Bakers Union and FELRA
Health and Welfare Fund
Board of Trustees Meeting
June 8, 2022

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

8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
Telephone: (301) 459-3020
Toll Free: (866) 662-2537
www.associated-admin.com

BOARD OF TRUSTEES MEETING
JUNE 8, 2022

AGENDA

I. Call to Order

II. Minutes - Regular Meeting held March 9, 2022

III. Financial Report - Chris Little, PNC

IV. Cigna – Cynthia Horne
   A. Enhanced Cost and Quality Tool
   B. Savings Report

V. Co-Counsel Report

VI. Administrative Managers Report

VII. Invoices

VIII. Participant Appeals

IX. Other Fund Business

X. 2022 Meeting Dates: Wednesday 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
MARCH 9, 2022
LANDOVER, MARYLAND

The following Trustees were present:

UNION TRUSTEE
L. Jones
G. Oskoian – Chairman

EMPLOYER TRUSTEES
J. Williams
Michael Goble - (via telephone[KJT1])

Also present were:
L. Tarro - Optum Rx
M. DeLancey - Blank Rome, LLP - (via telephone)
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 at 10:06 am.

II. MINUTES

The Trustees reviewed the minutes of the regular Board meeting held on December 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 December 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 February 28, 2022, 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 $338,997, net contributions and withdrawals that resulted in a loss of $1,463, investment income of $368, producing an ending market value of $580,193.

Mr. Little presented the portfolio holdings as of February 28, 2022. The Fund holds 46% in limited maturity bonds, with a market value of $267,073 and 54% in cash with a market value of $313,120. 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. Lissa Tarro of Optum Rx to the meeting.

Ms. Tarro reviewed the OptumRx 2021 Annual Review Plan Performance Report for March 9, 2022, 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 December 2021. The Plan cost per member per month (pmpm) was $108.33 for the period January 2021 to December 2021 as compared to $123.55 for the period January 2020 through October 2020. The OptumRx Taft Hartley book of business ("BOB") per member per month cost for the period January 2021 to December 2021 was $102.14. Specialty drugs accounted for less than 1% of the Plan's drug cost. The top twenty traditional and specialty

drugs paid by the Plan from January 1, 2021 to December 31, 2021 were reviewed. She also reported the Clinical Outcome savings for January 2021 through December 2021 was $82,000. This includes Prior Authorization, Step Therapy, Quantity Limits and the Vigilant Drug Program. Ms. Tarro noted that the home delivery rate had increased from 1.0% to 2.9% since the Fund implemented the Mail Service Saver Program July 1, 2021.

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

V. CO-COUNSEL REPORT

A. Vendor Contracts

Mr. Kimble reported on the status of Co-Counsel's review of the contracts with OptumRx and Cigna.

B. Deadline Extensions

Mr. Kimble informed the Trustees that deadlines tolled due to the COVID-19 National Emergency and were set to expire on March 1, 2022, but have been extended. The deadlines related to COBRA, claims, appeals, and HIPAA special enrollment elections will be extended until the earlier of one year or, if earlier, 60 days from the end of the National Emergency.

VI. ADMINISTRATIVE MANAGER REPORT

Ms. Welch presented the Administrative Manager Report for the fourth quarter of 2021. The report showed employer contribution income of $1,106,645, employee payroll deductions of $35,946, interest and dividend income of $483, and miscellaneous income of $26,900, producing a total income of $1,169,974. Expenses included $647,981 for medical benefits, $31,710 for CIGNA premiums, $42,837 for dental premiums, $7,143 for disability benefits, $196,092 for prescription drug benefits, $4,382 for life insurance benefits, $25,315 for stop loss insurance, $6,026 for optical benefits, and $72,496 in operating expenses, producing total expenses of $1,033,925 and resulting in a surplus of $135,992. Contributions were made on behalf of 452 active participants. There were no

delinquencies. Ms. Welch noted that as of February 28, 2022, the Fund had $580,002.40 in reserves, representing 1.7 months.

Ms. Welch reviewed a High Cost Medical Claims Report for January 1, 2022 through February 28, 2022 and informed the Trustees that twelve participants had incurred claims above $50,000 that totaled $1,142,224.90. She noted four of the twelve participants are deceased.

The Trustees reviewed a Savings Report for the 2021 Plan year. The chart noted a savings of $168,596.36 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 March 9, 2022. 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 March 9, 2022 as presented.

VIII. PARTICIPANT APPEALS

A. Appeal M22/102-9299

The Trustees considered an appeal from a participant requesting payment of a claim for telehealth services.In considering appeal the Trustees reviewed the participant's letter of appeal dated February 7, 2022, a copy of the claim, and the terms of the SPD related to coverage for telehealth services.

Afer reviewing the foregoing the Trustees approved the appeal noting that the participant was suffering from "Acute recurrent maxillary sinusitis" and that the provider was not seeing any patients in person.

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

B. Appeal M22/103-8606

The Trustees considered an appeal from Remote Neuromonitoring Physicians on behalf of the participant as his authorized representative for payment of a surgical claim that was denied because it was an out-of-network claim for neurophysiology monitoring during the participant's surgical procedure.

The Trustees tabled a decision on the participant's appeal pending additional information from the provider.

IX. OTHER FUND BUSINESS

A. Fiduciary Liability Policy

Ms. Welch reported that the Fiduciary Liability Policy was renewed for the period of January 1, 2022 through January 1, 2023. She confirmed all Trustees have paid their individual waiver of recourse premiums.

B. Cyber Liability Policy

Ms. Welch noted that the Trustees unanimously approved via email poll on December 22, 2021 obtaining a Cyber Liability Policy with Travelers, through the broker Segal for the period of January 1, 2021 to January 1, 2022. Segal provided quotes from Beazley and Travelers. They recommended Travelers based on the broad scope of coverage and competitive premiums. The one year policy premium is $4,303.

C. OptumRx Rebate

Ms. Welch reported that the Fund had received a rebate from OptumRx for the second quarter of 2021 in the amount of $26,900.

D. **Summary of Material Modifications ("SMM")**

Ms. Welch informed the Trustees thar the SMM which detailed modifications to the Plan in accordance with the No Surprises Act was mailed to Plan participants on January 5, 2022.

She reported the SMM regarding the over-the-counter COVID test kits was mailed to Plan participants on February 4, 2022.

D. **Independent Dispute Resolution ("IDR")**

Ms. Welch informed the Trustees that Cigna will be able to perform post payment negotiations and the arbitration management services with the support of MultiPlan to meet the IDR requirements under the No Surprises Act. She distributed the IDR Resolution Solution recently received from Cigna to the Trustees.

Fund Counsel recommended pending additional discussion until Co-Counsel and the Administrative Manager could review and discuss the information received via teleconference with Cigna.

E. **Transparency in Coverage**

Ms. Welch noted that under the Transparency in Coverage Rule issued in 2020 by the U.S. Departments of Health & Human Services, Labor and Treasury, enforced beginning July 1, 2022 the Plan will be required to publish machine readable files for in-network negotiated rates for all covered items and services between the Plan and in-network providers. She noted that Cigna will be producing and hosting client specific in-network machine readable files and they are expected to release additional information by the end of the week. Ms. Welch stated she would circulate the additional information to Co-

Counsel and the Trustees once received.

She noted the Transparency in Coverage Rule also requires cost sharing information to be made available to participants through an internet based self-service tool and in paper form upon request. An initial list of 500 shoppable services will be required beginning on January 1, 2023. The remainder of all items and services will be required beginning January 1, 2024. Ms. Welch informed the Trustees that Cigna will have an internet based self-service tool available by January 1, 2023. The Trustees requested that Ms. Welch invite Cigna to the next meeting to provide a presentation regarding the self-service tool.

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

Ms. Welch informed the Trustees that the questionnaire and request for information developed by Co-Counsel was sent to all providers for completion and execution.

G. Weekly Accident & Sickness Benefit

The Trustees discussed the weekly Accident & Sickness Benefit. After discussion,

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

RESOLVED to request a proposal from Segal for the cost to the Plan to increase the weekly Accident & Sickness Benefit to 50% of gross straight time pay for 18 weeks and 40% of gross straight time pay for 8 weeks.

XI. NEXT MEETING DATE AND LOCATION

The quarterly Board meetings for the 2022 Plan year are scheduled to be held on 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 February 28, 2022
Exhibit B: Optum Rx Plan Performance Report January 2021 through December 2021

BAKERS UNION AND FELRA

HEALTH AND WELFARE FUND

FIRST QUARTER 2022

ADMINISTRATIVE MANAGER'S REPORT

FIRST QUARTER 2022
PLAN 1
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	FT	$ 1,225.62	92	$ 339,496
SAFEWAY	FT	$ 1,225.62	153	$ 562,559
TOTAL			**245**	**$ 902,055**

EMPLOYEE PAYROLL

GIANT	$ 42.54	102	$ 13,204
SAFEWAY	$ 42.54	199	$ 23,733
TOTAL			**$ 36,937**

FIRST QUARTER 2022
PLAN 1
EXPENSES

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	COMMENT
MEDICAL		$ 428,083	
CIGNA	$ 31.13	$ 23,396	
DENTAL-DENEX	$ 50.95	$ 30,298	
DISABILITY		$ 6,543	
OPTUM RX		$ 188,973	1,483 SCRIPTS
LIFE/AD&D	$3.90/.20	$ 3,014	
OPTICAL PROVIDER	$ 5.36	$ 4,182	
STOP LOSS	$ 27.83	$ 19,398	
SUB TOTAL		$ 703,887	

OPERATING EXPENSES

ADMINISTRATION	$ 30.98	$ 22,863	
MISCELLANEOUS		$ 23,131	
SUB TOTAL		$ 45,994	

TOTAL EXPENSES	**$ 749,881**

MISCELLANEOUS EXPENSES

BONDING AND FIDUCIARY INSURANCE	$ 6,072
LEGAL	$ 15,004
MEETINGS	$ 810
PNC ACCOUNT FEE	$ 357
POSTAGE	$ 733
PRINTING	$ 77
TELEPHONE	$ 78

TOTAL MISCELLANEOUS EXPENSES	**$ 23,131**

2022
PLAN 1
QUARTERLY RECAP

INCOME	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
EMPLOYER CONTRIBUTIONS	$ 902,055				$ 902,055
EMPLOYEE PAYROLL	$ 36,937				$ 36,937
COBRA	$ 1,767				$ 1,767
TOTAL INCOME	$ 940,759	$ -	$ -	$ -	$ 940,759

