VERY IMPORTANT ISSUE!
Be sure to read!

For Your Benefit

Bakers Union & FELRA Health and Welfare Fund

January 2012 Vol. 8 No. 1

Material Modification

New Dependent Eligibility Rules For Medical, Prescription And Optical

The following is a Summary of Material Modification (change) to your Health and Welfare Summary Plan Description booklet. Please keep this notice with your booklet so you have it when you need to refer to it.

Effective January 1, 2011, to qualify for dependent coverage under the Fund for MEDICAL, PRESCRIPTION AND OPTICAL BENEFITS, a child must: (1) meet the definition of "Child" below, and (2) be under age 26. Under these new rules, a Child under age 26 can be married, does not have to be financially dependent on you, and does not have to be a student to qualify for dependent health coverage. However, 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 the Child's spouse (if any).

"Child" Defined: Your biological or legally adopted child (including a child legally placed for adoption); a stepchild; a child for whom you have been appointed a legal guardian provided the child is claimed by you as a dependent on your federal tax return; and a child for whom you have been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

Coverage for a disabled Child may continue beyond age 26 provided the Child meets the eligibility requirements (other than age) in the Fund's Summary Plan Description.

Effective January 1, 2011, the ELIGIBILITY, "Student Coverage" subsection of the Summary Plan Description does not apply medical, prescription and vision benefit coverage because, as described above, dependent eligibility has been extended until age 26 for these benefits. The Student coverage requirements detailed in your Summary Plan Description still apply for dental benefit coverage. **All eligible dependents must use a participating CIGNA PPO shared administration provider in order for benefits to be covered, effective January 1, 2011.** Services performed by a non-CIGNA PPO shared administration provider will not be paid under the Fund, with limited exceptions.

Eligibility requirements for Dental benefits are detailed in the Fund's Summary Plan Description.

This Issue—

Material Modification

Increase In Annual Deductible

The following is a Summary of Material Modification (change) to your Health and Welfare Summary Plan Description booklet. Please keep this notice with your booklet so you have it when you need to refer to it.

Effective January 1, 2012, the annual deductible for **Plan 1 participants** increased from $250 to $300 per calendar year for individual coverage and from $500 to $600 per calendar year for family coverage.

Please make this change on page 96 of your Summary Plan Description booklet.

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.

Material Modification

Catalyst Formulary Advantage

The following is a Summary of Material Modification (change) to your Health and Welfare Summary Plan Description booklet. Please keep this notice with your booklet so you have it when you need to refer to it.

Effective August 1, 2011, the Trustees of the Bakers Union and Food Employers Labor Relations Association Health and Welfare Fund approved the following change to the Plan. The 2011 Catalyst Formulary Advantage Program now includes:

1. Angiotensis II Receptor Blocks ("ARBs");

2. Bisphophonates;

3. Nasal Steroids;

4. Proton Pump Inhibitors ("PPIs"); and

5. Triptans, subject to the following conditions:

a. all Participants currently receiving the above drugs are grandfathered (i.e., exempt from the requirements of the Formulary Advantage Program for the applicable drug category); however, if the participant stops taking the applicable drug for more than six months, the participant would lose grandfathered status, and

b. any Participant for whom a physician specifically prescribed a brand name drug or "targeted medication" because the participant for whatever reason cannot take a generic or preferred alternative drug also is exempt from the Formulary Advantage Program for that drug category.

Plan I Participants: Annual Dollar Limit On Essential Health Benefits Is Now $1,250,000

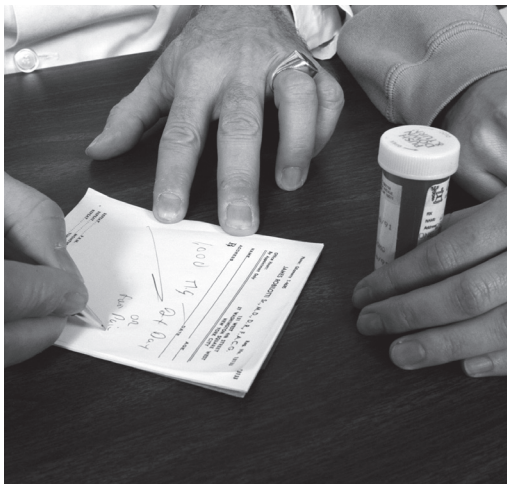
Material Modification

The following is a Summary of Material Modification (change) to your Health and Welfare Summary Plan Description booklet. Please keep this notice with your booklet so you have it when you need to refer to it.

Effective January 1, 2012 the overall annual dollar limit on essential health benefits under the Plan has increased from $1,000,000 to $1,250,000 for eligible participants in Plan I. Please make this change on pages 25 and 96 of your Summary Plan Description booklet.

What are essential health benefits?

