Fund-amentals

UFCW NATIONAL HEALTH AND WELFARE FUND
small enough to care...BIG enough to make a difference!®

Issue No. 57 Spring 2021

SPECIALTY DRUGS – FUND ENHANCEMENT AS OF JULY 1, 2021

George J. Orlando
Chairman

We have previously written about Specialty Drugs in this newsletter. Due to a change coming on July 1, 2021, we want to update you on the action the National Fund is taking. First, let's define what we mean by specialty drugs in general terms:

1. They are expensive!
2. Many are injectable drugs and require special handling (refrigeration, infusion)
3. They treat complex, uncommon or rare diseases.
4. They are often developed from biological sources (living and not just chemical)
5. They are expensive! (Many cost $600 per month or more.)

It is well known that over the past few years there has been great progress made in treating Hepatitis C, Rheumatoid Arthritis, Multiple Sclerosis, Anemias and Cancer. Many of these breakthrough drugs are specialty drugs with huge cost components. The use of specialty drugs now accounts for almost 55% of all the dollars spent on drugs by the National Fund.

These drugs are not a good thing…they are a great thing and among the most spectacular achievements in modern medicine. But, they do come at a high cost, so it is important that they are used correctly. Tests are being developed to determine which drug will work for a specific individual and which drug might not be as effective. The National Fund uses a prior authorization procedure (similar to Pre-Certification for x-rays and scans) to make sure that the drug is verified for use for a specific individual and condition. These drugs are dispensed by a special division of the National Fund's Prescription Benefit Manager (PBM) to insure the special handling and conditions necessary.

But are they affordable? The major issue we have to face is the very high co-payment due to the cost of the drugs regardless of what Plan of Benefits is in force. A maximum member co-payment is reached, often making the drug unaffordable. The National Fund's Patient Assistance Program with our partners Payer Matrix and EmpiRx is designed to assist in this regard to decrease the co-payment significantly – sometimes to $0!

Members on these Specialty Drugs or for those who will be prescribed them, will be required as part of the Prior Authorization Protocol to apply for the patient assistance program in the hope that it will decrease their co-pay. We hope that many will be eligible for the program, but if they apply and are not eligible for the Patient Assistance Program, they will still be covered under their Plan of Benefits. The National Fund and its partners will work diligently to provide the best benefits possible.

■

JOIN THE HERD

Herd immunity or community immunity occurs when enough people become immune to a disease to make its spread unlikely. If enough people are resistant to the cause of a disease, such as a virus or bacteria, it has nowhere to go. While not every single individual may be immune, the group as a whole has protection. This is because there are fewer high-risk people overall. The infection rates drop, and the disease peters out.

As a result, the entire community is protected, even those who are not themselves immune. Herd immunity is usually achieved through vaccination, but it can also occur through natural infection

Herd immunity protects at-risk populations. These include babies and those whose immune systems are weak and can't get resistance on their own.

Herd immunity depends on the contagiousness of the disease. Diseases that spread easily, such as measles, require a higher number of immune individuals in a community to reach herd immunity.

Herd immunity protects the most vulnerable members of our population. If enough people are vaccinated against dangerous diseases, those who are susceptible and cannot get vaccinated are protected because the germ will not be able to "find" those susceptible individuals.

The percentage of people who need to be immune in order to achieve herd immunity varies with each disease. For example, herd immunity against measles requires about 95% of a population to be vaccinated. The remaining 5% will be protected by the fact that measles will not spread among those who are vaccinated.

For polio, the threshold is about 80%. The proportion of the population that must be vaccinated against COVID-19 to begin inducing herd immunity is not known, but experts estimate that herd immunity would require around 80-90% of the population to have COVID-19 immunity, either through prior infection or vaccination. That's why experts are encouraging the public to get the COVID-19 vaccine. ■

SPECIALITY DRUG – COST AVOIDANCE PROGRAM – THROUGH PAYER MATRIX AND EMPIRX

The UFCW National Health and Welfare Fund has initiated a cost avoidance program coordinated through Payer Matrix for specialty drugs. The goal of the program is helping you avoid any out-of-pocket expense for specialty medications and decrease the cost to the National Fund, if possible. If you are currently taking or have been prescribed most specialty drugs (these are the impacted drugs involved), you are required to apply to participate in the Payer Matrix program. The program will help you enroll in any applicable alternate funding programs for your eligible drug therapy.

If you are eligible to participate in the Payer Matrix program, you will receive a telephone call to your current telephone number on file with the Fund office, or a letter by mail, outlining the enrollment process.

