Questions about your Benefits? Call Participant Services at the Fund Office (866) 662-2537. Press "2" for a representative or #1" to use the automated system.

For Your Benefit

Bakers Union & FELRA Health and Welfare Fund

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Children May Elect Parents' Coverage Up to Age 26

Material Modifications

Under the "Dependent Coverage" section of your Summary Plan Description ("SPD") book (pg. 36), it states that "… a Child between the ages of 19 and 26 will not qualify for coverage if the Child is eligible for his/her own employment-based health coverage, including through a Child's spouse (if any)." This is repeated at the top of pg. 37.

According to the United States Department of Labor, the Affordable Health Care for America Act requires "plans and issuers that offer dependent child coverage to make the coverage available until the adult child reaches the age of 26."

Children have the right to elect their parents' coverage instead of their own employment-based coverage until they reach age 26.

ACA Preventive Services Benefits

This Fund provides coverage for certain preventive services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided on an in-network basis only, with no cost sharing (for example, no deductibles, coinsurance, or copayments).

In-network preventive services that are identified by the Fund as part of the ACA guidelines will be covered with no cost sharing. This means that the service will be covered at 100% of the Fund's allowable charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this preventive services benefit. To locate a network provider, please visit the Cigna website at www.cignasharedadministration.com or call (800) 768-4695.

For a list of services covered under the Fund's preventive services benefit, please see page 77 of your Summary Plan Description booklet.

This Issue—

Save $$ by Using Denex Dental

Your dental benefits under the Plan are offered through Denex/Group Dental Service of Maryland. The Denex plan uses Dentemax's vast network of providers to choose from.

Choosing an in-network provider is in your best interests although it is not *required*. When you use an in-network provider you receive a higher benefit level and enjoy access to negotiated network fees, resulting in lower out-of-pocket expenses.

To find a dental provider, visit www.denexdental.com and click on "Locate a Dental Provider" or call (866) 433-6391.

If your dentist is not in the Denex network, you may encourage him or her to join. Simply have the dentist or practice call Denex at (800) 451-7715 to receive information on how to become a participating provider.

In addition to an ID card, you will receive a "Certificate of Coverage" from Denex Dental, which details covered procedures and exclusions.

Your dependents are eligible for dental coverage from age 19-23 if they are full-time students. A student certification will need to be submitted annually.

For more information on your dental benefits, please refer to your Summary Plan Description ("SPD") book, pages 129-139.

Remember, it is not mandatory that you see a dentist in the Denex Dental network. But you will receive the best discounts when you do.

Call Cigna Shared Administration When Lab Work Is Needed

Your Plan of benefits requires that you ***must*** use a laboratory in the Cigna shared administration network.

Your Responsibility

It is your responsibility to check before you make your appointment for lab services that the laboratory you are going to is in the Cigna shared administration network.

You can do this by:

1. Calling Cigna at 800-768-4695, or
2. Logging online to the Cigna provider directory at www.cignasharedadministration.com. Select "Provider Directory" shown on the horizontal bar located at the top of your screen. Next, choose the "Facility and Ancillary Directory." After questions #1 and #2, choose "Laboratory Services" under specialty, and click on "Continue Search." You will be directed to a listing of various labs located near the zip code you entered.

Be sure your doctor knows this before having laboratory work done. If your doctor, nurse or surgeon performs lab work in the office, explain that your lab work ***must*** be sent to a lab that is in the Cigna shared administration network in order for the claim to be covered.

Remember, labs can be in the Cigna network one month and not be in the network the next month. So it is very important for you to confirm your lab's status prior to any testing.

Material Modifications

Emergency Room Visits

Trips to the emergency room are covered, but the level of coverage and co-pays vary for participants in Plans 1, 2, and 3. Out-of-network coverage providers are covered the same as in-network if the situation is determined to be a true emergency.

On page 100, your Summary Plan Description ("SPD") book states there is a $25 co-pay per emergency room visit for Plan 3 participants. This should say $75 per visit, which is waived if the participant is admitted to the hospital.