EXPENSES	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
MEDICAL	$ 428,083				$ 428,083
CIGNA	$ 23,396				$ 23,396
DENTAL-DENEX	$ 30,298				$ 30,298
DISABILITY	$ 6,543				$ 6,543
DRUG	$ 188,973				$ 188,973
LIFE	$ 3,014				$ 3,014
OPTICAL	$ 4,182				$ 4,182
STOP LOSS	$ 19,398				$ 19,398
OPERATING EXPENSE	$ 45,994				$ 45,994
TOTAL EXPENSE	$ 749,881	$ -	$ -	$ -	$ 749,881
SURPLUS (DEFICIT)	**$ 190,878**	**$ -**	**$ -**	**$ -**	**$ 190,878**

	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	AVERAGE
TOTAL PARTICIPANTS	245				245

FIRST QUARTER 2022
PLAN 3
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	FT	$ 593.00	35	$ 61,672
GIANT	PT	$ 161.42	26	$ 12,752
SAFEWAY	FT	$ 593.00	52	$ 91,915
SAFEWAY	PT	$ 161.42	63	$ 29,940
TOTAL			**176**	**$ 196,279**

FIRST QUARTER 2022
PLAN 3
EXPENSES

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	COMMENT
MEDICAL		$ 24,605	
CIGNA	$ 31.13	$ 11,690	
DENTAL-DENEX	$ 50.95	$ 12,703	
DISABILITY		$ 1,343	
OPTUM RX		$ 26,029	300 SCRIPTS
LIFE/AD&D	$ 3.90 /.20	$ 1,109	
OPTICAL PROVIDER	$ 5.36	$ 1,882	
STOP LOSS	$ 27.83	$ 7,180	
SUB TOTAL		$ 86,541	

OPERATING EXPENSES

ADMINISTRATION	$ 30.98	$ 16,295	
MISCELLANEOUS		$ 8,310	
SUB TOTAL		$ 24,605	

TOTAL EXPENSES	**$ 111,146**

MISCELLANEOUS EXPENSES

BONDING AND FIDUCIARY INSURANCE	$ 2,182
LEGAL	$ 5,390
MEETINGS	$ 291
PNC ACCOUNT FEE	$ 128
POSTAGE	$ 263
PRINTING	$ 28
TELEPHONE	$ 28

TOTAL MISCELLANEOUS EXPENSES	**$ 8,310**

2022
PLAN 3
QUARTERLY RECAP

INCOME	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
EMPLOYER CONTRIBUTIONS	$ 196,279				$ 196,279
TOTAL INCOME	$ 196,279	$ -	$ -	$ -	$ 196,279

EXPENSES	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
MEDICAL	$ 24,605				$ 24,605
CIGNA	$ 11,690				$ 11,690
DENTAL-DENEX	$ 12,703				$ 12,703
DISABILITY	$ 1,343				$ 1,343
DRUG	$ 26,029				$ 26,029
LIFE	$ 1,109				$ 1,109
OPTICAL	$ 1,882				$ 1,882
STOP LOSS	$ 7,180				$ 7,180
OPERATING EXPENSE	$ 24,605				$ 24,605
TOTAL EXPENSE	$ 111,146	$ -	$ -	$ -	$ 111,146
SURPLUS (DEFICIT)	**$ 85,133**	**$ -**	**$ -**	**$ -**	**$ 85,133**

	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	AVERAGE
TOTAL PARTICIPANTS	176				176

FIRST QUARTER 2022
PLAN 4
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	PT	$ 25.72	8	$ 642
SAFEWAY	PT	$ 25.72	13	$ 978
TOTAL			**21**	**$ 1,620**

FIRST QUARTER 2022
PLAN 4
EXPENSES

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	COMMENT
DENTAL-DENEX	$ 50.95	$ 2,837	
DISABILITY		$ 3,571	
LIFE/AD&D	$ 3.90 /.20	$ 288	
OPTICAL PROVIDER	$ 5.36	$ 241	
SUB TOTAL		$ 6,937	

OPERATING EXPENSES

ADMINISTRATION	$ 30.98	$ 1,952	
SUB TOTAL		$ 1,952	

TOTAL EXPENSES	**$ 8,889**

2022
PLAN 4
QUARTERLY RECAP

INCOME	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
EMPLOYER CONTRIBUTIONS	$ 1,620				$ 1,620
TOTAL INCOME	$ 1,620	$ -	$ -	$ -	$ 1,620

EXPENSES	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
MEDICAL	$ -				$ -
CIGNA	$ -				$ -
DENTAL-DENEX	$ 2,837				$ 2,837
DISABILITY	$ 3,571				$ 3,571
DRUG	$ -				$ -
LIFE	$ 288				$ 288
OPTICAL	$ 241				$ 241
STOP LOSS	$ -				$ -
OPERATING EXPENSE	$ 1,952				$ 1,952
TOTAL EXPENSE	$ 8,889	$ -	$ -	$ -	$ 8,889
SURPLUS (DEFICIT)	**$ (7,269)**	**$ -**	**$ -**	**$ -**	**$ (7,269)**

	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	AVERAGE
TOTAL PARTICIPANTS	21				21

2022
COMBINED
QUARTERLY RECAP

INCOME	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
EMPLOYER CONTRIBUTIONS	$ 1,099,954	$ -	$ -	$ -	$ 1,099,954
EMPLOYEE PAYROLL	$ 36,937	$ -	$ -	$ -	$ 36,937
COBRA	$ 1,767	$ -	$ -	$ -	$ 1,767
INTEREST & DIVIDENDS	$ 537	$ -	$ -	$ -	$ 537
MISCELLANEOUS INCOME[1]	$ 21,040	$ -	$ -	$ -	$ 21,040
TOTAL INCOME	$ 1,160,235	$ -	$ -	$ -	$ 1,160,235

EXPENSES	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
MEDICAL	$ 453,038	$ -	$ -	$ -	$ 453,038
CIGNA	$ 35,054	$ -	$ -	$ -	$ 35,054
DENTAL-DENEX	$ 45,838	$ -	$ -	$ -	$ 45,838
DISABILITY	$ 11,457	$ -	$ -	$ -	$ 11,457
DRUG	$ 215,002	$ -	$ -	$ -	$ 215,002
LIFE	$ 4,411	$ -	$ -	$ -	$ 4,411
OPTICAL	$ 6,305	$ -	$ -	$ -	$ 6,305
STOP LOSS	$ 26,578	$ -	$ -	$ -	$ 26,578
OPERATING EXPENSE	$ 72,551	$ -	$ -	$ -	$ 72,551
TOTAL EXPENSE	$ 870,234	$ -	$ -	$ -	$ 870,234
SURPLUS (DEFICIT)	**$ 290,001**	**$ -**	**$ -**	**$ -**	**$ 290,001**

	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	AVERAGE
TOTAL PARTICIPANTS	442				442
FUND RESERVE	$ 681,439	$ -	$ -	$ -	

[1] OptumRX Pharmacy Rebate received 3/21/2022 for - 3Qtr. 2021 - $21,040.00

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	457

FUND RESERVE	$ 472,194	$ 292,195	$ 371,185	$ 338,828

Bakers Union and FELRA
Health and Welfare Fund
As of April 30, 2022

Fund Reserve

Months of Available Fund Reserve	
Expenses	
January 1 - December 31, 2021	$ 4,314,720.00
January 1 – April 30, 2022	$ 1,106,286.00
Total	$ 5,421,006.00
Per Month	$ 361,400.40
Fund Reserve	
As of April 30, 2022	**$ 778,821.57**
Months of Reserve	**2.2**
March 30, 2022	2.0
February 28, 2022	1.7
January 30, 2022	1.2
October 31, 2021	1.1
September 30, 2021	1.0
August 31, 2021	0.7
July 30, 2021	1.0

	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 May 31, 2022

Fund Reserve

Months of Available Fund Reserve	
Expenses	
January 1 - December 31, 2021	$ 4,314,720.00
January 1 – May 31, 2022	$ 1,129,286.73
Total	$ 5,444,006.73
Per Month	$ 320,235.69
Fund Reserve	
As of May 31, 2022	**$ 801,822.30**
Months in Reserve	2.5
April 30, 2022	2.2
March 30, 2022	2.0
February 28, 2022	1.7
January 30, 2022	1.2
October 31, 2021	1.1
September 30, 2021	1.0
August 31, 2021	0.7

	Plan 1	Plan 2	Plan 3	Plan 4
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 & FELRA	
HEALTH AND WELFARE	
GAIN/LOSS STATEMENT	
May-22	
Beginning Bank Balance	**$778,821.57**
INCOME:	
Contributions	386,311.81
Investments	276.97
TOTAL INCOME	**$386,588.78**
EXPENSES:	
Medical Claims	207,015.89
Cigna	11,317.19
Dental	15,251.81
Drug	76,407.79
Life and AD&D Insurance	1,453.40
Disability	2,771.40
Legal	16,672.00
Stop Loss	8,822.11
Operating Expenses	23,289.91
Change is value of Investments	586.55
TOTAL EXPENSES	**$363,588.05**
GAIN/LOSS	$23,000.73
Ending Bank Balance	$801,822.30
Current Months of Reserve	**2.5**

COVID-19 Claims Report (1/1/22 – 4/30/22)

Covid-19 Tests Performed by Month year 2022

Month	Number of Tests	Payment Total
January	111	$15,863.66
February	40	$6,293.44
March	43	$6,422.04
April	15	$2,670.28
Total	**209**	**$31,249.42**

Covid-19 Treatment Paid by Month year 2022

Month	Claims Paid	Total Payment
January	16	$8,159.89
February	6	$397.67
March	4	$937.07
April	20	$2,603.68
Total	**46**	**$12,098.31**

Covid-19 Vaccine Paid year 2022

	Administered	Total Paid
Vaccine	18	**$720.08**

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 – Laboratory Services #M22/107-9299

FUND RULE:
"SUMMARY OF MATERIAL MODIFICATION

Laboratory Benefit

For all laboratory service claims incurred on or after September 1, 2021, you must use either a Quest Diagnostics Patient Service Center ('Quest') or Laboratory Corporation of America Center ('LabCorp') in order for such services to be covered by the Plan.

