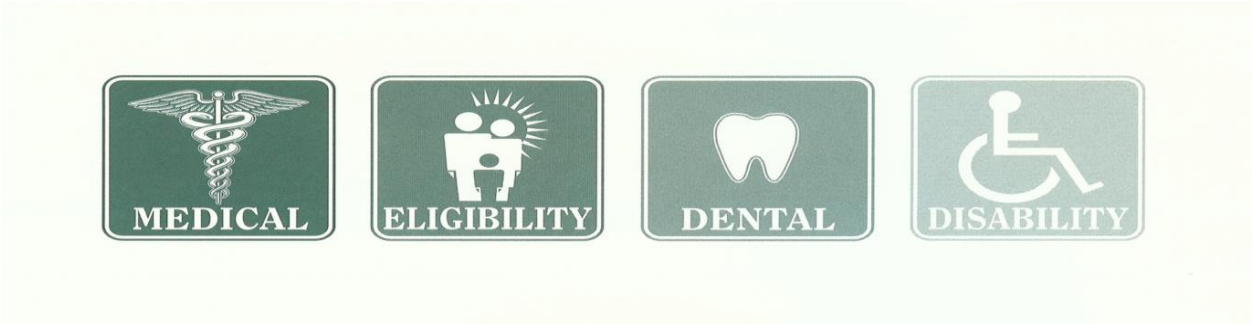
UNITED FOOD AND COMMERCIAL WORKERS LOCAL NO. 1529 AND EMPLOYERS' HEALTH AND WELFARE PLAN AND TRUST

BENEFITS AND ENROLLMENT BOOKLET

For Benefit Year 2024

Please reference your Plan's Summary Plan Description (SPD) Booklet and Summary of Benefits and Coverage (SBC) Booklet for all 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.

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 another 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.

Table of Contents

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
Upload: www.bams.bz

Important! **This benefit booklet provides an overview of your benefits; this booklet does not provide a complete description of your benefits. For example, this booklet does not describe the limitations and exclusions applicable to your benefits. For a more thorough description of your benefits, please review the Plan Document.**

IN THE EVENT OF A CONFLICT BETWEEN THIS BENEFIT BOOKLET AND THE TERMS IN THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL CONTROL.

HEALTHCARE REFORM – Affordable Care Act

GRANDFATHERED STATUS:

The Trustees believe that the United Food and Commercial Workers Union Local 1529 and Employers Health & Welfare Plan and Trust (the "Plan") 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 the 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, there are currently three Benefit Options:

Plan A: Employees on payroll and qualified as of July 1, 2001, shall continue to be eligible for the plan identified by the Health and Welfare Plan & Trust as Plan A. **(Closed Plan). At each Open Enrollment, these employees can choose to elect coverage in Plan B or Plan C as opposed to Plan A, thereby reducing the required weekly employee premium. If a Plan A eligible employee elects to enroll in Plan B or Plan C, the employee can elect Plan A during a future Open Enrollment period.**

Plan B: Full and part-time employees on the payroll and qualified after July 1, 2001, shall be eligible for a schedule of benefits identified as Plan B. **At each Open Enrollment, these employees can choose to elect coverage in Plan C as opposed to Plan B, thereby reducing the required weekly employee premium. If an election is made to enroll in Plan C, the employee can elect Plan B during a future Open Enrollment period.**

Plan C: Full-time employees hired after July 1, 2005 and part-time employees hired after January 1, 2005, shall be eligible for a schedule of benefits identified as Plan C. **After thirty-six (36) months of Plan C eligibility, the employee will be eligible to elect Plan B, otherwise they will remain in Plan C. If an election is made to stay in Plan C or enroll in Plan B, the employee can elect either Plan B or Plan C during a future Open Enrollment period. Employees will have 60 days to enroll in Plan B from the date they qualify to enroll in Plan B.**

When is Eligibility Effective?

All employees covered by the CBA will qualify for health coverage in accordance with the eligibility requirements outlined below. Effective March 1, 2020, employees will now become eligible for Medical, Prescription Drug, Dental, Vision, Life and Disability at initial eligibility. Article 15 of the CBA will be modified by the bargaining parties in accordance with the changes outlined in this document.

*All employees will become eligible for coverage by working the hours shown in the table below using the same "measurement" periods outlined in Article 15 of the contract for coverage in calendar years 2024.