The following are essential health benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Otherwise, until further federal guidance is released, the Trustees may determine whether a specific benefit is an "essential health benefit" under this Fund.



This Plan Is "Grandfathered" Under The PPACA

The Bakers Union and FELRA Health and Welfare Fund believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (i.e., the Act). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Act that apply to other plans, such as the requirement that certain preventive health services be provided without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, such as the elimination of lifetime dollar limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Office at 866-662-2537. You may also contact the U.S. Department of Labor at 1-866-444-3272 or on the web at www.dol/gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

Enroll A New Dependent For Coverage Within 30 Days

Once you are eligible for dependent coverage (see page 34 of your Summary Plan Description), you may add a new dependent to your benefit coverage if you enroll him/her within 30 days from the date they became your dependent.

Enrolling a newborn

Newborns may be covered from the date of birth if he or she is properly enrolled within 30 days. You must contact the Fund office at (866)-662-2537 and ask for an enrollment form. Complete the enrollment form and return it to the Fund office along with a copy of your baby's birth certificate. If you haven't received the birth certificate yet, send us 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.

Enrolling other new dependents

If you have recently married and have a new spouse, or 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 marriage, adoption, or placement for adoption. **Note:** 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 coverage through the child's spouse (if any).

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

How do I enroll my new dependents?

Log on to www.associated-admin.com, click on the words "Your Benefit" located at the top of the screen, select "Bakers Union and FELRA," and print the enrollment form, or call the Fund office at (866)-662-2537 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.

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.

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

Plan 2 Participants: Notice Of Waiver From Annual Limit Requirement

Material Modification

The following is a Summary of Material Modification (change) to your Health and Welfare Summary Plan Description booklet. Please keep this notice with your booklet so you have it when you need to refer to it.

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. **Effective January 1, 2012**, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least $1,250,000.

For Plan 2 participants, your health coverage offered by the Bakers Union and FELRA Health and Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of $100,0000 on all medical benefits and prescription drugs.

This means your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay for about 54 days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least $1,250,000 this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until December 31, 2012.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health coverage. For more information, go to: www.healthcare.gov.

If you have any questions or concerns about this notice, contact the Fund office toll free at 1-866-662-2537.

Material Modification

Medicaid And CHIP Offer Free Or Low-Cost Health Coverage To Children And Families

The following is a Summary of Material Modification (change) to your Health and Welfare Summary Plan Description booklet. Please keep this notice with your booklet so you have it when you need to refer to it.

Effective April 1, 2009, if you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or Children's Health Insurance Program ("CHIP") to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible and not already enrolled in the employer's plan. This is called a "special enrollment" opportunity," and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility.

State	Contact Information
Alabama (Medicaid)	Website: www.medicaid.alabama.gov Phone: 1-800-362-1504
Alaska (Medicaid)	Website: health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
Arizona (CHIP)	Website: www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437
Arkansas (CHIP)	Website: www.arkidsfirst.com/ Phone: 1-888-474-8275
California (Medicaid)	Website: www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
Colorado (Medicaid & CHIP)	Medicaid Website: www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
	CHIP Website: www.CHPplus.org CHIP Phone: 303-866-3243
Florida (Medicaid)	Website: www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268
Georgia (Medicaid)	Website: dch.georgia.gov/ (Click on Programs, then Medicaid) Phone: 1-800-869-1150
Idaho (Medicaid & CHIP)	Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588
	CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588
Indiana (Medicaid)	Website: www.in.gov/fssa Phone: 1-800-889-9948
Iowa (Medicaid)	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
Kansas (Medicaid)	Website: www.khpa.ks.gov Phone: 1-800-792-4884
Kentucky (Medicaid)	Website: chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570

State	Contact Information
Louisiana (Medicaid)	Website: www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207
Maine (Medicaid)	Website: www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557
Massachusetts (Medicaid & CHIP)	Medicaid & CHIP Website: www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120
Minnesota (Medicaid)	Website: www.dhs.state.mn.us/ (Click on Health Care, then Medical Assistance) Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670
Missouri (Medicaid)	Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
Montana (Medicaid)	Website: medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
Nebraska (Medicaid)	Website: www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
Nevada (Medicaid and CHIP)	Medicaid Website: dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
	CHIP Website: www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
New Hampshire (Medicaid)	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
New Jersey (Medicaid and CHIP)	Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561
	CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
New Mexico (Medicaid and CHIP)	Medicaid Website: www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583
	CHIP Website: www.hsd.state.nm.us/mad/index.html (Click on Insure New Mexico) CHIP Phone: 1-888-997-2583
New York (Medicaid)	Website: www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
North Carolina (Medicaid)	Website: www.nc.gov Phone: 919-855-4100
North Dakota (Medicaid)	Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
Oklahoma (Medicaid)	Website: www.insureoklahoma.org Phone: 1-888-365-3742
Oregon (Medicaid and CHIP)	Medicaid & CHIP Website: www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678
Pennsylvania (Medicaid)	Website: www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730
Rhode Island (Medicaid)	Website: www.dhs.ri.gov Phone: 401-462-5300
South Carolina (Medicaid)	Website: www.scdhhs.gov Phone: 1-888-549-0820
Texas (Medicaid)	Website: www.gethipptexas.com/ Phone: 1-800-440-0493
Utah (Medicaid)	Website: health.utah.gov/upp Phone: 1-866-435-7414
Vermont (Medicaid)	Website: www.greenmountaincare.org/ Phone: 1-800-250-8427
Virginia (Medicaid and CHIP)	Medicaid Website: www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924
	CHIP Website: www.famis.org/ CHIP Phone: 1-866-873-2647
Washington (Medicaid)	Website: hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
West Virginia (Medicaid)	Website: www.wvrecovery.com/hipp.htm Phone: 304-342-1604
Wisconsin (Medicaid)	Website: www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
Wyoming (Medicaid)	Website: www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

