event, 60 days due to special enrollment rights may be denied. The Plan has an Annual Open Enrollment. All elections are for the Plan's Calendar Year unless there is a qualifying life event.

SECTION 1: ENROLLMENT TYPE – Check All That Apply

☐ New Enrollee ☐ Add Dependent ☐ Open Enrollment ☐ Re-Enrollment

Are you enrolling 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

SECTION 2: WAIVING COVERAGE

I would like to waive Dental Coverage Only ☐ YES

I would like to waive all benefits ☐ YES

I would like to waive ancillary benefits ☐ 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**	**Maiden Name (if applicable)**	**Date of Birth: __/____/_____**
			Social Security # _____-_____-____

Mailing Address: _____City:_____ State:_____ Zip Code: _____

Gender	Phone Number	Email Address	Opt-In to Electronic Communication?	**Name of Employer(s)**	**Are you Retired from any Employer**? ☐ Yes, Date of Retirement___/__/____ ☐ No
MALE / FEMALE	**( )**		**YES** ☐ **NO** ☐		

SECTION 4: PLAN OPTIONS --- Reference "Eligibility Criteria" to know your options. You can only elect a Plan Change During Open Enrollment

☐ Plan A, only those employees previously qualified for Plan A can elect Plan A (closed Plan)

☐ Plan B, only those employees previously qualified for Plan A or Plan B can elect Plan B

☐ Plan C, only those employees previously qualified for Plan A, Plan B or Plan C can elect Plan C

*Applicable weekly copay premiums apply for each plan and are subject to change

SECTION 5: 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 (Month/Day/Year)	Gender	Are you Adding or Removing?	Does Dependent Live with You?	
			_____-____-_____	___/____/_____	Male/Female		**Yes**	**No**
			____-____-_____	__/____/_____	Male/Female		**Yes**	**No**
			____-____-_____	__/____/_____	Male/Female		**Yes**	**No**
			____-____-_____	__/____/_____	Male/Female		**Yes**	**No**
			____-____-_____	__/____/_____	Male/Female		**Yes**	**No**
			____-____-_____	__/____/_____	Male/Female		**Yes**	**No**

ACKNOWLEDGMENT and AUTHORIZATION:

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: _____**

SECTION 4 – Other Coverage Questionnaire

Employee Name:_____, 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 **ENTIRE** 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): _____

1. Benefits Included in Other Coverage: Medical ☐ Dental ☐ Vision ☐
2. Policy Holder's Relationship to covered persons: Spouse ☐ Parent ☐ Step-Parent ☐
3. Policy Holder's Date of Birth (other insurance carrier): ___/____/___
4. Name of Dependent(s) covered by other insurance carrier:_____
5. Name of Other Insurance Carrier (Example: MS Medicaid/Aetna/Blue Cross Blue Shield):_____
6. Policy Number:_____ Policy Effective Date ____/____/_____Policy Termination Date ____/____/_____
7. Name of Employer the insurance is provided by (Example: FedEx, Nike Corp., McDonald's)_____ Date of Hire with this Employer_____
8. Is there a court order regarding health care coverage for your children? Yes_____ No_____
9. If you answered "Yes" please supply us with a copy of the Medical Child Support Order.
10. If there is not a courts order, who has custody of children? _____
11. Has the custody parent remarried? Yes____ No____,
12. If Yes does the step-parent have family insurance coverage? Yes_____ No_____,
13. If Yes is anyone on your policy covered by the step-parent's policy? _____
14. Biological Father's Date of Birth: _____ Biological Mother's Date of Birth:_____
15. List the children the above information applies: _____

MEDICARE ONLY: Select what you have: ☐ Part A ☐ Part B ☐ Part D

Medicare Effect Date: ____/____/_____ Medicare HICN: _____

Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ End Stage Renal Disease **Date of Disability:** ____/____/_____

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: _____

Section 5 – Beneficiary Form for Death Benefit

See the Plan's SPD for all terms related to the Death Benefit and Accidental Death and Dismemberment Benefit. This form will be used to pay the employee's life benefits to the beneficiary assigned on the form.

