Coordination of Benefits Form - Complete & Return. See page 6.

For Your Benefit

Bakers Union & FELRA Health and Welfare Fund

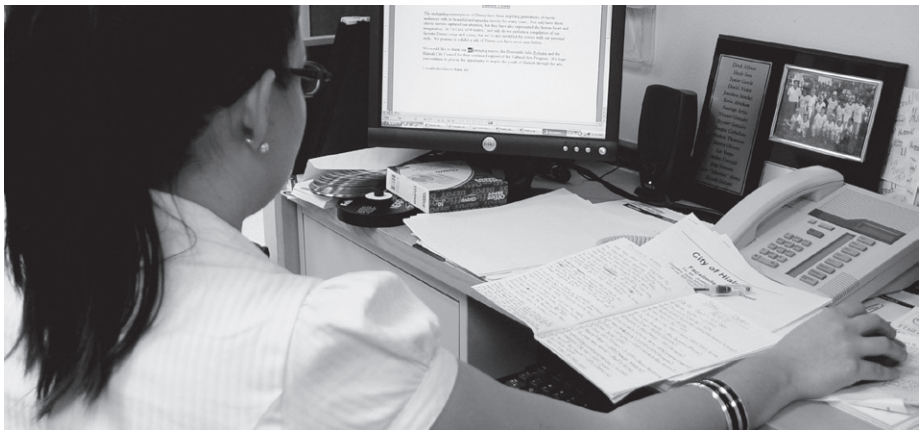
October 2019 Vol. 13 No. 2

Open Enrollment for Medical Coverage Runs November 1 – December 1

The following article applies to actively working participants in Plans 1, 2, 3 and Plan 4.

November 1st through December 1st is open enrollment to choose health and welfare coverage through the Fund effective January 1, 2020 and continuing (assuming you remain eligible) through December 31, 2020. If you don't currently have health coverage through the Fund, this is your opportunity to enroll. If you do have coverage, this is your chance to add dependents (if eligible) or to drop coverage.

Plan 4 Participants: If you are eligible to enroll in Plan 4, the benefits available to you include Accident & Sickness, Life Insurance, Accidental Death and Dismemberment coverage, Dental and Optical coverage. These benefits are available at **no cost to you**, but **you must complete an enrollment form and payroll deduction form for the benefits to be in effect.**



Open Enrollment Letter

You will soon receive an open enrollment letter, along with payroll deduction and enrollment forms, from the Fund Office. If you are changing your coverage or enrolling for the first time, the Fund Office must receive both the enrollment form and payroll deduction form. For example, if you are already enrolled with single coverage and want to add coverage for your spouse, note the change on the payroll deduction form, complete the enrollment form and return both to the Fund Office. If you don't want to make changes, there is no need to return the forms. You will remain in your current coverage (assuming you are still eligible for the same Plan).

Notice of Creditable Coverage Cut and keep. See page 3.

This Issue—

The purpose of this newsletter is to explain your benefits in easy, uncomplicated language. It is not as specific or detailed as the formal Plan documents. Nothing in this newsletter is intended to be specific medical, financial, tax, or personal guidance for you to follow. If for any reason, the information in this newsletter conflicts with the formal Plan documents, the formal Plan documents always govern.

New Drug Utilization Management Programs

Material Modifications

There are thousands of drugs available today and a large number coming to market; many increase costs without providing additional value. As a result, there may be several choices to treat a health condition, including over the counter, generic and brand name medications. Utilization Programs help to balance prescription benefit costs and provide members access to affordable, clinically proven medications.

Vigilant Drug Program - The Vigilant Drug Program helps to minimize drug spend by targeting certain drugs and removing them from coverage by exclusion or prior authorization in situations where the drug offers no additional health care value over lower cost options in their class. OptumRx performs a rigorous clinical and financial evaluation process on drugs before they can be excluded.

The Vigilant Drug Program includes the following programs:

New Drugs to Market Program – This program targets new drug products that have not undergone review by the OptumRx Pharmacy & Therapeutics Committee. They are placed on a temporary exclusion list pending their review. After six months (or sooner), the drug will be added to the formulary or added to one of the exclusion drug lists.

Me Too Drug Program – This Program excludes drugs that are therapeutically similar to covered drugs but cost significantly more, including but not limited to:

- Combination drugs that combine two or more available drugs to make a new one.
- Unique strengths or flavors – e.g., special cherry flavor which costs twenty-one times more than the generic equivalent.

