Not every article in this newsletter applies to you. Please check your Plan of Benefits.

For Your Benefit

The Warehouse Employees Union Local No. 730 Trust Funds

www.associated-admin.com

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What to Know About Your Legal Benefits

Eligible participants in the Warehouse Employees Union Local No. 730 and Contributing Companies' Prepaid Legal Services Fund can receive legal advice for various services. You can receive up to the maximum number of hours mentioned below in each category per calendar year (January 1st – December 31st). These hours represent the total hours used by the family as a whole, not to each individual in the family and regardless of whether both spouses are participants. These services include:

- Maximum of 6 hours for consultations with an attorney.
- Maximum of 6 hours for the preparation or execution of a will.
- Maximum of 8 hours for legal representation of an employee in a divorce or separation.
- Maximum of 6 hours for the preparation of documents in residential real estate transactions and representation at the real estate closing.
- Maximum of 10 hours for representation in a serious traffic case.
- Representation in criminal cases:
  - Maximum of 6 hours for a misdemeanor
  - Maximum of 24 hours for a felony
  - Maximum of 6 hours for juvenile or criminal cases involving your dependent child (not including representation for traffic cases).
- Maximum of 10 hours for representation in civil proceedings.
- Representation in cases involving personal injury to you or your eligible dependent is available on a contingency fee basis. See page 17 of the Warehouse Employees Union Local No. 730 and Contributing Companies Prepaid Legal Services Fund Summary Plan Description booklet for more details.

Getting Legal Help

The Board of Trustees has contracted with Steven M. Sindler, Esq. to provide legal services to Fund participants. Mr. Sindler will either handle the matter in his office or refer you to an attorney in the Plan's attorney network. Prior authorization is required for all services in order to receive benefits. Contact Mr. Sindler's office at (410) 551-9323 or toll free (877) 293-8730.

Coordination of Benefits Form – Complete & Return. See page 3.

This issue—

Enrolling Your New Dependent

Once you have satisfied the waiting period for coverage (worked at least 600 hours in six consecutive months for a participating employer), you may add a newly eligible dependent to your benefit coverage by notifying the Fund Office and completing a new enrollment form. In order for coverage to begin right away, you must enroll your new dependent – new spouse, newborn child, or adopted child – within 30 days from the date he or she became your dependent.

For example, in the case of a newborn, you must enroll him or her within 30 days from the date of birth for coverage to begin at birth. For a new spouse, enroll him or her within 30 days from the date of marriage for coverage to begin on the date of your wedding.

To ensure that your dependent has coverage from the first possible date, request a new enrollment form from the Fund Office before you have the baby (or get married, or whatever the situation may be) so you can mail it with supporting certifications to the Fund Office as soon as the event occurs.

How Do I Enroll My New Dependent?

- Log on to www.associated-admin.com, click on the words "Your Benefit" located at the left side of the screen, select "Warehouse Employees Local 730," and under "Downloads (Forms)" print the enrollment form, or
- Call the Fund Office at (800) 730-2241 and ask for an enrollment form.
- 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.

When You Don't Enroll Within 30 Days Fund Coverage (Class E)

- 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.

HMO Coverage (Class C – Adams Burch)

- If you don't add your new dependent within 30 days of the event, you will have to wait until the HMO open enrollment in July for coverage beginning in August.
- Class C participants who have coverage through UnitedHealthcare HMO must complete two separate enrollment forms, one for the Fund Office and one for UnitedHealthcare.

Send Information To:
Fund Office
Warehouse Employees Union Local No. 730
Health and Welfare Trust Fund
Attn: Eligibility Department
911 Ridgebrook Road
Sparks, MD 21152-9451

What Is Subrogation?

Subrogation is a service the Fund provides for **non work-related** injuries, illnesses or accidents. If the Fund Office determines that someone else may be liable for your expenses, we can process your claims, even though the responsibility for the claims may be someone else's.