Please advise all of your physicians and their offices of this change so they will refer you to the proper LabCorp or Quest facility for all laboratory services performed September 1, 2021 and after. The laboratory services must be performed at a LabCorp or Quest facility to be covered by the Plan. You can call 1-800-768-4695 to obtain the location of the nearest LabCorp or Quest facility or to find the most current list of LabCorp and Quest facilities log on to their website or call them directly at:

• www.questdiagnostics.com or by telephone at (800) 377-8448

• www.labcorp.com or by telephone at (800) 845-6167 [...]"
(Quoted from the Bakers Union and FELRA Health and Welfare Fund Summary of Material Modifications, dated July 2021, mailed to the participant on July 1, 2021)

SUMMARY:

Date(s) of Service:	January 25, 2022
Claim(s) Received:	February 3, 2022
Claim(s) Denied:	February 23, 2022
Appeal Received:	March 31, 2022

The participant is appealing for payment of a claim for laboratory services that was denied. The participant states that she has been going to Maryland Primary Care for years and previous claims have been covered. The participant further states that she did not know that she had to go to a LabCorp or Quest Diagnostics facility, and that she can't afford these out-of-pocket expenses.

Effective September 1, 2021, all laboratory services must be performed at a LabCorp or Quest Diagnostics facility to be covered by the Plan. A Summary of Material Modifications ("SMM") was mailed to the participant on July 1, 2021, advising of this benefit change. Maryland Primary Care submitted a claim for multiple outpatient blood tests rendered on January 25, 2022. The claim was denied because the tests were not perfromed by a LabCorp or Quest Diagnostics facility.

Note: The participant's address on file was last updated on June 28, 2005 and matches the return address on her appeal envelope. No return mail has been received from the post office.

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

1) Claim# BRFV45
2) Claim# BRYQ08

March 29, 2022

RECEIVED
MAR 31 2022
AA, LLC

employee #
Acct #
Acct #

Dear Appeals Coordinator,

My name is and I am the policy holder of Cigna healthcare. I wish to file appeal concering two visits to Mayland Primary Care. on January 25, 2022 in the amount of $115.00 Claim# BRFV45, And in the February 21, 2022 for amount of $325.00 Claim# BRYQ08.

I did not Know that these visits would not Be Covered. During the covid Pandemic and not reciving mail. I did not Know that we had to go to a facility that was labcorp or Quest, We been going to Mayland Primary care for years that they use labcorp and the insurance covered it.

I would never have gone to mayland Primary to have lab work done if I had to pay out of pocket. Thats like not having insurance. I can't afford these bills that are not covered. I work hard and I am paycheck to paycheck. Please reconsider these two visits.

Sincerly

Here are some examples of previous lab visits with Maryland Primary Care that was covered UNDER Cigna Health care Insurance.

Please reconsider my visits for 1/25/2022 And. 2/21/2022.

Thank you

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BJPD63											
Provider: PRIMARY CARE MARYLAND			Patient: Employee:						Patient Acct. #: Employee #:		
06/21/21-06/21/21	84436	20.00	4.43	A1 A2	15.57	0.00	M	80	12.46	0.00	3.11
06/21/21-06/21/21	84479	20.00	5.33	A1 A2	14.67	0.00	M	80	11.74	0.00	2.93
06/21/21-06/21/21	80050	100.00	57.56	A1 A2	42.44	0.00	M	80	33.95	0.00	8.49
06/21/21-06/21/21	82306	90.00	22.89	A1 A2	67.11	0.00	M	80	53.69	0.00	13.42
	TOTALS	230.00	90.21		139.79	0.00			111.84	0.00	27.95

Total Plan Pays:	111.84
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	111.84

Claim #: BECK97											
Provider: PRIMARY CARE MARYLAND			Patient: Employee:						Patient Acct. #: Employee #:		
03/08/21-03/08/21	84153	55.00	13.31	A1 A2 A3	41.69	0.00	B	100	41.69	0.00	0.00
03/08/21-03/08/21	80061	40.00	12.36	A1 A2 A3	27.64	0.00	B	100	27.64	0.00	0.00
03/08/21-03/08/21	84436	20.00	4.43	A1 A2 A3	15.57	0.00	B	100	15.57	0.00	0.00
03/08/21-03/08/21	84479	20.00	5.33	A1 A2 A3	14.67	0.00	B	100	14.67	0.00	0.00
03/08/21-03/08/21	80050	100.00	57.56	A1 A2 A3 A4	27.76	0.00	B	100	27.76	0.00	0.00
					14.68	14.68	M	80	0.00	0.00	14.68
	TOTALS	235.00	92.99		142.01	14.68			127.33	0.00	14.68

Total Plan Pays:	127.33
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	127.33

RECEIVED
MAR 31 2022
AA, LLC

March 29. 2022 Exc-27-ples of visits that were covered

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

Return Service Requested

83

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

001835
0101

BAKERS UNION & FELRA
H&W

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

Statement Date: 02/23/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BRFV29				Patient:					Patient Acct. #:		
Provider: MEDSOLUTIONS				Employee:					Employee #:		
01/25/22-01/25/22	77063	57.29	0.00	A1	57.29	0.00	B	100	57.29	0.00	0.00
01/25/22-01/25/22	77067	215.00	0.00	A1	100.00	0.00	B	100	100.00	0.00	0.00
					115.00	0.00	M	100	115.00	0.00	0.00
	TOTALS	272.29	0.00		272.29	0.00			272.29	0.00	0.00

Total Plan Pays:	272.29
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	272.29

Claim #: BRFV34				Patient:					Patient Acct. #:		
Provider: PRIMARY CARE MARYLAND				Employee:					Employee #:		
01/25/22-01/25/22	36415	15.00	10.50	A1 A2 A3	4.50	0.00	B	100	4.50	0.00	0.00
	TOTALS	15.00	10.50		4.50	0.00			4.50	0.00	0.00

Total Plan Pays:	4.50
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	4.50

Claim #: BRFV45				Patient:					Patient Acct. #:		
Provider: PRIMARY CARE MARYLAND				Employee:					Employee #:		
01/25/22-01/25/22	83036	30.00	30.00	A1 A2	0.00	0.00	0		0.00	0.00	30.00
01/25/22-01/25/22	84443	50.00	50.00	A1 A2	0.00	0.00	0		0.00	0.00	50.00
01/25/22-01/25/22	80053	35.00	35.00	A1 A2	0.00	0.00	0		0.00	0.00	35.00
	TOTALS	115.00	115.00		0.00	0.00			0.00	0.00	115.00

Total Plan Pays:	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 Number
MEDSOLUTIONS INC	272.29	119952
MARYLAND PRIMARY CARE PHYSICIANS	4.50	119911
MARYLAND PRIMARY CARE PHYSICIANS	0.00	119911

Claim #	Code	Description
BRFV29	A1	THANK YOU FOR USING A PPO PROVIDER. NO PPO DISCOUNT IS SHOWN BECAUSE CHARGES BILLED ARE EQUAL TO OR BELOW AMOUNT ALLOWED.THE CHARGES BILLED ARE EQUAL TO OR LESS THAN THE AMOUNT OF THE PROVIDER'S DISCOUNT.
		COVERAGE IS LIMITED TO 1 ROUTINE MAMMOGRAM PER YEAR.
BRFV34	A1	CIGNA HEALTHCARE PREFERRED PROVIDER SAVINGS.
	A2	4.50 HAS BEEN APPLIED TOWARD YOUR QUARTERLY MAXIMUM BASIC BENEFIT.
	A3	$10.50 DISCOUNTED BY CIGNA PPO. YOU DO NOT OWE THIS AMOUNT.
BRFV45	A1	CIGNA HEALTHCARE PREFERRED PROVIDER SAVINGS.
	A2	CHARGES ARE DENIED BECAUSE, EFFECTIVE SEPTEMBER 1, 2021, YOUR MEDICALPLAN REQUIRES THAT ALL LABORATORY SERVICES MUST BE OBTAINED AT LABCORPOR QUEST FACILITIES. SEE JULY 2021 SMM

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

BAKERS UNION & FELRA H&W

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

Statement Date: 02/23/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

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.**

000007437-B

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 indentificación o en el resúmen descriptivo del plan.

	Amount Charged	Not Covered		Amount Allowed	Deductible		Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	402.29	125.50		276.79	0.00		276.79	0.00	115.00

Deductible **Plan Pays**

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

8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
Telephone: (301) 459-3020
Toll Free: (866) 662-2537
www.associated-admin.com

July 2021

SUMMARY OF MATERIAL MODIFICATION

Dear Participant:

The Board of Trustees approved the following Material Modifications (changes) to your Health and Welfare benefits.

Dental Benefit Provider

Effective September 1, 2021, Delta Dental PPO will become the Fund's dental provider. Your benefits will remain the same, but you will have access to a broader range of providers. Visiting a dentist in the PPO network will maximize your savings. You can find a PPO dentist at www.deltadentalins.com.

You will receive a dental ID card from Delta Dental PPO. Keep this card to show to your dental provider so your claims will be processed correctly.

Laboratory Benefit

For all laboratory service claims incurred on or after September 1, 2021, you **must** use either a Quest Diagnostics Patient Service Center ("Quest") or Laboratory Corporation of America Center ("LabCorp") in order for such services to be covered by the Plan.

Please advise all of your physicians and their offices of this change so they will refer you to the proper LabCorp or Quest facility for all laboratory services performed September 1, 2021 and after. The laboratory services must be performed at a LabCorp or Quest facility to be covered by the Plan. You can call 1-800-768-4695 to obtain the location of the nearest LabCorp or Quest facility or to find the most current list of LabCorp and Quest facilities log on to their website or call them directly at:

- www.questdiagnostics.com or by telephone at (800) 377-8448
- www.labcorp.com or by telephone at (800) 845-6167

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you have any questions about the coverage provided under the Bakers Union and FELRA Health and Welfare Fund, the Summary Plan Description, or changes noted above, please contact the Administrative Manager at (866) 662-2537.

Sincerely,
The Board of Trustees

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

8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
Telephone: (301) 459-3020
Toll Free: (866) 662-2537
www.associated-admin.com

April 5, 2022

Name:
Claim #: **BRFV45**
Date of Service: **January 25, 2022**

Dear Mrs. :

The Fund office has received your recent letter to the Board of Trustees. The appeal is being researched and you will be notified, in writing, of the outcome.

If you should have any questions, you may contact this office.

Sincerely,

Erin Baker
Erin Baker, Appeals Department
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152

NAME: **SS#:**
REGARDING:

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 – Laboratory Services #M22/108-9299

FUND RULE:
"SUMMARY OF MATERIAL MODIFICATION

Laboratory Benefit

For all laboratory service claims incurred on or after September 1, 2021, you must use either a Quest Diagnostics Patient Service Center ('Quest') or Laboratory Corporation of America Center ('LabCorp') in order for such services to be covered by the Plan.