Tier of Coverage*	**2024**
Employee Only Coverage	22 hrs/wk
Employee plus Child (ren)	30 hrs/wk
Employee plus Spouse	36 hrs/wk
Employee plus Spouse and Child(ren)	36 hrs/wk

Employees hired on or after January 1, 2021, must work 22 hours per week for employee only coverage, 30 hours per week for employee plus child(ren) coverage, 36 hours per week for employee plus spouse coverage, and 36 hours per week for employee plus family coverage using the standard twelve (12) month measurement period.

Qualifications for Plan A, B and C will not change, except for the hour's requirement and the 12-month measurement/stability period in the following paragraph.

Employees hired after January 1, 2021, will qualify for benefits using their average worked hours per week over 12 months.

Employees that qualify will maintain their benefits for a full 12 months, if they remain employed and are otherwise eligible for coverage. For each following benefit years, employees' average weekly hours will be measured from the beginning of first pay roll period in October through the last payroll period in September, using the standard twelve (12) month measurement period.

Ancillary Benefits:

Employees who lose coverage due to the change in hours will be offered dental, vision and life insurance coverage at a cost of $5 per week so long as they average 12 hours per week using the same measurement periods established for healthcare coverage as described above. (Employees hired on or after January 1, 2021 must work 12 hours per week using the standard twelve (12) month measurement period to be eligible for ancillary benefits). Ancillary benefits are available for those associates who lose coverage and work less than 18 hours in 2020 and 20 hours in 2021 but at least 1 2 hours per week in either 2020 or 2021 in accordance with the chart above.

*Depending on your date of hire, the 12-hour work requirement may not apply. Please contact the Fund Office if you have questions about this.

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.*

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. 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.

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.

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.

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 must provide proof of their eligibility by providing the Required Documents listed in the Enrollment Matrix. Employees have 30 days to enroll due to a Qualifying Life Event and 60 days under Special Enrollment Rights.

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 Underage 26	Enrollment Application/Change Form Other Coverage Questionnaire PHI Form Government Issued Birth Certificate (including parents 'names) 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 Underage 26	Enrollment Application/Change Form Other Coverage Questionnaire PHI Form Government Issued Birth Certificate (including parents' names) 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 Stepchild, 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 Government Issued Birth Certificate (listing parents' names) 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 Government Issued Birth Certificate naming your child as the grandchild's parent. A copy of your child's Government Issued 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 Underage 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 *Court orders must include Judge's signature	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 Court-issued divorce decree or legal separation documentation (including date of divorce/separation, judge's signature, and employee name) OR Death Certificate	The date of qualifying event

Enrollment/Change Type	Eligibility Criteria	Documents Required for Verification	Effective Dates
Qualifying Life Event: Change in Dependents Covered	Birth, Death, Adoption, Placement for adoption, Award of Legal Guardianship, Loss of Other Coverage	See above for required documents for adding OR removing dependents based on a Qualifying Life Event.	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.

***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 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.**

Weekly Premium - 2024	Plan A (With Incentive)	Plan A (No Incentive)	Plan B (With Incentive)	Plan B (No Incentive)	Plan C (With Incentive)	Plan C (No Incentive)
EE Only	$19.00	$29.00	$17.00	$27.00	$15.00	$25.00
EE + CH	$28.00	$38.00	$23.00	$33.00	$20.00	$30.00
EE + SP	$35.00	$45.00	$29.00	$39.00	$26.00	$36.00
EE + FM	$42.00	$52.00	$32.00	$42.00	$29.00	$39.00
Ancillary Only	$5.00		$5.00		$5.00	
WSP (Monthly)	$46.15 ($200 per month)		$46.15 ($200 per month)		$46.15 ($200 per month)	

MEDICAL BENEFITS	PLAN A		PLAN B		PLAN C	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Your coinsurance	15%	50%	20%	50%	25%	50%
Annual deductible	$600/$1,200		$600/$1,200		$750/$1,500	
Out-of-Pocket Max	$6,000/$12,000	None	$6,000/$12,000	None	$6,000/$12,000	None
Primary Care Office Visit	$35	50% after deductible	$35	50% after deductible	$35	50% after deductible
Specialist Office Visit Coinsurance	15%		20%		25%	
Urgent Care	$35		$35		$35	
Emergency Room	$125 copay plus 15% coinsurance after deductible		$125 copay plus 20% coinsurance after deductible		$125 copay plus 25% coinsurance after deductible	

*__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 and Plan Document 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) …… **IRS mileage rate in effect at the time of travel.**
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

		Effective 1/1/2024
Spouse/Dependent Care		Yes
Annual Deductible		$50/$150
Preventive/Diagnostic Coverage		100%
Basic Coverage		80%
Major Coverage (excluding implants, cosmetic, and replacements for lost, misplaced, or stolen bridges or dentures)		80%
Annual Maximum		$1,500 (per person)
Waiting Period		Based on eligibility
Orthodontic Coverage		Children under age 19 only
Orthodontic Deductible		None
Orthodontic Coverage		80%
Orthodontic Lifetime Maximum		$1,250

*The dental fee schedule paid 80% of usual and customary charges.

