South Central United Food &Commercial Workers Unions and Employers Health and Welfare Plan and Trust

Enrollment Booklet

Employees represented by UFCW Locals 455 & 540 (The Funding 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.

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 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

Employee Self-Contribution Rates, Employees represented The Funding Group

Self-Contribution Rates 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.**

Plan C Employee Rates	2019-2020 Rates Plan C
Employee Only	$6
Employee Plus Child	$12

Plan B Employee Rates	Hired before October 1, 2010	Hired after September 30, 2010
Employee Only	$5 per week	$6
Employee and children	$10 per week	$12
Plan A Rates	Hired before October 1,2010. Spouse either doesn't have other coverage or **HAS elected** their employer's coverage	Working Spouse Surcharge. Rates apply when Spouse **does NOT** elect coverage through their employer.
Employee Only	$5	n/a
Employee and Spouse Only	$28.08 ($5 Med/$23.08 WSF)	$44.62 ($10 Med/$34.62 WSF)
Employee and Children Only (excluding Spouse)	$10	n/a
Employee and Family	$33.08 ($10 Med/$23.08 WSF)	$49.62 ($15 Med/$34.62 WSF)
Plan A Rates	Hired after September 30, 2010. Spouse either doesn't have other coverage or **HAS elected** their employer's coverage	Working Spouse Surcharge. Rates apply when Spouse **does NOT** elect coverage through their employer.
Employee Only	$6	n/a
Employee and Spouse Only	$29.08 ($6 Med/$23.08 WSF)	$48.62 ($14 Med/$34.62 WSF)
Employee and Children Only (excluding Spouse)	$12	n/a
Employee and Family	$35.08 ($12 Med/$23.08 WSF)	$54.62 ($20 Med/$34.62 MED)

Dual Coverage. For spouses who are both employed by a participating Employer in the Plan, the following weekly premiums shall be charged. Spouse One is the Spouse with the earlier hire date.

Employees hired on or before 09/30/2010	Spouse One	Spouse Two
Dual Employee + Spouse	$5	$23.08
Dual Family	$10	$23.08
Employees hired after 9/30/2010	**Spouse One**	**Spouse Two**
Employee + Spouse	$6	$23.08
Family	$12	$23.08

<u>Required Documents</u> – Enrollment Matrix

Employees who add a child or spouse as a result of Open Enrollment, New Hire, Special Enrollment Rights or a 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
NEW HIRES: Elect Coverage for yourself (the Employee only)	See Health Plan Overview and Eligibility Criteria	o Enrollment Application/Change Form o Other Coverage Questionnaire o PHI Form o Beneficiary Form
Natural Born Child	Your Natural Born Child AND Under age 26	o Enrollment Application/Change Form o Other Coverage Questionnaire o PHI Form o Certified Birth Certificate (listing you or your spouse as parent) o If applicable: court order/parenting plan
Stepchild	Your Stepchild AND Under age 26	o Enrollment Application/Change Form o Other Coverage Questionnaire o PHI Form o Certified Birth Certificate (listing your spouse as parent) o Verification of Spouse (Certified Marriage License) o If applicable: court order/parenting plan
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	o Enrollment Application / Change Form o A copy of the child's Certified Birth Certificate naming you or your spouse as the child's parent o Social Security Card o Other Coverage Questionnaire o Statement of Disability o 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.
Common Law Spouse	*As legally permissible in state of residence	o One form of dated (within 6 months) documentation establishing current marital status such as: a joint household bill, joint bank/credit account statement, joint mortgage or lease, or front page of your jointly-filed previous year tax return (with blacked out financial information) o Working Spouse Form o Affidavit of Common Law Marriage o Other forms of dated (within 3 months) documentation establishing current marital status such as: o Two pieces of evidence of from Category A (see attached) OR o One piece of evidence from Category B (see attached
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	o Enrollment Application o Other Coverage Questionnaire o Amended Certified Birth Certificate showing you as the child's parent OR o 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 o Copy of Qualified Medical Court Support Order (QMCSO) and o Copy of Child's Social Security Number

Required Documents – Enrollment Matrix Continued

Enrollment/Change Type	Eligibility Criteria	Documents Required for Verification
Add a Lawful Spouse		○ Enrollment Application ○ Other Coverage Questionnaire ○ Copy of Certified Marriage Certificate ○ Working Spouse Form
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
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.

Children and/or a spouse <u>will not be added to your policy</u> unless the Plan Office has received ***all of*** required enrollment forms and documents. Do not send original documents, they will not be returned.

<u>Social Security Numbers</u> 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.

<u>Newborn Child</u> 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.

Part 1 – Application to Enroll – Election Changes

Important Timelines: Applications received past 31 days from new hire eligibility, 31 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 or special enrollment event such as the loss of Medicaid.

Required Documents: You are required to submit proof of eligible dependents such as the state certified birth certificate for children, a certified marriage license for spouses and applicable court orders for adopted children. Reference the Enrollment Matrix for a full list.

SECTION 1: ENROLLMENT TYPE – Check All That Apply

☐ New Enrollee ☐ Add/Remove Spouse ☐ Add/Remove Child(ren)
☐ Open 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): _____

SECTION 2: WAIVING COVERAGE

I would like to waive 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

Employee's Name: (First, Last) **Date of Birth:** __/____/_____ **Social Security #** _____-_____-_____

Mailing Address: _____ **City:**_____ **State:**_____ **Zip Code:** _____

Gender MALE / FEMALE	Phone Number	Email Address	Opt-In to Electronic Communication?	**Name of Other Employer(s)**
	( )		**YES** ☐ **NO** ☐	

SECTION 4: PLAN OPTIONS --- Reference "Eligibility Criteria" to know your options. You can only elect a Plan Change During Open Enrollment. You will be enrolled in only what you are eligible for regardless of your election.

