Bakers Union and FELRA
Health and Welfare Fund
Board of Trustees Meeting
March 9, 2022

Bakers Union and FELRA
Health and Welfare Fund

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BOARD OF TRUSTEES MEETING
MARCH 9, 2022

AGENDA

I. **Call to Order**

II. **Minutes - Regular Meeting held December 8, 2021**

III. **Financial Report - Chris Little, PNC**

IV. **Optum Rx January - December 2021 Review – Lissa Tarro**

V. **Co-Counsel Report**

VI. **Administrative Managers Report**

VII. **Invoices**

VIII. **Participant Appeals**

IX. **Other Fund Business**

X. **2022 Meeting Dates: Wednesday June 8, 2022, September 7, 2022 and December 7, 2022**

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DRAFT

MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES OF THE BAKERS UNION AND FELRA HEALTH AND WELFARE FUND DECEMBER 8, 2021 ANNAPOLIS, MARYLAND

The following Trustees were present:

UNION TRUSTEE
L. Jones
G. Oskoian – Chairman

EMPLOYER TRUSTEES
J. Williams

Also present were:
H. Agoney - Optum Rx
M. DeLancey - Blank Rome, LLP
J. Kimble - Morgan, Lewis & Bockius, LLP
C. Little - PNC
K. Phillips - Associated Administrators, LLC
D. Welch - Associated Administrators, LLC

I. CALL TO ORDER

A quorum being present, the Chairman called the meeting to order. Ms. Welch reported that, due to extenuating circumstances, Trustee Goble was unable to attend the Board of Trustees meeting. Mr. Goble gave his proxy to Trustee Williams to act in all matters that come before the Trustees for this meeting.

II. MINUTES

The Trustees reviewed the minutes of the regular Board meeting held on September 8, 2021, which were circulated in advance of the meeting.

On MOTION made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, that the minutes of the regular Board meeting held on September 8, 2021 are approved as presented.

III. FINANCIAL REPORT – PNC BANK, NA – SUMMARY OF ACTIVITY

Mr. Little presented the Summary of Activity Report for the period ending October 31, 2021, a copy of which is attached to and made a part of these minutes as Exhibit A. The report showed a beginning market value of $413,788, net contributions and withdrawals that resulted in a loss of $16,337, investment income of $2,108, producing an ending market value of $398,974.

Mr. Little presented the portfolio holdings as of October 31, 2021. The Fund holds 67.4% in limited maturity bonds, with a market value of $268,725 and 32.6% in cash with a market value of $130,250. Mr. Little informed the Trustees that he did not recommend any changes to the asset allocation at this time, however he would continue to monitor the portfolio closely.

The Trustees thanked Mr. Little for his report and he was excused from the meeting.

IV. OPTUM Rx

The Trustees welcomed Ms. Holly Agoney of Optum Rx to the meeting.

Ms. Agoney reviewed the OptumRx Plan Performance Report for the period January 2021 to September 2021, a copy of which is attached to and made a part of these minutes as Exhibit B. She reviewed the Plan's drug utilization and costs for the period January 2021 to October 2021. The Plan cost per member per month (pmpm) was $109.72 for the period January 2021 to October 2021 as compared to $123.55 for the period of January 2020 through October 2020. The OptumRx Taft Hartley book of business ("BOB") per member per month cost for the period January 2021 to October 2021 was $100.30. Specialty drugs accounted for 0.7% of the Plan's drug cost. The top twenty traditional and specialty drugs

paid by the Plan from January 1, 2021 to October 30, 2021 were reviewed. She also reported the Utilization Management Program savings for October 2020 through September 2021 was $159,200.

Ms. Agoney reviewed the Vigilant Program Outcomes for October 2020 through September 2021. Total Plan Paid Savings was $35,535.

Ms. Agony informed the Trustees of two programs designed to protect plan incentives and guard members from undue cost exposure related to manufacturer assistance programs. The Copay Card Accumulator Adjustment Program ("CCAA") is an accounting mechanism that excludes copay card dollars from a members out of pocket expense. The Variable Copay Program ("VCS") provides saving on specialty medications obtained with manufacturer copay cards and coupons. The program leverages maximum available pharma subsidized coupons and co-payment assistance cards, which decrease the Plans cost share. VCS divides the coupons annual limit, over 12 months, to set drug specific copays to maximize yield and decrease the plan expenditure. She noted that both programs shift the costs from the Plan to pharma sponsored copayment assistance cards at no additional cost to the member. Ms. Agoney informed the Trustees there are no additional fees for the CCAA however, the VCS fee is $150 per VCS claim. She noted a net potential savings of $27,997.33 if both program are implemented.

The Trustees thanked Ms. Agoney for her presentation and excused her from the meeting

On MOTION made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to adopt the Copay Card Accumulator Adjustment and Variable Copay Solution Programs effective as soon as administratively possible.

V. CO-COUNSEL REPORT

A. Department of Labor ("DOL") Cybersecurity Best Practices

Mr. Kimble reported on the DOL's informal guidance related to cybersecurity best practices. He also reviewed the proposed Cybersecurity Policy that was circulated at the last Board meeting. Co-Counsel recommended that the Fund send out a questionnaire to all vendors that handle client and Fund related information to review the cybersecurity practices and determine if security is satisfactory.

After discussion, and on Motion made and seconded, the Trustees voted unanimous approval of the following resolution

RESOLVED, to approve the Cybersecurity Policy prepared by Co-Counsel and approved that the Fund send cybersecurity questionnaires to Plan professionals.

B. No Surprises Act – Complaint Procedure

Mr. Kimble presented a draft complaint procedure related to the No Surprises Act.

After discussion, and on Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED to approve the No Surprises Act complaint procedure as presented.

C. No Surprises Act

Mr. Kimble reported on the requirements related to the No Surprises Act, which establishes federal protections against surprise out-of-network emergency care or non-emergency care at an in-network facility from an out-of-network provider. He noted that Cigna will, as part of its repricing services, provide the Plan with the Qualified Payment Amount ("QPA") for each identified potential No Surprises Act claim. The QPA is based on the median rate (for 2019 and indexed for inflation) for a minimum of three contracts within a geographic region and include the consumer price index factor.

Mr. Kimble discussed the Independent Dispute Resolution process and noted that Cigna is currently developing a process to provide IDR services.

After discussion, and on Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to approve that Cigna provide the QPA for out-of-network claims

Mr. Kimble informed the trustees that Co-counsel is preparing a SMM detailing the required changes for the payment of Emergency Services, Non-Emergency Service provided at an in-network facility, and Air Ambulance Services ("covered services") under the No Surprises Act.

D. Purdue Pharma Class Action

Mr. Kimble presented a memo regarding the Purdue Pharma bankruptcy class action lawsuit. He informed the Trustees that given the administrative burden of completing a claim and the uncertainty as to how much money the Fund would receive and the restriction on how monies received could be used, Co-counsel recommends that the Fund forego filing a claim.

On Motion made and seconded, the Trustees voted unanimous approval of the following resolution

RESOLVED, Trustees voted to not participate in the Perdue Pharma bankruptcy class action lawsuit.

VI. ADMINISTRATIVE MANAGER REPORT

Ms. Welch presented the Administrative Manager Report for the third quarter of 2021. The report showed employer contribution income of $1,116,436, employee payroll deductions of

$39,084, interest and dividend income of $690, and miscellaneous income of $56,880, producing a total income of $1,213,090. Expenses included $729,058 for medical benefits, $31,212 for CIGNA premiums, $52,332 for dental premiums, $17,285 for disability benefits, $194,201 for prescription drug benefits, $4,640 for life insurance benefits, $26,333 for stop loss insurance, $5,656 for optical benefits, and $91,536 in operating expenses, producing total expenses of $1,152,253 and resulting in a surplus of $60,837; Contributions were made on behalf of 451 active participants and that there were no delinquencies. The Fund reserve was $371,185 as of October 31, 2021, which was projected to provide benefits for 1.1 months.

Ms. Welch presented the Third Quarter 2021 Savings Report prepared by Cigna. The plan incurred claims in the total amount of $919,072.22, Cigna allowed $439,647.22 for a 47.51% savings of $436,614.73.

Ms. Welch reviewed a High Cost Medical Claims Report for January 1, 2021 through December 7, 2021 and informed the Trustees that eleven participants had incurred claims above $50,000 that totaled $1,244,648.31. She noted four of the eleven participants are deceased.

The Trustees reviewed a Savings Report for the 2021 Plan year. The chart noted a savings of $73,247.62 as a result of plan benefit changes and a decrease in premiums for several plan providers.

VII. INVOICES

Ms. Welch reviewed a list of invoices dated December 8, 2021. She stated that there were no additions, deletions or changes to the list. The Trustees reviewed the list and determined that all invoices represent proper Fund expenses.