Employee Name: (First) _____ (Middle Initial) _____ (Last Name) _____
Social Security No._____-_____-_____ Telephone # (___) _____--_____ Email: _____
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) _____

I, the undersigned, hereby revoke any and all prior beneficiary designations made by me and hereby direct that any benefits payable under the Fund upon my death be payable to the following primary beneficiary(ies). In the event my primary beneficiary (or all of my primary beneficiaries) die or disclaim the benefit the full amount of benefits, if any, has been paid, I direct that my entire remaining interest in the Fund be paid to the following contingent beneficiary(ies). This beneficiary designation is effective when received by the Fund Office. If additional beneficiaries are needed, please attach a separate page listing the names and percentage amount. YOUR BENEFICIARY IS THE PERSON OR PERSONS YOU WISH TO RECEIVE YOUR LIFE INSURANCE PROCEEDS. PLEASE DO NOT NAME YOURSELF

Life Insurance Beneficiary	Name	Date of Birth	Telephone #	Relationship
Primary Beneficiary				
Primary Beneficiary				
Contingent Beneficiary				
Contingent Beneficiary				

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.

Signature of Employee_____ **Date** _____

Section 6: Spousal Other Coverage Affidavit **This form is to be completed by your spouse's employer.**

Beginning January 1, 2021, employees will pay a contribution of $150.00 per month ($34.62) per week in addition to the applicable weekly co-premium for spouse or family coverage. Such coverage will be for those spouses who have access to other employer sponsored coverage and who wish to ENROLL IN COVERAGE UNDER THIS PLAN. In addition, employee spouses who have access to other coverage must enroll in that plan (through their employer) and will be covered as secondary on this plan subject to all applicable contributions. **Employees with spouses who do not have access to other employer sponsored coverage may waive the $150 spousal fee upon PROOF of no other coverage. Employees with spouses working for Kroger will also be able to waive the spousal surcharge. * Employer-Sponsored medical coverage does not include coverage that is 100% employee paid.**

Name of Employee (UFCW 1529 Insurance): _____, Please select one of the following regarding the status of your spouse's access to other health insurance.

1. _____**Employed WITHOUT** access to **Medical benefits** from his/her employer **(EMPLOYER MUST COMPLETE SECTION B)**
2. _____**Employed WITH** access to **Medical coverage** from his/her employer **(EMPLOYER MUST COMPLETE SECTION B)**
3. _____ **Unemployed due to the Termination, lay off, (or by resignation of own will) of previous employment. (PREVIOUS EMPLOYER MUST COMPLETE SECTION B)**

Employee employment status may be subject to further verification. I hereby certify that the information provided is correct. I understand that any misrepresentation in the information I have provided above will permit UFCW Lo. 1529 Union & Employers Health & Welfare Fund to terminate my coverage and seek any other legal remedies available including possible prosecution for fraud. If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in the application for coverage under this Fund. **Employee Signature: _____ Date:___/____/____**

** Spousal Surcharges will not take effect until January 2021.

Authorized Personal ONLY: This form is to be completed by an authorized representative with your SPOUSES current or previous employer(s).

Employee's Name: _____ Employee's Hire Date: _____/_____/_____

Does your company offer employer-sponsored* medical coverage? YES☐ NO☐
If the Person named above is no longer an employee, were they at any time eligible to enroll for medical coverage prior to their termination of employment? YES☐ NO☐ Date Coverage Began: _____/_____/_____ Date Coverage Ended: ___/_____/____
If so, please answer the following question accordingly as past tense (such as > was, were, & did):

If the employee will have access to employer-sponsored coverage but has not yet qualified, please provide the date they will qualify qualify for coverage: _____/_____/_____

- If eligible, has the Person named above enrolled in the medical coverage with your company?___Yes ___No
- Is the Person named above enrolled in the dental coverage with your company? _____Yes _____No
- Does your company offer medical coverage to dependents of the Person named above? ____Yes _____No If so, did the dependents of the Person named above enroll for medical coverage with your company? ____Yes ____No
- What is the effective date of coverage, or date the employee would have been eligible to enroll in coverage? _____/_____/_____

Company/Employer Name				
Employer Phone Number	**( )**	**Benefit Administrator Phone: ( )**		
Company Address	**Street**	**City**	**State**	**Zip**

Authorized Personnel Name: _____ Your Title: _____

Authorized Personnel Signature: _____ Date: _____/_____/_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Policy Holder's Name: _____ Policy Holder's ID or SSN: _____
Phone Number: _____ Email Address: _____
Initial if you would like to Opt-In to receiving email and or text communication from the Fund _____

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 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 if applicable: _____

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_____/_____/_____.

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.

*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