As a first step, Plan members or their providers are required to send specialty medication prescriptions to EmpiRx as is the current process. While EmpiRx conducts the clinical prior authorization to ensure the medication is medically necessary for you, Payer Matrix conducts an administrative review to locate an alternate payer for you and the specific specialty medication you need. Payer Matrix and/or your Plan will assist you throughout the process, from enrollment to your receipt and use of your medication.

If you do not apply, or are eligible for a Payer Matrix identified alternate funding program and choose not to enroll in the program, you will be responsible for the full cost of your applicable specialty drug prescription. You will get no benefit from the National Fund, and this expense will not count toward your annual out-of-pocket maximum.

If you are not eligible after applying for any alternate funding program through Payer Matrix for any Specialty Drug prescription covered by the Plan, Payer Matrix will work with EmpiRx and you will receive your drugs with all your Plan provisions in force. Your cost would be the same, subject to the standard covered specialty drug copay/coinsurance as outlined by the Plan. ■

FROM THE FUND OFFICE

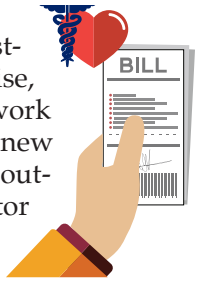
Maurice Hodos
Fund Administrator

SURPRISE MEDICAL BILLS – HELP IS ON THE WAY

Staying with in-network providers in your health Plan is known to be the most effective way to decrease your out of pocket costs. Surprise medical bills occur when patients cannot avoid getting services from out of network providers. This happens when a patient does not choose an in-network provider, but more often when the patient is unaware or has little choice of provider. Common examples are anesthesiologists, emergency room physicians, radiologists and pathologists. Recent studies have shown that 20 percent of emergency department visits and resulting admissions at in-network facilities involved an out-of-network physician. We have written before in this publication that a patient must take every opportunity to ask their provider if they or the people/centers that they work with are in-network. This is usually fairly easy for determining the status of outpatient surgery centers, anesthesiologists and others scheduled for elective and non-emergency procedures.

In the closing days of 2020, Congress enacted, and the President signed into law the No Surprises Act, providing new federal consumer protections against surprise medical bills. The measure was included in omnibus legislation funding the federal government for fiscal year 2021 and providing stimulus relief for the COVID-19 pandemic. Its enactment followed nearly two years of Congressional debate over competing approaches to the problem that, at times, appeared to be deadlocked.

The No Surprises Act contains key protections to hold consumers harmless from the cost of unanticipated out-of-network medical bills. Surprise bills arise in emergencies – when patients typically have little or no say in where they receive care. They also arise in non-emergencies when patients at in-network hospitals or other facilities receive care from ancillary providers (such as anesthesiologists) who are not in-network and whom the patient did not choose.

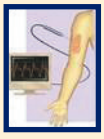
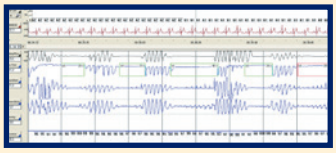


Starting January 1, 2022, it will be illegal for providers to bill patients for more than the in-network cost-sharing due under patients' insurance in almost all scenarios where surprise out-of-network bills arise, with the notable exception of ground ambulance transport. Health plans must treat these out-of-network services as if they were in-network when calculating patient cost-sharing. The legislation also creates a new final-offer arbitration process to determine how much insurers must pay out-of-network providers. If an out-of-network provider is dissatisfied with a health plan's payment, it can initiate arbitration. The arbitrator must select between the final offers submitted by each party, taking into consideration several factors including the health plan's historical median in-network rate for similar services.

The new law takes effect for health plan years beginning on or after January 1, 2022 and it applies to nearly all private health plans offered by employers (including grandfathered group health plans and the Federal Employees Health Benefits Program). It has many other provisions that you will be reading about over the next year and is complicated, but very welcome as this is one surprise no one enjoys. ■

PRE-AUTHORIZATION REQUIREMENT



Pre-authorization is required for CT Scans, MRIs, EMGs (nerve tests) and Sleep Apnea services. Your doctor must follow the instructions on your Medical ID card for approved services to be paid. Do not have these services without confirming that pre-authorization has been obtained to be sure your claim will be processed and paid.

FROM THE LEGAL DEPARTMENT

Larry Magarik
General Counsel

ERISA (the Employee Retirement Income Security Act of 1974) was a landmark reform of employee benefits law in the US.