On MOTION made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to approve payment of the invoices dated December 8, 2021 as presented.

VIII. PARTICIPANT APPEALS

A. Appeal M21/114-3120

Ms. Welch reviewed an appeal from a participant requesting payment of a surgical pathology claim that was denied because the provider does not participate with CIGNA. The participant states that she had no control over where the specimen was sent for testing. Fund records indicate that the participant had a surgical procedure performed by Dr. Arun Mavanur of Surgical Oncology Associates (a participating provider) at Sinai Hospital, (a participating Facility) on September 15, 2021. Drs. Hicken, Cranley, Taylor, PA submitted a claim for pathology services rendered on September 15, 2021. The claim was denied because Drs. Hicken, Cranley, Taylor, PA does not participate with CIGNA. The Trustees notes that the Fund has historically covered out-of-network pathology claims when incurred at an in-network facility and when the underlying surgery is performed by an in-network surgeon.

After discussion and review of the terms of the Plan, upon a motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED to approve the appeal to pay the surgical pathology claim up to the usual, customary and reasonable rate, in accordance with the parameters of the Plan.

IX. OTHER FUND BUSINESS

A. Fiduciary Liability Insurance

Ms. Welch presented the fiduciary liability policy renewal proposal provided by Segal. The incumbent carrier Chubb proposed $3,951 which is a 5.3% increase in the current premium that would be effective January 1, 2022 through January 1, 2023. Segal requested quotes from Ullico, Euclid/Hudson, RLI and Hartford and they stated they could not

provide a competitive quote at this time.

After a discussion, on MOTION made and seconded the Trustees voted unanimous approval of the following resolution:

RESOLVED, to approve the Fiduciary Liability Insurance Policy renewal with the incumbent carrier CHUBB for the period of January 1, 2022 through January 1, 2023 with a premium of $3,951.

B. Stop Loss Policy Renewal

Ms. Welch reviewed the Stop Loss Policy Renewal received from Madison Consulting. The current stop loss vendor Gerber Life Insurance Company proposed a 4% increase in the current premium of $26.76 pmpm to $27.83 pmpm. The stop loss individual deductible would remain $350,000 with a $50,000 aggregate.

RESOLVED, to approve the stop loss policy renewal with Gerber Life Insurance Company for the period of January 1, 2022 to December 31, 2022, with an individual deductible of $350,000 with a $50,000 aggregate, for a rate of $27.83 pmpm.

C. Rebates

The Fund received a rebate check from OptumRx on September 7, 2021 for the first quarter of 2021 in the amount of $26,780.

D. Administrative Services Contract Renewal

Ms. Welch informed the Trustees that Associated Administrators, LLC ("Associated") had been acquired by Harbour Benefit Holdings, Inc. (Harbour) on November 30, 2021. She noted that Associated will remain its own legal entity and its name will not change and will have no effects on locations, personnel, or Associated's existing agreements.

Ms. Welch stated that the Fund's administrative services contract with Associated will

expire on December 31, 2021. She presented a letter from Associated dated December 7, 2021, proposing a three-year contract renewal for the period of January 1, 2022 to December 31, 2024 with an annual fee increase of 2% each year.

After discussion, on Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

> **RESOLVED, to approve a three-year extension of the administrative contract between the Fund and Associated Administrators, LLC for the period January 1, 2022 through December 31, 2021 as presented.**

E. Calibre CPA Groups Plan Year 2021 Audit Engagement Proposal

Ms. Welch reviewed Calibre's 2021 audit engagement proposal. She reported that Calibre was requesting a fee of $13,500, which represents a $700 increase (5.47%) over the prior year's fee. She noted that hourly rates for additional services not covered by the agreement would be in the range of $72 to $345 per hour. Fund Counsel has forwarded several questions to Calibre regarding the engagement proposal that are currently unanswered. The Trustees tabled a decision on the engagement proposal pending Calibre's response to Fund Counsel's questions.

F. COVID-19 Related Claims Processing

Ms. Welch provided a summary of the COVID-19 medical claims experience from January 1, 2021 through October 31, 2021. She noted that 385 tests were paid at a cost of $46,356.37. Treatment was provided to 10 plan participants at a cost of $118,896.54.

G. Open Enrollment

Ms. Welch reported that open enrollment materials were mailed to all participants on November 10, 2021 for coverage effective January 1, 2022.

H. Medical Plan Identification Cards

Ms. Welch reviewed the new member identification ("ID") card template prepared by OptumRx that includes the Plan deductible, out-of-pocket maximum, telephone number and website address that members can use to receive assistance as required by the No Surprises Act. She noted that the new ID cards will be available and sent to all new members beginning January 1, 2022. The ID card changes will also be reflected on the virtual ID cards that members can obtain on the OptumRx website at www.optumrx.com

On MOTION made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to approve the new ID card template to be provided to participants effective January 1, 2022.

XI. NEXT MEETING DATE AND LOCATION

The quarterly Board meetings for the 2022 Plan year are scheduled to be held on March 9th, June 8th, September 7th and December 7th.

XII. ADJOURNMENT

There being no further business to come before the Board, the meeting was adjourned.

Respectfully submitted,

Gary Oskoian

Attachments:

Exhibit A: PNC Capital Advisors Investment Review for Period Ending October 31, 2021
Exhibit B: Optum Rx Plan Performance Report January 2021 through October 2021
Exhibit C: Bakers Union and Felra Health and Welfare Fund Financial Statements December 31, 2020

BAKERS UNION AND FELRA

HEALTH AND WELFARE FUND

FOURTH QUARTER 2021

ADMINISTRATIVE MANAGER'S REPORT

FOURTH QUARTER 2021
PLAN 1
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	FT	$ 1,225.62	94	$ 345,625
SAFEWAY	FT	$ 1,225.62	155	$ 571,139
TOTAL			**249**	**$ 916,764**

EMPLOYEE PAYROLL

GIANT	$	42.54	110	$ 13,469
SAFEWAY	$	42.54	204	$ 22,477
TOTAL				**$ 35,946**

FOURTH QUARTER 2021
PLAN 1
EXPENSES

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	COMMENT
MEDICAL		$ 581,101	
CIGNA	$ 31.13	$ 23,887	
DENTAL-DENEX	$ 50.95	$ 28,366	
DISABILITY		$ 5,629	
OPTUM RX		$ 177,957	1,432 SCRIPTS
LIFE/AD&D	$3.90/.20	$ 2,971	
OPTICAL PROVIDER	$ 5.36	$ 3,688	
STOP LOSS	$ 26.76	$ 18,491	
SUB TOTAL		$ 842,090	

OPERATING EXPENSES

ADMINISTRATION	$ 30.39	$ 22,717	
MISCELLANEOUS		$ 23,262	
SUB TOTAL		$ 45,979	

TOTAL EXPENSES	**$ 888,069**

MISCELLANEOUS EXPENSES

LEGAL	$ 22,639
PNC ACCOUNT FEE	$ 401
POSTAGE	$ 160
PRINTING	$ 24
TELEPHONE	$ 38

TOTAL MISCELLANEOUS EXPENSES	**$ 23,262**

2021
PLAN 1
QUARTERLY RECAP

INCOME	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$ 851,534	$ 835,304	$ 917,051	$ 916,764	$ 3,520,653
EMPLOYEE PAYROLL	$ 30,847	$ 39,143	$ 39,084	$ 35,946	$ 145,020
COBRA	$ 1,906	$ -	$ -	$ -	$ 1,906
TOTAL INCOME	$ 884,287	$ 874,447	$ 956,135	$ 952,710	$ 3,667,579

EXPENSES	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
MEDICAL	$ 762,526	$ 417,601	$ 692,933	$ 581,101	$ 2,454,161
CIGNA	$ 23,410	$ 23,094	$ 22,693	$ 23,887	$ 93,084
DENTAL-DENEX	$ 38,111	$ 37,092	$ 34,538	$ 28,366	$ 138,107
DISABILITY	$ 8,429	$ 4,971	$ 9,714	$ 5,629	$ 28,743
DRUG	$ 195,321	$ 199,536	$ 158,728	$ 177,957	$ 731,542
LIFE	$ 3,212	$ 3,100	$ 3,075	$ 2,971	$ 12,358
OPTICAL	$ 4,000	$ 4,628	$ 3,658	$ 3,688	$ 15,974
STOP LOSS	$ 19,990	$ 19,401	$ 19,107	$ 18,491	$ 76,989
OPERATING EXPENSE	$ 37,280	$ 56,941	$ 60,589	$ 45,979	$ 200,789
TOTAL EXPENSE	$ 1,092,279	$ 766,364	$ 1,005,035	$ 888,069	$ 3,751,747
SURPLUS (DEFICIT)	**$ (207,992)**	**$ 108,083**	**$ (48,900)**	**$ 64,641**	**$ (84,168)**

