For Your Benefit

Bakers Union & FELRA Health and Welfare Fund

January 2013 Vol. 9 No. 1

Material Modification

Plan 1 Participants: Annual Dollar Limit on Essential Health Benefits Is Now Two Million Dollars

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, 2013, the overall annual dollar limit on essential health benefits under the Plan has increased from $1,250,000 to $2,000,000 for eligible participants in Plan 1. Please make this change on pages 25 and 26 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, as well as 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.

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.

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Plan 2 Participants: Notice of Waiver from Annual Limit Requirement

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 arbitrary dollar limits for coverage for key benefits. If a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $2,000,000.

Your health insurance coverage, offered by the Bakers Union and FELRA Health and Welfare Fund under Plan 2 does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of $100,000 on all essential health benefits, effective January 1, 2013.

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year.

That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums, a significant increase in employer contributions or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to www.HealthCare.gov.

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

Continuing Medical, Prescription, and Optical Coverage For Your Child Age 19-26

Q. My daughter will soon become 19 years old. Can she continue to receive coverage for benefits?

A. Your daughter may qualify for dependent coverage for medical, prescription drug, and optical benefits if she meets the following requirements:

- She must either be your biological or legally adopted child, your stepchild, a child for whom you have been appointed as legal guardian–provided the child is claimed by you as a dependent on your federal tax return, or a child for whom you have been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).
- **She must have been enrolled in medical coverage prior to age 19 to continue coverage up to age 26**. She can be married and does not have to be financially dependent on you.Also, she does not have to be a student to qualify for dependent health coverage. However, **any 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).**

Your daughter must use a participating CIGNA PPO shared administration provider in order to receive coverage.

Dental Coverage

In order for your child to receive dental coverage from age 19 – 23, he/she must be enrolled as a full-time student and must submit a Student Certification form annually.

Additional Drug Classes Added To 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 10, 2012, the Trustees of the Bakers Union and Food Employers Labor Relations Association Health and Welfare Fund approved the following change to the Plan. The 2012 Catalyst Formulary Advantage Program now includes the following drug classes:

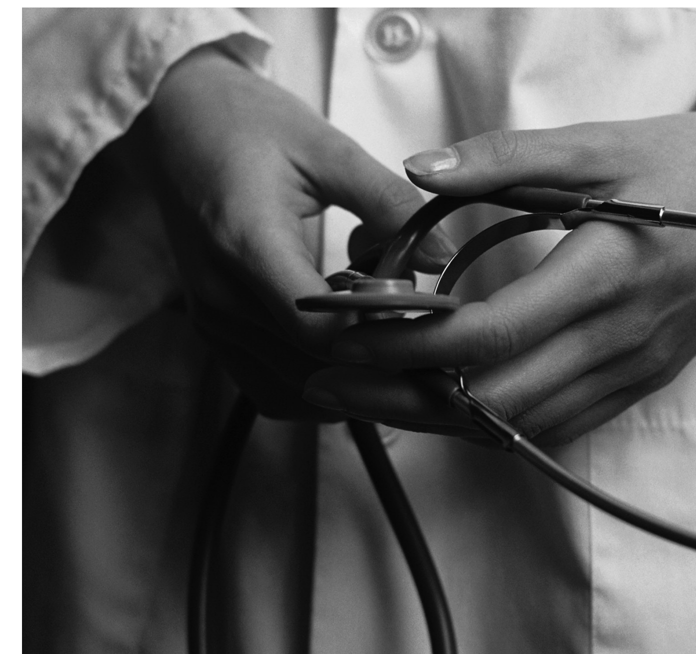
1. Albuterol Inhalers	10. Hepatitis C
2. Androgens	11. Insulin
3. Basal Insulin	12. Interferons
4. Antipsychotics	13. Multiple Sclerosis Drugs
5. Diabetic Test Strips	14. Opthalmic Prostaglandins
6. Fibrates	
7. FSH Agents	15. Sleep Aids
8. GLP Inhibitors	16. SSRI's
9. Growth Hormones	17. TNF Inhibitors

