For Your Benefit

The Warehouse Employees Union Local No. 730 Trust Funds

www.associated-admin.com

July 2015 Vol. 20, No. 2

You Must Get Pre-Authorization for More than 8 Visits to a Chiropractor

*The following article applies to eligible **Class E** participants whose medical benefits are provided through the Fund, not an HMO.*

Your Plan covers up to 8 visits per calendar year to a chiropractor without pre-authorization. However, if you will need more than 8 visits in one calendar year, **you must, before your 9th visit, get pre-authorization** from CareAllies. CareAllies is a utilization review fi m which helps the Fund control the cost of hospital admissions by reducing unnecessary admissions and finding alternative treatment settings which are effective and medically sound.

Notice of Creditable Coverage

Cut and Keep. See page 3.

In order to be covered, the treatment must be medically necessary to improve your condition. Treatment to maintain a level of function is not considered medically necessary.

Be Careful. Because of the delay in billing time, we may not know you are nearing 8 visits until you've already gone over that amount. If CareAllies does not certify the visits over 8 as medically necessary, you may be responsible for all charges for the uncovered visits. If you think there is a possibility that you may go over 8 chiropractic visits, it's a good idea to call CareAllies, just in case. CareAllies toll-free number is (800) 768-4695.

Note: All treatment performed by a chiropractor will be considered chiropractic care, even if the chiropractor submits a bill as physical therapy or other treatment.

Open Enrollment for HMO Coverage Ends July 31

*The following article applies to eligible **Plan C Participants (Adams Burch).***

Open enrollment for medical and prescription drug coverage through United Healthcare HMO will end July 31. You have until July 31 to either enroll in United Healthcare for the fi st time or to add or drop dependents from your policy.

If you wish to enroll in United Healthcare or add a dependent to your policy, please complete the Fund Office Enrollment Form and the United Healthcare HMO application that were recently sent to you with the

continued on page 4

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

This issue—

Life And Accidental Death & Dismemberment Insurance through Voya Financial

Participants in Class C and Class E are eligible for Life and Accidental Death & Dismemberment benefits through Voya Financial. Your Group Policy Number is GL-61182-4.

If you die while eligible for benefits the amount of your Health and Welfare life benefit may be paid to the beneficia y(ies) you designated on your Health and Welfare Enrollment Form. You may name any person(s) you choose to be your beneficia y. However, if you name a beneficia y who is under the age of 18, he/she must have a court appointed guardian to handle all matters related to the Health and Welfare life benefit Even a child's mother must obtain court appointed guardianship.

Refer to the Schedule of Benefits on page 3 of the former ING/ReliaStar Life Insurance Company Group Plan booklet for the amounts payable for Life Insurance and Accidental Death and Dismemberment Insurance.

Beginning on and after your 65th birthday, Voya Financial decreases the amount of your insurance. Voya Financial pays a percentage of the amount otherwise payable as follows:

- From your 65th birthday to age 70, Voya Financial pays 65%
- From your 70th birthday to age 75, Voya Financial pays 50%
- From your 75th birthday and after, Voya Financial pays 30%.

Changing Beneficia y(ies)

You may change the named beneficia y at any time, without the beneficia y's consent. If you name more than one beneficia y without indicating a specific share for each, the benefits may be paid in equal shares or to the survivor.

To designate or change a beneficia y, follow the steps below.

1. On your computer, log on to www.associated-admin.com and click on "Your Benefits" Next, select "Warehouse Local 730" which will take you to Local 730's homepage. Under the heading entitled "Downloads," you can print the "Enrollment Form" (to name a beneficia y) or you can print the "Change in Beneficia y for Life Insurance Benefit (to change your beneficia y).

2. You may also call the Fund Office at (800) 730-2241 and ask for either an Enrollment Form or Change in Beneficia y for Life Insurance Benefit Form.

3. Complete all sections of the form and sign it.

4. Return the Form to:
   Fund Office
   Warehouse Employees Union Local No. 730
   Health and Welfare Trust Fund
   Attn: Eligibility Dept.
   911 Ridgebrook Road
   Sparks, MD 21152-9451

Beneficia y should call Fund Office soon after your death.

The person(s) you name as beneficia y(ies) should call the Fund Office within 20 days of your death to file a Life Insurance claim. The Fund Office needs to receive written proof of death (a certified copy of the death certificate) within 90 days of the date of death. You may not assign your Life Insurance Benefits to any debtor.