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	AVERAGE
TOTAL PARTICIPANTS	262	258	250	249	255

FOURTH QUARTER 2021
PLAN 3
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	FT	$ 593.00	31	$ 55,149
GIANT	PT	$ 161.42	25	$ 12,106
SAFEWAY	FT	$ 593.00	48	$ 85,392
SAFEWAY	PT	$ 161.42	71	$ 34,221
TOTAL			**175**	**$ 186,868**

FOURTH QUARTER 2021
PLAN 3
EXPENSES

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	COMMENT
MEDICAL		$ 66,553	
CIGNA	$ 31.13	$ 7,695	
DENTAL-DENEX	$ 50.95	$ 11,470	
DISABILITY		$ 1,514	
OPTUM RX		$ 18,129	311 SCRIPTS
LIFE/AD&D	$ 3.90 /.20	$ 1,097	
OPTICAL PROVIDER	$ 5.36	$ 1,410	
STOP LOSS	$ 26.76	$ 6,824	
SUB TOTAL		$ 114,692	

OPERATING EXPENSES

ADMINISTRATION	$ 30.39	$ 15,914	
MISCELLANEOUS		$ 8,356	
SUB TOTAL		$ 24,270	

TOTAL EXPENSES	**$ 138,962**

MISCELLANEOUS EXPENSES

LEGAL	$ 8,133
PNC ACCOUNT FEE	$ 144
POSTAGE	$ 57
PRINTING	$ 8
TELEPHONE	$ 14
TOTAL MISCELLANEOUS EXPENSES	**$ 8,356**

2021
PLAN 3
QUARTERLY RECAP

INCOME	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$ 157,218	$ 163,489	$ 169,703	$ 186,868	$ 677,278
TOTAL INCOME	$ 157,218	$ 163,489	$ 169,703	$ 186,868	$ 677,278

EXPENSES	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
MEDICAL	$ 54,254	$ 29,837	$ 34,400	$ 66,553	$ 185,044
CIGNA	$ 8,530	$ 8,965	$ 8,299	$ 7,695	$ 33,489
DENTAL-DENEX	$ 13,757	$ 14,419	$ 12,789	$ 11,470	$ 52,435
DISABILITY	$ 600	$ 1,600	$ 7,571	$ 1,514	$ 11,285
DRUG	$ 13,459	$ 22,320	$ 35,150	$ 18,129	$ 89,058
LIFE	$ 1,161	$ 1,217	$ 1,152	$ 1,097	$ 4,627
OPTICAL	$ 1,410	$ 1,517	$ 1,436	$ 1,410	$ 5,773
STOP LOSS	$ 7,198	$ 7,546	$ 7,172	$ 6,824	$ 28,740
OPERATING EXPENSE	$ 19,551	$ 27,204	$ 28,003	$ 24,270	$ 99,028
TOTAL EXPENSE	$ 119,920	$ 114,625	$ 135,972	$ 138,962	$ 509,479
SURPLUS (DEFICIT)	**$ 37,298**	**$ 48,864**	**$ 33,731**	**$ 47,906**	**$ 167,799**

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	AVERAGE
TOTAL PARTICIPANTS	163	173	170	175	170

FOURTH QUARTER 2021
PLAN 4
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	PT	$ 25.72	17	$ 2,138
SAFEWAY	PT	$ 25.72	11	$ 875
TOTAL			**28**	**$ 3,013**

FOURTH QUARTER 2021
PLAN 4
EXPENSES

BENEFIT EXPENSES

BENEFIT [1]	RATE	EXPENSE	COMMENT
DENTAL-DENEX	$ 50.95	$ 3,001	
DISABILITY		$ -	
LIFE/AD&D	$ 3.90 /.20	$ 314	
OPTICAL PROVIDER	$ 5.36	$ 928	
SUB TOTAL		$ 4,243	

OPERATING EXPENSES

ADMINISTRATION	$ 30.39	$ 2,247	
SUB TOTAL		$ 2,247	

TOTAL EXPENSES	**$ 6,490**

2021
PLAN 4
QUARTERLY RECAP

INCOME	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$ 2,520	$ 2,400	$ 3,054	$ 3,013	$ 10,987
TOTAL INCOME	$ 2,520	$ 2,400	$ 3,054	$ 3,013	$ 10,987

EXPENSES	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
DENTAL-DENEX	$ 4,433	$ 4,586	$ 4,862	$ 3,001	$ 16,882
DISABILITY	$ 1,543	$ -	$ -	$ -	$ 1,543
LIFE	$ 374	$ 370	$ 404	$ 314	$ 1,462
OPTICAL	$ 515	$ 531	$ 541	$ 928	$ 2,515
OPERATING EXPENSE	$ 3,310	$ 3,128	$ 2,581	$ 2,247	$ 11,266
TOTAL EXPENSE	$ 10,175	$ 8,615	$ 8,388	$ 6,490	$ 33,668
SURPLUS (DEFICIT)	**$ (7,655)**	**$ (6,215)**	**$ (5,334)**	**$ (3,477)**	**$ (22,681)**

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	AVERAGE
TOTAL PARTICIPANTS	36	33	32	28	32

2021
COMBINED
QUARTERLY RECAP

INCOME	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS[1]	$ 1,011,272	$ 1,001,193	$ 1,116,436	$ 1,106,645	$ 4,235,546
EMPLOYEE PAYROLL	$ 30,847	$ 39,143	$ 39,084	$ 35,946	$ 145,020
COBRA	$ 1,906	$ -	$ -	$ -	$ 1,906
INTEREST & DIVIDENDS	$ 899	$ 718	$ 690	$ 483	$ 2,790
MISCELLANEOUS INCOME[2]	$ 32,460	$ 29,720	$ 56,880	$ 26,900	$ 145,960
TOTAL INCOME	$ 1,077,384	$ 1,070,774	$ 1,213,090	$ 1,169,974	$ 4,531,222

EXPENSES	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
MEDICAL	$ 817,853	$ 450,406	$ 729,058	$ 647,981	$ 2,645,298
CIGNA	$ 32,220	$ 32,339	$ 31,212	$ 31,710	$ 127,481
DENTAL-DENEX	$ 56,760	$ 56,556	$ 52,332	$ 42,837	$ 208,485
DISABILITY	$ 10,572	$ 6,571	$ 17,285	$ 7,143	$ 41,571
DRUG	$ 217,710	$ 222,842	$ 194,201	$ 196,092	$ 830,845
LIFE	$ 4,786	$ 4,726	$ 4,640	$ 4,382	$ 18,534
OPTICAL	$ 5,973	$ 6,719	$ 5,656	$ 6,026	$ 24,374
STOP LOSS	$ 27,429	$ 27,161	$ 26,333	$ 25,315	$ 106,238
OPERATING EXPENSE	$ 60,269	$ 87,593	$ 91,536	$ 72,496	$ 311,894
TOTAL EXPENSE	$ 1,233,572	$ 894,913	$ 1,152,253	$ 1,033,982	$ 4,314,720
SURPLUS (DEFICIT)	**$ (156,188)**	**$ 175,861**	**$ 60,837**	**$ 135,992**	**$ 216,502**

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	AVERAGE
TOTAL PARTICIPANTS	461	464	452	452	610
FUND RESERVE	$ 472,194	$ 292,195	$ 371,185	$ 338,828	

[1] Third Quarter Includes Balanced Owed for June Rate Increase- $26,628.24

[2] OptumRX Pharmacy Rebate received 12/28/2021 for - 2Qtr. 2021 - $26,900.00

2020
COMBINED
QUARTERLY RECAP

INCOME	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$ 983,777	$ 989,581	$ 1,014,488	$ 1,022,098	$ 4,009,944
EMPLOYEE PAYROLL	$ 37,785	$ 37,747	$ 31,896	$ 38,505	$ 145,933
COBRA	$ 8,309	$ 3,713	$ 4,047	$ 3,032	$ 19,101
INTEREST & DIVIDENDS	$ 4,431	$ 2,977	$ 2,032	$ 1,362	$ 10,802
MISCELLANEOUS INCOME	$ 54,110	$ 26,770		$ 26,070	$ 106,950
TOTAL INCOME	$ 1,088,412	$ 1,060,788	$ 1,052,463	$ 1,091,067	$ 4,292,730