Beginning in 1942, the Internal Revenue Code provided that pension plans were not to "discriminate" in favor of employees who are officers, shareholders, or highly compensated employees of a company sponsoring the plan. In 1947, Section 302(c)(5) of the Labor Management Relations Act (the Taft-Hartley Act) required that employee benefit plans administered by unions must have an equal number of management-appointed and union-designated trustees and be structured for the "sole and exclusive benefit" of covered employees and their families. In 1958, disclosure, bonding, and other provisions for employee benefit plans were established. After over a decade of hearings, Congress enacted the reforms embodied in ERISA in August of 1974 almost unanimously, and it was signed on Labor Day 1974. ERISA has been amended a number of times, but its structure has remained constant.

ERISA's Policy Declaration states that minimum standards to assure the equitable character and financial soundness of benefit plans is in the interest of employees and their beneficiaries. With certain exceptions (such as governmental plans) , ERISA's coverage extends to all employee benefit plans "established or maintained" by any employer or employee organization engaged in any industry or activity affecting commerce."

In enacting ERISA, Congress created minimum standards for pension plans, which are also tax-qualification requirements under the Internal Revenue Code by parallel amendments. ERISA also covers employee welfare benefit plans, such as group health, medical insurance, severance pay, disability and death benefit plans.

ERISA mandates disclosure , fiduciary duties; and covers enforcement. It also includes the"COBRA" rules that mandate group health insurance continuation coverage, and " HIPAA," ensuring health privacy. The Affordable Care Act added a number of minimum provisions as a floor to health insurance coverage.

As ERISA has been applied, a large body of regulations, rulings by the Department of Labor, and Court decisions has developed. Additionally, the actual experience and practice of plans and their greater complexity has added to the customs and standards of the law. The sum of all of these developments is what we call the "developing federal common law" of employee benefits. This framework is essential to an understanding of benefits law questions. ■

In these difficult and troubling times, we know that you are some of the FEW, and the Trustees and Staff want to say "Thank You"!

F - Friends, vendors and associates of the UFCW National Fund.
E - Employers providing exceptional benefits to their employees.
W - Workers' Local Unions for whom we are fortunate to serve and provide benefits.

UFCW NATIONAL HEALTH AND WELFARE FUND
small enough to care...BIG enough to make a difference!®

MEDICAL CORNER

Norman H. Kupferstein, M.D.
Medical Director

WHAT NEXT

At this point, most members that want a vaccine have either gotten the vaccine Or will get it shortly.

The data suggest the covid-19 vaccines presently used in the United States provide Protection from infection for at least 6 months.

So what will be afterwards? It has become apparent that a booster vaccine is being considered. Pfizer CEO Albert Bouria indicated that people are likely to need a third Dose of the Pfizer vaccine within a year, and may need an annual shot. At the same time, Moderna CEO Bancel indicated that people who received the Moderna vaccine will likely need a third dose after 6 to 12 months. He, further said, that the booster shot will be available in the United States by the fall.

Researchers of both vaccines are still investigating what the proper timing of this booster shot would be and ascertaining how it would affect the pandemic. The main concern, in light of the new variant strains of covid-19, is making sure that all Vaccines are effective against all strains. At present, the current vaccines are effective against the known strains. The idea is to prevent the pandemic from becoming an endemic.

Dr. Fauci emphasized that it is public health, and not the drug companies, which will determine the need and timing for the booster vaccine. That will depend on when it is felt that protection is low thereby enabling breakthrough infections.

The timing of the booster vaccine will become more apparent towards the end of the summer. By then, it will be around 1 year since the phase 3 trial (which all drugs and vaccines require). ■

WHEN IS THE BEST TIME TO TAKE VITAMINS?

Since many of us take vitamins, we have asked the experts as to what is the best time to take them. The following are general rules that several physicians and nutritionists have advised so as to obtain maximum absorption and support your nutritional needs.

Vitamin C and Vitamin B12: Because these are water soluble vitamins, it is best to take them with water, and for B-12, in the morning so it won't affect your sleep.

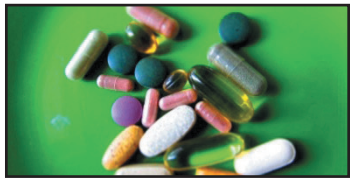
Vitamin A, D, E, and K: These are fat soluble vitamins which require fat for best absorption. The best time to take them is after you have eaten foods containing fat – even a minimal amount like milk, yogurt, food cooked with oil, etc.

Multivitamins – Because they may contain water and fat soluble vitamins, they should be taken with food and a water based beverage although the absorption will not be as optimal for the water based vitamins as opposed to the fat based.

