Notice of Creditable Coverage.
See page 6.

VERY IMPORTANT ISSUE!
Be sure to read!

For Your Benefit

Bakers Union & FELRA Health and Welfare Fund

Material Modifications

July 2011 Vol. 7 No. 2

Changes As A Result of Health Care Reform ("PPACA") And Mental Health Parity Act

This notice is a Summary of Material Modifications (SMMs) for the Bakers Union and FELRA Health and Welfare Fund as required by the Employee Retirement Income Security Act of 1974 (ERISA). It describes changes to the information presented in your Summary Plan Description (SPD), other plan communications, and any previous SMMs. Please keep this notice with your booklet so you have it when you need to refer to it.

Effective January 1, 2011, pursuant to the Patient Protection and Affordable Health Care Act ("PPACA") and the Mental Health Parity and Addiction Act of 2008, the Board of Trustees of the Bakers Union and FELRA Health and Welfare Fund ("Fund") has made several changes to the Fund's Plan of benefits and eligibility rules.

NEW DEPENDENT ELIGIBILITY RULES

As discussed in the Fund's "Special Enrollment Notice – Dependents Ages 19 – 26" of November 15, 2010, **effective January 1, 2011**, to qualify for dependent coverage under the Fund, 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; or 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 SPD is eliminated because, as described above, dependent eligibility has been extended until age 26. 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.

OVERALL LIFETIME DOLLAR LIMIT CHANGED TO AN ANNUAL DOLLAR LIMIT

For Plan 1 Participants And Eligible Dependents

Effective January 1, 2011, Plan 1's overall lifetime dollar limit (currently $1,000,000) changed to an annual dollar limit of $1,000,000, which is applied to "essential health benefits." See below for an explanation of essential health benefits.

If you exhaust the annual dollar limit, it is possible that the full maximum will be restored (including expenses for substance abuse treatment) after you pay at least $1,000 in eligible expenses and submit evidence of good health to the Board of Trustees. The Board will determine whether to restore the full maximum or a

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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.

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partial amount on a case-by-case basis, after receiving the evidence of good health.

In addition, for the three consecutive Plan Years beginning January 1, 2011, the following overall annual limits on the value of all essential health benefits provided under the Plan will be in effect for members (and their dependents) for all plan options:

- 2011: $1,000,000
- 2012: $1,250,000
- 2013: $2,000,000

For Plan 2 Participants And Eligible Dependents

Effective January 1, 2011, Plan 2's overall lifetime dollar limit (currently $100,000) changed to an annual dollar limit of $100,000, which is applied to "essential health benefits." See below for an explanation of essential health benefits.

Notice of Waiver from Annual Limit Requirement for Plan 2

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

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

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.

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 use 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.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Effective January 1, 2011, Plan 1 will pay mental health/substance abuse ("MH/SA") inpatient physician charges at 100%, with no deductible or coinsurance applied, for up to 70 days per calendar year. After 70 inpatient MH/SA days in a single calendar year, the Plan will pay 80% of physician charges, after the deductible (which is $250/individual and $500/family) is applied. You will be responsible for the remaining 20% of inpatient physician charges.

Also **effective January 1, 2011**, the requirement under both Plan 1 and Plan 2 that you obtain pre-certification before receiving outpatient MH/SA treatment is eliminated.

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, for example, 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, for example, 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.

Your Surgical Benefits

Your Plan of benefits covers surgical services to you or your eligible dependent for operative and cutting procedures, the reduction of fractures and dislocations, as well as major endoscopic and other surgical-diagnostic procedures. ***You must use a participating provider (whether a hospital, physician, or other health care provider) in the CIGNA Shared Administration network.*** Services performed by non-CIGNA providers will not be covered under the Fund, with limited exceptions such as emergencies.

Locating a Provider in the CIGNA Shared Administration Network

To locate the most current providers in the CIGNA Shared Administration network, log on to its website at www.cignasharedadministration.com. The names of providers are updated regularly. If you wish to receive a CIGNA Provider Directory, call the Fund office toll-free at (866) 662-2537 and we will mail one to you.

Surgical Expenses

Plan 1 Participants

Surgical expenses are paid at 100%, with no deductible, based upon a surgical schedule (by procedure). The maximum surgical schedule benefit is $800 per procedure. Eligible expenses over $800 are covered under Major Medical.

Plan 2 Participants

All eligible expenses are paid under Major Medical at 75%.

Outpatient Surgical Facility Expense Benefits

Plan 1 Participants

For surgery performed as an outpatient, the facility charge is covered at 100% with no deductible, up to the CIGNA allowed amount. Expenses above the CIGNA allowed amount are not covered.

Plan 2 Participants

All eligible expenses are paid under Major Medical at 75%.

