1099Rs Will Be Mailed in Late January. Look for Yours!

For Your Benefit

The Warehouse Employees Union Local No. 730 Trust Funds

www.associated-admin.com

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Summary of Material Modifications

This Issue!

- Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund
- Warehouse Employees Union Local No. 730 Pension Fund
- Warehouse Employees Union Local No. 730 and Contributing Companies' Prepaid Legal Services Fund

Form 1095-B Will Soon Be Mailed To You

The Affordable Care Act is a federal law that requires almost everyone in the United States to have medical coverage. People who don't have at least a minimal level of coverage could have to pay a fine to the Internal Revenue Service (IRS). The Form 1095-B is proof that you and your covered dependents had medical coverage, so you can report it on your 2016 tax filing and avoid paying the fine.

Form 1095-B is a tax form (like a W-2 or 1099-R) you will receive from the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund as proof that you and your tax dependents had the required medical coverage. You should keep your Form 1095-B with all your tax records as supporting documentation.

If you had medical coverage through the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund in 2016 and you do not receive a Form 1095-B by the end of February, please contact the Fund Office at (800) 730-2241.

Change in Out-of-Pocket Maximum for Active Class E Participants

The following is a Summary of Material Modifications for Active participants in **Class E.** *Please keep this with your Plan booklet.*

Effective January 1, 2017, the out-of-pocket maximum is $6,100 medical and $1,050 prescription for individual coverage and $12,200 medical and $2,100 prescription for family coverage. The medical deductible is $800.

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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.

When Help Is Needed, Call Cigna's 24-Hour Health Information Line

The following article applies to eligible **Class E** *participants with Fund coverage.*

It's 3 a.m. and your child wakes with a fever, or you are away from home and don't feel well, or you have questions regarding a new prescription.

Whom Do You Call?

Call the Cigna 24-Hour Health Information Line no matter what time it is. A registered nurse or clinical specialist is available to you, 24 hours a day, 7 days a week. You can receive:

- Advice on where and when to seek medical treatment,
- Information on a specific health issue,
- Questions about a new prescription,
- Locating nearby doctors, health care facilities and pharmacies, and
- Receiving access to a pre-recorded health information library on over 1,000 health topics.

So How Can You Reach A Nurse?

Call 1-800-768-4695.
The call is always free! Please take a moment to put this phone number into your cell phone or personal contact list as a reminder of this service

You Can Print Temporary ID Cards From Your Home Computer

The following article applies to eligible Class E and Class C participants.

If you need a copy of your medical or prescription drug identification ("ID") card, you can print a temporary card by logging onto the provider's website and printing the card from home.

Before you begin, you will need to have the following:
1. A computer with internet access
2. Your customer ID or Social Security Number

Class E Participants Use Cigna HealthCare's Website. Eligible participants in Class E who have prescription drug coverage through the Fund will first have to establish an account by logging onto www.myCigna.com.

Once you have registered for myCigna, you can access your account over the internet in a safe, secure environment.

Detailed instructions:
1. Go to the myCigna website at www.myCigna.com and then click on the button marked "REGISTER NOW."
2. Enter your name and city into the required fields and then click on the button marked "Search."
3. Enter your personal information into the field and then click on the button marked "Next."
4. The registration procedure will prompt you in how to proceed.
5. On the bottom of the myCigna homepage, click on "Request New ID Card."
6. Follow prompts to print your ID card.

Class C Participants Use UnitedHealthCare HMO

Eligible participants in Class C with HMO benefits will have to establish an account by logging onto www.uhc.com. Complete the registration process by creating a username and password. Once created, you will be directed to the "myuhc" home page. On the right side of the page you will see the question "What would you like to do today?" Click on "Print an ID Card."

Besides using the internet to print ID cards, participants can always call the Fund Office at (800) 730-2241 to request one.

Summary of Material Modifications During The Past Year

Below are Summaries of the Material Modifications (changes) made to your Plans during the past year. Please clip this summary and keep it with your Plan booklets so you will have it for easy reference.