Please advise all of your physicians and their offices of this change so they will refer you to the proper LabCorp or Quest facility for all laboratory services performed September 1, 2021 and after. The laboratory services must be performed at a LabCorp or Quest facility to be covered by the Plan. You can call 1-800-768-4695 to obtain the location of the nearest LabCorp or Quest facility or to find the most current list of LabCorp and Quest facilities log on to their website or call them directly at:

• www.questdiagnostics.com or by telephone at (800) 377-8448

• www.labcorp.com or by telephone at (800) 845-6167 [...]"
(Quoted from the Bakers Union and FELRA Health and Welfare Fund Summary of Material Modifications, dated July 2021, mailed to the participant on July 1, 2021)

SUMMARY:

Date(s) of Service:	February 21, 2022
Claim(s) Received:	February 28, 2022
Claim(s) Denied:	March 18, 2022
Appeal Received:	March 31, 2022

The **participant** is appealing for payment of a claim for laboratory services, provided to her spouse, that was denied. The participant states that they have been going to Maryland Primary Care for years and previous claims have been covered. The participant further states that they did not know that they had to go to a LabCorp or Quest Diagnostics facility, and that they can't afford these out-of-pocket expenses.

Effective September 1, 2021, all laboratory services must be performed at a LabCorp or Quest Diagnostics facility to be covered by the Plan. A Summary of Material Modifications ("SMM") was mailed to the participant on July 1, 2021, advising of this benefit change. Maryland Primary Care submitted a claim for multiple outpatient blood tests rendered on February 21, 2022. The claim was denied because the tests were not performed by a LabCorp or Quest Diagnostics facility.

Note: The participant's address on file was last updated on June 28, 2005 and matches the return address on her appeal envelope. No return mail has been received from the post office.

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

1) Claim# BRFV45
2) Claim# BRYQ08

March 29, 2022

RECEIVED
MAR 31 2022
AA, LLC

employee #
Acct #
Acct #

Dear Appeals Coordinater,

My name is and
I am the policy holder of Cigna healthcare.
I wish to file appeal concering two visits
to Mayland Primary Care. on January 25, 2022
in the amount of $ 115.00 Claim# BRFV45, And in the
February 21, 2022 for
amount of $325.00 Claim# BRYQ08.
I did not Know that these visits would not
Be Covered. During the Covid Pandemic and
not reciving mail. I did not Know that we
had to go to a facility that was labcorp or Quest,
We been going to Mayland Primary Care for years that
they use labcorp and the insurance covered it.
I would never have gone to mayland Primary
to have lab work done if I had to pay out of
pocket. Thats like not having insurance. I can't
afford these bills that are not covered. I work
hard and I am paycheck to paycheck. Please
reconsider these two visits,

Sincerly

Here are some examples of previous lab visits with Maryland Primary Care that was covered UNDER Cigna Health care Insurance.

Please reconsider my visits for 1/25/2022 And. 2/21/2022.

Thank you

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BJPD63											
Provider: PRIMARY CARE MARYLAND			Patient: Employee:						Patient Acct. #: Employee #:		
06/21/21-06/21/21	84436	20.00	4.43	A1 A2	15.57	0.00	M	80	12.46	0.00	3.11
06/21/21-06/21/21	84479	20.00	5.33	A1 A2	14.67	0.00	M	80	11.74	0.00	2.93
06/21/21-06/21/21	80050	100.00	57.56	A1 A2	42.44	0.00	M	80	33.95	0.00	8.49
06/21/21-06/21/21	82306	90.00	22.89	A1 A2	67.11	0.00	M	80	53.69	0.00	13.42
	TOTALS	230.00	90.21		139.79	0.00			111.84	0.00	27.95

Total Plan Pays:	111.84
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	111.84

Claim #: BFCK97											
Provider: PRIMARY CARE MARYLAND			Patient: Employee:						Patient Acct. #: Employee #:		
03/08/21-03/08/21	84153	55.00	13.31	A1 A2 A3	41.69	0.00	B	100	41.69	0.00	0.00
03/08/21-03/08/21	80061	40.00	12.36	A1 A2 A3	27.64	0.00	B	100	27.64	0.00	0.00
03/08/21-03/08/21	84436	20.00	4.43	A1 A2 A3	15.57	0.00	B	100	15.57	0.00	0.00
03/08/21-03/08/21	84479	20.00	5.33	A1 A2 A3	14.67	0.00	B	100	14.67	0.00	0.00
03/08/21-03/08/21	80050	100.00	57.56	A1 A2 A3 A4	27.76	0.00	B	100	27.76	0.00	0.00
					14.68	14.68	M	80	0.00	0.00	14.68
	TOTALS	235.00	92.99		142.01	14.68			127.33	0.00	14.68

Total Plan Pays:	127.33
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	127.33

RECEIVED
MAR 31 2022
AA, LLC

March 29. 2022 Ex-34-ples of visits that were covered

PS14401400D

202203213309

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

Return Service Requested

76

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

005458
0101

BAKERS UNION & FELRA
H&W

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

Statement Date: 03/18/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BRYQ08				Patient:					Patient Acct. #:		
Provider: PRIMARY CARE MARYLAND				Employee:					Employee #:		
02/21/22-02/21/22	84153	55.00	55.00	A1 A2	0.00	0.00		0	0.00	0.00	55.00
02/21/22-02/21/22	82306	90.00	90.00	A1 A2	0.00	0.00		0	0.00	0.00	90.00
02/21/22-02/21/22	80061	40.00	40.00	A1 A2	0.00	0.00		0	0.00	0.00	40.00
02/21/22-02/21/22	84436	20.00	20.00	A1 A2	0.00	0.00		0	0.00	0.00	20.00
02/21/22-02/21/22	84479	20.00	20.00	A1 A2	0.00	0.00		0	0.00	0.00	20.00
02/21/22-02/21/22	80050	100.00	100.00	A1 A2	0.00	0.00		0	0.00	0.00	100.00
	TOTALS	325.00	325.00		0.00	0.00			0.00	0.00	325.00

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

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BRYQ09				Patient:					Patient Acct. #:		
Provider: PRIMARY CARE MARYLAND				Employee:					Employee #:		
02/21/22-02/21/22	99396	250.00	64.46	A1 A2 A3	185.54	0.00	M	100	185.54	0.00	0.00
02/21/22-02/21/22	36415	15.00	10.50	A1 A2	4.50	0.00	B	100	4.50	0.00	0.00
	TOTALS	265.00	74.96		190.04	0.00			190.04	0.00	0.00

Total Plan Pays:	190.04
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	190.04

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BSJP43				Patient:					Patient Acct. #:		
Provider: PRIMARY CARE MARYLAND				Employee:					Employee #:		
01/17/22-01/17/22	99214 95	250.00	92.62	A1 A2 A3	157.38	157.38	M	80	0.00	0.00	157.38
	TOTALS	250.00	92.62		157.38	157.38			0.00	0.00	157.38

Total Plan Pays:	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 Number
MARYLAND PRIMARY CARE PHYSICIANS	0.00	120074
MARYLAND PRIMARY CARE PHYSICIANS	190.04	120074
MARYLAND PRIMARY CARE PHYSICIANS	0.00	NC

Claim #	Code	Description
BRYQ08	A1	CIGNA HEALTHCARE PREFERRED PROVIDER SAVINGS.
	A2	CHARGES ARE DENIED BECAUSE, EFFECTIVE SEPTEMBER 1, 2021, YOUR MEDICALPLAN REQUIRES THAT ALL LABORATORY SERVICES MUST BE OBTAINED AT LABCORPOR QUEST FACILITIES. SEE JULY 2021 SMM.
BRYQ09	A1	CIGNA HEALTHCARE PREFERRED PROVIDER SAVINGS.
	A2	YOU HAVE COVERAGE FOR ONE ANNUAL ROUTINE PHYSICAL.
	A3	$64.46 DISCOUNTED BY CIGNA PPO. YOU DO NOT OWE THIS AMOUNT.
	A2	$10.50 DISCOUNTED BY CIGNA PPO. YOU DO NOT OWE THIS AMOUNT.
BSJP43	A1	CIGNA HEALTHCARE PREFERRED PROVIDER SAVINGS.
	A2	$157.38 APPLIED TO $300.00 INDIVIDUAL ANNUAL DEDUCTIBLE.
	A3	$92.62 DISCOUNTED BY CIGNA PPO. YOU DO NOT OWE THIS AMOUNT.
		THE BOARD OF TRUSTEES REVIEWED THE FACTS OF THIS CASE AND AFTER CAREFUL CONSIDERATION, THE REQUEST IS APPROVED. THIS IS A CORRECTED EXPLANATION OF BENEFITS.
		$157.38 APPLIED TO $600.00 FAMILY DEDUCTIBLE.

RECEIVED
MAR 31 2022
AA, LLC

P5144014000

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

BAKERS UNION & FELRA
H&W

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

Statement Date: 03/18/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

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.**

000002659-B

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 indentificación o en el resúmen descriptivo del plan.

	Amount Charged	Not Covered		Amount Allowed	Deductible		Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	840.00	492.58		347.42	157.38		190.04	0.00	482.38

Deductible Plan Pays

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

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Landover, MD 20785-2361
Telephone: (301) 459-3020
Toll Free: (866) 662-2537
www.associated-admin.com

July 2021

SUMMARY OF MATERIAL MODIFICATION

Dear Participant:

The Board of Trustees approved the following Material Modifications (changes) to your Health and Welfare benefits.

Dental Benefit Provider

Effective September 1, 2021, Delta Dental PPO will become the Fund's dental provider. Your benefits will remain the same, but you will have access to a broader range of providers. Visiting a dentist in the PPO network will maximize your savings. You can find a PPO dentist at www.deltadentalins.com.

You will receive a dental ID card from Delta Dental PPO. Keep this card to show to your dental provider so your claims will be processed correctly.

Laboratory Benefit

For all laboratory service claims incurred on or after September 1, 2021, you **must** use either a Quest Diagnostics Patient Service Center ("Quest") or Laboratory Corporation of America Center ("LabCorp") in order for such services to be covered by the Plan.