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 participating 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

***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.**

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.

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

VISION PLAN LIMITATIONS AND EXCLUSIONS

- Orthoptist 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 because 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 sanglasses
- 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 cease 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 another 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.

PRESCRIPTION DRUG PLAN

The prescription drug plan vendor is Elixir

Copays, the portion of the drug cost that you are responsible to pay, are listed in the table below.

Please note that drugs classified as Maintenance Medications require a 90 day fill at Kroger pharmacy only.

Prescription Benefits	All Plans	
Retail	30 Days	90 Days
Generics	Greater of $10 or 10% with a max of $20	Greater of $28 or 10% with a max of $56
Preferred Brand	Greater of $20 or 20% with a max of $50	Greater of $42 or 15% with a max of $140
Non-Preferred Brand	Greater of $35 or 30% with a max of $75	Greater of $70 or 10% with a max of $210
Specialty Drug	Cost dependent on type of drug (generic, preferred, or non-preferred)	
Mail Order	30 Days	90 Days
Generics	Not Covered	Greater of $25 or 10% with a max of $40
Preferred Brand	Not Covered	Greater of $50 or 15% with a max of $100
Non-Preferred Brand	Not Covered	Greater of $75 or 25% with a max of $150
Specialty Biosimilar	8% with a max of $100	
Specialty Brand Formulary	15% with a max of $250	
Specialty Non-Formulary	25% with a max of $400	
Out-of-Pocket Max	$5,000/$10,000	

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 Elixir Customer Care at 1-800-361-4542.

Mail Order Pharmacy Services

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 Elixir Mail. You may use any of the following 3 easy registration options:

1. **Online: (Recommended method)** Visit www.elixirsolutions.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 Elixir Mail Customer Service at 1-866-909-5170 to speak with a representative.
3. **Mail:** Complete the Registration and Prescription Order Form. You can call Elixir Mail Customer Service to request the Form.

Once registered, your physician can fax your prescription(s) to Elixir Mail 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

Your Elixir benefits include a program to provide you with a FREE blood glucose monitoring device (glucometer). To take advantage of this offer, call 866-224-8892 for an Abbott Diabetes Care FreeStyle Glucometer (FreeStyle Lite® Meter, FreeStyle Freedom Lite® Meter, FreeStyle InsuLinx® Meter) or Precision Xtra® Blood Glucose & Ketone Monitoring System (Precision Xtra® Meter) or call 866-868-8425 for a OneTouch Glucometer (Verio Meter, Verio IQ Meter, Verio Sync System. **Please identify Elixir as your pharmacy benefits administrator**. Limit of one glucometer per member.

Questions and Appeals.

If you have a question or need assistance, please call Elixir Customer Care. Please refer to the SPD or contact your Plan Administrator for instructions on how to file an appeal. If you have any questions regarding your prescription drug benefit, please call the Elixir Rx Customer Service Help Desk at 1-800-361-4542.

SHORT TERM DISABILITY INCOME BENEFIT

Loss of Time Benefit for Active Employees

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

Amount of Weekly Benefit…….66 – 2/3% of weekly earnings up to a maximum weekly benefit
Waiting Period for Injury or 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.

WEEKLY BENEFIT PAYABLE

Employees working 12-35 hours per week, the maximum benefit is $175 per week.
Employees working greater than 36 hours per week, the maximum benefit is $350 per week.