If the beneficia y you designate dies before you and/or you fail to designate a beneficia y, the life benefits will be paid to the fi st survivor in the following order:

1. Your spouse.
2. Your natural and adopted children.
3. Your parents.
4. Your estate.

Only those forms (the Enrollment Form, or if completed, the Change in Beneficia y for Life Insurance Benefit Form) that have been properly completed, signed, and received by the Fund Office prior to a participant's death will be honored.

Important Notice about Your Prescription Drug Coverage and Medicare

The following Notice of Creditable Coverage applies to all Medicare-eligible participants, retirees, 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 Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered 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 minimum standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Warehouse Employees Union Local No. 730 Health and Welfare Trust 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 fi st become eligible for Medicare and each year thereafter from October 15th to December 7th.

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, your current coverage under the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

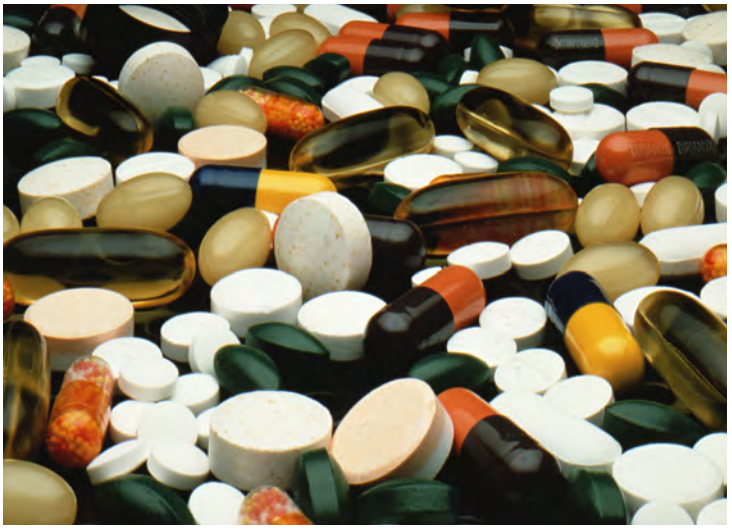
keep this no tice

You cannot have both Medicare prescription drug coverage and prescription drug coverage through the Fund at the same time. If you do decide to join a Medicare drug plan and drop your Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund prescription drug coverage, be aware that you and your dependents may not be able to get the same coverage back.

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 Warehouse Employees Union Local No. 730 Health and Welfare Trust 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 beneficia y premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficia y 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 (800) 730-2241. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan or if this coverage through the Warehouse Employees Union Local No. 730 Health and Welfare Trust 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).

Date: July 1, 2015

Name of Entity/Sender: Fund Offic
Warehouse Employees Union
Local No. 730
Health and Welfare Trust Fund
911 Ridgebrook RD
Sparks, MD 21152-9451
Phone Number: (800) 730-2241

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 whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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open enrollment letter. Send them, along with a copy of the required certification to the Fund Offic , postmarked **no later than July 31.** Be sure to include your dependent(s) Social Security Number(s) on the enrollment form and HMO application. All approved changes to your policy will become effective on August 1.

What if I dropped coverage for my dependents? Can I add coverage back later?

If you drop dependent coverage, you may add it again at the next open enrollment.

What if I want to add a new dependent after the open enrollment period?

If you didn't have any dependents, but during the year, got married, had a baby, etc., you may add the new dependent provided you do so **within 30 days** from the time he or she became your dependent. Coverage will begin retroactive to the dependent's date of eligibility.

If you have questions about open enrollment or need an additional open enrollment form, please call the Fund Office toll free at 800-730-2241.

Reviewing Your Dental Benefits

The following article applies to eligible participants in **Plan C and Plan E** *who have dental benefits provided under the Fund.*

Taking good care of your teeth by brushing daily and visiting your dentist every six months for a checkup and cleaning can help prevent more serious problems down the road.