Prenatal Vitamins: These are best started before you become pregnant, and taken with water and a meal for optimum absorption. We will leave it up to you to figure that out! Don't forget to add Folic Acid, too.

Calcium: Although it is a mineral, and not a vitamin, many people take it to decrease bone loss and osteoporosis. There are two basic types: Calcium carbonate – this should be taken with a meal as it requires acid in the stomach to be properly absorbed. Calcium citrate – can be taken and absorbed with or without food.

If you eat a nutritious, balanced diet, you may not need supplements. As in all cases when there is a question about your health, a good conversation with your physician or nutritionist can give you the best advice. ■



UFCW NATIONAL HEALTH AND WELFARE FUND SUMMARY ANNUAL REPORT

SUMMARY ANNUAL REPORT FOR PERIOD
OCTOBER 1, 2019 TO SEPTEMBER 30, 2020

TO: ALL PLAN PARTICIPANTS

FROM: THE TRUSTEES

This is a summary of the annual report for the UFCW National Health and Welfare Fund, Employer Identification Number 22-1458594 Plan No. 501, for the period October 1, 2019 to September 30, 2020. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The plan has committed itself to pay all health, disability, dental, prescription drug, death and vision benefits claims incurred under the terms of the plan.

INSURANCE INFORMATION

The plan has a contract with the U.S. Fire Insurance Company to pay stop loss claims incurred under terms of the plan. The total premiums paid for the plan year ending September 30, 2020 were $1,523,650.

BASIC FINANCIAL STATEMENTS

The value of plan assets, after subtracting liabilities of the plan, was $81,769,754 as of September 30, 2020 compared to $72,696,559 as of October l, 2019. During the plan year, the plan experienced an increase in its net assets of $9,073,195. This increase includes unrealized appreciation or depreciation in the value of the plan's assets, that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $151,595,646 including employer contributions of $144,605,040, participant contributions of $1,517,376, realized loss from the sale of assets of ($412,745), earnings from investments of $5,737,792 and other income of $148,183.

The plan had total expenses of $142,522,451 including $137,340,173 in benefit payments and $5,182,278 in administrative expenses.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report, or any part thereof, upon request. The items listed below are included in that report:

An accountant's report.

Financial information and information on payments to service provides.

Assets held for investment.

Transactions in excess of 5 percent of plan assets.

Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of:

UFCW NATIONAL HEALTH AND WELFARE FUND
66 Grand Avenue, Englewood, NJ 07631-0751
(201) 569-8801

The charge to cover copying costs will be determined by the administrator.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of the income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover the copying costs does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan:

UFCW NATIONAL HEALTH AND WELFARE FUND
66 Grand Avenue, Englewood, NJ 07631-0751

or at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department of Labor should be addressed to:

PUBLIC DISCLOSURE ROOM, N-1513
EMPLOYEE BENEFITS SECURITY ADMINISTRATION
U.S. DEPARTMENT OF LABOR
200 CONSTITUTION AVENUE, N.W.
WASHINGTON, DC 20210