Emergency room visits do not require pre-certification with CareAllies (see related article regarding non-emergency hospital admissions on pg. 3). Notification to CareAllies is required within 48 hours from the time of admission or the next business day following a weekend or federal holiday, whichever comes first. Be sure you or someone on your behalf contacts CareAllies at (800) 768-4695.

Non-Emergency Hospital Admissions Require Pre-Certification

CareAllies is a health management company which helps the Fund ensure that you receive quality and cost-effective health care through the Fund's medical care programs. 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.

CareAllies is required to certify the medical necessity of procedures. It does not certify that you are eligible for benefits, that the procedure or Hospital stay is covered under the Plan, or the amount of coverage provided by the Plan. You must verify eligibility with the Fund Office.

For ALL hospital admissions, you (or your family member/caregiver or provider) ***must*** call CareAllies 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-insurance.***

No benefits will be paid for services excluded by the Plan. For a list of *General Exclusions*, please refer to pages 114-117 of your Summary Plan Description ("SPD") book.

How do I obtain precertification/ authorization for my hospital admission?

- Before your admission, call CareAllies at (800) 768-4695 to pre-certify all planned (non-emergency) or elective hospital stays. For an emergency admission, call CareAllies within 48 hours of the admission.

- 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.
- 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. When you become aware of the need to extend your stay, inform your physician that CareAllies must be contacted. You (or a family member/caregiver) should also contact CareAllies to confirm authorization for your continued stay.

Continued on page 4

How to File for Weekly Accident & Sickness Benefits

If you are unable to work because you are sick or injured, you may be paid Weekly Accident & Sickness ("A&S") pay.

How do I apply?

1. Call the Fund Office at (866) 662-2537 and we will send you an Accident & Sickness ("A&S") claim form.
2. You can also print the form from our website. Go to www.associated-admin.com and click on "Your Benefits," located at the left side of the homepage. Select "Bakers Union and FELRA." You will be directed to a list of forms. Click on the Accident & Sickness claim form. From there you can print it.

This claim must be filed within 24 months (two years) from the date your disability began.

What do I do next?

1. Answer all the questions on the form;
2. Sign the form;
3. Write the date you signed the form;
4. Take the form to your doctor to have him/her complete the physician's section; and
5. Mail the form to the address at the top of the form.

Once we receive your completed A&S form, and if there are no questions regarding your sickness or injury, your claim will be processed. If the Fund Office sends you questions about the disability, you must answer within two weeks from the date mailed by the Fund. If approved, weekly checks will begin for the period you are disabled. You may be eligible for A&S benefits of $200 per week for up to a maximum of 26 weeks.

If you are disabled because of an illness, the Fund will start paying benefits on the 8th day of your disability. If you are disabled because of an accident which immediately disables you from working, benefits will begin on the 1st day of your disability.

For further details about your A&S benefits, refer to your Summary Plan Description booklet on pages 70-74.

Participants Encouraged to Use Website for Valuable Benefit Information

Benefits change frequently, but you can find the most up-to-date information regarding your Plan online at www.associated-admin.com. Simply click "Your Benefits" (at top or at left) and choose Bakers Union/FELRA.

In addition to important notices, the website includes various forms you may download, such as an enrollment form, weekly accident and sickness claim form, and more.

Your Summary Plan Description ("SPD") booklet is available, as well as any modifications (benefit changes) that have occurred since the book's print date.

Every *For Your Benefit* newsletter, dating back to July 2011, is archived for quick access by participants. Simply click on the month and year of the issue you'd like to access (for example, "September 2018") and a PDF of that issue will open in another tab in your browser. You may download the file for reading offline. Links for Plan Providers are listed as well.

The "Language Line" Can Help

The Fund Office can help you if English is not your primary language. Call **(800) 638-2972** to reach the Fund Office. Press #2 on your phone to talk with someone from Participant Services who will help you if you need a translator to answer your questions.

The Fund Office has helped many people who have difficulty speaking English and whose main language is Vietnamese, Burmese, Mandarin, French, Spanish or others.

If you haven't called the Fund Office (or you know someone who hasn't) because you think you/they won't be understood, go ahead and call!

The language line is a service provided to help you so that you may ask questions about your benefits. Take advantage of it.