EXPENSES	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
MEDICAL	$ 812,345	$ 752,140	$ 733,036	$ 682,629	$ 2,980,150
CIGNA	$ 31,107	$ 31,882	$ 30,895	$ 31,680	$ 125,564
DENTAL-DENEX	$ 59,095	$ 58,150	$ 48,775	$ 58,039	$ 224,059
DISABILITY	$ 9,229	$ 8,628	$ 11,343	$ 17,858	$ 47,058
DRUG	$ 210,384	$ 287,164	$ 255,441	$ 178,766	$ 931,755
LIFE	$ 4,712	$ 4,670	$ 4,691	$ 4,686	$ 18,759
OPTICAL	$ 8,146	$ 8,432	$ 8,313	$ 7,881	$ 32,772
STOP LOSS	$ 26,270	$ 25,627	$ 25,987	$ 25,730	$ 103,614
OPERATING EXPENSE	$ 58,656	$ 62,225	$ 69,265	$ 73,416	$ 263,562
TOTAL EXPENSE	$ 1,219,944	$ 1,238,918	$ 1,187,746	$ 1,080,685	$ 4,727,293
SURPLUS (DEFICIT)	**$ (131,532)**	**$ (178,130)**	**$ (135,283)**	**$ 10,382**	**$ (434,563)**

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	AVERAGE
TOTAL PARTICIPANTS	467	451	457	460	459

FUND RESERVE	$ 802,025	$ 590,406	$ 630,791	$ 413,455

Bakers Union and FELRA
Health and Welfare Fund
As of January 31, 2021

Fund Reserve

Months of Available Fund Reserve	
Expenses	
January 1 - December 31, 2021	$ 4,445,903.78
January 1 – January 31, 2022	$ 291,579.21
Total	$ 4,737,482.99
Per Month	$ 364,421.77
Fund Reserve	
As of October 31, 2021	**$ 430,160.00**
Months of Reserve	**1.2**
October 31, 2021	1.1
September 30, 2021	1.0
August 31, 2021	0.7
July 30, 2021	1.0
May 31.2021	0.9
April 30, 2021	1.0
December 31, 2020	1.0
October 31, 2020	1.1
September 30, 2020	1.6
June 30, 2020	1.5
May 31, 2020	1.7

	Plan 1	Plan 2	Plan 3	Plan 4
2016	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2015	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2017	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2018	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2019	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
2020	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
2021	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
June 1, 2021	F/T $ 1,225.62	F/T $ 334.00	F/T $ 593.00 P/T $ 161.42	$ 25.72

Bakers Union and FELRA
Health and Welfare Fund
As of February 28, 2022

Fund Reserve

Months of Available Fund Reserve	
Expenses	
January 1 - December 31, 2021	$ 4,314,720.00
January 1 – February 28, 2022	$ 525,400.06
Total	$ 4,840,120.06
Per Month	$ 345,722.86
Fund Reserve	
As of February 28, 2022	**$ 580,002.40**
Months of Reserve	**1.7**
January 30, 2022	1.2
December 31, 2021	0.9
November 30, 2021	1.2
October 31, 2021	1.1
September 30, 2021	1.0
August 31, 2021	0.7
July 30, 2021	1.0
May 31.2021	0.9
April 30, 2021	1.0

2013	Full Time $844.00	$485.00		
2014	Full Time $853.00	$485.00		
2015	F/T $830 P/T $479	F/T $267 P/T $105	F/T $262 P/T $103	$18.40
2016	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2015	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2017	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2018	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2019	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
2020	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
2021	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
June 1, 2021	F/T $1,225.62	F/T $334	F/T $593 P/T $161.42	$25.72
2022	F/T $1,225.62	F/T $334	F/T $593 P/T $161.42	$25.72

BAKERS UNION & FELRA
HEALTH AND WELFARE
GAIN/LOSS STATEMENT

2022	February
Beginning Bank Balance	**$430,160.00**
INCOME:	
Contributions	383,485.58
Investments	177.67
Other - Rebates	
TOTAL INCOME	**383,663.25**
EXPENSES:	
Medical Claims	111,331.99
Dental	15,950.68
Drug	86,183.17
Optical	1,377.04
Life and AD&D Insurance	1,470.60
Disability	4,085.69
Legal	3,102.00
Stop Loss	9,245.86
Operating Expenses	195.90
Change is value of Investments	877.92
TOTAL EXPENSES	**$233,820.85**
GAIN/LOSS	**$149,842.40**
Ending Bank Balance	**$580,002.40**
Current Months of Reserve	**1.7**

High Claims Paid January 1, 2021 to February 28, 2022

	Diagnosis	Paid	Status	Plan
Dependent	Breast Cancer	$294,437.80		1
Spouse	Cerebral Infarction, Tongue Cancer	$198,489.43	Deceased	1
Spouse	Pancreatic Cancer	$169,689.76		1
Spouse	Acute Respiratory Failure	$167,275.82	Deceased	1
Spouse	Myocardial Infarction	$133,092.68		1
Member	COVID-19	$117,803.47	Deceased	1
Spouse	Cerebral Hemorrphage	$85,319.56	Deceased	1
Member	Cervical Disc Displacement	$79,390.20		1
Dependent	Disc Disorder/Depression	$71,083.60		1
Spouse	Uterine Cancer	$67,212.67		1
Member	Psoriatic Arthritis	$52,867.71		1
Spouse	Mandibular Hypoplasia	$50,819.04		1
	Total	$1,142,224.90		

SAVINGS REPORT

POTENTIAL SAVINGS ACTION	ESTIMATED MONTHLY SAVINGS	ESTIMATED ANNUAL SAVINGS	ACTUAL SAVINGS AS OF 02/28/2022
Transitioning Plan 1 to 80/20 Effective July 1, 2021*	$29,434	$353,208	$145,224.36
Rx Mail Order Program (Mail Service Saver max. copay increase) ($36,000) Effective July 1, 2021*	$3,000	$36,000	TBD
Drugs (Select to Premium Formulary ($16,000)) Effective July 1, 2021*	$1,333	$15,996	TBD
Changing Lab Benefit to only LabCorp and Quest* September 1, 2021	$7,666.67	$92,000	
Dental Rate Change to Delta $41.11 from $50.95 effective September 1, 2021. January 1, 2021 GDS/Denex deceased rate from $52.53 to $50.95	$3650.67	$43,808	January to September 2021 Denex rate decreased and Delta Savings September 1 to December 31, 2022 - $15,574
Optical (premium reduction with renewal ($7,095.60) Effective January 1, 2021 $6.98 to $5.36	$589.03	$7,069	January to December 2021 savings $7,798
Total	$46,652.20	$559,826	$73,247.62

* Savings estimate based on prior Claim Utilization. Savings will vary on actual claim experience after change implemented.

Client Name: Bakers Union Date Range: Jan 2021 - Dec 2021			
Testing	**Count of Tests**	**Total Charges**	**Total Allowed**
Testing	633	$58,940	$26,992
Home Testing Kits	2	$458	$430
Antibodies Testing	15	$1,406	$1,306
Grand Total	**650**	**$60,804**	**$28,728**
Virtual Visits	**Count of Visits**	**Total Charges**	**Total Allowed**
Virtual Visits (costs included in total claims)*	7	$927	$562
Claim Category	**Claim Count**	**Total Charges**	**Total Allowed**
Inpatient	51	$139,608	$58,133
Outpatient	96	$16,088	$12,970
Professional	715	$79,169	$35,505
Grand Total	**862**	**$234,864**	**$106,609**
Confirmed COVID 19 Cases	**Member Count**	**Total Charges**	**Total Allowed**
Confirmed Total	30	$176,517	$80,080
Vaccines	**Count of Vaccine**	**Total Charges**	**Total Allowed**
	31	**$1,594**	**$892**
Laboratory - Preferred	**Claim Count**	**Total Charges**	**Total Allowed**
LabCorp	180	$12,061	$9,502
Quest	116	$7,310	$5,845
Grand Total	**296**	**$19,371**	**$15,347**
Count of Individuals	**Count of Gender**	**Total Charges**	**Total Allowed**
Member			
Male	31	$30,583	$25,951
Female	105	$37,562	$17,209
Spouse			
Male	18	$5,700	$2,770
Female	18	$141,126	$50,117
Child			
Male	32	$6,379	$3,719
Female	44	$13,515	$6,843
Grand Total	**248**	**$234,864**	**$106,609**

* Total and allowed charges reflected in testing totals

Bakers Union and FELRA Health and Welfare Fund

INVOICES

March 9, 2022

Associated Administrators, LLC

11/1/2021	Administrative Fee for November 2021	$13,696.87
12/1/2021	Administrative Fee for December 2021	$13,605.76
12/1/2021	866 Phone Line, Postage and Printing	$107.12
1/1/2022	Administrative Fee for January 2022	$13,724.14
1/10/2022	Postage and Printing, No Surprises Act SMM	$345.61
1/13/2022	866 Phone Line, Postage and Meeting Expense	$1,149.95
2/14/2022	Postage and Printing, OTC Covid Test SMM	$207.27

Blank Rome, LLP

11/30/2021	Professional Services Rendered through November 30, 2021	$3,432.00
1/10/2022	Professional Services Rendered through December 31, 2021	$4,290.00
2/3/2022	Professional Services Rendered through January 31, 2022	$3,102.00

Morgan Lewis and Brokius LLP

12/10/2021	Professional Services Rendered through November 30, 2021	$10,108.50
1/14/2022	Professional Services Rendered through December 31, 2021	$8,492.00
2/9/2022	Professional Services Rendered through January 31, 2022	$2,710.50

Segal Select Insurance Services

1/1/2022	Fiduciary Liability Premium - 01/01/2022-01/01/2023	$3,951.00
1/4/2022	Cyber Liability Premium - 12/29/2021-12/29/2022	$4,303.00

NAME: **SS#:**

Bakers Union and FELRA Health and Welfare Fund

EMPLOYER:	Safeway	**LOCAL:**	118
DATE OF HIRE:	June 16, 1993	**STATUS:**	Full Time
PLAN:	1		

ISSUE: Hospital/Medical – Excluded Services #M22/102-9299

FUND RULE:
"**General Exclusions**

The expenses listed below are excluded from payment under all benefit categories, for Plan 1, Plan 2 and Plan 3 Participants, unless otherwise stated. [...]