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

- **Effective January 1, 2017,** the out-of-pocket maximum is $6,100 medical and $1,050 prescription for individual coverage and $12,200 medical and $2,100 for family coverage. The medical deductible is $800.

- **Effective September 1, 2016,** the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund requires pre-certification for outpatient procedures through Cigna's Care Management Program. Cigna Care Management will assist you and your dependents to receive the right care, at the right time, in the right place.

With Cigna's Pre-Certification Process, You Can:

- Get the most appropriate inpatient and outpatient care
- Find lower cost services
- Avoid unnecessary or uncovered medical treatment or procedures
- Improve your health with case management services, which helps when you need extra assistance

How Pre-Certification Works

If you use an in-network provider, you don't need to do anything for pre-certification. The provider is responsible for getting the pre-certification for all required non-emergency in-network services.

If you use an out-of-network provider for non-emergency services, you are responsible for pre-certification. To do this, call the customer service phone number on the back of your Cigna ID card. A service representative will walk you through the pre-certification process.

What Services Need to Be Pre-Certified?

Your doctor will help you decide which procedures require a hospital stay and which can be handled on an outpatient basis. Inpatient services require you to stay overnight in a hospital or related facility. Outpatient services don't require an overnight stay.

Examples of Outpatient Services

- High-tech radiology (MRIs, CAT scans, PET scans, nuclear radiology)
- Injectible drugs
- Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)
- Home health care/home infusion therapy
- Dialysis (to direct to a participating facility)
- External prosthetic appliances
- Cosmetic or reconstructive procedures
- Sleep management
- Transplants
- Radiation

Important: Even if CareAllies certifies that a procedure is medically necessary, ***it does not guarantee payment of benefits.*** Be sure the service you are receiving is covered under your Plan. For questions about your coverage, contact the Fund Office.

- **Effective September 1, 2016 – Benefit Changes for Active Class E Participants.**

Medical

- The medical deductible will be $800 effective January 1, 2017.
- Your out-of-pocket maximum will be $6,100 medical and $1,050 for individual coverage; $12,200 medical and $2,100 for family coverage effective January 1, 2017.
- Your co-insurance will be 20% (i.e., the Fund will pay 80% of qualifying medical costs after you have reached your deductible).

Prescription Drug

- The prescription drug benefit will be re-structured as a three-tier in-network benefit as follows:
  - o copay for generic prescription drugs will be $15,
  - o copay on brand formulary prescription drugs will be $40, and

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continued from page 3

- o copay on brand prescription drugs, non-formulary, will be $75.
- o Mail-order prescription drugs for a 90-day supply will have copays double the amount of the above stated copays of $30/$80/$150 respectively; i.e., copay for mail-order generic drugs will be $30.

Preventive Services

- You will receive preventive services at no cost for you and your eligible dependents. This includes routine physical exams, routine gynecological exams, well-child exams, mammography screenings, colonoscopy screenings, and approved contraceptives.

Retiree Coverage

- Benefits to all retirees under the Fund will terminate effective August 31, 2016. Thus, after August 31, 2016, the Fund will no longer process claims for prescriptions incurred after August 31, 2016. Letters were sent to the following retiree groups announcing this change and offering transition assistance.

- o Pre-Medicare HMO Retirees who are interested in purchasing an individual medical plan through the state or federal healthcare marketplace, may contact the CLRA Group, LLC, an insurance brokerage firm the Fund has engaged who has experience in assisting individuals in enrollment.
- o Retirees with Fund prescription coverage can contact the CLRA Group, LLC, to offer assistance with coverage options.
- o CLRA Group, LLC phone number is (855) 215-2572.

Warehouse Employees Union Local No. 730 and Contributing Companies' Prepaid Legal Services Fund

No changes.

Warehouse Employees Union Local No. 730 Pension Fund

No changes.