Your dental benefits are provided through Dental Health Centers & Associates, and certain covered expenses are paid in full when performed by a participating dentist. (See the list of covered services below.) **Be sure to make your appointment with a dentist that participates with Dental Health Centers & Associates.** If you contact the provider (dentist) yourself, make sure you confi m that he/she still participates with Dental Health Centers. This is very important! If the provider no longer participates, you may be required to pay for services. You are required to pay for any services not covered by the Plan. As long as you use a Dental Health Centers & Associates provider, you will receive a 25% discount off the cost of non-covered services.

Services that are covered at 100% when performed by a participating dentist include the following:

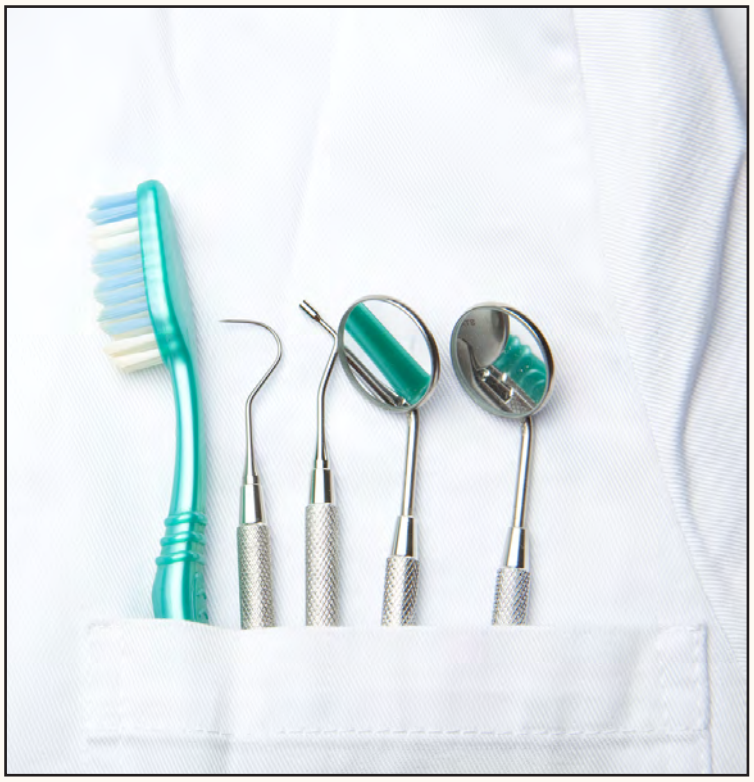
1. Routine examinations, emergency exams,
2. X-rays – including those needed for a complete diagnosis, and any required due to accidents, emergencies, or unusual circumstances,
3. Consultations,
4. Cleaning with fluo ide paste and routine plaque removal,
5. Sealants on children 14 and under,
6. Restorative dentistry – silver and tooth-colored fillings with local anesthesia,
7. Children's restoration by a general dentist or a pediatric dentist, including nerve treatment and stainless steel crowns where needed,
8. Emergency gum treatment for infection, and emergency treatment for toothaches, and oral pain not requiring hospitalization,
9. Oral surgery under local or general anesthesia by a general dentist or oral surgeon to include extractions, impactions, bone reshaping for dentures, biopsies, and other surgical procedures not requiring hospitalization,
10. Prosthetic procedures required to make new full and partial dentures every fi e years, and
11. Unlimited repair and relining of dentures when necessary.
12. **Plan E participants only:** Endodontic benefits are included with a 25% co-payment at any participating general dentist or specialist who participates in the endodontia program. Services covered with the co-payment include exam/consultation with the endodontist, endodontic therapy (root canals), apicoectomy, retrograde amalgams, and root amputations.

When You Need Emergency Care

If you need emergency dental services, and you are unable to contact and be treated by any of the participating dentists or the emergency staff at Dental Health Centers, you can receive reimbursement up to a maximum of **$50 per person,** per year, when you send a copy of the paid bill, along with a note explaining the circumstances, to: Dental Health Centers & Associates, 1450 Mercantile Lane, Suite 131, Largo, Maryland 20774.

Locating A Provider

If you need help locating a participating dentist or have questions about your benefits please call the Fund Office at (800) 730-2241 or Dental Health Centers & Associates at their **new telephone number** (301) 583-1400. You can also check the list of participating dentists on the web at www.dhcandassociates.com.



Visit a MinuteClinic to Save Time for Minor Health Concerns

The following article applies to eligible Plan E participants who have Health and Welfare benefits through the Fund.