Here is how it works:

Suppose you are hurt in a car accident and the accident is not your fault. The person that hit you is responsible for payment of your medical bills and lost wages. When you submit medical claims to the Fund Office, we will send you a Subrogation Agreement which you and your attorney must complete and return. The Agreement states that you promise to re-pay the Fund in full **for anything we have paid** if you receive reimbursement from any third party. It does not matter whether the payment is specified as being for your medical claims and/or lost wages or not. If you receive payment, you must reimburse the Fund. If you don't receive payment from the third party, you (or your providers) may keep the money the Fund has paid. However, certain conditions apply, so be sure to read the subrogation packet for details or contact the Fund Office.

Rules and obligations of subrogation:

- Notify the Fund Office immediately if you file suit.
- Cooperate and assist the Fund Office to recover money from any third party.
- Pay back the Fund Office immediately from any money recovered from third parties.
- You must not do anything to impair, prejudice, or discharge the Fund's right of subrogation.

Warehouse Employees Union Local No. 730
Health and Welfare Trust Fund

COMPLETE AND RETURN

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (800) 730-2241
www.associated-admin.com

4301 Garden City Drive, Suite 201
Landover, Maryland 20785-6102
Telephone: (800) 730-2241
www.associated-admin.com

COORDINATION OF BENEFITS UPDATE

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

Participant Name: _____

Participant SSN: _____

There is Other Group Coverage On (Choose One):

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

If spouse:	If other dependent:
a. Name:	a. Name:
b. SSN:	b. SSN:
c. Birth Date:	c. Birth Date:
d. Spouse's Employer	d. Spouse's Employer
Co. Name:	Co. Name:
Address:	Address:
Phone No. ( )	Phone No. ( )
Benefit/HR Dept.	Benefit/HR Dept.
(Contact Name)	(Contact Name)

Coverage is from:

___ Medicare A ___ Medicare B ___ Medicare D ___ Spouse's Employer

___ Other ___ Participant's Employer at Another Job

Insurance Co. Name:	
Address:	
Phone Number:	
Group Policy #:	**Effective Date:**

If more than one family member has more than one additional 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

If other group coverage is for a dependent child, are the child's natural parents legally separated or divorced? ___ Yes ____ No

Are you/your dependent eligible for Medicare coverage? ___ Yes ___No

Participant's Signature _____ **Date** _____

Send to: Fund Office
Warehouse Employees Union Local No. 730
Health and Welfare Trust Fund
911 Ridgebrook Rd.
Sparks, MD 21152

L730 COB 0806rt

If You Are Injured On The Job, Follow These Steps:

If you have an illness or injury which may be work-related, there are certain steps to follow in order for your claim to be processed. Below is a review of those procedures.

1. Submit your claim to the Fund Office as usual. Be sure to file within the time frame required (within 365 days from the date the injury/illness began).
2. At the same time, file your claim with your employer's Workers' Compensation carrier.
3. The Fund Office will deny the claim as work-related because it falls under Workers' Compensation. Importantly, your claim will be on record as received on time by the Fund Office.
4. If your claim is denied by Workers' Compensation as "non-compensable under Workers' Compensation law," you may choose to file an appeal with the Workers' Compensation Commission. ***Filing an appeal does not guarantee eligibility for benefits.*** In order to maintain eligibility, a claim must be paid by Workers' Compensation or Accident & Sickness.
5. If your claim is approved by Workers' Compensation, the Workers' Compensation carrier will process your bills.
6. The Fund Office will pay a supplement to the Weekly Temporary Total Disability paid by Workers' Compensation ***(Class E participants only).***
7. **If the Commission disallows your claim** on the grounds that the claim is non-compensable under Workers' Compensation (meaning the claim was determined NOT to be work-related), the Fund will process your claims. We must receive verification of this information – such as a copy of the denial by the Commission. We will process any bills received in accordance with the Plan.
8. **If the Commission awards benefits** because your claim is determined compensable, the Workers' Compensation carrier will process your claim.
9. Submit copies of your Temporary Total Disability checks to the Fund Office. The Fund will then pay a Supplement to the Weekly Workers' Compensation payment not to exceed the 52 weeks allowed according to the Plan ***(Class E participants only).***

If you have questions about what to do if your claim may be work-related, contact Participant Services at (800) 730-2241.