Eligible Children Have Coverage Until Age 26

Once you become eligible for benefits (have worked at least 600 hours in six consecutive months for a participating employer), your biological children, stepchildren, or legally adopted children may receive coverage until the end of the month in which they turn age 26. If you have legal guardianship over a child and you provide one half of his/her support, that child may also be eligible for coverage. The Trustees may rely on evidence that the child has been claimed as a dependent on your tax return.

When Should I Enroll My New Dependent Child?

In order for coverage to begin right away for a newborn child, new stepchild, or newly adopted child, you must enroll him/her 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. 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 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 Union Local No. 730 Health and Welfare Fund," and under "Downloads (Forms)," print the enrollment form, or
- Call the Fund Office at (800) 730-2241 to ask for an enrollment form.
- Complete the form and return it to the Fund Office along with supporting documentation (baby's birth certificate and/or adoption papers). Be sure to include your dependent's Social Security Number on the enrollment form. This is very important! Enrollment will not be processed until the Fund Office receives 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 when he/she became your dependent, you will have to wait until the HMO open enrollment in July for coverage beginning in August.
- Class C participants who have coverage through United Healthcare HMO must complete two separate enrollment forms, one for the Fund Office and one for United Healthcare.

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

Group Vision Service Offers Savings on Hearing Aid Devices

The following article applies to eligible participants who have Health and Welfare Fund coverage.

The EPIC Hearing Savings Program, administered through Group Vision Service, offers participants a savings of 30 – 60% off the manufacturer's suggested retail price on all hearing aid devices.

Participants should call EPIC Hearing Healthcare at (866) 956-5400 to locate a provider and access savings.

Note: this Program is not affiliated with the medical benefits under the Fund.

Contact CareAllies When More Than Eight Visits to a Chiropractor Are Needed

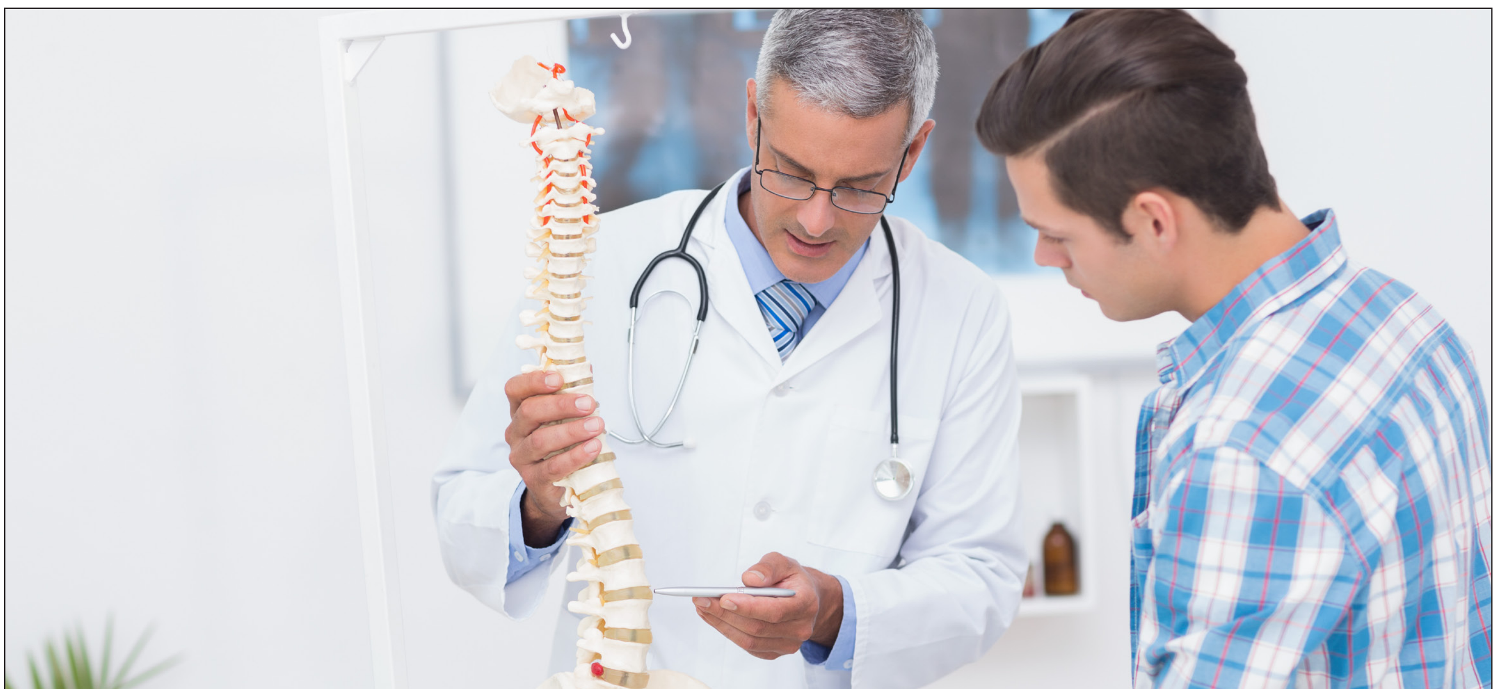
The following article applies to eligible ***Class E*** *participants whose medical benefits are provided through the Fund, not an HMO.*