Please advise all of your physicians and their offices of this change so they will refer you to the proper LabCorp or Quest facility for all laboratory services performed September 1, 2021 and after. The laboratory services must be performed at a LabCorp or Quest facility to be covered by the Plan. You can call 1-800-768-4695 to obtain the location of the nearest LabCorp or Quest facility or to find the most current list of LabCorp and Quest facilities log on to their website or call them directly at:

- www.questdiagnostics.com or by telephone at (800) 377-8448
- www.labcorp.com or by telephone at (800) 845-6167

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you have any questions about the coverage provided under the Bakers Union and FELRA Health and Welfare Fund, the Summary Plan Description, or changes noted above, please contact the Administrative Manager at (866) 662-2537.

Sincerely,
The Board of Trustees

Bakers Union and FELRA
Health and Welfare Fund

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COPY

April 5, 2022

Name:
Claim #: **BRYQ08**
Date of Service: **February 21, 2022**

Dear Mr. :

The Fund office has received your recent letter to the Board of Trustees. The appeal is being researched and you will be notified, in writing, of the outcome.

If you should have any questions, you may contact this office.

Sincerely,

Erin Baker
Erin Baker, Appeals Department
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152

NAME: **SS#:**

Bakers Union and FELRA Health and Welfare Fund

EMPLOYER:	Giant	**LOCAL:**	118
DATE OF HIRE:	October 23, 2002	**STATUS:**	Part Time
PLAN:	1		

ISSUE: Hospital/Medical – Laboratory Services #M22/109-2194

FUND RULE:
"SUMMARY OF MATERIAL MODIFICATION

Laboratory Benefit

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• www.questdiagnostics.com or by telephone at (800) 377-8448

• www.labcorp.com or by telephone at (800) 845-6167 [...]"
(Quoted from the Bakers Union and FELRA Health and Welfare Fund Summary of Material Modifications, dated July 2021, mailed to the participant on July 1, 2021)

SUMMARY:

Date(s) of Service:	February 15, 2022
Claim(s) Received:	February 28, 2022
Claim(s) Denied:	March 18, 2022
Appeal Received:	April 8, 2022

The **participant** is appealing for payment of a claim for laboratory services that was denied. The participant states that as the patient, she has no knowledge of where her provider sends her blood work and that she did not know that laboratory services are now required to be performed at a LabCorp (or Quest Diagnostics) facility.

Effective September 1, 2021, all laboratory services must be performed at a LabCorp or Quest Diagnostics facility to be covered by the Plan. A Summary of Material Modifications ("SMM") was mailed to the participant on July 1, 2021, advising of this benefit change. Sentara Reference Lab submitted a claim for multiple outpatient blood tests rendered on February 15, 2022. The claim was denied because the tests were not performed by a LabCorp or Quest Diagnostics facility.

Note: The participant's address on file was last updated on September 12, 2006 and matches the return address on her appeal envelope. No return mail has been received from the post office.

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

April 5, 2022

Board of Trustees
911 Ridge Brook Road
Sparks MD 21152

Subject: Appeal to pay my medical lab work

Dear Sir/Madam

I have attached the statement from (Bakers Union)

As per the attached it states that any lab work ordered should be done at Lab Corp centers only.

As a patient, I have no knowledge where my provider sends the blood work. After receiving the statement I have come to know that only Lap Corp is an approved provider for lab work. Previously any lab work done was all covered.

For Example, If an x-ray is ordered, I will have no knowledge where to go for x-ray, I would follow my doctor's instructions.

As a patient and employee of giant for the past eighteen years, I request you to look into this and pay the share that the insurance has to pay

Regards

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

Return Service Requested

77

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

005692
0101

BAKERS UNION & FELRA H&W

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

RECEIVED
APR 08 2022
AA, LLC

Statement Date: 03/18/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BRYP62				Patient:					Patient Acct. #:		
Provider: REFERENCE LAB SENTARA				Employee:					Employee #:		
02/15/22-02/15/22	85025	23.31	23.31	A1 A2	0.00	0.00	0		0.00	0.00	23.31
02/15/22-02/15/22	84443	50.40	50.40	A1 A2	0.00	0.00	0		0.00	0.00	50.40
02/15/22-02/15/22	83735	20.10	20.10	A1 A2	0.00	0.00	0		0.00	0.00	20.10
02/15/22-02/15/22	80053	31.68	31.68	A1 A2	0.00	0.00	0		0.00	0.00	31.68
02/15/22-02/15/22	86803	42.81	42.81	A1 A2	0.00	0.00	0		0.00	0.00	42.81
02/15/22-02/15/22	80061	40.17	40.17	A1 A2	0.00	0.00	0		0.00	0.00	40.17
	TOTALS	208.47	208.47		0.00	0.00			0.00	0.00	208.47

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

Claim #: BSGL58				Patient:					Patient Acct. #:		
Provider: REFERENCE LAB SENTARA				Employee:					Employee #:		
10/28/21-10/28/21	86803	42.81	42.81	A1 A2	0.00	0.00	0		0.00	0.00	42.81
10/28/21-10/28/21	80061	40.17	40.17	A1 A2	0.00	0.00	0		0.00	0.00	40.17
10/28/21-10/28/21	80050	89.85	89.85	A1 A2	0.00	0.00	0		0.00	0.00	89.85
	TOTALS	172.83	172.83		0.00	0.00			0.00	0.00	172.83

Total Plan Pays:	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 Number
SENTARA REFERENCE LAB SOLUTIONS LLC	0.00	NC
SENTARA REFERENCE LAB SOLUTIONS LLC	0.00	NC

Claim #	Code	Description
BRYP62	A1	THE PROVIDER IS NOT A PPO NETWORK PARTICIPANT.
	A2	SVCS MUST BE PROVIDED BY A CIGNA PROVIDER TO BE COVERED. PG 75 OF SPD. CHARGES ARE DENIED BECAUSE, EFFECTIVE SEPTEMBER 1, 2021, YOUR MEDICAL PLAN REQUIRES THAT ALL LABORATORY SERVICES MUST BE OBTAINED AT LABCORP OR QUEST FACILITIES. SEE JULY 2021 SMM.
BSGL58	A1	THE PROVIDER IS NOT A PPO NETWORK PARTICIPANT.
	A2	CHARGES ARE DENIED BECAUSE, EFFECTIVE SEPTEMBER 1, 2021, YOUR MEDICALPLAN REQUIRES THAT ALL LABORATORY SERVICES MUST BE OBTAINED AT LABCORPOR QUEST FACILITIES. SEE JULY 2021 SMM.

Bakers Union and FELRA
Health and Welfare Fund

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Toll Free: (866) 662-2537
www.associated-admin.com

COPY

April 12, 2022

Name:
Claim #: BRYP62
Date of Service: February 15, 2022

Dear Ms. ,

The Fund office has received your recent letter to the Board of Trustees. The appeal is being researched and you will be notified, in writing, of the outcome.

If you should have any questions, you may contact this office.

Sincerely,
Teresa Cook-Simpkins
Teresa Cook-Simpkins, Appeals Department
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152

NAME: **SS#:**
REGARDING:

Bakers Union and FELRA Health and Welfare Fund

EMPLOYER:	Giant	**LOCAL:**	118
DATE OF HIRE:	October 23, 2002	**STATUS:**	Part Time
PLAN:	1		

ISSUE: Hospital/Medical – Laboratory Services #M22/110-2194

FUND RULE:
"SUMMARY OF MATERIAL MODIFICATION

Laboratory Benefit

For all laboratory service claims incurred on or after September 1, 2021, you must use either a Quest Diagnostics Patient Service Center ('Quest') or Laboratory Corporation of America Center ('LabCorp') in order for such services to be covered by the Plan.

Please advise all of your physicians and their offices of this change so they will refer you to the proper LabCorp or Quest facility for all laboratory services performed September 1, 2021 and after. The laboratory services must be performed at a LabCorp or Quest facility to be covered by the Plan. You can call 1-800-768-4695 to obtain the location of the nearest LabCorp or Quest facility or to find the most current list of LabCorp and Quest facilities log on to their website or call them directly at:

• www.questdiagnostics.com or by telephone at (800) 377-8448

• www.labcorp.com or by telephone at (800) 845-6167 [...]"
(Quoted from the Bakers Union and FELRA Health and Welfare Fund Summary of Material Modifications, dated July 2021, mailed to the participant on July 1, 2021)

SUMMARY:

Date(s) of Service:	October 28, 2021
Claim(s) Received:	March 8, 2022
Claim(s) Denied:	March 18, 2022
Appeal Received:	April 8, 2022

The **participant** is appealing for payment of a claim for laboratory services, provided to her son (DOB: 8-30-1999), that was denied. The participant states that as the patient, they have no knowledge of where their provider sends their blood work and that she did not know that laboratory services are now required to be performed at a LabCorp (or Quest Diagnostics) facility.

Effective September 1, 2021, all laboratory services must be performed at a LabCorp or Quest Diagnostics facility to be covered by the Plan. A Summary of Material Modifications ("SMM") was mailed to the participant on July 1, 2021, advising of this benefit change. Sentara Reference Lab submitted a claim for multiple outpatient blood tests rendered on October 28, 2021. The claim was denied because the tests were not performed by a LabCorp or Quest Diagnostics facility.

Note: The participant's address on file was last updated on September 12, 2006 and matches the return address on her appeal envelope. No return mail has been received from the post office.

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

April 5, 2022

Board of Trustees
911 Ridge Brook Road
Sparks MD 21152

Subject: Appeal to pay my medical lab work

Dear Sir/Madam

I have attached the statement from (Bakers Union)

As per the attached it states that any lab work ordered should be done at Lab Corp centers only.

As a patient, I have no knowledge where my provider sends the blood work. After receiving the statement I have come to know that only Lap Corp is an approved provider for lab work. Previously any lab work done was all covered.

For Example, If an x-ray is ordered, I will have no knowledge where to go for x-ray, I would follow my doctor's instructions.