As a CIGNA HealthCare member, you have the opportunity to receive treatment for common ailments and injuries by going to a MinuteClinic Health Care center. CIGNA Health Care provides convenient care clinics throughout the country where you can receive high quality, affordable health care services. These centers are conveniently located in select retail grocery stores and drug stores, as well as certain corporate Office buildings and college campuses.

Advantages:

- No waiting for an appointment. When you need care, you walk in and appointments usually take about 15 minutes.
- Open seven days a week, including evening hours.
- Receive high-quality medical care in a facility overseen by doctors and staffed by certified nurse practitioners and physician assistants.

To Find a Participating Clinic Near You:

- Log on to www.cignasharedadministration.com
- Select "Medical PPO Provider Directory" and then the category called "CIGNA Facility and Ancillary Directory"
- Enter a zip code of the area you wish to go to 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.

NOTE: Not all services offered at MinuteClinics are covered. Call the Fund Office at (800) 730-2441 before receiving treatment to be sure services are covered. Use of a MinuteClinic is subject to the same terms and conditions set forth in your Plan of benefits and, where appropriate, co-payments and deductibles apply.

You Can Continue Your Eligibility for Health Benefits through Self-Payments

If you are no longer employed full-time, or have taken a reduction in hours and haven't worked 300 hours for your Contributing Employer in the current Calendar Work Quarter, or 600 hours in the preceding two Calendar Work Quarters, you may make personal contributions ("self-pay") for up to 300 hours for the **current** Calendar Work Quarter in order to maintain your health benefits You can "self-pay" for a maximum of **two consecutive** Calendar Work Quarters.

Let's review this. The hours worked in Calendar Work Quarter of January, February, and March 2015 allow you to receive benefits during the benefit quarter of June, July, and August 2015. If you failed to earn either of the necessary hours mentioned above, you can continue **(if you are eligible)** to make personal contributions to make up missing hours from full employment. The Fund Office will send you a notice to inform you that you are eligible to make self-payments to continue eligibility and the amount of payment due. **The amount due for continuing eligibility must be paid before the Benefit Quarter begins.**

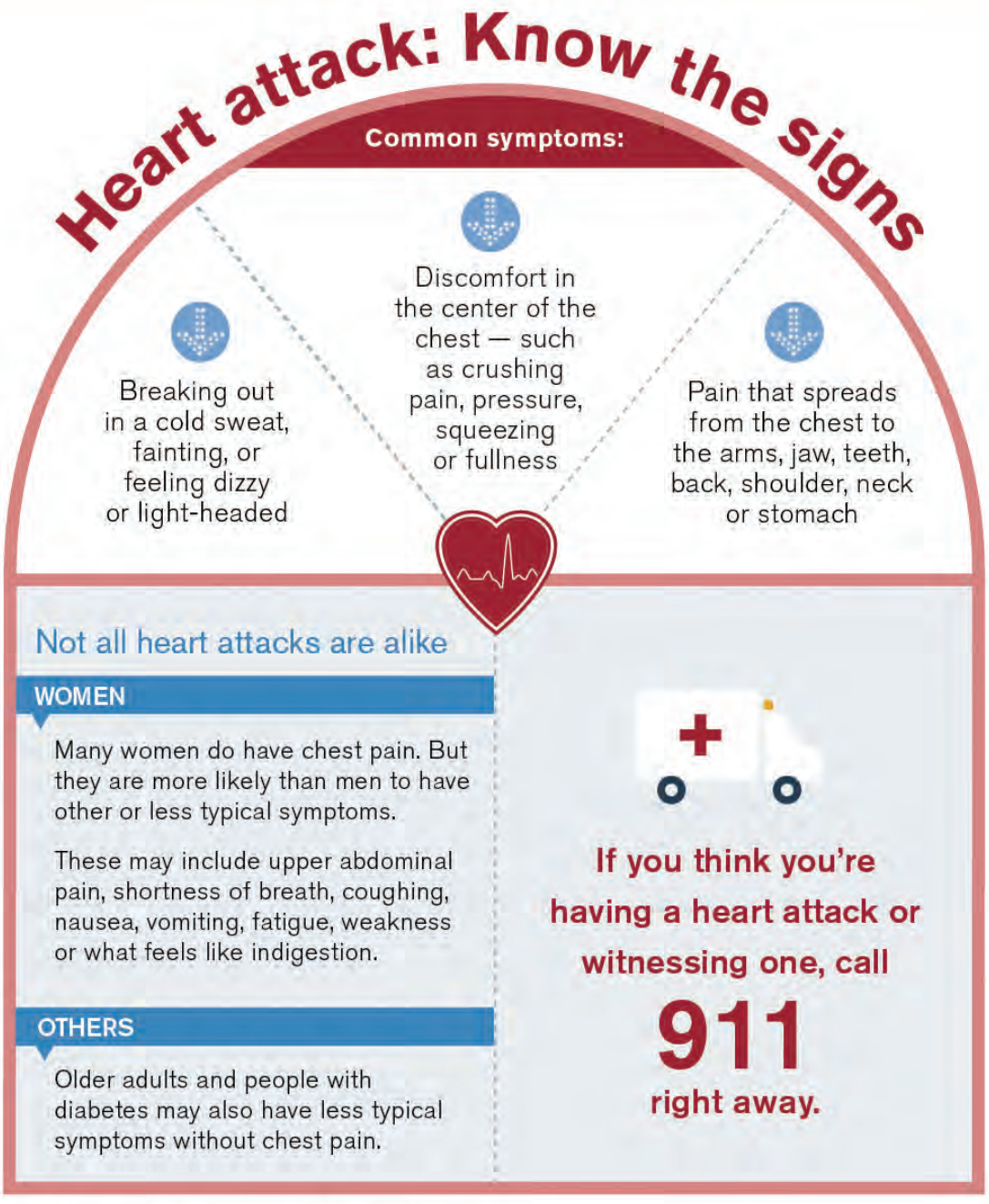
For more information on Self-Pay, see page 18 of your Summary Plan Description, entitled "Personal Contributions – Self Pay."