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 firm 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.

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.



You Can Make Self-Payments To Maintain Eligibility for Benefits

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 October, November and December 2016 allow you to receive benefits during the benefit quarter of March, April and May 2017. 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 an 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 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 may 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.

Reconstructive Surgery Following Mastectomy Covered

The following article applies to you if your medical benefits are provided through the Fund and not through an HMO. If you have coverage through an HMO, you should receive a notice directly from the HMO.

The Women's Health and Cancer Rights Act ("WHCRA") provides protections for 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:

1. Reconstruction of the breast on which a mastectomy is performed;
2. Surgery on the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Physical complications of all stages of mastectomy, including lymphedemas.

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.

HEALTH CORNER

An Overview on Over-the-Counter Medicine

Eight of every 10 adults use over-the-counter (OTC) medicines for colds, coughs, and aches and pains. Do you keep OTC medicines on hand for regular use? Do you also take vitamins and herbal supplements for your health? Being cautious and informed may help you avoid problems. Check with your doctor or pharmacist about your prescription medicines, OTC products and supplements.

Read those labels

Look for the following information on labels of medicines and supplements:

- Product name
- Active ingredients
- Purpose (type of product, such as antihistamine)
- Uses (symptoms treated)
- Warnings
- Directions (how much to take and for how long)
- Other information (such as proper storage)
- Inactive ingredients (such as binders, colors or flavoring)

Read the label each time you buy a product. If symptoms persist or worsen after you've taken the recommended dose for the suggested length of time, see a doctor.

Be careful with acetaminophen

Check your OTC and prescription labels for acetaminophen. Acetaminophen is a pain reliever and fever reducer found in Tylenol®. It may be one of your go-to medicines to keep on hand. However, taking too much can cause liver damage. Stay safe with these steps.

- Make sure that you're taking the right dose.
- Don't take two medicines containing acetaminophen at the same time.
- Avoid multi-ingredient cold and flu products that treat a number of symptoms.

Manage your medications wisely

Here are three steps you can take to help yourself or a loved one safely manage medicines.

1. **Talk with your doctor and pharmacist.** This is the best way to learn about your medicines and how to take them properly.
2. **Keep a checklist** of all your prescription and OTC medicines. It should include how much you take, when and whether to take them with food.
3. **Follow instructions exactly.** Pay attention to warnings about interactions with other drugs, supplements, foods or drinks.
4. **Ask your doctor for a yearly "medication checkup."** You should review what you're taking, including supplements and herbal products. Your doctor can help you adjust or stop medicines if needed.

The above article was provided with permission from CareAllies, VitaMin. It is intended to be general health information and not medical advice or services. You should consult your doctor for medical advice or services.

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