Certain Conditions Apply

The above drug classes are added to the 2012 Catalyst Formulary Advantage Program subject to the following conditions:

1. All Participants currently receiving any of the above drugs are grandfathered–i.e., exempt from the requirements of the Formulary Advantage Program, for the applicable drug category. Should a Participant stop taking the applicable drug for more than six months, he/she will lose grandfathered status; and
2. Any Participant for whom a physician specifically prescribes a brand name drug/"targeted medication" because the Participant, for any reason, cannot take a generic or preferred alternative drug, will also be exempt from the Formulary Advantage Program for that drug category.

You Must Use A Doctor/Hospital In The CIGNA Shared Administration Network For Medical Coverage



Before you make an appointment to see a doctor (whether a general practitioner, OB/GYN, pediatrician, etc.), and before scheduling any non-emergency hospital procedure (inpatient or outpatient), **you must be sure the doctor and/or hospital is a CIGNA Shared Administration provider. If you don't use a CIGNA provider, services will not be covered and you will have to pay the bill.** It doesn't matter if you make your appointment months or a couple of days ahead, you still need to check again on the day of the visit to be sure he/she is still in the CIGNA Shared Administration network.

Locating Providers

To locate the most current providers in the CIGNA network, log on to its website www.cignasharedadministration.com. The names of providers are updated regularly. You can also call CIGNA at (800) 768-4695.

Catalyst Rx Is Now Called Catamaran Rx And Briova Rx Is Your Specialty Drug Provider

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 July 12, 2012, Catalyst Rx rebranded the company as Catamaran. This name change **does not alter your benefits and you will continue to use your current prescription card.** You can also continue to use the same "labor friendly" pharmacies, such as Safeway, Giant/SuperG, Acme, Super*Fresh, Pathmark, ShopRite or Rite Aid, and the phone number for customer service remains the same (888) 869-4600.

Specialty Drugs Now Filled Through Briova Rx Ascend

Prescriptions for specialty medications are now provided through Briova Rx Ascend program. **There is no change in the cost of prescriptions with this name change.** Formerly these medications were filled through BioScrip, Catalyst Rx's specialty pharmacy.

Specialty medications are used to treat genetic or chronic conditions like multiple sclerosis, hepatitis C, Crohn's disease, Gauchers disease, hemophilia, oncology, psoriasis, rheumatoid arthritis, transplants, and HIV/AIDs. If you have a prescription for a specialty drug, it will not go through at the retail pharmacy level–the pharmacist will receive a message indicating you must get the drug from a Briova specialty pharmacy.

To have a specialty medication filled, contact Briova Rx Ascend at 1-855-427-4682. Remember, specialty medications are <u>not</u> filled through your retail pharmacy.

In your Summary Plan Description booklet, wherever NMHC Rx appears, replace with the prescription benefit manager Catamaran Rx and replace NMHC Ascend program with the name Briova Rx Ascend.

Prescriptions Filled At MinuteClinics Are <u>Not</u> Covered

As a Bakers FELRA participant, you have the opportunity to receive treatment for common ailments and injuries by going to a MinuteClinic health care center. However, if you are given a prescription, do not get it filled at the MinuteClinic since it is NOT in-network. ***To receive coverage for your prescription, you must use a pharmacy that is in-network (Safeway, Giant/SuperG, Acme, Super*Fresh, Pathmark, ShopRite or Rite Aid pharmacy).***

NOTE: CIGNA HealthCare does **<u>not</u>** cover the cost for visits to a MinuteClinic–the Fund office does. The use of a MinuteClinic is subject to the same terms and conditions set forth in your Plan of benefits, where appropriate co-payments and deductibles apply.