As a patient and employee of giant for the past eighteen years, I request you to look into this and pay the share that the insurance has to pay

Regards

P5144014001D 20220321310J

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

Return Service Requested

77

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

005692
0101

BAKERS UNION & FELRA
H&W

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

RECEIVED
APR 08 2022
AA, LLC

Statement Date: 03/18/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BRYP62				Patient:					Patient Acct #:		
Provider: REFERENCE LAB SENTARA				Employee:					Employee #:		
02/15/22-02/15/22	85025	23.31	23.31	A1 A2	0.00	0.00	0		0.00	0.00	23.31
02/15/22-02/15/22	84443	50.40	50.40	A1 A2	0.00	0.00	0		0.00	0.00	50.40
02/15/22-02/15/22	83735	20.10	20.10	A1 A2	0.00	0.00	0		0.00	0.00	20.10
02/15/22-02/15/22	80053	31.68	31.68	A1 A2	0.00	0.00	0		0.00	0.00	31.68
02/15/22-02/15/22	86803	42.81	42.81	A1 A2	0.00	0.00	0		0.00	0.00	42.81
02/15/22-02/15/22	80061	40.17	40.17	A1 A2	0.00	0.00	0		0.00	0.00	40.17
	TOTALS	208.47	208.47		0.00	0.00			0.00	0.00	208.47

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
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Total Benefits Paid:	0.00

Claim #: BSGL58				Patient:					Patient Acct #:		
Provider: REFERENCE LAB SENTARA				Employee:					Employee #:		
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10/28/21-10/28/21	80050	89.85	89.85	A1 A2	0.00	0.00	0		0.00	0.00	89.85
	TOTALS	172.83	172.83		0.00	0.00			0.00	0.00	172.83

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Payment To	Amount	Check Number
SENTARA REFERENCE LAB SOLUTIONS LLC	0.00	NC
SENTARA REFERENCE LAB SOLUTIONS LLC	0.00	NC

Claim #	Code	Description
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July 2021

SUMMARY OF MATERIAL MODIFICATION

Dear Participant:

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Dental Benefit Provider

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Sincerely,
The Board of Trustees

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COPY

April 12, 2022

Name:
Claim #: BSGL58
Date of Service: October 28, 2021

Dear Mr. ,

The Fund office has received your recent letter to the Board of Trustees. The appeal is being researched and you will be notified, in writing, of the outcome.

If you should have any questions, you may contact this office.

Sincerely,
Teresa Cook-Simpkins
Teresa Cook-Simpkins, Appeals Department
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152

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July 2021

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Sincerely,
The Board of Trustees

MEMORANDUM

TO: Board of Trustees of the Bakers Union and FELRA Health and Welfare Fund

FROM: Jim Kimble

Merle DeLancey

DATE: June 4, 2022

SUBJECT: Compliance with Fee Disclosure Rules under ERISA Section 408(b)(2)

The Consolidated Appropriations Act of 2021 ("CAA") amended section 408(b)(2) of the Employee Retirement Income Security Act ("ERISA") to require certain covered service providers to health and welfare funds that expect to receive $1,000 or more in direct or indirect compensation to disclose specific information regarding that compensation to the Board of Trustees. The new disclosure requirements apply to contracts or arrangements entered into, extended, or renewed on or after December 21, 2021.

Failure to comply with these rules could result in a prohibited transaction for both the Trustees and the service providers. Trustees should document and keep a record of any actions taken to comply with the new disclosure requirements. There are three recommended steps for compliance:

Step 1: Identify Covered Service Providers

Identify service providers that may be covered by the disclosure rules. These include brokerage and consulting services for which the covered service provider, an affiliate, or a subcontractor, reasonably expects to receive indirect or direct compensation of $1,000 or more, to the Fund with respect to:

- insurance or selection of insurance products (including vision and dental)
- recordkeeping services
- medical management vendor
- benefits administration (including vision and dental)
- stop-loss insurance
- pharmacy benefit management services
- transparency tools and vendors
- group purchasing organization preferred vendor panels
- disease management vendors and products
- compliance services
- employee assistance programs
- third party administration services
- the development or implementation of plan design

Step 2: Request Fee Disclosures from Service Providers

"Covered service providers" must disclose information to the Trustees about the amount of direct and indirect compensation the service provider receives and information that may highlight certain conflicts of interest related to the receipt of the compensation. We recommend sending a letter to each service provider requesting that the service provider either provide the required disclosures or provide a statement explaining why it is not a Covered Service Provider.

To document this process, Trustees should keep copies of the letters sent and enter the dates the letters were sent in the 408(b)(2) Compliance Worksheet.

Step 3: Confirm Receipt and Evaluate Responses for Completeness

We expect that the responses received from service providers will fit within one of the following three categories:

A. Responses explaining that the service provider is not a Covered Service Provider.

B. Responses intended to meet the 408(b)(2) disclosure requirements.

C. No response/Incomplete response.

The procedures to be followed with respect to each type of response are as follows:

A. If the response states that a service provider is not a Covered Service Provider:

Trustees should review this type of response in accordance with procedures they have adopted to verify whether or not they agree with this conclusion.

- If the Trustees conclude the service provider is not a Covered Service Provider, the conclusion should be documented in the 408(b)(2) Compliance Worksheet and no further action is required.

- If the Trustees conclude that additional information is required to determine whether the service provider is a Covered Service Provider, or conclude that the service provider is a Covered Service Provider, a written request for additional information, or disclosures, should be sent to the service provider specifying a response deadline (e.g., 10 days). Keep copies of all correspondence to service providers and record the dates of correspondence in the 408(b)(2) Compliance Worksheet.

B. If the response states that it is intended to meet disclosure requirements:

Trustees should review this type of response to determine whether all information required to be disclosed under ERISA section 408(b)(2) is in fact disclosed and whether the disclosure otherwise satisfies the requirements of ERISA section 408(b)(2).

- If the Trustees conclude that the disclosure is complete, this conclusion should be documented in the 408(b)(2) Compliance Worksheet.

- If the Trustees conclude that the disclosure is incomplete, a written request for additional information should be sent to the service provider specifying a response deadline (e.g., 10 days). Keep copies of all correspondence to service providers and record the dates of correspondence in the 408(b)(2) Compliance Worksheet.

C. If there is no response, or an incomplete response:

If a service provider fails to respond to the initial request for fee disclosures (or fails to respond to a request for additional information needed to make a disclosure compliant) within 90 days of the request, the Trustees must file a notice with the DOL. This notice must be filed within 30 days of the earlier of (1) the end of the 90-day response period, or (2) the service provider's refusal to provide the requested information.

In addition to providing notice to the DOL, Trustees must consider the expeditious termination of the services agreement.

Trustees should evaluate the information disclosed to confirm that the arrangement for services and the service provider's compensation are reasonable. The concept of "reasonable" under ERISA section 408(b)(2) does not require the Trustees to obtain services from the lowest cost provider. Rather, the Trustees should consider whether a service provider's compensation is reasonable in light of the quality and level of services provided to the Fund.

Trustees should establish and follow a process for evaluating the disclosures and document the steps taken and the conclusions reached. The process used to evaluate the disclosures should be consistent with the Trustees' fiduciary duty of prudence and may vary depending on the circumstances.

[LETTERHEAD]

_____, 2022

[NAME]
[COMPANY NAME]
[STREET ADDRESS]
[CITY, STATE ZIP]

RE: Board of Trustees of the Bakers Union and FELRA Health and Welfare Fund written request for fee disclosure under ERISA section 408(b)(2)

Dear [NAME]:

The Consolidated Appropriations Act of 2021 (the "CAA") amended section 408(b)(2) of the Employee Retirement Income Security Act ("ERISA") to require certain covered service providers of group health plans, expecting to receive $1,000 or more in direct or indirect compensation, to disclose specific information to the plan regarding its expected direct and indirect compensation. Covered service providers include entities that provide brokerage or consulting services to health and welfare funds. These include, but are not limited to, services related to the selection of insurance products, recordkeeping services, medical management vendors, benefits administration, stop-loss insurance, pharmacy benefit management services, and consulting on such matters as the development or implementation of plan design and benefit administration selection. This disclosure requirement became effective December 27, 2021.

Because you provide [TYPE OF SERVICES] to the Board of Trustees of the Bakers Union and FELRA Health and Welfare Fund (the "Fund"), you may be required to provide disclosures under ERISA section 408(b)(2) pursuant to the foregoing guidance.

We request that you provide us with the disclosures required under the CAA no later than **[insert date]**. In the alternative, if you believe you are not such a covered service provider with respect the Plan, please provide us with a written statement explaining why you are not required to provide the Fund with such disclosures.

Please do not hesitate to contact us if you have any questions or concerns. We thank you for your assistance with this matter.

Please note that in the event that you fail to timely respond to this request for such disclosures, we may be required to notify the Department of Labor of your non-compliance.

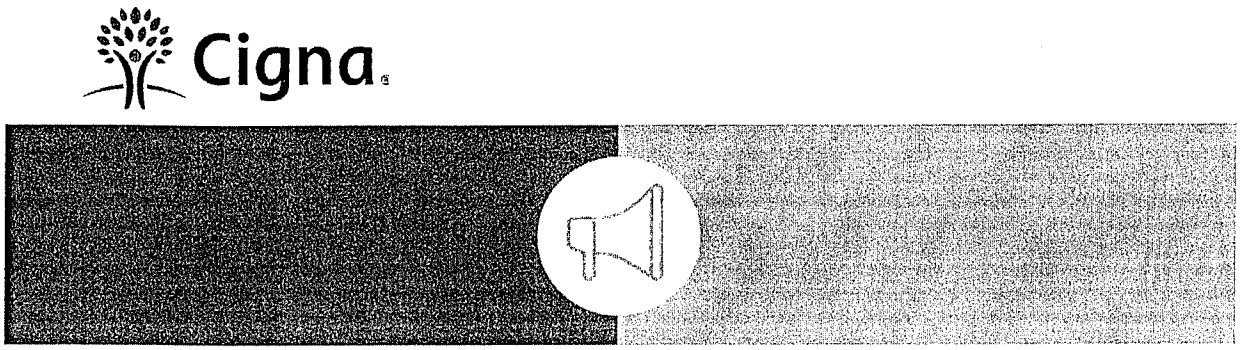
Sincerely,

INSERT NAME OF PLAN

ERISA Section 408(b)(2) Compliance Worksheet

Prepared [INSERT DATE]

Service Provider Name	Service Provider Address	Type of Services Provided (Select from Drop Down List)	Date Request Sent	Response Deadline	Date Response Received	Type of Response (Select from Drop Down List)	For Failures to Respond Only, Deadline for DOL Notice	For Refusals to Respond Only, Deadline for DOL Notice	Date Response Reviewed for Completeness	Response Complete?	If Response Incomplete, describe action taken	Date Follow-Up Request Sent	Deadline for Response	Date Response Received	Date Response Reviewed for Reasonableness	Actions taken Following Reasonableness Review	Notes



IMPORTANT MESSAGE

Critical Information about Transparency in Coverage

Action required for 7/1/22 compliance

This communication is being sent to all Shared Administration Cigna medical Funds with a standard machine-readable files hosting service.