RIFs Are Being Sent.
Complete And Return Promptly.

The Fund Office will soon be sending Retiree Information Forms (RIFs) to all pensioners to be completed and returned to the Fund Office. The form is required by the Board of Trustees and asks questions about your current address, your beneficiary, whether you and/or your spouse have other health coverage, and whether you are employed.

Failure to return the form may result in an administrative hold on your pension payments. Take the time now to complete and return the RIF as soon as possible

Even if you completed this form last year, you still must complete and return this year's RIF. It is very <u>important</u> that the retiree complete all sections of this form and <u>promptly</u> send it back to the Fund Office. To assist you, the Fund Office will include a postage-paid, return envelope with the first mailing.

Helpful Reminders

- Let the Fund office know if you have a new telephone number. ***This is very important if we have to contact you.***
- Do not attach checks or claims to the RIF.
- Report any earnings from all employers.
- Let us know if you, or your spouse, have other health coverage.
- Be sure to sign the RIF.

Contact Group Vision Service for Optical Exams

The following article applies to eligible Active participants in Class C and Class E who have Health and Welfare benefits through the Fund.

Your vision benefits are provided through Group Vision Service ("GVS") which has many providers available through its relationship with EyeMed Vision Care. Using the GVS Select Provider Network, you have the option of going to independent providers or retail locations including LensCrafters, Sears Optical, Target Optical, JCPenney Optical and participating Pearle Vision locations. You must use a vision provider in the GVS network.

Locating a GVS Network Provider

- Find network providers at www.gvsmd.com. Click on "Provider Locator."
- Contact GVS customer service or use the Interactive Voice Recognition (IVR) system at (866) 265-4626 between 8:00 a.m. to 11:00 p.m. EST, Monday through Saturday, and 11:00 a.m. to 8:00 p.m. EST on Sunday.
- Schedule an exam with the provider of your choice. When scheduling your appointment, inform the provider that you are a GVS/EyeMed member and provide your name and date of birth. The provider will verify your eligibility and plan benefits prior to your appointment.
- Show your ID card at the time of service or provide your name and date of birth for quick verification of eligibility and plan coverage. It is not necessary to have your ID card when you go to your vision provider. They can verify your eligibility through your name and date of birth. If, however, you would like an ID card, call the Fund Office at (800) 730-2241 and we will be happy to send one to you.
- You will be responsible to pay the provider at the time of service for any co-payment or other cost that exceeds the plan coverage.

Group Vision Service strives to make it easy for members to manage their vision benefits. Below is the information on how to set up a username and password via the GVS web site to view:

- Benefit Details
- Service eligibility
- Claim Status
- Print an ID card
- Vision Wellness
- Email Customer Service

Personalized Member Website Access

For Members to Access their Benefits:

1. You must first register on the GVS website – www.gvsmd.com
2. Under the **MEMBER** tab Click on member login
3. When you enter the Member Site to Register for an Account - Use the LAST FOUR DIGITS of your social security number and pick your own user ID.
4. Site will send an Email confirmation and password selection

Please refer to pages 82 - 86 of your Summary Plan Description booklet for a description of your vision benefits.

Appeals Must Be Filed On Time

If your claim was denied in whole or in part, you may appeal the decision by writing to the Board of Trustees.

Up to 180 Days to Appeal Medical Claims:
The Board of Trustees must receive your written appeal letter within 180 days after you receive written notice that your claim has been denied (within 60 days for non-medical, non-disability claims). If it is not received within that time, the appeal will be denied due to late filing.

Up to 60 Days to Appeal Pension Claims:
You must send a written request to the Board of Trustees within 60 days from the date your claim was denied. If it is not received within that time, the appeal will be denied due to late filing.

If you choose to appeal a claim denial, send a letter to:

Board of Trustees
Warehouse Employees Union Local No. 730
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: Appeals Dept.