*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) to be unable to perform the duties of your employment.
- ✓ You are under the direct and continuing care of a physician.
- ✓ The disability is continuous and
- ✓ The disability extends beyond the expiration of the waiting period, if any. Your disability must be certified by a physician, and you 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, short term 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 your eligibility date, the date your employer contributes for you**
2. **Qualifying Life Event – 30 days from a Qualifying Life Event (marriage, birth of a child)**
3. **Plans Annual Open Enrollment Period**

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

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	Phone Number	Email Address	Name of Employer(s)	Are you Retired from any Employer?
MALE / FEMALE				☐ Yes, Date of Retirement___/__/____ ☐ 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

☐ 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	Gender	Are you Adding or Removing?	Date of Event

SECTION 6: COORDINATION OF BENEFITS (COB):

Do you or anyone you would like to add to this Plan have other health insurance? Yes ☐ or No ☐ If you answer yes, please complete section below. If the other coverage has terminated, you must submit a letter of credible coverage to the benefits office listed above. You are responsible for requesting this letter from the other insurance provider. If you answer "Yes" please attached a copy of that Provider's COB rules

Name of Insurance Company: _____ Effective Date: _____Policy Holder's Name: _____

Name of Covered Individuals: _____Benefits Included in Other Coverage: Medical ☐ Dental ☐

If Medicare ☐ **Part A** ☐ **Part B** ☐ **Part D** **Medicare Effect Date:** **Medicare HICN:**

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

Initial if you would like to Opt-In to receiving email and or text communication from the Fund _____

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: _____**

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 ☐ Stepparent ☐
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 stepparent have family insurance coverage? Yes_____ No_____,
13. If Yes is anyone on your policy covered by the stepparent'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 (complete below if you have Medicare Part A, B or D or any advantage plan through Medicare)

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 those 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 # (___) _____--_____ 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) _____
Initial if you would like to Opt-In to receiving email and or text communication from the Fund _____

Primary Beneficiary(ies): (LIST BELOW)

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 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 _____

Wellness Affidavit Form

Instructions: Provide this Form to the Medical Professional that completes your exam, then send your form to the Fund office.
Wellness Incentive: Employees that return this form completed will receive a $10.00 weekly premium discount.
Due Date: During Open Enrollment, forms are due by the Open Enrollment close date. New eligible employees have 60 days to complete enrollment.

Step 1: Employee Complete	
Employee's Name	Date of Birth (MM/DD/YYYY)
Employee ID	
Employee Phone	Employee Email Address
	Do you Opt-in to Electronic Communication? Yes or NO
Participant Signature	Date Signed

Step 2: Medical Professional Complete	
Blood Pressure	Please check ( ) YES Reading _____
BMI	Please check ( ) YES Reading _____
Total Cholesterol	Please check ( ) YES Reading _____
Blood Sugar	Please check ( ) YES Reading _____
Medical Professional Signature	Date Signed
Medical Professional's Name (Please Print)	UPIN/NPI/EIN
Address	Phone Number

Step 3: Employee Return Form to:
UFCW Local 1529 & Employers H&W Plan & Trust **661 North Ericson Road** **Cordova, TN 38018** **Fax to 901-758-3021** **Upload to www.bams.bz**

Choose an In-Network provider and the visit is covered 100% under Preventive Care!
Options include but are not limited to Kroger Pharmacy, The Little Clinic, Primary Care Doctor, Family Practitioner

United Food and Commercial Workers Lo. Union 1529
and Employers Health and Welfare Plan & Trust ("The Plan")

SPOUSE SURCHARGE WILL BE EFFECTIVE JANUARY 1, 2021

Employees may choose to have their spouse covered under the Plan; however, there will now be a required monthly payment requirement (a surcharge) that will apply for those spouses who have access to other employer sponsored coverage but who still wish to enroll in coverage under this plan. **EMPLOYEE SPOUSES WHO HAVE ACCESS TO OTHER COVERAGE WILL ONLY BE ELIGIBLE FOR SECONDARY COVERAGE UNDER THIS PLAN SUBJECT TO ALL APPLICABLE CONTRIBUTIONS.** For your spouse to have full coverage, they will need to enroll in their own employer sponsored plan.

Employees with spouses who do not have access to other employer sponsored coverage are exempt from the $200.00 (per month) payment requirement upon execution of the below required spousal affidavit. In addition, employees with spouses working for Kroger will also be able to waive this contribution.

The spouse surcharge will be deducted automatically from your paycheck if you have a spouse covered under your medical plan. To make a change due to a qualifying life event, your will have 30 days from the date of the qualifying event to make sure election.

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:		

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

☐ My spouse has elected coverage through his/her employer. I elect to pay the Working Spouse Fee of $200 per month. I consent to having this fee collected by my employer via payroll deduction 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 $200 per month. I consent to having this fee collected by my employer via payroll deduction. I understand that this Fund will provide secondary coverage for my spouse.

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 UFCW Local 1529 and Employers Health & Welfare Plan & Trust 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 UFCW Local 1529 and Employers Health & Welfare Plan & Trust. 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:

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_____/_____/_____.

*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.