☐ Plan A, Employee Only, ☐ Plan A, Employee & Spouse, ☐ Plan A, Employee & Children, ☐ Plan A, Employee & Family
☐ Plan B, Employee Only, ☐ Plan B Employee & Children
☐ Plan C, Employee Only, ☐ Plan C Employee & Children

SECTION 5: WHO ARE YOU ADDING OR REMOVING? Do NOT list a spouse and/or child if you are not eligible or do not wish for them to have coverage.

*Applicable weekly copay premiums apply for each plan and are subject to change. Refer to Employee Self Contribution Rates. Your deduction will reflect your election & what you are eligible for with that election.

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**

DENTAL BENEFITS: You may have a dental coverage choice if you are in the UFCW Lo. 455, or 540 jurisdictions. Depending upon your hire date and the availability of providers in your zip code. IF OFFERED A CHOICE OF DENTAL PLANS, PLEASE SELECT: **____ PPO/Indemnity OR ___ DHMO** Your election may not be valid depending upon your service area & hire date.

ACKNOWLEDGMENT and AUTHORIZATION: I understand that I will not be able to add or change my coverage or rescind or change any payment authorization until the next open enrollment period, (i.e., my election will remain in effect beginning on the upcoming January 1, or if later, my effective date of coverage through the following December 31), except as permitted by the Notice of Special Enrollment Rights. By submitting this enrollment, I hereby certify that the information provided, to the best of my knowledge and belief, is true, correct and complete. I understand that any false statements in this enrollment may affect my continued eligibility for benefits under the Fund. I further understand that, if applicable, I am authorizing the weekly pre-tax payroll deductions for any required participant contributions detailed during this enrollment process. I have read and understand the terms and conditions of these payroll deductions and the Notice of Special Enrollment Rights.

Signature: _____ **Date: _____**

Part 2 – Other Coverage Questionnaire

Employee Name:_____, Do you or ANY of your children or spouse 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, your child, your spouse has other coverage, Please complete the **following questions:**

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)/Spouse 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 custodial 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 all the individuals the above information applies: _____

MEDICARE ELIGIBILITY INFORMATION – If you or a child or spouse are covered by or eligible to enroll in Medicare, please complete the following:

Medicare Covered Person(s)	Medicare # (HCIN)	Part A Effective Date	Part B Effective Date	Part D Effective Date	ESRD Onset Date

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

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: _____

Part 3 – 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: _____

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	Relationship & Date of Birth	Telephone #	Percentage
Primary Beneficiary				
Primary 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 _____

Part 4 – Working Spouse Form/ Fee

This form must be completed and returned with the enrollment application and certified marriage license

If your spouse is (1) employed, (2) eligible for group health plan by employer, and (3) declines the covered offered by his or her employer, you can elect to have the Fund provide primary coverage for your spouse if you pay the "Working Spouse Fee". The fee is $100 per month/ $23.08 per week and is in addition to your regular weekly employee premiums. If your spouse does not elect applicable coverage through their employer and you do not elect to pay the Working Spouse Fee, then the Plan will pay your spouse's claims on a secondary basis.

To be completed by you, the Member of this Plan		
Spouse's Name:		
Spouse's Employer (Company Name):		
Spouse's Social Security#:		
Is your spouse employed?	☐ Yes	☐ No
Is your spouse self-employed?	☐ Yes	☐ No
Effective date your spouse retired or became unemployed:		

To be completed by the Spouse's Employer

If your spouse has coverage available through his/her employer:

☐ My spouse has elected coverage through his/her employer and I understand this Fund will provide secondary coverage.

☐ My spouse has declined coverage through his/her employer. I elect to pay the Working Spouse Fee of $100 per month. I consent to having this fee collected by my employer via payroll deduction.

☐ My spouse has declined coverage through his/her employer. I elect not to pay the Working Spouse Fee. I understand that this Fund will provide secondary coverage for my spouse and estimate primary coverage, if elected, would pay 80% of allowable charges.

If your spouse is not employed or does not have coverage available through his/her employer:

☐ My spouse is unemployed or has no health coverage available through his/her employer. I understand that this Fund will provide primary coverage for my spouse.

Name Spouses Company:	**Name of Spouses Insurance:**
Effective Date of Spouses Insurance:	
Phone Number of above Owner or Benefits/HR Administrator:	

I hereby certify that the information provided is correct. I understand that any misrepresentation in the information I have provided above will permit South Central UFCW Unions & Employers Health & Welfare Fund to terminate the spouse 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 South Central UFCW Unions & Employers Health & Welfare Fund. I also understand that if my spouse becomes eligible for medical coverage from his or her employer during the plan year I must notify the Plan Administrator. I understand if my spouse is/was eligible through their employer and I have not been charged the applicable surcharge, I will be responsible for all charges for the amount of time my spouse was covered and eligible under their employer's plan.

Employee Signature:

Date:

Part 5 – Privacy Authorization Form

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: **ACS on behalf of South Central H&W Fund.**

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
___Other, please list if applicable: _____

___Performed Procedure
___Lack of Claim Payment
___Benefit Eligibility
___Medical Records (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 legally authorizes them to act in your behalf must be attached to this form.