For Your Benefit

Bakers Union & FELRA Health and Welfare Fund

Cut and Keep

July 2012 Vol. 8 No. 2

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.

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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.

Summary of Material Modifications (Changes) This Issue!

This Issue—

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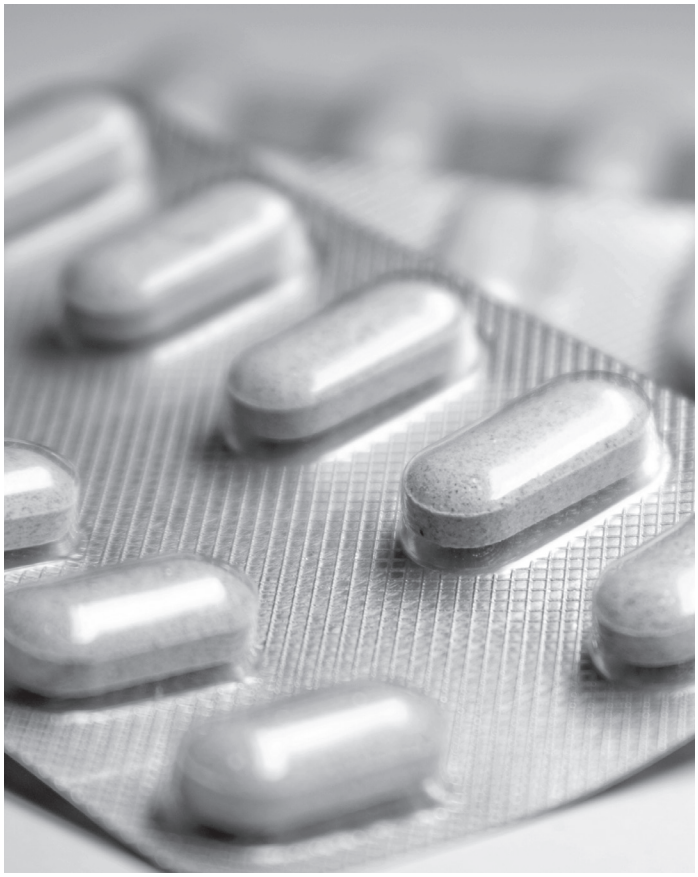
You cannot have both Medicare prescription drug coverage and prescription drug coverage through the Fund at the same time. If you do decide to join a Medicare drug plan and drop your Bakers Union and FELRA Health and Welfare prescription drug coverage, be aware that you and your dependents may not be 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 join 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:

- 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.

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).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	July 1, 2012
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

Summary of Material Modifications

Below are recent Summary of Material Modifications (changes) made to your Plan. Please read them, clip them where indicated, and keep with your Summary Plan Description ("SPD") booklet so you will have it for easy reference.

Effective January 1, 2012 – increase in annual deductible (Plan 1).

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 SPD booklet.

Effective January 1, 2012 – Notice of waiver from annual limit requirement (Plan 2).

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 $100,000 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.

Effective January 1, 2012 – Annual dollar limit on essential health benefits is now $1,250,000 (Plan 1).

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 1. Please make this change on pages 25 and 96 of your SPD 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.

Effective January 1, 2011 – New Dependent Eligibility Rules.

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 SPD.

Effective January 1, 2011 – Student Coverage Eligibility.

The ELIGIBILITY, "Student Coverage" subsection of the SPD does not apply to 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 SPD 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

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for Dental benefits are detailed in the Fund's SPD.

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 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

Effective January 1, 2011– Notice of Waiver from Annual Limit Requirement for Plan 2.

For Plan 2 participants and eligible dependents, the 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.

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.

Health insurance coverage offered by the Bakers Union and FELRA Health and Welfare Fund under Plan 2 does not meet the minimum standards of 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.

Effective January 1, 2011, Mental Health and Substance Abuse Benefits.

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.

Effective January 1, 2011– Elimination of pre-certification for mental health/substance abuse treatment.

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 believe 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.

Effective August 1, 2011 – Catalyst Formulary Advantage

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. Bisphosphonates;
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.

Effective April 1, 2009 – CHIP.

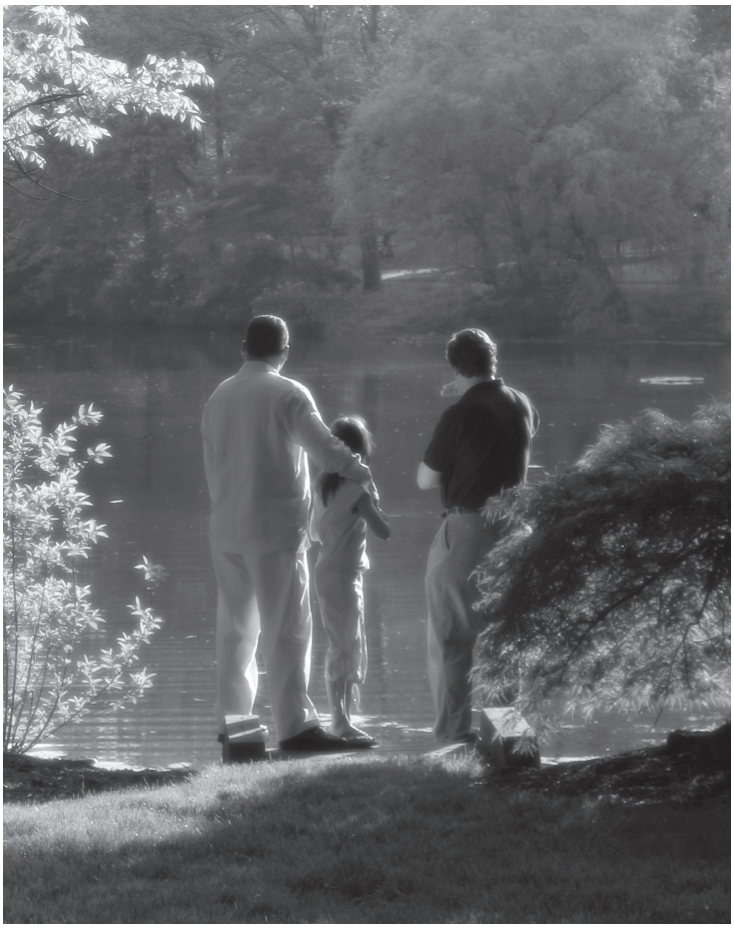
If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or Children's Health Insurance Program ("CHIP") to help people who are eligible for 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 in the January ***For Your Benefit*** newsletter, 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 states mentioned in the January 2012 ***For Your Benefit*** newsletter, you may be eligible for assistance paying your employer health plan premiums. You should contact your state for further information on eligibility.