Major Medical Benefits

Plan 1 Participants

Major Medical benefits cover expenses at 80% after you have paid your $250 annual deductible per person ($500 per family maximum). The remaining 20% is payable by you.

Plan 2 Participants

Expenses for Major Medical benefits are covered at 75% after satisfying a $300 per person ($600 per family maximum) per calendar year deductible. The remaining 25% is payable by you. Participants in this group have a $4,000 annual out-of-pocket maximum after which benefits for the remainder of the calendar year will be paid at 100%.

Reminder – All hospital stays must be certified by CareAllies in order to be considered for payment under the Fund. Be sure you (or a family member or the provider of service) contact CareAllies within 48 hours of emergency admission to a hospital. Call CareAllies at (800) 768-4695 to pre-certify your admission.

Visit A MinuteClinic for Minor Health Concerns

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 HealthCare provides convenience care clinics throughout the country where you can receive high quality, affordable health care services. In our Mid-Atlantic area, these centers are called MinuteClinics and are conveniently located in select retail grocery stores and drug stores, as well as certain corporate office buildings and college campuses.

To Find A Participating MinuteClinic 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.

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.
- The Fund covers the cost for eligible services and treats MinuteCare visits the same as primary care physician office visits, with appropriate co-payments and deductibles being applied.

Reminder

*If you are given a prescription, do not get it filled at the MinuteClinic since it is NOT in the pharmacy network. To receive coverage for your prescription, you must use a pharmacy that is in-network (Giant/Super G, Safeway, Acme, Super*Fresh, Pathmark, ShopRite or Rite Aid pharmacy).*

When Lab Work Is Needed, You Must Use A Lab in the CIGNA Shared Administration Network

Your plan of benefits requires that you ***must*** use a laboratory in the CIGNA shared administration network.

Your Responsibility

It is your responsibility to check before you make your appointment for lab services that the laboratory you are going to is in the CIGNA shared administration network. You can do this easily by:

1. Calling CIGNA at 800-768-4695, or
2. Logging on to the CIGNA website at www.cignasharedadministration.com.

Be sure your doctor knows this up front before having laboratory work done. If your doctor, nurse or surgeon performs lab work in the office, explain that your lab work ***must*** be sent to a lab that is in the CIGNA shared administration network in order for the claim to be covered.

Remember, labs can be in the CIGNA network one month and not be in the network the next month. So it is very important for you to confirm your lab's status prior to any testing.

Laboratory Benefits

Plan 1 Participants

The first $100 of payable charges per calendar quarter is covered at 100% with no deductible under your Basic Benefit. Any remaining balances are covered under Major Medical.

Plan 2 Participants

All eligible expenses are paid under Major Medical at 75%.

To Locate a Laboratory in the CIGNA Shared Administration Network

- Call the CIGNA Customer Service Center at 800-768-4695, or
- Access the CIGNA provider directory online at www.cignasharedadministration.com. Select "Provider Directory" shown on the horizontal bar located at the top of your screen. Next, choose the "Facility and Ancillary Directory." After questions #1 and #2, choose "Laboratory Services" under specialty, and click on "Continue Search." You will be directed to a listing of various labs located near the zip code you entered.

Send Appeals to New Address

As you know, you have the right to appeal a denial of your claim by writing to the Board of Trustees.

For Health and Welfare Claims:

You must send a written request to the Board of Trustees within 180 days after you receive written notice that your claim has been denied.

All appeals should now be sent to the Fund's Sparks office:

Bakers Union and FELRA
Health and Welfare Fund
Board of Trustees
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: Appeals Dept.

If you have already sent an appeal to the Landover office, we will forward it. **You do not need to send it again**.

Update Your Benefit Information With the Fund Office

Form on next page →

If you, your spouse, or your dependents have benefit coverage in more than one group health plan, the Fund office needs to know. Why? Because there are Coordination of Benefits ("COB") rules to determine which plan processes the claim first, second and even third (if you have coverage under three group plans).

Virtually every group health plan has COB rules. They are designed to protect the Fund (and all group health and welfare plans) from paying claims for which it is not liable. The Fund's COB rules are described in your Summary Plan Description.

Even if you have completed a COB form before and nothing has changed, please complete the form on the next page and return it to the Fund office at the address shown at the bottom of the form.

Remember, updating this information NOW saves time LATER (when you have a claim waiting to be processed). If you do not tell the Fund office about the other coverage and it is discovered later (after claims have been paid), you will be billed for the amount that was paid in error. Do not let this happen to you.

Thank you.

Complete & Return

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)

The 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 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

Are you/your dependent eligible for Medicare coverage? ____ Yes ____ No

(PLAN 2 Participants Only)

[1] Was your spouse offered other coverage where the employer pays at least 70% of the premium?