Enroll Your Newborn Baby Within 30 Days Of Birth

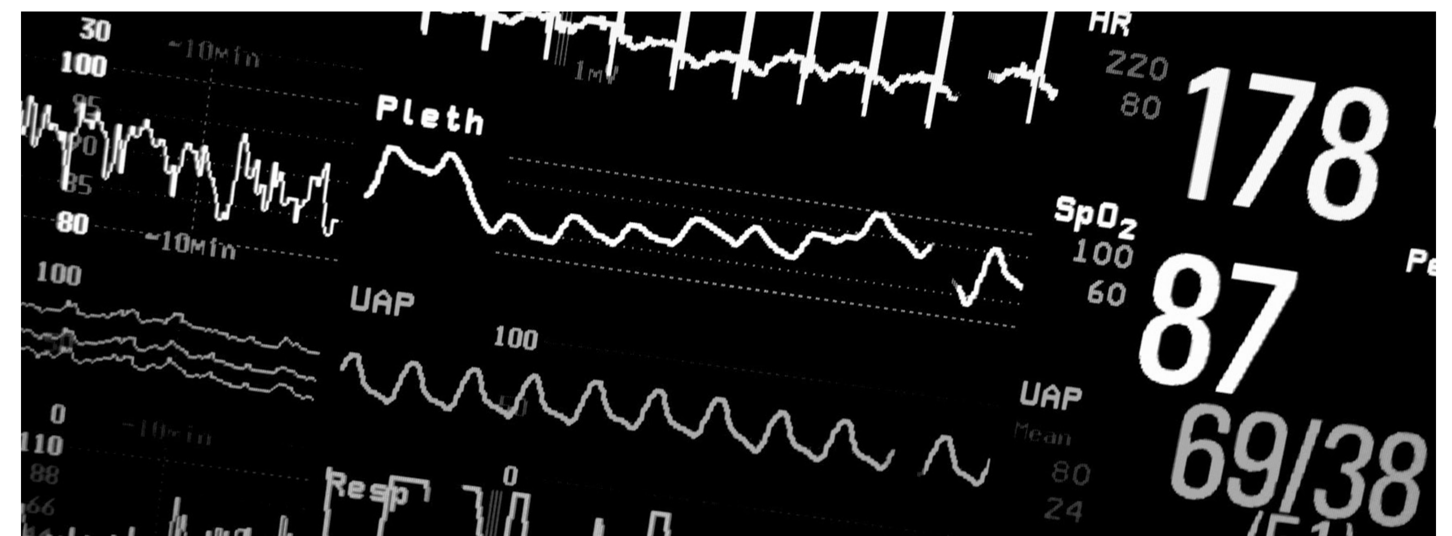
To be sure your new baby's expenses are covered, you must enroll him/her with the Fund office **within 30 days** (assuming you are eligible for dependent coverage). If you don't enroll your baby within 30 days, your baby will not have coverage until the beginning of the following month after which we receive your paperwork. To ensure that your baby has coverage from the first possible date, request an enrollment form **before** you have the baby.

Enrolling is easy–just call the Fund office at (866) 662-2537 and ask for an enrollment form. You can also print the form from your computer by logging onto www.associated-admin.com. Click on "Your Benefits" located at the left side of screen and select the fund "Bakers Union/FELRA." From the Bakers Union and FELRA homepage, you can select and print the Enrollment Form. Complete the form and return it to the Fund office along with a copy of your baby's birth certificate. **Be sure to include your baby's Social Security Number on the enrollment form.** If you haven't received the birth certificate yet, send us the birth verification notice from the hospital. We will accept that <u>until</u> you receive the birth certificate. We <u>still need</u> a copy of the actual birth certificate once you receive it, so be sure to follow up. 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.

Coverage When Seeing An Out-of-Network Anesthesiologist

If you use an anesthesiologist who is not in the CIGNA Shared Administration ("CIGNA") network, the nonparticipating anesthesiologist will be paid at the CIGNA allowed amount only if:

1. Your doctor ***and*** the hospital are CIGNA participating providers; ***and***
2. You have received authorization from CIGNA.



Going to the Hospital? Be Sure To Call CareAllies

CareAllies is a health management company which helps the Fund ensure that you receive quality and cost-effective healthcare through its medical care programs. CareAllies provides a broad portfolio of services such as pre-certification, complex case management, specialty case management, 24-Hour Nurse Line programs, and web tools to help improve your health and well-being.