34. Telephone consultations with patients or charges for failure to keep a regularly scheduled appointment [...]"
(Bakers Union and FELRA Health and Welfare Fund SPD, July 2016, Pages 114-116, #34)

"**Telehealth Services Extension**

In response to the continuing COVID-19 pandemic and recognizing the challenges the pandemic is causing Participants in obtaining medical services and exercising their rights under the plan, the Board of Trustees has extended coverage of Telehealth Services. The Fund will continue to provide coverage for medical services unrelated to COVID-19 provided by a PPO provider by telephone conference or video conference, subject to any applicable Plan limits, rules, and cost-sharing requirements that would apply to an in person visit for the same service. ***Coverage is limited to the period from March 18, 2020 through June 30, 2021***."
(Quoted from the Bakers Union and FELRA Health and Welfare Fund "For Your Benefit" newsletter, April 2021, Page 8) (emphasis added)

SUMMARY:

Date(s) of Service:	January 17, 2022
Claim(s) Received:	January 24, 2022
Claim(s) Denied:	January 26, 2022
Appeal Received:	February 9, 2022

The **participant** is appealing for payment of a claim for telehealth services that was denied. The participant states, "At the time of making the doctor's appointment they were only taking appointments for telemedicine video due to the COVID-19 pandemic. I needed to be seen by the doctors, so that was the only appointment that I could get. I honestly did not know that it would not be covered by my insurance."

Fund records indicate that Maryland Primary Care submitted a claim for telehealth services rendered on January 17, 2022 with a primary diagnosis of "Acute recurrent maxillary sinusitis." The claim was denied because the Plan specifically excludes coverage of telehealth services. The Board of Trustees amended the Plan to allow coverage of telehealth services for the temporary period from Mach 18, 2020 through June 30, 2021, only. This claim was incurred after June 30, 2021.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

Claim # BQVW51

February 7. 2022

Employee #
Acct # 104905003710

Dear Appeals Coordinator,

My name is and I am the policy holder of Cigna healthcare. I wish to file an appeal concerning my visit to Mayland Primary Care on January 17, 2022 that was not covered. At the time of making the doctors appointment they were only taking appointments for Telemedicine video due to the covid 19 pandemic. I needed to be seen by the doctors, so that was the only appointment that I could get. I honestly did not know that it would not be covered by my insurance. Please reconsider my visit at mayland Primary care for January 17, 2022.

Sincerely

RECEIVED
FEB 09 2022
AA, LLC

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Return Service Requested

110

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

005742
0101

BAKERS UNION & FELRA H&W

If you have any questions, please call (866) 66-BAKER

Claim #: BQVW51
Statement Date: 01/26/22
Employee Name:
Employee #:
Patient's Name:
Patient Acct#: 10490500270
Provider: PRIMARY CARE MARYLAND

In	Dates of Service	Service Description	Amount Charged	Not Covered	Remark Codes	Allowed Amount	Deductible	Type	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	01/17/22-01/17/22	OFFICE CALL	250.00	250.00	A1 A2	0.00	0.00		0	0.00	0.00	250.00
		TOTALS	250.00	250.00		0.00	0.00				0.00	250.00

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Total Plan Benefit:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check #	Paid Date
MARYLAND PRIMARY CARE PHYS	0.00	NC	01/26/22

Line#	Code	Messages
1	A1	CIGNA HEALTHCARE PREFERRED PROVIDER SAVINGS.
1	A2	THIS SERVICE/SUPPLY IS NOT COVERED BY YOUR PLAN. SPD PG. 116, #34

Appeal Rights

If your claim has been wholly or partially denied (as shown in the Messages section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal or state court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in state or federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "**Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator**". You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en el resúmen descriptivo del plan.

RECEIVED
FEB 09 2022
AA, LLC

NAME: **SS#:**

Bakers Union and FELRA Health and Welfare Fund

EMPLOYER:	Safeway	**LOCAL:**	118
DATE OF HIRE:	August 1, 1985	**STATUS:**	Full Time
PLAN:	1		

ISSUE: Hospital/Medical – Nonparticipating Provider #M22/103-8606

FUND RULE:
"Hospital and Medical Benefits

Important! You must use a participating [CIGNA] provider in order to be covered. Services performed by non-[CIGNA] providers will not be paid under the Fund, with limited exceptions."
(Bakers Union and FELRA Health and Welfare Fund SPD, July 2016, Page 94)

SUMMARY:

Date(s) of Service:	September 20, 2021
Claim(s) Received:	October 7, 2021
Claim(s) Denied:	October 8, 2021
Appeal Received:	February 10, 2022

The **provider,** Remote Neuromonitoring Physicians, is appealing on behalf of the participant as his authorized representative for payment of a surgical claim that was denied because the provider does not participate with CIGNA. The provider states in summary that their services were unsolicited and would not have been performed without the request of the attending surgeon. The provider further states that there is a lack of contracted IONM (intraoperative neuromonitoring) providers nationwide, and that the participant did not know until the time of surgery that their services would be utilized. Lastly, the provider states that they are willing to negotiate a rate for this service.

Fund records indicate that the participant had an outpatient surgical procedure performed by Dr. Charles Seal of Blue Ridge Orthopaedic Associates (a participating provider) at UVA Haymarket Medical Center (a participating facility) on September 20, 2021. Remote Neuromonitoring Physicians submitted a claim for continuous neurophysiology monitoring during the surgical procedure. The claim was denied because Remote Neuromonitoring Physicians does not participate with CIGNA.

Note: Intraoperative neuromonitoring is a service performed by neurologists to monitor and protect a patient's neurological system and alert the surgeon in real time of any changes that may occur during high risk surgical procedures.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

SpecialtyCare

Remote Neuromonitoring Physicians
PO Box 11407, Dept 2105
Birmingham, AL 35246-2105
336-776-0393 | 866-632-5902 *facsimile*

January 13, 2022

Associated Administrators
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn Appeals Coordinator

Provider: Remote Neuromonitoring Physicians
TAX ID: 262188574
Patient:
ID:
Group#: Bakers Union and FELRA H&W
DOS: 09/20/2021 ENC#: 001700457148
Claim #: BMQW98
Charge Amount: $10701.00
Service Location: Haymarket Medical Center

Healthcare Professional Appeal

Appeals examiner:

You have denied benefits for medically necessary IONM services due to provider being Out of Network. We are respectfully appealing this decision and are asking that you please consider making a benefit exception in this case and enhance benefits to pay In Network. The services were rendered at an In-Network Hospital and your member did not have a choice in providers.

Your participating surgeon applied his medical expertise and knowledge and deemed our services medically necessary for the safety of his patient - your member. The services were unsolicited and would not have been performed without his request.

There is a lack of contracted IONM providers nationwide, so the surgeon who requested our services likely had no option to select a participating provider. The member's plan therefore likely did not have access to a participating provider, so we are respectfully requesting that you make an exception in this case and process the claim at the in-network benefit level.

Finally, your member, who is the person most effected by the processing of this claim, did not know until the time of surgery that our services would be utilized during their surgery. They would have been unable to seek a contracted provider, or to obtain any kind of prior authorization for out-of-network services. Therefore, your valued member should not be held responsible for such a large out-of-pocket expense under these circumstances that were out of their control; especially when this service were ordered by your in-network surgeon in the interest of the patient's safety

Neurological intra-operative monitoring is a neurological diagnostic specialty that monitors nerves, muscles, and blood flow constrictions during surgery. Our technologist and our real time monitoring neurologist are able to provide valuable information to the surgeon to help with the quality of patient care during operations. Our services are provided to help surgeons avoid iatrogenic injuries that can be sustained during surgery. Obviously avoiding harmful or fatal injuries to your members—our patients, is always our first concern. There are only 3000 certified technologists nationwide.