____ Yes ____ No

[2] Was the coverage accepted or rejected by the spouse? ____ Accepted ____ Rejected

Participant's Signature _____ **Date** _____

Send to: Bakers Union and FELRA
Health and Welfare Fund
911 Ridgebrook Rd.
Sparks, MD 21152
ATTN: BakersFELRA COB

BF COB 0806rt

Keep This Notice

Important Notice about Your Prescription Drug Coverage and Medicare

The following Notice of Creditable Coverage applies to all Medicare-eligible participants 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 Bakers Union and FELRA Health and Welfare 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 standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Bakers Union and FELRA Health and Welfare 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 first 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 Bakers Union and FELRA Health and Welfare Fund coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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 Bakers Union and FELRA Health and Welfare 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 Bakers Union and FELRA Health and Welfare 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 beneficiary 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 beneficiary 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 (866) 662-2537 or (410) 683-6500. **NOTE:** You'll get this notice each year. You will also get it before the next period you can joi n a Medicare drug plan, and if this coverage through the Bakers Union and FELRA Health and Welfare 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:

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- 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).

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).

Date:	July 1, 2011
Name of Entity/Sender:	Fund Office Bakers Union and FELRA Health and Welfare Fund 911 Ridgebrook Road Sparks, Maryland 21152
Phone Number:	(866) 662-2537 or (410) 683-6500

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.

When does the 48-hour (or 96-hour) period start?
If a woman delivers her baby in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery.

As an example, if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

However, if the woman delivers outside the hospital and is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission. For example, if a woman gives birth at home by vaginal delivery, but begins bleeding excessively in connection with childbirth and is admitted to the hospital, the 48-hour period starts at the time of admission.

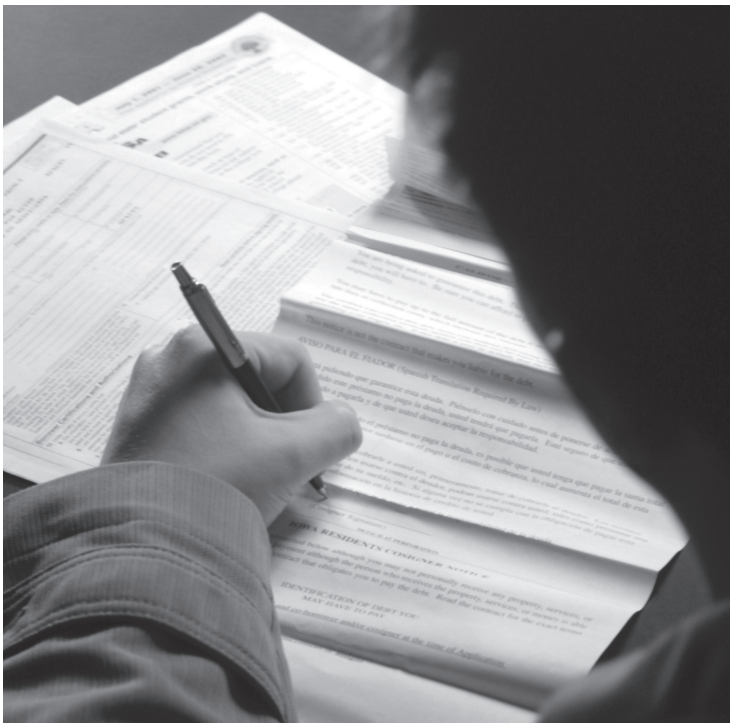
WHCRA Allows Reconstructive Surgery Following Mastectomy

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.

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 fund name "Bakers/FELRA" located on the left-hand side of the screen. Under the heading "Downloads," select and print the "Statement of Privacy." 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

HEALTH CORNER

Best Foods to Fight High Cholesterol

If your total cholesterol is over 199 mg/dl, and especially over 240 mg/dl, it's time to make a change. The first step is altering what you eat, a few meals at a time. The Mayo Clinic recommends swapping high-fat dishes for these five cholesterol-busting foods:

1. Oatmeal – Try eating about 1.5 cups of oatmeal daily. Add apples or bananas for an extra boost of flavor and soluble fiber, which helps prevent cholesterol from entering your bloodstream.

2. Fish – The omega-3 fatty acids in fish like albacore tuna, salmon and lake trout help reduce blood pressure and the risk of blood clots. Enjoy at least two servings of baked or grilled fish each week.

3. Walnuts – Just a handful of unsalted, unsugared walnuts, almonds, pistachios or other nuts each day may reduce your risk of heart disease.

4. Olive Oil – The antioxidants in this oil help lower cholesterol. Replace butter, margarine or other fats with two tablespoons of extra virgin olive oil each day.

5. Fruits and Vegetables – The fiber in these foods help sweep cholesterol from your body. Go for five to nine servings a day for best results.

This information is general and is not intended to replace the advice of your doctor. Consult your personal physician about your own medical condition. The above information was provided by Segal Multiemployer Publications, Spring 2011.