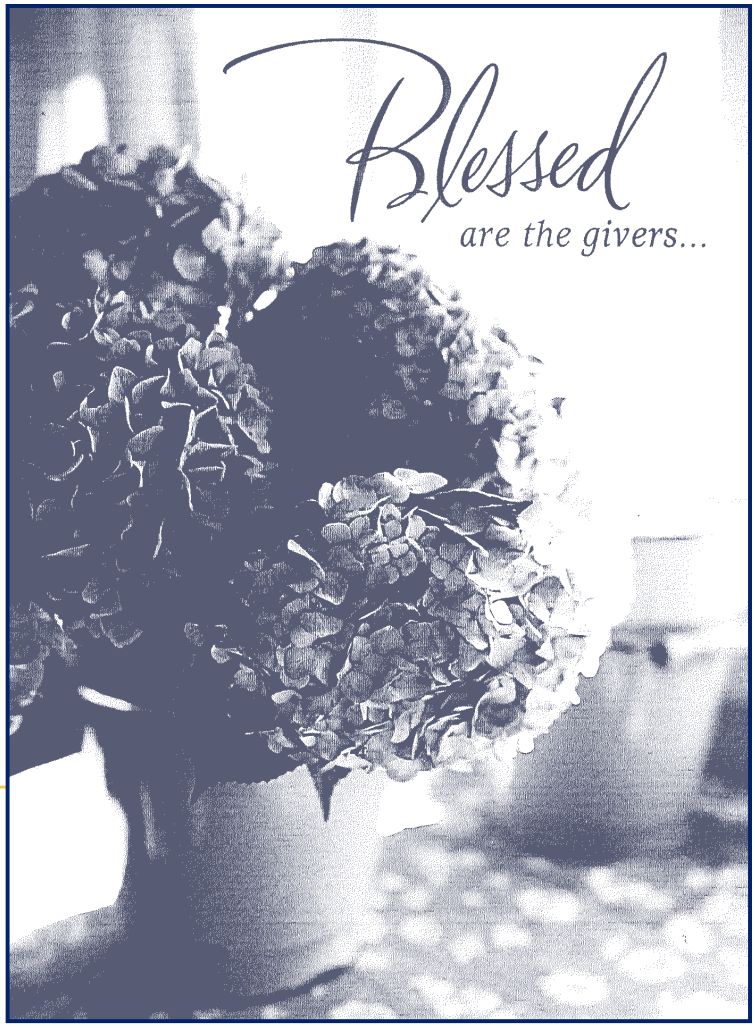
■

Our job is to help our participants, and a thank you is never necessary. But sometimes we want to share our "feel good" moment and we want to say 'Thank You" for recognizing what we do.

"Thank you" isn't enough for all the support and work you put into case. Cancer is such a scary illness that overwhelms and breaks the heart of family and friends. You gave me support so many times when I was terrified and felt so alone facing my husband's illness. I thank you with my whole heart for every phone call, every conversation and every bit of advice. May God Bless you for being so caring

And grateful
are the receivers.

Thank you so much.



TELEHEALTH SERVICES

The National Fund is waiving member cost-sharing obligations for covered telemedicine services provided by in-network physicians during the Federally mandated State of Emergency. This waiver applies to eligible telehealth services for any covered purpose including the diagnosis or treatment of COVID-19, routine care or mental health care. In-network claims are to be paid at 100% of the eligible, allowable amount with no member balance. ■

WHEN YOUR LIFE CHANGES BECAUSE OF

Marriage, birth of a child, adoption of a child, divorce, death, Medicare eligibility, or for a change of name or of your life insurance beneficiary. Please inform the Fund Office within 30 days of the event to protect your benefits. 1-201-569-8801.

TREATMENT DELAYS

FROM ROTTEN TEETH TO ADVANCED CANCER, PATIENTS FEEL THE EFFECTS OF TREATMENT DELAYS

*By **Bruce Alpert** APRIL 20, 2021, The Washington Post*

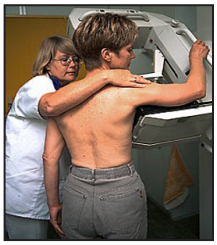
With medical visits picking up again among patients vaccinated against covid-19, health providers are starting to see the consequences of a year of pandemic-delayed preventive and emergency care as they find more advanced cancer and rotting and damaged teeth, among other ailments.

Dr. Brian Rah, chair of the cardiology department at Montana's Billings Clinic, was confused in the early days of the covid pandemic. Why the sudden drop in heart attack patients at the Billings Clinic? And why did some who did come arrive hours after first feeling chest pains?

Two patients, both of whom suffered greater heart damage by delaying care, provided what came to be typical answers. One said he was afraid of contracting covid by going to the hospital. The other patient went to the emergency room in the morning, left after finding it too crowded, and then returned that night when he figured there would be fewer patients — and a lower risk of catching covid.

"For a heart attack patient, the first hour is known as the golden hour," Rah said. After that, the likelihood of death or a lifelong reduction in activities and health increases, he said.

Dr. JP Valin, executive vice president and chief clinical officer at SCL Health of Colorado and Montana, said he is "kept awake at night" by delays in important medical tests. "People put off routine breast examinations, and there are going to be some cancers hiding that are not going to be identified, potentially delaying intervention," he said.



Valin is also concerned that patients aren't seeking timely treatment when suffering appendicitis symptoms like abdominal pain, fever and nausea. A burst appendix generally involves more risk and a week's hospitalization, instead of one day of treatment for those who get care quickly, he said.

Dr. Fola May, a gastroenterologist who is also quality director and a health equity researcher at UCLA Health, worries about the consequences of an 80% to 90% drop in colonoscopies performed by the health system's doctors during the first months of covid.

"All of a sudden we were downplaying health measures that are usually high-priority, such as trying to prevent diseases like cancer, to manage the pandemic," May said.