We would be willing to negotiate a settlement in lieu of billing your member. Please contact me if you would be willing to negotiate a rate for this service.

If you have any questions regarding this appeal, please contact me at the number below. Thank you for your prompt attention to this matter.

Kindly,

Cindy Reid

Cindy Reid
AR Representative
336-776-0393

Authorization for a Designated Representative to Appeal

Patient Name: RNP 457148

Policy #:

Patient DOB:

Patient Address:

Date of Service: 09/20/2021

Description of Service: Intraoperative Neuromonitoring

I hereby authorize Cindy Reid/Change Healthcare to appeal a benefit determination made by my insurance company, on my behalf, as my Designated Representative. As part of this authorization, I hereby authorize you to process any appeal submitted by my Designated Representative.

Signature of Patient or Legal Guardian: 1.6.22 Date

Printed Name of Patient or Legal Guardian:

RECEIVED
FEB 10 2022
AAA LLC

w American Center | 3100 West End Avenue . Suite 800 Nashville Tennessee 37203
15-345-5400 615-345-5405 facsimile · specialtycare.net

P5144014006

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

202110293302

Return Service Requested

ALL FOR AADC 350
379 0.3584 AB 0.458

REMOTE NEUROMONITORING PHYSICI 7
PO BOX 11407
DEPT 2105
BIRMINGHAM, AL 35246-0100

BAKERS UNION & FELRA
H&W

If you have any questions, please call
(866) 66-BAKER

1 OF 1

ENV 379

Claim #: BMQW98
Statement Date: 10/28/21
Employee Name:
Employee #:
Patient's Name:
Patient Acct#: 001700457148
Provider: NEUROMONITORING PHYSICI REMOTE

Line	Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes	Allowed Amount	Deductible	Type	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	09/20/21-09/20/21	95938 26	3,003.00	3,003.00	A1 A2	0.00	0.00		0	0.00	0.00	3,003.00
	09/20/21-09/20/21	95939 26	3,685.00	3,685.00	A1 A2	0.00	0.00		0	0.00	0.00	3,685.00
	09/20/21-09/20/21	95861 26	1,561.00	1,561.00	A1 A2	0.00	0.00		0	0.00	0.00	1,561.00
	09/20/21-09/20/21	95941	2,452.00	2,452.00	A1 A2	0.00	0.00		0	0.00	0.00	2,452.00
		TOTALS	10,701.00	10,701.00		0.00	0.00			0.00	0.00	10,701.00

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Total Plan Benefit:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check #	Paid Date
REMOTE NEUROMONITORING PHY	0.00	NC	10/28/21

Line#	Code	Messages
01	A1	THE PROVIDER IS NOT A PPO NETWORK PARTICIPANT.
01	A2	SVCS MUST BE PROVIDED BY A CIGNA PROVIDER TO BE COVERED. PG 75 OF SPD.

Appeal Rights

If your claim has been wholly or partially denied (as shown in the Messages section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal or state court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in state or federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "**Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator**". You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Dawn Welch

From: Agoney, Holly J <Holly.Agoney@optum.com>
Sent: Monday, January 10, 2022 9:01 AM
To: Agoney, Holly J
Cc: Marcelle, Tammy E; Payton, David B; Scuro, Joseph; Escobedo, Ernesto; Gonzalez, Fabian; Aldaco, Araceli; Smith, Leslie M; Almonte, Vladimir; Leblanc, Autumn D; Marrel, Yachiyl; Grigal, Amy A; Fagan, Nicole M; Cannistraro, Susan; Mesri, Naeirika
Subject: OptumRx - UPDATE - Consolidated Appropriations Act: Section 204: Reporting

Good Morning All,

On December 27, 2020, Section 204 of Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) was passed into law requiring all impacted plans report brand drug utilization and cost information as well as total rebates paid and impact to premiums Year over Year to the secretaries of Health and Human Services, Labor, and the Treasury annually.

The departments then clarified in FAQ 49 that they will exercise discretion to provide temporary deferral of enforcement for a year, and that plans will be expected to report on December 27, 2022, with respect to 2020 and 2021 data.

An **Interim Final Rule** (IFR) implementing Section 204 of the CAA and confirming the initial effective date of 12/27/2022, and an information collection request (ICR) providing more technical guidance, have since been published by the departments. Both the IFR and the ICR have commentary periods and OptumRx will be responding via our industry partner, The Pharmaceutical Care Management Association (PCMA). OptumRx continues to oppose administrative burden reports that are duplicative and provide minimal insight or ability to reduce drug pricing.

OptumRx will continue to review and analyze the IFR and ICR to understand the applicability and to create efficient processes to provide the data needed to meet this multi-agency regulation before the 12/27/2022 deadline date. We are committed to partnering with you to provide the appropriate files to allow you to meet the compliance deadline.

Key Reporting Segments of Section 204:

1. P1-3: Plan List (Plan demographic details based on the Market Segment
2. D1: Premium and Life Years (premiums paid and enrollments)
3. D2: Spending by Category (total healthcare costs by category – hospital. Primary care, prescription drugs etc.)
4. D3: Top 50 Most Frequent Brand Drugs
5. D4: Top 50 Most Costly Drugs
6. D5: Top 50 Drugs by Spending Increase
7. D6: Rx Totals
8. D7: Rebates by Therapeutic Class
9. D8: Rx Rebates for the Top 25 Drugs

The ICR discusses methods for data aggregation which are still under review. This may make TPA and Insurer reporting less onerous. I hope you find this information helpful. We will keep you apprised as additional details become available. In the meantime, please contact me if you have questions or want to discuss further.

Please Note: This update is distinct from the Transparency in Coverage Final Rule on prescription drug Machine-Readable Files, which are currently still on hold.

Sincerely,

Bakers Union and FELRA
Health and Welfare Fund

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

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Notice of Provider Termination and Continuity of Care Coverage

DATE

MEMBER NAME
123 MAIN STREET
CITY, STATE 01234

Re: Termination of Provider/Facility Coverage and Eligibility for Continued Care

Dear _____,

According to our records, you are currently receiving a course of treatment or care from ___Name of Provider/Facility____. This letter serves as notification that ___Name of Provider/Facility_____ is no longer part of your Plan's network of coverage as of _____Date of Termination_____. Depending on your type of care, you may be eligible to continue receiving care from this provider or facility at the in-network rate for up to 90 days from the date of this letter, or until you are no longer receiving care, whichever is first. This extended period of coverage will allow you time to find another provider within your network, while still receiving uninterrupted coverage from your current provider for a limited time.

Please complete the attached form to indicate your election of your right to receive coverage as a Continuing Care patient, and have your provider complete the relevant section. Return it to the Fund Office at the address noted above. Please also see the enclosed Continuity of Care FAQ, explaining your rights if you are a Continuing Care patient. If you have any questions, please contact the Fund Office at 410-683-6500.

Sincerely,

Fund Office

Continuity of Care Request Form

INSTRUCTIONS
Mail the completed form and any attachments to: **Fund Office, Attn: Medical Claims, Sparks, MD 21152-1096** Or fax the completed form and any attachments to: 410-683-7788 (fax)

INSURANCE INFORMATION			
Member's Name		Date of Birth	
Street Address		Member ID #	
City		Group Name	Effective Date of Coverage
State, Zip	Phone Number	Group #	

PATIENT INFORMATION	
Patient's Name	Patient's Date of Birth

PHYSICIAN INFORMATION – To be completed by your physician.				
Name of Physician Currently Treating Condition			Diagnosis Code(s) (ICD-10)	Date Treatment Started
Specialty	Physician TIN/NPI		Procedure Code(s) (CPT/HCPCS)	Date of Next Treatment/Visit
Date of Termination, if applicable			For pregnancy, please indicate the patient's anticipated due date	
Street Address			Telephone:	
City	State	Zip Code	Fax:	
Indicate which category this treatment falls under, if any: ☐ Institutional or Inpatient Care ☐ Serious & Complex Condition ☐ Pregnancy ☐ Nonelective Surgery and/or Postoperative Care ☐ Terminal Illness			Describe: _____	
Physician's Signature		Date	OFFICE USE ONLY—COC begin and end date	

I hereby elect to continue coverage with my current provider or facility. I authorize my provider or facility to release any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my eligibility for Continuity of Care coverage. I authorize my health plan to speak to my provider or facility regarding such coverage. This information will be used for determining the appropriate level of benefit reimbursement for services provided on or afterthe effective date of using my coverage, if I continue treatment with the above named provider for the above diagnosis/medical condition.