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Adding Dependents to Your Coverage Isn't Complicated

If you are newly married or just had a baby, you will want the new addition(s) to your family to have health coverage. It's easy to add dependents to your Plan – simply enroll the new person(s) within 30 days (60 days for spouses) from the date he or she became your dependent.

Contact the Fund Office at (866) 662-2537 and ask for an enrollment form. To ensure that your new dependent has coverage from the first possible date, return the form with supporting documentation to the Fund Office as soon as the event (birth, marriage, adoption) occurs. The form is available on the web at https://www.associated-admin.com/?page_id=36.

Complete the form and return it to the Fund Office along with supporting documentation (baby's birth certificate, adoption papers and/or marriage certificate). **Be sure to include your dependent's Social Security Number on the enrollment form.** This is very important! Enrollment will not be processed until we receive both the enrollment form (with your dependent's Social Security Number) and the required proof of dependent status.

If you fail to enroll your new dependent when he/she is first eligible, coverage will begin on the first day of the month following the date the Fund Office receives the enrollment form and documentation.

Enrolling newborns and adopted children

Include a copy of your newborn's birth certificate with the enrollment form. If you haven't received the birth certificate yet, send the birth verification notice from the hospital. We will accept that until you receive the birth certificate. We still need a copy of the actual birth certificate once you receive it, so be sure to follow up.

If you have adopted a child under the age of 26, or have a child placed with you for adoption or legal custody, you must enroll him/her within 30 days from the date he or she became your new dependent to receive coverage the first of the month following the date of adoption, or placement for adoption.

Enrolling Spouses

To enroll a spouse, simply fill out the enrollment form and send it to the Fund Office within 60 days from the date of marriage. Include a copy of your marriage license.

If you become legally separated, you may keep your spouse as a dependent until the divorce is finalized.

There is no medical and prescription drug coverage for spouses of participants in Plan 3.

Student Dental Coverage

In order for a dependent over the age of 19 to receive dental coverage, they must be a full-time student. This coverage can last until the dependent reaches the age of 23. A student certification needs to be requested and sent in every year.

Where do I mail the enrollment form and documentation?

Send the information to:

Bakers Union and FELRA
Health and Welfare Fund
Eligibility Department
911 Ridgebrook Road
Sparks, MD 21152-9451

Dependent coverage remains in effect as long as your coverage is current. If you lose your coverage, so do your dependents. Other reasons for loss of dependent coverage include divorce, a child reaching age 26, or if the dependent "abuses Fund benefits or fails to comply with reasonable requests by the Fund." Upon your death, dependent coverage may continue for up to one year (see pg. 39 of your SPD for more information).

Subrogation: What It Is and How It Works

What is subrogation?

Suppose you're in a car accident and it is clearly not your fault. Your car is wrecked and your neck and back have been injured. Expenses relating to the accident are mounting, but the person (or his/her insurance) responsible for paying your (or your eligible dependent's) expenses has not yet paid you. As a service to you, the Fund will pay your (or your eligible dependent's) benefits so long as you agree that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive from the responsible third party. This is called subrogation.

How does this work?

After you submit a claim to us to pay for your injuries, we will send you a Subrogation Agreement, which you and your attorney (and, if applicable, your dependent and his/her attorney) must complete and return to us. This form must be completed and returned to the Fund with any other forms the Fund may need before the Fund will pay claims related to the accident.

Whatever amount the Fund pays for the accident, you must reimburse the Fund out of anything you receive from the responsible party (the other driver's car insurance, for example). By signing the Subrogation Agreement, you (or your dependent) and attorney agree that if you are successful in your claim against the third party, the Fund will be reimbursed first, even before your attorney collects fees.

If you or your dependent submit claims for or receive any benefit payments from the Fund for an injury or sickness that may give rise to any claim against any third party, you and/or your dependent will be required to sign a Subrogation Agreement affirming the Fund's right of reimbursement and subrogation for all benefit payment and claims related to the injury or sickness.

Benefit payments are not payable unless you and/or your dependent sign a Subrogation Agreement. The Agreement must also be executed by you or your dependents attorney.