Complete & Return

Bakers Union and FELRA Health and Welfare Fund

911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (410) 683-6500
Toll Free: (866) 662-2537
www.associated-admin.com

4301 Garden City Drive, Suite 201
Landover, MD 20785-6102
Telephone: (301) 459-3020
Toll Free: (866) 662-2537
www.associated-admin.com

COORDINATION OF BENEFITS UPDATE

Update for Yourself, Your Spouse, or Your Dependent(s)

Participant's Name: _____ **Participant's SSN**: _____

There is Other Group Coverage On (Choose One):

1) ___ Myself 2) ___ My Spouse 3) ___ Other Eligible Dependent

If Spouse:

a) Name: _____
b) SSN: _____
c) Date of Birth: _____
d) Spouse's Employer:

_____ Co. Name
_____ Address
_____
(____)_____Phone No.
_____Benefit/HR Dept. (Contact Name)

If Other Dependent:

a) Name: _____
b) SSN: _____
c) Date of Birth: _____
d) Spouse's Employer:

_____ Co. Name
_____ Address
_____
(____)_____Phone No.
_____Benefit/HR Dept. (Contact Name)

The coverage is from:

___ Medicare Part A ___ Medicare Part B ___ Medicare Part D

___ Spouse's Employer ___ Other ___ Participant's Employer at Another Job

Insurance Co. Name: _____

Address: _____

Phone Number: _____

Group Policy #: _____**Effective Date** _____

NOTE: 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? _____Yes _____No.**

Participant's Signature _____ **Date** _____

Send to: Bakers Union and FELRA
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Bakers Union/FELRA COB RT bns 06.2012

Update Your Benefit Information With the Fund Office

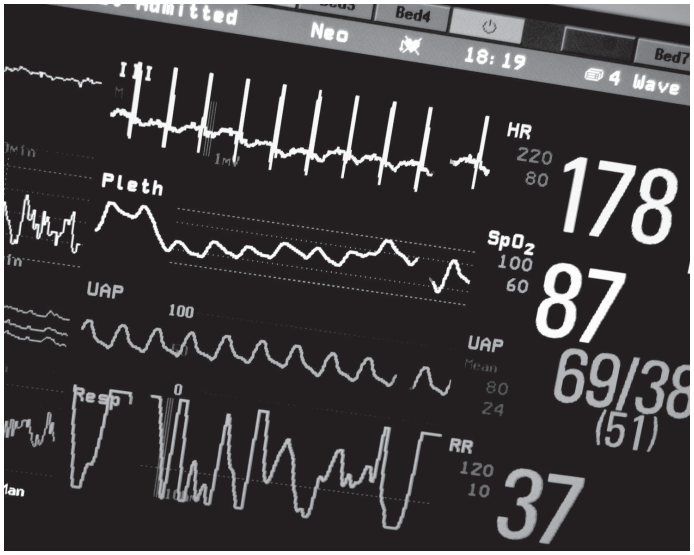
If you, your spouse, or your dependents have benefit coverage in more than one group health plan, the Fund office needs to know. Why? Because there are Coordination of Benefits ("COB") rules to determine which plan processes the claim first, second and even third (if you have coverage under three group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

Reminder: Reading of Heart Monitors Must Be Performed by A CIGNA Provider



If you have been prescribed to wear a heart monitor holster, be sure the monitor is sent to a provider in the CIGNA Shared Administration ("CIGNA") network for analysis. Just because the doctor that ordered and placed the monitor on you is in the CIGNA network, does not mean that the provider that does the reading of the monitor is also in-network. Claims will only be paid if the provider reading the heart monitor is 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. You can also call CIGNA at (800) 768-4695 to verify that the provider is in-network.

HEALTH CORNER

Stay Fit – Even While You Sit

When you spend most of your day in roughly the same position, it can be hard to get active and stretch beyond your comfort zone. But in just five minutes, you can improve blood circulation and flexibility – and feel rejuvenated for your next task. All it takes is a chair and some smart stretches. Here are a few to get you started:

- Sit straight in your chair. Leave a bit of space between your back and the chair. Squeeze your shoulder blades together. Count to five. Release and repeat.
- Lift your arms until they're level with your shoulders. Using your left hand, grasp your right arm above the elbow. Gently pull it toward your left shoulder. Hold. Release and repeat with your left arm.
- Cross your right leg and rest your ankle on your left knee. Grasp your ankle and rotate it clockwise, then counterclockwise. Rotate about 15 times each way. Repeat on your left ankle.