I understand that Continuity of Care is granted discretionarily and is subject to contractual limitations and exclusions set forth in the group contract. I understand and agree that Continuity of Care does not extend the contractual benefits in any way, except to provide in-network level benefits for a non-network provider for a temporary time period.

*If the patient is younger than 18, the employee/retiree must sign this form.

Patient's Signature	Date:
Employee/Retiree's Signature*	Date

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CONTINUITY OF CARE FAQ

Under the Consolidated Appropriations Act, beginning January 1, 2022, if you are a continuing care patient of an in-network provider or facility whose contract is terminated with your health plan, your health plan will notify you of the termination and will give you the option to continue your care with that provider or facility as if they were still in-network with your Plan. The continuation of this coverage will last 90 days, or until you are no longer a continuing care patient, whichever comes first.

Am I a continuing care patient?

A continuing care patient is any individual who is:

- Undergoing a course of institutional or inpatient care from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider, including postoperative care from the provider or facility with respect to such a surgery;
- Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or,
- Determined to have been terminally ill and receiving treatment for such illness from the provider or facility.
- Undergoing a course of treatment for a "serious and complex" condition from the provider or facility;

What is a serious and complex condition?

- In the case of an acute illness, it is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, it is a condition that:
    - is life-threatening, degenerative, potentially disabling, or congenital; and
    - requires specialized medical are over a prolonged period of time.

What can the provider or facility charge me?

The provider or facility can only charge you the in-network copayment, coinsurance and deductible amounts for your continued care. The terms of coverage and care must also remain the same as when the provider or facility was in-network.

When does the 90 days start and end?

The timing of the 90 days starts on the date you are provided a notice of your right to elect continuing care, and ends either 90 days later, or the date on which you are no longer undergoing continuing care by that provider or facility, whichever is first.

Are there exceptions to the continuity of care protections?

Yes. If your treating provider or facility's contract with your health plan was terminated because of quality standards or fraud, the protections do not apply.

If I am a continuing care patient, is there anything I need to do?

If you are a continuing care patient and you qualify for continuity of care protection, the Plan will send you a notice of your right to elect to continue receiving care at the terminated provider or facility. If you believe you are a continuing care patient, or would like to inquire whether you qualify, please contact the Fund Office at 410-683-6500.

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ANNOUNCEMENT TO PARTICIPANTS

BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees ("Board") of the Bakers Union and FELRA Health and Welfare Fund ("Fund") has adopted the following changes to the Fund's Plans One, Two, and Three, in compliance with the No Surprises Act, which was included in the 2021 Consolidated Appropriations Act. The No Surprises Act generally seeks to protect patients from surprise bills arising out of emergency and certain other medical care.

Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits of Coverage ("SBC"). These changes are effective **January 1, 2022.**

A. First Change

The following definitions are added to the "Definitions" section of the SPD.

Continuing Care Patient

An individual who is: (1) undergoing a course of treatment for a "serious and complex condition," defined as (i) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (ii) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time; (2) undergoing a course of institutional or inpatient care; (3) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; or (4) determined to be terminally ill and receiving treatment for such illness.

Emergency Services

A situation which arises suddenly, and which poses a serious threat to life or health. Medical Emergencies include heart attack, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and other acute conditions. The diagnosis or the symptoms, and the degree of severity, must be such that immediate Medical Care is required. *Emergency* Services also includes: (1) anything a prudent layperson possessing an average knowledge of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent

immediate care; (2) an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; (3) such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and (4) services provided by an out-of-network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:

(a) The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;

(b) The patient is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and

(c) The patient gives informed consent to continued treatment by the nonparticipating provider, acknowledging that she or he understands that continued treatment by the out-of-network provider may result in greater cost to the patient.

No Surprises Services

The following services, to the extent covered under the Plan, are "No Surprises Services": (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) ancillary services as defined under the No Surprises Act and its implementing regulations (including anesthesiology, pathology, radiology, diagnostic services) when performed by out-of-network providers at in-network facilities; and (4) other out-of-network non-Medical Emergency services performed at in-network facilities for which the provider does not comply with federal notice and consent requirements.

B. Second Change

The following definition in the "Definitions" section of the SPD is changed to read:

Maximum Allowable Charge

Except for *No Surprises Services*, the *Maximum Allowable Charge* for any supply or service shall be the lesser of: a) the Cigna HealthCare allowed amount; b) an amount stipulated by the Board as the maximum allowable or reasonable charge for that service or supply; or c) the amount normally charged by a selected segment of *Physicians* or other providers in that geographic area (such segment and areas as defined by the Board). For *No Surprises Services*, the *Maximum Allowable Charge* is the "Qualifying Payment Amount" ("QPA"), as defined under regulations to

the No Surprises Act, and is based on the median of the in-network rates payable for the same or similar service in the same geographic region, adjusted for inflation.

C. Third Change

The following notice is inserted after page 27 of the SPD.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
Even if you get services at an in-network hospital or ambulatory surgical center, certain providers at the facility may be out-of-network. In these cases, the most the out-of-network providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover Emergency Services without requiring you to get approval for services in advance (prior authorization).
    - Cover Emergency Services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for Emergency Services or out-of-network services toward your deductible and out-of-pocket limit.

Beginning January 1, 2022, if you believe you've been wrongly billed, you may contact the Department of Health and Human Services (HHS) at 1-800-985-3059 or the Fund Office.

. Visit https://www.cms.gov/nosurprises/consumers or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

D. Fourth Change

The section "Medical Services" under the "Summary of Benefits for Full-Time Plan 1 Participants" on page 55 of the SPD is changed to read:

80% up to the Cigna allowed amount, plus deductible up to the out-of-pocket maximum. Cigna Share Administration Network Mandatory or no benefits will be paid, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

E. Fifth Change

The section "Medical Services" under the "Summary of Benefits for Full-Time Plan 2 Participants" on page 57 of the SPD is changed to read:

75% up to the Cigna allowed amount, plus deductible up to the out-of-pocket maximum. Cigna Share Administration Network Mandatory or no benefits will be paid, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

F. Sixth Change

The section "Medical Services" under the "Summary of Benefits for Full-Time and Part-Time Plan 3 Participants" on page 59 of the SPD is changed to read:

70% up to the Cigna allowed amount, plus deductible up to the out-of-pocket maximum. Cigna Share Administration Network Mandatory or no benefits will be paid, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

G. Seventh Change

The section "Exceptions to Mandatory Use of Cigna HealthCare" on page 76 of the SPD is changed to read:

There are some exceptions to the mandatory Cigna HealthCare requirement. They are:

Emergency Services (inpatient or outpatient), regardless of whether they occur inside or outside the Cigna HealthCare area.

Eligible *Dependent* students who attend a school outside the Cigna HealthCare network area are not required to use a Cigna HealthCare provider.

Claims from non-Cigna HealthCare providers for services ancillary to non-*Emergency Services*, (including anesthesiology, pathology, radiology, and diagnostic services) if (1) the *Participant* uses a participating surgeon/physician and (2) the service is performed at an in-network facility/Hospital.

Ambulance transportation for *Emergency Services*.

Air ambulance services for *Emergency Services*.

Other *No Surprises Act Services*.

When this Plan's coverage is secondary, a Cigna HealthCare PPO provider is not required.

H. Eighth Change

The text box in the section "Hospital and Medical Benefits" on page 94 of the SPD is changed to read:

> **Important!**
> You must use a participating Cigna HealthCare provider in order to be covered. Services performed by non-Cigna HealthCare Providers will not be paid under the Fund, with the exception of *No Surprises Services, Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

I. Ninth Change

The section "Ambulance Transportation" is changed to read:

Ambulance Transportation

Plan 1 *Participants*: Transportation by ambulance for Emergency Services within the continental United States and Canada or within the geographical boundaries of Puerto Rico and Hawaii will be covered at 100% with no *Deductibles.* You will never be responsible for payment of ambulance transportation for Emergency Services. Air transportation is covered from the city/town in which the *Injury* or *Illness* occurs to the nearest *Hospital* qualified to provide care for that *Illness* or *Injury*. If, under these circumstances, air transportation is required, it is only covered for the first trip to and from a *Hospital.*

Ambulance transportation from one facility to another in non-emergency situations is not covered. **The requirement to use a Cigna HealthCare provider is waived for *Emergency Services* ambulance transportation.**

Plan 2 and Plan 3 *Participants*. Coverage provided under the same conditions as listed above but all payment is made under Major Medical at 75% for Plan 2 *Participants* and 70% for Plan 3 *Participants.* However, regardless of the determination made by the Fund Office, you will never be responsible for payment of more than 25% (for Plan 2 *Participants*) or 30% (for Plan 3 *Participants*) of the amount that the Fund determines is reasonable for emergency medical transportation.