Rules and obligations of subrogation:

- To pay back the Fund first for any benefits related to an accident once you receive a recovery from a third party;
- To authorize any insurance company that is obligated to make any payment to you to first directly pay the Fund the amount that was advanced to you;
- To provide the Fund with a lien against any monies recovered;
- To keep the Fund updated on developments in any litigation against a third party;
- To authorize the Fund to intervene in any suit or other proceeding to recover losses because of your non-work related accident, injury or illness; and
- To notify the Fund before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid.
- To notify the Fund of any recovery related to the injury or sickness payable to you or your dependents' from any third party or parties in connection with the injury.

Material Modifications

Language Change to Your Summary Plan Description Book

Regarding your prescription drug benefits, the table on page 122 titled "Drugs Which Require Prior Authorization" says that oral/topical contraceptives for dependents are "Not covered solely for prevention of pregnancy." Under the Affordable Care Act, the Fund is required to cover this benefit. Please strike-through this sentence.

Be Sure to Send Claims to Right Address!

To keep from having your claims or mail returned, and to be sure your claims are received on time, be sure to send to the correct address.

Send Weekly Accident & Sickness Claims to:

Bakers Union & FELRA
Health and Welfare Fund
P.O. Box 1064
Sparks, MD 21152-1064

Some stores still have old Weekly Accident & Sickness Claim forms in stock which show our old address. Make sure to mail the form to our current P.O. Box.

Send Medical Claim Forms and All Other Correspondence to:

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

Manage Home Delivery Prescriptions with the OptumRx App

Managing your prescriptions is easy with OptumRx' new app. Download the app from iTunes® or Google Play™ and you can have complete control over your personal pharmacy experience.

Here are just a few of the things the OptumRx app allows you to do:

- Refill or renew a home delivery prescription
- Transfer a retail prescription to home delivery
- Find drug prices and lower-cost options
- View your prescription claim history or order status
- Locate a pharmacy
- Access your ID card
- Set up refill reminders
- Track your order

These services are also available via the web at www.optumrx.com.

You Have 180 Days to File an Appeal

If your claim was denied in whole or in part, you may appeal the decision by writing to the Board of Trustees. **Appeals must be filed within 180 days after you receive written notice that your claim has been denied.** This means the Board of Trustees must receive your letter within 180 days from the date of the denial. If it is not received within that time, the appeal will be denied due to late filing.

Note: Only appeals from participants or covered dependents will be presented to the Trustees for consideration. If you wish, you may assign appeal rights to a provider to appeal on your behalf.

To appeal a claim denial, send a letter to:

Bakers Union and FELRA
Health and Welfare Fund
Attn: Appeals
911 Ridgebrook Road
Sparks, MD 21152

The appeal should include the participant's name and Social Security Number, the date(s) of service and why you believe the claim should be covered. Include any additional information in support of the appeal. Remember, you have 180 days from the date of the denial to appeal. Once the Board of Trustees has made a decision on your appeal, the Board will send you notice of its decision within 5 days of the date the decision is made. The decision of the Board of Trustees is final and binding.

During Active Military Service, Your Coverage Is Protected under USERRA

The Uniformed Services Employment and Re-employment Rights Act ("USERRA") provides individuals with re-employment rights and protection from discrimination when they either volunteer or are inducted into military service in any branch of the armed forces of the United States.

If you will be out on military leave for 31 days or less, your health and welfare coverage will be continued just as it is currently. If your absence will be anywhere from 32 days up to 24 months, you may elect to continue your health coverage – but you will need to pay the same monthly rate as would be required for coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA").

You must give advance notice to your employer and the Fund Office that you will be absent for military service, unless such notice is not possible due to military necessity or is unreasonable under the circumstances.

You also must notify your employer and the Fund Office that you wish to continue your coverage under USERRA. This is important because no separate notice will be sent to you.

If you satisfied the Plan's initial eligibility requirements prior to your military leave, you will not have to satisfy those requirements again when you return to work. If you partially satisfied the Plan's eligibility requirements, that service will be counted towards the requirement upon your return – you will not have to start over.