What happens when my eligibility ends?

The Fund Office will send you a packet of information letting you know what options you have to continue eligibility. In this packet, you will receive self-pay information, a COBRA Election form, information about your rights under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), and how you can continue coverage. The Election form must be completed, signed and returned to the Fund Office within sixty (60) days from the later of: (1) the date of the notice or (2) the date your Plan coverage terminates.

Under COBRA, coverage for you and your dependents can be continued for up to 18 months following the date on which coverage is lost due to termination or reduction in hours of employment. (See your Summary Plan Description booklet, pages 24-27, for more information). Failure to notify the Fund on time will result in forfeiture of COBRA rights.

HEALTH CORNER



Sources: National Heart, Lung, and Blood Institute; U.S. Department of Health and Human Services; American Heart Association

UnitedHealthcare®

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

Medical Claims Must Be Filed within One Year

The following article applies to eligible participants who have medical coverage through the Fund, and not through an HMO.

You have **365 days (one year)** from the date of service to file a medical claim with the Fund Offic . After that time, your claim will be considered late and **will be denied.** If your doctor's Office or the hospital says it will file the claim for you, that's fin , but it's ultimately your responsibility to be sure that the bill has been sent to the Fund Offic . Dental, vision, or prescription drug claims are handled through the provider. They are not processed through the Fund Offic .

When the Fund Office processes a medical claim, you will receive an "EOB" (Explanation of Benefits) If you haven't received an EOB within a couple of months from your date of service (it takes providers a while to submit the bills sometimes), check with the Fund Offic . If we haven't received a bill, contact the provider to see if one was sent.

Remember, you are the one who is responsible for the bill if your provider fails to submit it to the Fund Offic , so it's in your best interest to follow up.

Request for Additional Information

If a claim is not complete, the Fund Office will deny the claim within a 30-day period. If your claim is denied for lack of response, but you then get the information to us – within the original 365 days – your claim will be processed as usual. An inquiry on the phone about whether a service is covered (except an urgent claim) is not a claim.

If Your Medical Claim Is Denied

If part or your entire claim is denied, you will be notified in writing. The notice will explain:

- The reason(s) for the denial,
- The specific Fund rule on which the denial is based,
- Notice that you may receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to the claim, and
- A statement that you have the right to bring an action under ERISA.

The Fund Office will send you this notice within 90 days after receipt of your claim for benefits unless there are special circumstances which require more time to process your claim. In that case, the claimant will be notified of the need for an extension in writing, before the expiration of the initial 90 days.