On 3/14/22, we contacted you regarding the Machine Readable Files (MRFs) requirement of the Transparency in Coverage Rule. This communication outlines the next steps and key information needed by the 7/1/22 enforcement date.

As a reminder, under the Transparency in Coverage Rule, issued in 2020 by the U.S. Department of Health & Human Services, U.S. Department of Labor and U.S. Department of the Treasury and enforced beginning 7/1/22, health plans (which includes clients who sponsor employee benefit plans) and health insurance issuers must publish two separate MRFs.

- **In Network:** Negotiated rates for all covered items and services between the plan or issuer and in-network providers

- **Out of Network:** Cigna is **NOT** able to support this file for Shared Administration Funds.

What Cigna is doing

- In preparation for the 7/1/22 enforcement date, Cigna is providing you with instructions to help you understand the actions you need to take to be compliant under the rule.

- The actual link and recommended verbiage to include with the link are below.

What YOU need to do

To meet regulatory requirements, Cigna recommends you keep the following in mind:

- On or before 7/1/22, copy the link below and post it to your public website. This is the link the general public can use to access the MRFs: https://www.cigna.com/legal/compliance/machine-readable-files.
  - Note, that prior to 7/1/22, this link will take you to the home page of Cigna.com. but will access the MRF's page after that date.
  - You can determine where on your public website you would like to place the link.
  - Per the regulation, anyone in the United States should be able to access this link on your website without any requirement such as a password, a fee or an age restriction.

- Along with the link, please include the following recommended overview verbiage:

  This link leads to the machine readable files that are made available in response to the federal Transparency in Coverage Rule and includes negotiated service rates between health plans and healthcare providers. The machine-readable files are formatted to allow researchers, regulators, and application developers to more easily access and analyze data.

You need only follow this process once to establish the link. Cigna will update the files each month and this link will remain constant and always access the most up-to-date files.

More information

- If you have any questions please do not hesitate to contact me at 443.602.5115 or via e-mail John.Peppe@Cigna.com.

TRANSPARENCY IN COVERAGE & CONSOLIDATED APPROPRIATIONS ACT, 2021

Update for Cigna Shared Administration (SAR) Clients, Consultants, and Plan Administrators

The information in this document is accurate as of May 1, 2022 and is subject to change.

Together, all the way.®

Cigna®

The information in this document is accurate as of May 1, 2022 and is subject to change.

Cigna's position

At Cigna, we are committed to complying with all applicable laws, rules, and regulations. We are actively preparing for the upcoming requirements as part of the Transparency in Coverage rule and Consolidated Appropriations Act. We understand the implications and have established a rigorous compliance implementation program in connection with these requirements. The rulemaking process is likely to produce additional requirements prior to the scheduled effective dates and/or enforcement dates. We will be evaluating the anticipated rulemaking and will work to address the final requirements as they are issued.

In addition, Cigna understands the impact of the Transparency in Coverage rule and Consolidated Appropriations Act to our clients, and we are providing programs and tools to support you where appropriate.

To keep clients, consultants, and plan administrators informed and up to date on these requirements, this document summarizes information regarding provision requirements, Cigna's actions for SAR clients, client next steps and key dates.

Please contact your Cigna representative with any questions.

UPDATE: No <u>new</u> charges will apply for standard Transparency in Coverage and Consolidated Appropriations Act support on effective dates through the end of 2023, including delivery/hosting of machine readable files. Charges for 2024 effective dates will be evaluated at a later date.

DETAILED UPDATES BY PROVISION

The information in this document is accurate as of May 1, 2022 and is subject to change.

Transparency in Coverage Rule Updates

The information in this document is accurate as of May 1, 2022 and is subject to change.

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Machine-readable file requirements (MRF)	Requires health plans or issuers to publish three separate machine-readable files (1) negotiated rates for all covered items and services between the plan or issuer and in-network providers; (2) historical payments to, and billed charges from, out-of-network providers; and (3) in-network negotiated rates and historical payment net prices for all covered prescription drugs at the pharmacy location level. Per the 8/20 announcement from the Tri-Agencies, the Departments will defer enforcement of the machine-readable files requirements until July 2022 for the in-network and out-of-network files, and pending further rulemaking for the prescription drug file.	Cigna will host the IN Medical file that we provide on the client's behalf and at no cost on cigna.com. If a client does not have their own public website, we will build a website with a link to the cigna.com MRF subpage at no cost to the client. Clients who choose to opt out of our standard offering can download applicable MRFs through cignaforemployers.com, customize with their EIN/Name, and post on their own website. Cigna will not be providing a service to intake MRFs provided by non-Cigna carriers. Cigna will not provide a hosting service for a clients' OON Medical MRF.	As required by Transparency in Coverage: • **Clients who did not opt out of our standard MRF support will need to post a link on their public website to where their files are hosted.** • **Clients for whom Cigna has created a public website will need to make available the URL of that website when requested.** • **Clients who opt out of our standard delivery will need to download applicable MRFs through cignaforemployers.com, customize with their EIN/Name, and post on their own website.** • **Downloading the files is not necessary when Cigna is hosting the files on our clients' behalf. There are significant system requirements needed to download the files.**	Enforcement deferred until July 2022 for the in-network and out-of-network files, and pending further rulemaking for the prescription drug file. Cigna will make the files available through Cignaforemployers.com on or before **June 1, 2022**. Files will be available to the general public as of **July 1, 2022**. Cigna provided system requirements to clients to assist their decision making regarding hosting their own files. This same information is also available to clients on CignaforEmployers.com.
Cost-share liability estimator tool requirements	Requires health plans or issuers to have an internet-based, self-service tool and paper(if required) that provides real-time, personalized, out-of-pocket cost information, based on the member's plan for covered items and services furnished by a particular provider	Cigna has allocated significant resources to expand our existing cost estimator tools/paper process and is actively working toward compliance with the self-service tool requirements, effective 2023 and 2024.	No action needed at this time.	For plan years beginning on or after 1/1/2023, plan/issuer must disclose cost-share information for 500 shoppable items and services identified within the rule. For plan years beginning on or after 1/1/2024, all covered items and services must be included in the cost-share tool.

CAA Updates – Title I: No Surprises Act

The information in this document is accurate as of May 1, 2022 and is subject to change.

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Sections 102 and 105: Medical Billing & Air Ambulance	Requires health plans or issuers to cover emergency services without prior authorization at the in-network benefit level, regardless of whether emergency services were rendered in-network or out-of-network. Individuals cannot be required to pay out-of-network cost sharing for certain services provided by an out-of-network provider at an in-network facility, unless the nonparticipating provider gives notice to the individual and the individual consents to out-of-network care.* When determining a member's cost share liability, insurers are required to apply the member's in-network benefits to a Median Contracted Rate meant to represent the typical in-network rate a provider would receive for that service.	Cigna will provide assistance to our clients for compliance with the CAA No Surprises – Surprise Billing requirements by identifying potential NSA claims and providing the plan administrator with the Qualifying Payment Amount (QPA) via the 837 file. The plan administrator will be responsible for validation of NSA eligibility, as well as benefit adjudication as directed in the interim final rules released on 7/1/2021.	Additional operational detail was emailed under a separate attachment in December 2021.	**Effective upon renewal for plan years on or after 1/1/2022.**
Section 103: Independent Dispute Resolution (IDR)	Requires health plans to implement an independent dispute resolution process which applies to emergency services rendered out-of-network or non-emergency services rendered by an out-of-network provider at an in-network facility, in a state that does not have an applicable specified state law that provides a method for determining the total amount payable for out-of-network services. After a 30 day negotiation period, if the Insurer and the Provider can't come to an agreement, then either can initiate the IDR process.	Cigna will provide these services thru MultiPlan to our Out-of-Network Savings Program clients as a standard part of the program. Cigna will provide these services thru MultiPlan to our NON Out-of-Network Savings Program clients at a fee per claim.	Clients should plan for identifying key employees who will be able to answer question during negotiation and/or IDR. Non OONSP Clients will have to intake the dispute and enter into system. Will also need designated contacts to answer questions during negotiation and/or IDR..	**Effective upon renewal for plan years on or after 1/1/2022.**

*For purposes of the balance billing prohibition for non-emergency services provided by a nonparticipating provider at a participating health facility, a participating health care facility is a hospital, hospital outpatient department, critical access hospital or ambulatory surgical center that has a direct or indirect contractual relationship with the health plan or health insurance issuer with respect to the item or service furnished.

CAA Updates – Title I: No Surprises Act

The information in this document is accurate as of May 1, 2022 and is subject to change.

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 106: Air Ambulance Reporting	Requires insurers to submit two years of claims data related to air ambulance services to the Secretary of HHS.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	Reporting required for 2022 and 2023 plan years (to be submitted by March 31, 2023 and March 30, 2024, respectively).
Section 107: ID Cards	Requires health plans to include the following on their plan or insurance IDs issued to enrollees: • Amount of the in-network and out-of-network deductibles • Out-of-pocket maximum limitations	Cigna is making enhancements to ID cards to include in-network and out of network deductibles and out-of-pocket maximums for those clients for which *Cigna performs ID card production services.* **New Business** - Effective Dates 1/1/22 & After: ID cards will be mailed to members with this new information. **Renewing Business** - Renewal Dates 1/1/22 & After: Updated cards will be printed and mailed on renewal only for a change of benefit, of election, a qualifying life event, or at an individual member's request. Fees will be consistent with the current client agreement. No new fees for standard ID card support are being instituted in conjunction with the CAA. When an ID card is requested to be mailed for a 1/1/22 effective date or later, the ID card will be updated to reflect the additional information.	Contact your account team with any questions regarding your members' ID cards.	**Effective for plan years on or after 1/1/2022.** Pending future rulemaking in 2022, plans and issuers are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law. Plans and issuers may design various, but reasonable, methods to comply with the law.

Cigna is also making other changes to its ID card processes, not related to the CAA. PCP information will no longer print or generate a reissued medical ID card. ID cards will not be mass reissued for this change. A myCigna.com activation sticker will be applied to medical ID cards based on the registration status of the customer. If the customer has not registered on myCigna.com, the sticker will be adhered to the card. These changes will go into effect at the end of October.

CAA Updates – Title I: No Surprises Act

The information in this document is accurate as of May 1, 2022 and is subject to change.