Along with exacerbating existing health problems, the covid pandemic has also caused a host of new medical issues in patients. The American population will be coming out of the pandemic with teeth worn down from grinding, back problems from slouching at makeshift home-work stations and mental health problems from a combination of isolation and being too close to family.

Dr. Despina Markogiannakis, a dentist in Chevy Chase, Maryland, said patients don't argue when she tells them they have been grinding or clenching their teeth and might require a root canal procedure, dental implant or night guard.

"These are people stuck at home all day and feeling lonely and feeling a little depression. It is induced by the world we live in and all the changes in our lives," said Markogiannakis.

A recent American Dental Association survey found that more than 70% of member dentists reported an increase in patients grinding or clenching their teeth since covid. More than 60% reported an increase in other stress-related conditions, such as chipped and cracked teeth.

Dr. Gerard Mosby, a Detroit pediatrician, finds his young patients are suffering more stress, depression and weight gain than before the pandemic. They are confined in their homes, and many are living in multigenerational homes or foster homes or have experienced covid illnesses or death among family members.

"Since their ability to get out is limited, they can't vent to friends or other family members. Also, most will not have access to mental health for grief counseling," Mosby said.

Nancy Karim, a Bridgeport, Connecticut, licensed professional counselor and art therapist, said that, in addition to struggling with isolation, her patients are conversely stressed by living too closely with people without the benefit of breaks on work and school days.

Physical therapy needs are also on the rise.

"Patients that have transitioned to remote work are typically working with poor ergonomic set-ups and spending a lot more time sitting," said Kaylee Smith, founder and president of Smith Physical Therapy and Performance Studio in San Diego.

"I am seeing more pain and injuries related to poor posture (i.e., neck pain, low back pain, etc.) and a significant increase in patients coming in with tight hips related to increased sitting time," Smith said in an email.

Some providers report they are finally nearing pre-covid patient levels, but others still face covid resistance.

"Although we have seen an improvement over the past six weeks, it's still not much," said Neville Gupta of Gupta Gastro in Brooklyn and Far Rockaway, New York. "Our patients are still avoiding getting the care they need, no matter the safety precautions in place." ■

SUMMARY OF MATERIAL MODIFICATIONS

To: All Participants in the UFCW National Health and Welfare Fund Plans of Benefits

From: Maurice Hodos, Fund Administrator

Re: Change in Benefits for Specialty Drug Cost Avoidance Program

Date: Effective July 1, 2021

This document is a Summary of Material Modifications ("Summary") intended to notify you of important provisions in the UFCW National Health and Welfare Fund Plans of Benefits (You should take the time to read this Summary carefully and keep it with the copy of the Summary Plan Description that was previously provided to you. If you need another copy of the Summary Plan Description or if you have any questions regarding the Plan, please contact the Fund Office during normal business hours at 66 Grand Avenue, Englewood, NJ 07631, 1-888-773-8329 or visit our website at www.ufcwnationalfund.org.

The UFCW National Fund Health and Welfare Fund, has initiated a cost avoidance program coordinated through Payer Matrix for specialty drugs. The goal of the program is helping you avoid any out-of-pocket expense for specialty medications and decrease the cost to the National Fund, if possible. If you are currently taking or have been prescribed most specialty drugs (these are the impacted drugs involved), you are required to apply to participate in the Payer Matrix program. The program will help you enroll in any applicable alternate funding programs for your eligible drug therapy. If you are eligible to participate in the Payer Matrix program, you will receive a telephone call to your current telephone number on file with the Fund office, or a letter by mail, outlining the enrollment process.

As a first step, Plan members or their providers are required to send specialty medications prescriptions to EmpiRx as is the current process. While EmpiRx conducts the clinical prior authorization to ensure the medication is medically necessary for you, Payer Matrix conducts an administrative review to locate an alternate payer for you and the specific specialty medication you need. Payer Matrix and/or your Plan will assist you throughout the process, from enrollment through your receipt and use your medication.

If you do not apply, or are eligible for a Payer Matrix identified alternate funding program and choose not to enroll in the program, you will be responsible for the full cost of your specialty drug prescription. You will get no benefit from the National Fund, and this expense will not count toward your annual out-of-pocket maximum. If you are not eligible after applying for any alternate funding program through Payer Matrix for any Specialty Drug prescription covered by the Plan, Payer Matrix will work with EmpiRx and you will receive your drugs with all your Plan provisions in force. Your cost would be subject to the standard covered specialty drug copay/coinsurance as outlined by the plan.