A written appeal should include the participant's name, Social Security Number, the date(s) of service, and any documentation in support of the appeal. Include all the facts relating to your claim as well as the reasons you feel the denial was incorrect.

You may, at your own expense, have legal representation at any stage of these review procedures. Regardless of the outcome of your appeal, neither the Board nor the Fund will be responsible for paying any legal expenses that you incur during the course of your 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.

Coordination of Benefits: When You (Or Your Spouse) Are Covered Under More Than One Plan

Many couples are covered under two different group health plans when both spouses work and each has health and welfare coverage through his/her employer. For example, a participant may be covered under this Plan and also under his/her spouse's plan. In order to determine which plan pays first and which pays second, the Fund (like most other group health plans) has what is called Coordination of Benefits ("COB") rules. These rules ensure that the Fund does not pay benefits on claims for which it is not liable. Nor will the Fund pay benefits beyond the actual medical expenses incurred.

How does it work?
If a person has coverage under two or more plans, or if a person is covered by the Fund both as a participant and a dependent, the order in which benefits are paid is determined as follows:

1. If you have primary coverage with the Fund, those benefits are paid first. Any remaining balance should be submitted to your spouse's plan for processing as the "secondary" payor. If the claim is for your spouse, his/her plan pays first. Any remaining balance should be submitted to the Fund (along with a copy of the Explanation of Benefits showing how the primary carrier processed the claim).
2. If a covered child is the patient, the plan covering the parent whose birthday falls earlier in the year pays first (except children of legally separated or divorced parents. See page 91 of your Summary Plan Description for more information).
3. When the rules mentioned above do not establish an order of benefit determination, the benefits of the plan which has covered the person for the longer period of time shall be determined first.

What about HMO coverage?
If you or your eligible dependent has other coverage through an HMO (Health Maintenance Organization), be very careful! If the HMO coverage is primary and you don't use an HMO provider, you will not be eligible for secondary benefits under the Fund, since most HMOs cover all charges, if used properly.

Where to Go When You Need Quick Care

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

ER

Open 24/7

If a situation seems life threatening, call 911 or go to the nearest ER. The general rule of thumb is that your symptoms, including the degree of severity, must be such that immediate care would normally be required. Trust your instincts when choosing if you or a loved one needs immediate medical care.

The ER should be reserved for these urgent problems and should not be used for general illnesses/injuries that could be treated for 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

) Vaccine

Call the Fund Office at (800) 730-2441 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.

THE WAREHOUSE EMPLOYEES
UNION LOCAL NO. 730 TRUST FUNDS
911 Ridgebrook Road
Sparks, MD 21152-9451

HEALTH CORNER

Arthritis

Risk increases with age. Other risk factors include:

- Being overweight or obese
- Having a history of joint injuries or serious infections
- Working in a job that requires repetitive motions
- A family history of arthritis

The most common types of arthritis are osteoarthritis, rheumatoid arthritis, lupus, fibromyalgia and gout.

What you can do to treat arthritis

Arthritis cannot be cured, but early detection and treatment may help improve your quality of life. You can delay the most damaging effects if you:

- Maintain a healthy weight
- Follow a moderate daily exercise plan
- Avoid activities that could lead to injury
- Protect joints from repetitive overuse

Treatment choices also vary depending on the type of arthritis you have. Most options focus on controlling pain and minimizing joint damage. Treatment may include:

- Medication
- Physical or occupational therapy
- Braces, splints or other joint protection aids
- Weight loss
- Alternative care, such as acupuncture
- Surgery

How to talk to your doctor

Talk to your doctor if you're at risk for developing arthritis to determine if there are steps you can take to manage it. Make sure to tell your doctor of any persistent or frequent pain and stiffness in your joints. Different types of arthritis come with different symptoms. Your doctor may use a combination of methods to determine if your joint inflammation is a form of arthritis. Diagnosis includes review of your medical history and may involve a physical exam, X-rays, blood work or other lab tests.

This information is general and is not intended to replace the advice of your doctor. Consult your personal physician about your own medical condition.

Source: UnitedHealthcare