The requirement to use a Cigna HealthCare provider is waived for *Emergency Services* ambulance transportation.

J. Tenth Change

The following subsection is inserted under the "Hospital and Medical Coverage" section on page 104 of the SPD:

Continuing Care Patients

If an in-network provider leaves the Cigna HealthCare network, a *Continuing Care Patient* who is receiving care with that provider will receive notification of such change in network status and the *Continuing Care Patient* may continue to receive such care at the same in-network *Co-Payment* for up to 90 days after the later of the provider leaving the network or being notified of such change.

K. Eleventh Change

Under the section "Major Medical Benefits" on page 110 of the SPD, the language is changed to:

You must receive services at a Cigna Shared Administration network facility or no benefits will be paid, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

L. Twelfth Change

Under the section "General Exclusions," Number 39 on page 117 of the SPD is changed to:

39. Services or supplies which are in excess of the Cigna HealthCare PPO allowed amount or in excess of the amount approved by CARE Programs, except that you will not be responsible for amounts in excess of the Cigna HealthCare PPO allowed amount or in excess of the amount approved by CARE Programs for *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

If you have any questions on the announcement or the Plan, please contact the Plan Administrator at (866) 662-2537. Also, note that the public notice your rights and protections against surprise medical bills is available for review in the Your Benefits section of the Associated Administrators website at www.associated.com.

M. Thirteenth Change

The following is added on page 156 to the list of claims eligible for external review:

You may request external review for any adverse benefit determination relating to a No Surprises Service. You must file a request for external review of a denial of No Surprises Services claims within four months of the date you received the final adverse benefit determination. The Plan will refer your appeal to an Independent Review Organization (IRO). You will receive a decision from the IRO within 45 days of the IRO's receipt of your request for review.

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ANNOUNCEMENT TO PARTICIPANTS

BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Bakers Union and FELRA Health and Welfare Fund has adopted the following change to the Bakers Union and FELRA Health and Welfare Fund Plans One, Two, and Three. Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits of Coverage ("SBC").

Effective January 15, 2022, the Plan will cover up to 8 Food and Drug Administration ("FDA") approved at home COVID-test kits per covered member, per month up to $12 per test (Please note: if a test kit includes 2 tests, reimbursement will be limited to 4 test kits.)

You can obtain a kit, at no cost to you, at a Rite Aid Pharmacy, Sam's Club Pharmacy or Walmart Pharmacy. Simply go to the pharmacy counter, present your member ID card, and ask to have your over-the-counter at-home COVID-19 test kits submitted to your plan for coverage. If you purchase test kits from these specific retailers, there is no need to submit a reimbursement form.

You can also purchase an FDA-authorized at home COVID-19 test kit at other stores or through online retailers. Your purchase receipt must be submitted with a reimbursement form. The Plan will reimburse you $12 per test for up to 8 tests per covered member, per month. Reimbursement forms can be obtained on the optumrx.com website or by contacting the Fund Office at (866) 662-2537. A separate form will be required for each covered member.

Please note that the Plan's reimbursement is limited to tests for personal use and not for employment-related testing or resale. The OptumRx reimbursement form will require you to provide an attestation certifying that the test kits received were not for employment-related COVID-19 testing requirements and were used for personal use and not resale.

In addition, you can also order 4 free at home COVID-19 test kits per household online at COVIDTests.gov.

If you have any questions on the announcement or the Plan, please contact the Plan Administrator at (866) 662-2537.

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Date

Re: Bakers Union & FELRA Health and Welfare Fund
DOL EBSA Cybersecurity Guidance - VENDOR ACTION REQUIRED

Dear (Provider):

This letter is being sent to you as an entity that provides services to the Bakers Union & FELRA Health and Welfare Fund ("Fund"). The purpose of this letter is to request your cooperation in the Fund's review and documentation of its service providers' cybersecurity policies for the protection of participant information and the security of plan accounts and assets.

As you may be aware, in April 2021, the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") issued guidance for employee benefit funds governed by the Employee Retirement Income Security Act of 1974 ("ERISA") concerning cybersecurity in light of the obligation to ensure proper mitigation of cybersecurity risks. Much of this guidance is focused on steps ERISA trust funds should take to ensure that the service providers with whom they contract have appropriate cybersecurity programs in place to protect participant information and plan assets. While this guidance is currently advisory, we anticipate that some form of it will eventually become minimum standards.

In *Cybersecurity Program Best Practices*[1], EBSA observes that "plan fiduciaries have an obligation to ensure proper mitigation of cybersecurity risks" and lists twelve "best practices for...service providers responsible for plan-related IT systems and data, and for plan fiduciaries making prudent decisions on the service providers they should hire." The specific best practices recommended by EBSA are:

1. a formal and well-documented cybersecurity program that identifies and assesses cybersecurity risks, both external and internal;
2. prudent annual risk assessments that identify, estimate and prioritize system risks;
3. annual third-party audits of security controls that provide a clear, unbiased report of existing risks, vulnerabilities and weaknesses;

[1] https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/best-practices.pdf

4. clearly defined and assigned information security roles and responsibilities, including ensuring that the program is managed at the senior executive level (e.g., a Chief Information Security Officer) and executed by qualified personnel;
5. strong access control procedures, i.e., guaranteeing through authentication and authorization that users who access IT systems and data are who they say they are and are indeed entitled to access;
6. security reviews and independent assessments of data maintained in the cloud or managed by third-party providers;
7. cybersecurity awareness training for all personnel, conducted at least annually, which is updated to reflect risks identified by the organization's latest risk assessment;
8. a secure system development life cycle program including annual penetration tests and regular vulnerability scans;
9. an effective business resiliency program that addresses business continuity, disaster recovery and incident response;
10. encrypting sensitive data when stored and in transit;
11. implementing strong technical controls in accordance with best security practices; and
12. responding appropriately to cybersecurity incidents or breaches.

The EBSA bulletin *Tips for Hiring a Service Provider with Strong Cybersecurity Practices*[2] provides additional guidance intended to help fiduciaries "meet their responsibilities under ERISA to prudently select and monitor ... service providers" that "maintain plan records" and are expected to "keep participant data confidential and plan accounts secure." EBSA identifies several questions fiduciaries should raise with such service providers, including asking about the provider's information security standards, practices, and policies to assess whether the provider follows any recognized standards; how the service provider validates its security practices; and insurance coverage, including insurance coverage that addresses cybersecurity losses and identity theft caused by both internal and external threats. EBSA also suggests that a plan should inquire into each service provider's history of security breaches, including what happened and how the service provider responded. It is important that each of the Fund's service providers respond directly to the issues raised in the EBSA guidance and demonstrate compliance with the stated guidelines.

Also, in its *Tips for Hiring a Service Provider*, EBSA identifies terms that plans should address in their contracts with service provider, including provisions recognizing the duty to safeguard plan information; ensuring ongoing compliance with cybersecurity protocols; and requiring that any security incidents be reported. These topics and any contract language that attempts to limit liability for security breaches will need to be discussed with the Trustees at renewal.

Information Request

[2] https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/tips-for-hiring-a-service-provider-with-strong-security-practices.pdf

To enable the Trustees to fulfill their duties to safeguard participant information, plan accounts and assets, and to monitor the Fund's service providers, please review the EBSA guidance, easily located on DOL's website (see the links we have provided in notes 1 and 2 of this letter). We request that you provide a cybersecurity report that addresses what steps you have taken to protect any participant information you have in your role as a service provider to the Fund. If you handle any plan assets, we ask that you also advise us of the steps you are taking to ensure the safety and security of those assets. If you have an existing cybersecurity policy, please provide us with a copy. In addition, please advise whether you have any insurance policies that cover losses caused by cybersecurity incidents and, if so, please provide details of that coverage (e.g., limits and scope of coverage). Please provide your response within thirty (30) days of receipt of this letter. All responses will be reviewed and reported on to the Fund's Board of Trustees.

The Fund understands that some of its service providers already maintain comprehensive cybersecurity policies and/or programs that are responsive to the EBSA guidance, while others will need to document and supplement their existing cybersecurity programs to address the EBSA guidance in consultation with their IT vendors. If your company falls into the latter category and you need additional time to respond to this request, please let the Fund Office know before the 30-day deadline to respond and indicate when you expect your response will be ready which, in no event, should be later than sixty (60) days of receipt of this letter.

The EBSA guidance indicates that plan vendors' risk analysis should be updated at least annually, so please feel free to supplement your response as needed. As substantive changes to your cybersecurity program occur, they should be reported to the Fund so that the Board of Trustees can document their efforts to monitor all service providers.

Thank you in advance for your help in ensuring the Bakers Union & FELRA Health and Welfare Fund is compliant with the new EBSA guidance. Should you have any questions, feel free to contact me in writing.
Sincerely,

Dawn Welch
Account Executive