Non-Essential Drug Program – The Non-Essential Drug Program excludes new drugs that are deemed non-essential treatments and outside the scope for Pharmacy & Therapeutics Committee Review, including but not limited to:

- Outrageously expensive topical pain preparations and "kits" made up of ingredients that are inexpensive when sold individually, but expensive when sold in combinations.
- High dollar, non-FDA approved drugs.

Members impacted by the Program will receive a letter 30 days prior to the effective date and can visit www.optumrx.com to find lower cost medication with greater health care value.

Diabetes Management Program
Diabetes requires careful management. This Program provides targeted guidance and services designed to prevent costly and clinically dangerous complications.

The Diabetes Management Program is free to high risk eligible members with diabetes, as part of your health plan. The Program offers support to help you learn about your medications, prevent complications, manage your symptoms and live a healthy lifestyle. The Program offers:

- **Savings** – Free diabetes testing supplies. You can get a wireless blood glucose meter and all related blood glucose testing supplies for a $0 copay.
- **Support** – Up to 4 free one-on-one coaching sessions and a full medication screening with a pharmacist who specializes in diabetes care.
- **Education** – Tools and resources on how to better manage all aspects of Diabetes such as medications and diet.

Personalized care and ongoing monitoring are key to improving diabetes health. OptumRx will identify high-risk members and they will be automatically enrolled in the Program. Eligibility is based on your pharmacy claims history. If you are eligible, you will receive a welcome letter providing them the name of the certified diabetes educator that will be available to you for one-on-one counseling and the phone number you can call to receive the free meter and supplies.

Reinstating Eligibility

There are several ways participants may lose eligibility, including:

- Layoff
- Lack of work
- Reduction in hours

To regain eligibility, you must meet the *Minimum Work Requirement* within one year from the date of your benefit's termination.

The *Minimum Work Requirement* is a specified number of hours per calendar month for which contributions are made to the Fund. The Fund uses the hours worked in your Employer's four or five payroll periods ending in a calendar month to determine eligibility. If you fail to meet the *Minimum Work Requirement*, you must again meet the initial eligibility requirements.

More information on eligibility issues may be found starting on page 30 of your Summary Plan Description ("SPD") booklet.

Cut and Keep!

Important Notice about Your Prescription Drug Coverage and Medicare

The following Notice of Creditable Coverage applies to all Medicare-eligible participants and/or spouses.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Bakers Union and FELRA Health and Welfare Fund, and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered and at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Bakers Union and FELRA Health and Welfare Fund has determined that the prescription drug coverage offered by the Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2)-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, you will no longer be eligible to receive your current Bakers Union and FELRA Health and Welfare Fund coverage. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

You cannot have both Medicare prescription drug coverage and prescription drug coverage through the Fund at the same time. If you decide to join a Medicare drug plan and drop your Bakers Union and FELRA Health and Welfare prescription drug coverage, be aware that you and your dependents may not be able to get the same coverage if you later decide to return to the Fund's drug coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Bakers Union and FELRA Health and Welfare Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact the Fund Office for further information at (866) 662-2537 or (410) 683-6500. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your coverage through the Bakers Union and FELRA Health and Welfare

Continued on page 4

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Fund changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date:	October 1, 2019
Name of Entity/ Sender:	Fund Office Bakers Union and FELRA Health and Welfare Fund 911 Ridgebrook Road Sparks, MD 21152
Phone Numbers:	(866) 662-2537 (410) 683-6500

Don't Forget to Complete Payroll Deduction Form to Receive Benefits

Completing a *Payroll Deduction Form* is necessary to receive benefits. There is one form for Plans 1 and 2 participants and a separate form for Plan 3 participants. The only difference in the forms is that in Plan 3, participant's spouses are only eligible to receive optical and dental coverage.

If you plan to add dependent coverage, please send proper documentation along with the *Payroll Deduction Form.* Copies of the following are acceptable documentation:

- Birth certificate
- Adoption certificate
- Placement for adoption certificate
- Legal custody order
- Qualified Medical Child Support Order (QMCSO)

Participants must also complete an enrollment form to receive benefits. To request either form, please call the Fund Office at (866) 662-2537.