This Summary of Material Modifications is intended to provide you with an easy-to-understand description of certain changes to the Summary Plan Description. The Summary Plan Description previously provided to you also serves as the Plan Document. While every effort has been made to make this description as complete and as accurate as possible, this Summary of Material Modifications, of course, cannot contain a full restatement of the terms and provisions of the Plan. The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan. ■

MEDICAL SERVICES REQUIRING PRIOR AUTHORIZATION

The following medical services require prior authorization by the National Fund by calling the Fund Office (West Coast – 1-800-821-1222, East Coast – 1-888-773-8329).

- All Outpatient Magnetic Resonance Imaging (MRIs), Computerized Tomography or Computed Axial Tomography Imaging (CT or CAT Scans) and Electromyograms (EMG) Testing and studies (except when ordered by a surgeon prior to back surgery), Sleep Apnea (studies, treatment, devices, test, surgery or any services related to sleep disorders).

If the particular course of treatment or medical service is not certified/authorized, it means that the Plan may not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. Failure to obtain prior authorization for the required medical services, and procedures listed above may will result in a reduction or denial of benefits when your claim is received for processing.

The following medical services require pre-certification by the National Fund's Case Managers, Conifer Health Solutions or HealthSmart Care Management:

- Organ Transplants
- Private Duty/Skilled Nursing
- Home Health Care
- Inpatient Hospital Confinements

Providers must call the Case Manager's number listed on the back of the member's ID Card to obtain pre-certification before the medical procedure; service or course of treatment is actually performed. The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or substitute for the medical judgment of the attending physician or other health care provider. ■

SUN PROTECTION FACTOR EXPLAINED

IN BRIEF

SPF measures sunscreen protection from UVB rays, the kind that cause sunburn and contribute to skin cancer.

SPF does not measure how well a sunscreen will protect from UVA rays, which are also damaging and dangerous.

Dermatologists recommend using a **SPF15 or SPF30 sunscreen**. Higher SPFs don't provide much more protection.

What is SPF Sunscreen?

SPF, or **Sun Protection Factor**, is a measure of how well a sunscreen will protect skin from UVB rays, the kind of radiation that causes sunburn, damages skin, and can contribute to skin cancer.

- If your skin would normally burn after 10 minutes in the sun, applying an SPF 15 sunscreen would allow you to stay in the sun without burning for approximately 150 minutes (a factor of 15 times longer). This is a rough estimate that depends on skin type, intensity of sunlight and amount of sunscreen used. SPF is actually a measure of protection from amount of UVB exposure and it is not meant to help you determine duration of exposure.
- For best protection, experts recommend using a minimum SPF sunscreen of 15, applying the proper amount (2mg/cm2 of skin, or about one ounce for full body coverage), and reapplying every 2 hours.
- Most people under-apply sunscreens, using ¼ to ½ the amount required. Using half the required amount of sunscreen only provides the square root of the SPF. So, a half application of an SPF 30 sunscreen only provides an effective SPF of 5.5!

The **SPF (Sun Protection Factor)** scale is not linear:

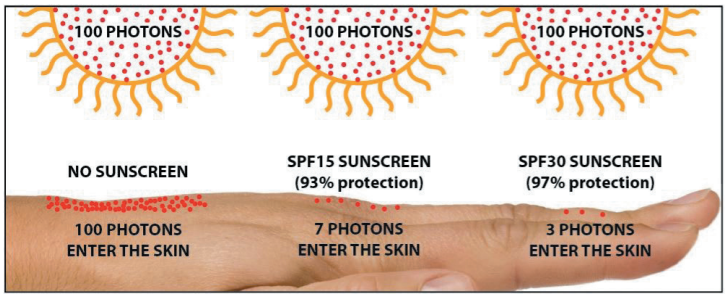
- SPF 15 blocks 93% of UVB rays
- SPF 30 blocks 97% of UVB rays
- SPF 50 blocks 98% of UVB rays

So, one way of looking at this is that SPF 30 sunscreen only **gives you 4% more protection than** SPF 15 sunscreen.

Or, another way of looking at it is:

- SPF 15 (93% protection) allows 7 out of 100 photons through
- SPF 30 (97% protection) allows 3 out of 100 photons through.

So, while you may not be doubling your level of protection, an SPF 30 will **block half the radiation** that an SPF 15 would let through to your skin.



It's complicated, but to keep it simple, most dermatologists recommend using a SPF 15 or SPF 30 sunscreen.