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To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Your Wellness Benefits

Your plan of benefits covers a variety of wellness benefits. Below is a summary.

Plan 1 Participants

Plan 1 participants and their eligible spouses (not dependent children) can receive a physical examination once every two years. Benefits are paid under Major Medical at 80%, with a combined maximum of $200 between the participant and spouse, up to the CIGNA allowed amount.

Plan 1 and Plan 2 Participants

One flu shot per calendar year for the participant and eligible dependent if received at a Giant or Safeway Pharmacy. The cost of the flu shot will be reimbursed by the Fund in an amount up to $20 per shot. Send the paid register receipt showing you received the flu shot to: The Fund Office, Bakers Union and FELRA, 911 Ridgebrook Road, Sparks, MD 21152-9451. Include your name, address, and ID number from your Medical card when submitting the receipt for reimbursement.

Children up to age 5 can receive routine immunizations and up to eight well child examinations. Coverage ends on the child's 6th birthday or after the eighth visit, whichever occurs first.

Male participants and dependents age 50 and over can receive routine PSA tests (prostate specific antigen tests), with coverage at 100%, up to the CIGNA allowed amount, with no deductible, once every 12 months.

Routine colonoscopies for participants and dependents age 50 and over are covered at 100%, up to the CIGNA allowed amount, with no deductible, once every five years.

Newborns' & Mothers' Health Protection Act Provides Minimum Hospital Stay

In accordance with the Mothers' and Newborns' Health Protection Act of 1998 (the "Newborns' Act"), the Fund provides coverage for mothers and eligible newborns to remain in the hospital after birth for a minimum of 48 hours for a normal, vaginal delivery, and a minimum of 96 hours for a cesarean delivery. The Fund cannot and does not require that providers obtain authorization for prescribing a length of stay not in excess of the above period of time.

How To File For Weekly Accident And 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 toll free 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," found at the top horizontal section of the homepage. Select "Bakers Union and FELRA." You will be directed to a list of forms. Click on the Accident & Sickness claim form and 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 written on 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 at $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 injury, benefits will begin on the 1st day of your disability.

For further details about your A&S benefits, refer to your Summary Plan Description ("SPD") booklet on pages 64 – 67.

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 you (or your eligible dependent) benefits with the understanding that ***you are required to reimburse the Fund in full*** for 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 (or 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 any 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 your 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.

Rules and obligations of subrogation:

- To pay back the Fund office first for any benefits related to an accident once you recover those costs 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.

Privacy Statement Available Upon Request

As you know, in accordance with federal law, the Fund has established Privacy Practices, which are the rules on how protected health information (PHI) about you may be used and disclosed by the Fund and other parties under the Health Insurance Portability and Accountability Act of 1996 and how you can get access to this information.

The Notice of Privacy Practices that you received in April 2003 (or when you first became a participant, if later) describes these rules. If you would like another copy of the "Statement of Privacy Practices," log onto www.associated-admin.com and click on the words "Your Benefits," located at the top of the screen. Select Bakers Union and FELRA and print the Statement of Privacy Notice. You can also call the Fund office at (866) 662-2537 or write to:

HIPAA Privacy Officer
Bakers Union and FELRA
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, Maryland 21152-9451

WHCRA Allows Reconstructive Surgery Following Mastectomy

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:

- 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 lymph edema.

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.

Let The Fund Office Know If Health Coverage Is Offered To Your Dependent

If your dependent child (age 19 to 26) is offered health coverage through his or her employer, or through their spouse's employer, it is your responsibility to let the Fund office know. Once a dependent child is offered coverage **(whether he or she accepts the coverage or not)** from an employer or the spouse's employer, the dependent does not qualify for the Fund's medical coverage. It is important to keep the Fund office informed by calling toll free (866) 662-2537.