WHCRA Allows Reconstructive Surgery Following Mastectomy

The Women's Health and Cancer Rights Act ("WHCRA") protects individuals who elect breast reconstruction after a mastectomy. Under federal law related to mastectomy benefits, the Plan is required to provide coverage for the following:

- All stages of reconstruction of the breast on which a mastectomy is performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedema.

Such benefits are subject to the Plan's annual deductibles and co-insurance provisions. Federal law requires that all participants be notified of this coverage annually.

If you have any questions about this Notice, please call the Fund Office toll-free at (866) 662-2537.

Where to Go When Medical Care Is Needed

Sprained ankle over the weekend? Fever late at night? If it's not an emergency, take a moment to review the options. Choosing the right place for your care can help you get the appropriate level of medical care, while saving you time and money.

ER

Open 24/7

If a situation seems life threatening, call 911 or go to the nearest ER. The ER should be reserved for urgent problems and should not be used for general illnesses/injuries that could be treated at urgent care facilities, MinuteClinics, or at the doctor's office during regular office hours.

Some examples that generally signal an emergency:

- Heart attack
- Chest pains
- Cardiovascular accidents
- Poisonings
- Convulsions
- Loss of consciousness or respiration

Urgent care center

Typically open extended hours (nights and weekends)

For a minor mishap that requires medical care but isn't life threatening, consider visiting an urgent care clinic.

Examples of conditions treated

- Minor cuts, sprains, burns and rashes
- Fever and flu symptoms
- Vomiting, diarrhea and stomach pain
- Urinary tract infections

Doctor's office

Regular clinic hours

Your doctor's office is the best place to go for routine or preventive care. For chronic health problems, such as low back pain or headaches, see your doctor so he or she can manage your care and/or direct you to a specialist for further treatment.

Examples of health care services offered:

- General health issues
- Preventive care, vaccines and screenings
- Referrals to specialty care

Convenience care clinic

Typically open extended hours (nights and weekends)

To visit a convenience care clinic, such as a MinuteClinic, no appointment is necessary. MinuteClinics are conveniently located in select retail grocery stores and drug stores, as well as certain corporate office buildings and college campuses.

Examples of conditions treated:

- Common cold/flu, sore throat or earache
- Rashes or skin conditions
- Vaccines

Call the Fund Office at (866) 662-2537 before receiving treatment to ensure services are covered, or log on to:

- www.cignasharedadministration.com.
- Select "Medical PPO Provider Directory" and then click "Cigna Facility and Ancillary Directory."
- Enter the Zip code of the area you choose and click on "Continue Search." Scroll down the screen and select "Specialty." After you click on "Convenient Care Centers," you will be able to view all the various MinuteClinics in your area.

This is intended to be general health information and not medical advice or services. You should consult your doctor for medical advice or services, including seeking advice prior to undertaking a new diet or exercise program. The above information is provided by Cigna.

Update Your Benefit Information with the Fund Office

If you, your spouse, or your dependents have benefit coverage in more than one group health plan, the Fund Office needs to know. Why? Because there are Coordination of Benefits ("COB") rules to determine which plan processes the claim first, second and even third (if you have coverage under three group plans).

Virtually every group health plan has COB rules. They are designed to protect the Fund (and all group health and welfare plans) from paying claims for which it is not liable. The Fund's COB rules are described in your SPD on page 42.

Even if you have completed a COB form before and nothing has changed, you are required to complete the form on the next page and return it to the Fund Office at the address shown at the bottom of the form.

Remember, updating this information now saves time later (when you have a claim waiting to be processed). If you do not tell the Fund Office about the other coverage and it is discovered later (after claims have been paid), you will be billed for the amount that was paid in error. Do not let this happen to you.

COB Form on Next Page 

Complete & Return

Bakers Union and FELRA
Health and Welfare Fund

911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (410) 683-6500
Toll Free: (800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
Telephone: (301) 459-3020
Toll Free: (866) 662-2537
www.associated-admin.com

COORDINATION OF BENEFITS UPDATE

Update for Yourself, Your Spouse, or Your Dependent(s)

Participant's Name: _____ **Last Four Digits of SSN#:** _____

There is Other Group Coverage On (Choose One):

1) ___ Myself 2) ___ My Spouse 3) ___ Other Eligible Dependent

If Spouse:

a) Name: _____
b) SSN: _____
c) Date of Birth: _____
d) Spouse's Employer:
_____ Co. Name
_____ Address
_____
(____)_____ Phone No.
_____ Benefit/HR Dept. (Contact Name)