For ALL hospital admissions, you (or your family member/caregiver or provider) ***must*** call CareAllies for authorization in order for the Fund to pay benefits. ***If you fail to call CareAllies, you may be responsible for paying up to $1,000 or 20% of the cost (whichever is less), in addition to any other deductibles or co-payments.***

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

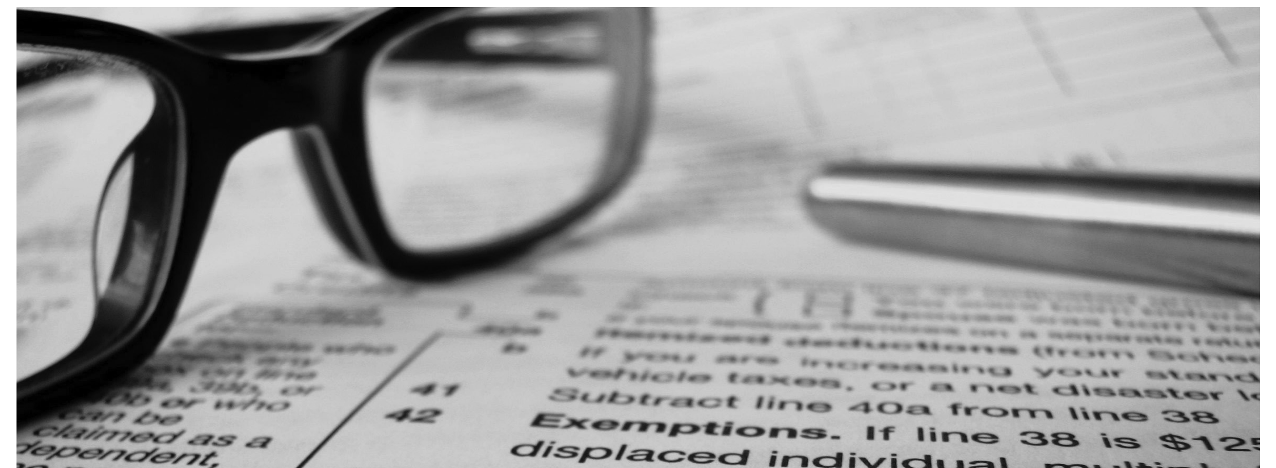
- Before your admission, call CareAllies at (800-768-4695) to pre-certify all planned (non-emergency) or elective hospital stays. For an emergency admission, call CareAllies within 48 hours of the admission.
- If CareAllies determines that your admission is medically necessary, you will receive an authorization letter from CareAllies which includes the number of days approved. Be sure to take a copy of the authorization letter with you when you go to the hospital to be admitted.
- If your medical condition requires an extension of your hospital stay, CareAllies will need to be contacted by your physician or a facility staff member. Therefore, when you become aware of the need to extend your stay, inform your physician that CareAllies will need to be contacted. You (or a family member/caregiver) should also contact CareAllies to confirm authorization for your continued stay.

Keep Track of Your COBRA Continuation Coverage

If you are receiving COBRA Continuation Coverage, it is your responsibility to keep track of how long you have received coverage. Generally, you may continue COBRA Continuation Coverage for up to 18 months, unless there is a second qualifying event occurring within the 18-month period. When a second qualifying event occurs, you may be eligible for an additional 18 months of coverage, not to exceed a total of 36 months. An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled.

The Fund does not bill you for monthly COBRA payments, nor do we send a notice telling you your coverage is ending. It is your responsibility to remember to mail your COBRA payments to us. Naturally, we will return your check if you made a payment for a month for which you are no longer eligible. Keeping track of your length of coverage protects you from incurring a claim you thought would be covered, but in fact, is not.

If you have any questions or wish to request additional information about COBRA continuation coverage, please contact the Fund office at (866) 662-2537.



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 lymphedema.

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.