Why not use a really high Sun Protection Factor?
Sunscreens with really high SPFs, such as SPF 75 or SPF 100, do not offer significantly greater protection than SPF 30 and mislead people into thinking they have more protection than they actually do. Additionally, in order to have broad spectrum protection, the UVA protection should be at least 1/3 of the UVB protection. High SPF sunscreens usually offer far greater UVB than UVA protection, thus offering a false sense of full protection. ■

WHAT IS STEP THERAPY?

Step Therapy (also called Step Protocol) is a practice of beginning a specific drug therapy for a medical condition with the most cost-effective and safest drug therapy. If a patient does not respond satisfactorily, progressively most costly, risky or different therapy is prescribed as needed. Step Therapy allows the Plan to define a logical sequence of therapeutic alternatives. The aims are to control costs and minimize risks.

If your plan uses Step Therapy, you may be directed to try a cost-effective alternative to save money for both you and the Fund. ■

IN ONE YEAR, THE PANDEMIC FORCED MILLIONS OF WORKERS TO RETIRE EARLY

by Jon Marcus, AARP, March 10, 2021 | Reprinted with Permission aarp.com

From flight attendants to grocery store managers, older adults made the tough decision to end careers

Retirement is supposed to be a happy time, but Lucie Desmond expects there will be tears when her paperwork comes through.

Desmond, 62, has been a flight attendant for 36 years, most recently on the American Airlines route between Phoenix and London. But after repeated leaves forced by the COVID-19 pandemic, she has put in to retire much earlier than she had planned.

"I could have done that till I was 70," Desmond says. "Then COVID hit."

Her friends who have already retired early from the airline went through the same anguish. "They cried. They literally cried," says Desmond. "It hasn't honestly sunk in yet. It's very sad."

There are also financial considerations. Although she'll get a payout from the airline, "I won't be getting my salary, so I have to dip into my savings." She hasn't yet decided when to claim Social Security, since monthly benefits are lower for people who claim them before they reach the program's full retirement age.

In the meantime, "I won't be getting a paycheck, which is scary for me."

A year after the COVID-19 pandemic was declared a national emergency, many of the disproportionate number of older Americans pushed out of the workforce by the combined health crisis and economic downturn are retiring earlier than planned, risking long-term financial insecurity because of lower-than-anticipated savings and payouts from pensions, Social Security and other sources.

"Older workers, millions of them, are going to be downwardly mobile from the comforts of middle-class life," says Teresa Ghilarducci, a labor economist at The New School and director of its Schwartz Center for Economic Policy Analysis, who specializes in retirement security.

"People plan their retirement years and they look at their spreadsheets. They assume raises. They assume they will pay off their debts. Then this recession hits and they're forced out of the labor force, and all of those assumptions disappear at once."

Two million older adults have stopped looking for work

The number of people affected by this problem is beginning to come into focus.

In a reversal of previous recessions, when they were protected by their longevity, older Americans are more likely than mid-career workers to be out of work this time, according to the Center for Retirement Research at Boston College.

More than a quarter of all workers say COVID has prompted them to move up their retirement date, found a survey released in February by the National Institute for Retirement Security.

Nearly 2 million older workers have left the labor force for good since the start of the pandemic, the Schwartz Center says. That means the number of older workers still employed is down by about 5 percent, compared to less than 2 percent for workers ages 35 to 54.

The rate at which older workers continue to participate in the workforce, either by staying in their jobs or by seeking new ones, fell in January to its lowest point since the start of the pandemic, the Schwartz Center says. The Center estimates that 3 million more older workers would be working now if the pandemic did not happen.

The proportion of all Americans who will be financially insecure when they retire — meaning they will be unable to maintain their pre-retirement standard of living — has also increased, from 50 percent to 55 percent, according to the Center for Retirement Research.

"These workers were already at risk for downward mobility, but [the pandemic] accelerated this trend," Ghilarducci says. And that will bring "a lot of silent and solitary misery as people cut down their spending."

Job losses have hurt some groups more than others

Lower-income older workers are the most affected.

"People in higher-paid tracks have kept their jobs. At the same time, the folks at the bottom are involuntarily losing their jobs," says Dan Doonan, executive director of the National Institute on Retirement Security.

Those older workers who have jobs that can be done from home are typically the ones with greater education and higher incomes, the Center for Retirement Research estimates.

Unemployment for people in lower-paying jobs and for Black, Hispanic and Asian older workers has been more than twice that of higher-income older workers during the pandemic.

"The other side of this is the inequality of it," says Siavash Radpour, associate director of The New School's Retirement Equity Lab. "Many who have lost their jobs are in the bottom half of income. They didn't have much retirement savings anyway. If they had the prospect of wage growth, they have lost it by losing their jobs." ■

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