If Other Dependent:

a) Name: _____
b) SSN: _____
c) Date of Birth: _____
d) Spouse's Employer:
_____ Co. Name
_____ Address
_____
(____)_____ Phone No.
_____ Benefit/HR Dept. (Contact Name)

The coverage is from:

___ Medicare Part A ___ Medicare Part B ___ Medicare Part D
___ Spouse's Employer ___ Other ___ Participant's Employer at Another Job

Insurance Co. Name: _____

Address: _____

Phone Number: _____

Group Policy #: _____ **Effective Date:** _____

NOTE: If more than one family member has more than one coverage, or if an individual is covered by more than one other policy, attach a sheet listing the information for each.

Is it an Active or Retiree Plan? ___ Active ___ Retiree
Are you/your dependent eligible for Medicare coverage? ___Yes ___No

(PLAN 2 Participants Only) **[1] Was your spouse offered other coverage where the employer pays at least 70% of the premium? ____Yes _____No. [2] Was the coverage accepted or rejected by the Spouse? _____Yes _____No.**

Participant's Signature _____ **Date** _____

Send to: Bakers Union and FELRA
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Precertification/Authorization Required for Non-Emergency Hospital Admissions

The following applies to participants and eligible dependents in Plans 1, 2, and 3. ***NOTE: Spouses are not covered in Plan 3.***

Taking good care of yourself can help lessen the chances you'll need to be admitted to a hospital. However, if and when you do require admission, you ***must*** call CareAllies (800-768-4695) for authorization in order for the Fund to pay benefits.

If you fail to call CareAllies, you may be responsible for paying up to $1,000 or 20% of the cost (whichever is less), in addition to any other deductibles or co-payments.

CareAllies certifies the necessity of medical procedures, but it **DOES NOT** certify your eligibility for benefits – i.e., that the procedure or *Hospital* stay is covered under the Plan, or the amount of coverage provided be the Plan. You must verify eligibility with the *Fund Office* (866-662-2537).

How to obtain precertification/authorization for hospital admissions:

- Before your admission, call CareAllies to pre-certify all planned (non-emergency) or elective hospital stays. For an emergency admission, call CareAllies within 48 hours of the admission. Trips to the emergency room that DO NOT result in admission to the hospital do not require certification.
- If CareAllies determines that your admission is medically necessary, you will receive an authorization letter from CareAllies which includes the number of days approved. Be sure to take a copy of the authorization letter with you when you go to the hospital to be admitted.
- If your medical condition requires an extension of your hospital stay, CareAllies will need to be contacted by your physician or a facility staff member. Therefore, if you need to extend your hospital stay, tell your physician to contact CareAllies. You (or a family member/caregiver) should also contact CareAllies to confirm authorization for your continued stay.

CareAllies, a subsidiary of Cigna Healthcare, is a health management company that helps "contain inpatient hospital costs by reducing unnecessary admissions and, when appropriate, finding treatment alternatives that both you and your physician find safe and effective."

CareAllies provides a broad portfolio of services such as pre-certification, complex case management, specialty case management, 24-Hour Nurse Line programs, and web tools to help improve your health and well-being.

Bakers Union and FELRA Helpful Phone Numbers & Websites

Below is a list of phone numbers and websites for Fund providers. Keep it handy so you'll have the number when you need it.

Fund Office
(866) 662-2537
911 Ridgebrook Road
Sparks, MD 21152-9451
www.associated-admin.com

Cigna HealthCare
(800) 768-4695
www.Cignasharedadministration.com

Cigna HealthCare PPO Address for Claims
P.O. Box 936
Frederick, MD 21705-0936

CareAllies
(800) 768-4695
www.myCareAllies.com

24-Hour NurseLine
(800) 768-4695
www.myCareAllies.com

Briova Rx Ascend
(Specialty medications)
(855) 427-4682

OptumRx
(888) 869-4600
www.optumrx.com/myCatamaranRx

Denex Dental
(866) 433-6391
www.DenexDentalcom

Vision Service Plan (VSP)
(800) 877-7105
www.vsp.com

LabCorp Laboratories
(888) 522-2677
www.labcorp.com

Quest Laboratories
(800) 377-7220
www.questdiagnostics.com