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 110: External Review of Surprise Medical Bills	Allows for existing external review process to apply to determining whether surprise billing protections are applicable when there is an adverse determination by a health plan.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	**Effective 1/1/2022.**
Section 111: Advanced Explanation of Benefits (AEOB)	Requires group health plans or issuers offering individual or group coverage to automatically provide an AEOB upon receiving notification from a provider or facility that a participant or enrollee is scheduled to receive an item or service from a specific provider*.	We will share more information as rulemaking is provided.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022.
Section 112: Good Faith Estimate	Requires health care providers and facilities to verify, three days in advance of service and not later than one day after scheduling of service, what type of coverage the patient is enrolled in and provide notification of Good Faith Estimate whether or not patient has coverage.	We will share more information as rulemaking is provided.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022.

*No later than 1 business day after the plan receives notification from a provider or if the item or service is scheduled at least 10 days in advance,.no later than 3 business days after the plan receives the notification (or request).

CAA Updates – Title I: No Surprises Act

The information in this document is accurate as of May 1, 2022 and is subject to change.

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 113: Continuity of Care (COC)	Requires health plans to provide continued coverage at an in-network cost for patients with complex care needs for up to a 90-day period if a provider changes network status due to: (1) the provider's contractual relationship is terminated; (2) benefits are no longer provided because of a change in the terms of network participation; or (3) a contract between a group health plan and a health insurance issuer is terminated, resulting in a loss of benefits provided under the plan with respect to such provider. The plan or issuer must notify continuing care patients on a timely basis of the termination and their right to elect continued transitional care from the provider. Individuals must also have an opportunity to notify the plan or issuer of their need for transitional care.	To assist our clients with the continuity of care requirements, Cigna will send a provider termination file to the plan administrator on a weekly basis. The provider term file will include the necessary information for provider terminations identified the previous week. Cigna expects that plans will identify their members that meet the CAA COC criteria, notify those members of the provider termination, as well as notification of the member's right to elect continued transitional care from the provider. Cigna expects that the plan will complete the Continuity of Care review and approval. Cigna also expects that the plan will notify Cigna when they receive a claim that is approved for CAA COC, is priced as non-par, and requires a pricing adjustment to the providers previously contracted rate.	Additional operational detail is included as a separate attachment within this communication.	**Effective for plan years on or after 1/1/2022.** The Departments do not intend to issue regulations addressing continuity of care requirements prior to the effective date. Any rulemaking will include a prospective applicability date that provides a reasonable amount of time to comply with new requirements, and plans and issuers are expected to use a good faith, reasonable interpretation of the statute.
Section 114: Cost Comparison Tool	Requires health plans to offer a price comparison tool for consumers and make information available by phone. The tool (to the extent practicable) must allow an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.	Cigna has allocated significant resources and is actively working toward compliance with the similar Transparency in Coverage cost-estimator tool requirements, effective 2023 and 2024.	No action needed at this time.	Enforcement has been deferred. Rulemaking expected in 2022. Enforcement date is expected to be aligned with the 1/1/23 cost-estimator tool requirements outlined in the Transparency in Coverage rule.

CAA Updates – Title I: No Surprises Act

The information in this document is accurate as of May 1, 2022 and is subject to change.

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 116: Provider Directory Information	Requires health plans to have up-to-date directories of their in-network providers, which shall be available to patients online, or within one business day of an inquiry. Plans must verify key data elements (name, address, telephone, specialty and digital contact information) every 90 days and have a process to suppress providers from the directory that do not respond. Data element updates must be displayed in the directory within 2 business days of validation. Requires plans to make publicly available and post on website and include on each EOB, information on prohibitions on balance billing, information related to the applicable state law, the requirements applied and information on contacting applicable State and Federal agencies. Requires health plans to respond to an individual who requests information on a provider's network status through a telephone call within 1 business day, in writing electronically or in print, per individual's request. If a patient provides documentation that they received incorrect information from an insurer about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount. Health plans must retain communication records related to network status inquiries for two years.	**Provider digital contact fields (email and/or website) will be added to the directory and continue to be populated through the validation/suppression processes beginning in 2022. Surprise billing disclosure will be added to directory, Cigna.com and EOBs. We are assessing the 2 day turnaround requirement to understand impacts to our current processes.** **Cigna has a process in place for handling customer calls inquiring about a provider's network status. Cigna has created a letter to respond to the customers within the 1 day turnaround time as requested in writing electronically or in print, per individual's request.** **Cigna will update member cost share liability as required when notification of an incorrect directory network status is received.** **Cigna will be able to retain this information for 2 years as well as audit the responses.**	No action needed at this time.	**Effective for plan years on or after 1/1/2022.** Pending future rulemaking in 2022 for some parts of this provision, plans and issuers are expected to implement the requirements using a good faith, reasonable interpretation of the law.

CAA Updates – Title II: Transparency

The information in this document is accurate as of May 1, 2022 and is subject to change.

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 201: Removing Gag Clauses	Bans gag clauses in contracts between providers and health plans (includes network or association of providers, third-party administrator, or other service provider offering access to a network of providers) that prevent enrollees, plan sponsors, or referring providers from seeing provider-specific cost and quality data.	Cigna does not standardly enter into any contracts that would prohibit the disclosure of information contemplated by Section 201 of the Consolidated Appropriations Act, 2021 ("CAA"). In fact, Cigna's template contracts include compliance provisions that would render ineffective any language that would be non-compliant with the CAA. Cigna continues to review its nonstandard contracts. Such language, if any is identified, will be removed from the contract as soon as practicable.	No action needed.	**Already effective as of 12/27/2020.**
Section 202: Broker Compensation Reporting	Requires group health brokers and consultants to disclose to plan sponsors all direct and indirect compensation received from insurers and associated with selection of insurance products, benefits administration, wellness services, or other defined broker and consultant services.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	**Effective 12/27/2021.**

CAA Updates – Title II: Transparency

The information in this document is accurate as of May 1, 2022 and is subject to change.

	Provision Requirements	Cigna's Actions for SAR Clients	Client Next Steps	Key Dates & Further Rulemaking
Section 203: Parity NQTL Program	Requires that plans perform, and provide to a regulator or participant on request, a comparative analysis for any non-quantitative treatment limitation (NQTL) applied to mental health/substance use disorder (MH/SUD) benefits.	Cigna will be prepared to provide necessary information to SAR clients that is consistent with the information it develops for use in evidencing non-quantitative treatment limitations (NQTLs) compliance as an insurer. Cigna is not in a position to perform client-specific testing for NQTL compliance. The comparative analyses that Cigna shares with clients are those Cigna develops by assessing its group-client book of business and not any specific client.	Clients should plan accordingly. Future inquiries should be sent through your Cigna sales representative.	**Already in effect as of 2/10/2021.**
Section 204: Medical Cost and Drug Spend eporting	Requires health plans to report information on plan medical costs and prescription drug spending to the Secretaries of HHS, Labor, and the Treasury.	Cigna will not provide services or support for this regulatory requirement.	Clients should plan accordingly.	Enforcement of compliance expected by 12/27/2022 (for plan years 2020 & 2021) and by 6/1 annually thereafter. Rulemaking expected in 2022

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Segal

30 Waterside Drive
Suite 300
Farmington, CT 06032-3069
segalco.com

Memorandum

To: Board of Trustees Bakers Union and FELRA Health and Welfare Fund

From: Josh Timm
Tracey Witkowski

Date: June 6, 2022

Re: Estimated Costs of Increasing the Weekly Accident and Sickness Benefit

We were asked to provide the Trustees with estimated costs associated with increasing the Weekly Accident and Sickness Benefit. The current benefit is $200 per week for a maximum of 26 weeks; benefits begin the 1st day for a disability caused by an accident or on the 8th day for a disability caused by a sickness. We were requested to provide projected costs to increase the benefit to 50% of gross salary for the 1st 18 weeks, then 40% of gross salary for the remaining 8 weeks.

The Fund reports that it paid approximately $268,610 in Weekly Accident and Sickness Benefit claims during the last five years, as summarized in the chart below:

Year	# of Eligibles	# of Claimants	Total Claim Dollars
2017	487	28	$56,943
2018	485	37	$71,160
2019	488	23	$54,543
2020	467	25	$54,343
2021	461	20	$31,622
5-Year Total	**2,388**	**133**	**$268,610**

Based on the most recent census information, and a detailed claimant listing provided by the Fund, the estimated additional annual costs for the improved benefits are $38,050 to $56,500 based on 27 to 35 claimants annually (as shown on the attached exhibit). The high end of the estimates includes a 20% load for adverse selection due to the increased benefit for the majority of eligible members.

The average hours worked by member on the census was not provided. Segal made the following assumptions for each of the weekly hour categories for purposes of the analysis.

# Hours per Week Category	Census Eligible	Average Hourly Rate	Assumed Average # of Hours Worked per Week
28 hours or over	84	$15.32	30.00
40 hours	328	$19.66	40.00
Under 28 hours	21	$15.22	20.00
Total	**433**	**$18.61**	**37.09**

We note that based on the 433 members in the census, their current hourly rates by member, and hours assumption above, there are:

- An estimated 36 part-time members (approximately 8.3% of total eligibles) that would receive a benefit of less than $200 per week during the 1st 18 weeks at 50% of gross salary, and
- An estimated 83 part-time members (approximately 19.2% of total eligibles) that would receive a benefit of less than $200 per week during the remaining 8 weeks at 40% of gross salary
- The remainder of the full-time and part-time members would receive a benefit equal to or greater than $200 per week.

These projections are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal Consulting has not audited the information it was provided to develop the projections. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases.

We look forward to discussing this information with you and answering any questions.

cc: Dawn R. Welch

Bakers Union and FELRA
Weekly Accident and Sickness Modeling

Weekly Accident and Sickness Modeling - Current vs. Proposed Benefit Change							
Year	Type of Claim	# of Claimants	Average Duration in Weeks	Paid Claim Dollars @ Current	Paid Claim Dollars @ Proposed	Percent Change from Current	Dollar Change from Current
2017	A	6	19.93	$23,914.26	$39,058.00		
	I	22	7.55	$33,028.43	$56,570.50		
		28	**10.20**	**$56,942.69**	**$95,628.50**	**67.9%**	**$38,685.81**
2018	A	5	12.66	$12,656.92	$21,308.85		
	I	32	9.45	$58,502.82	$102,383.04		
		37	**9.88**	**$71,159.74**	**$123,691.89**	**73.8%**	**$52,532.15**
2019	A	4	17.36	$13,885.66	$22,896.41		
	I	19	10.76	$40,656.95	$68,797.70		
		23	**11.91**	**$54,542.61**	**$91,694.10**	**68.1%**	**$37,151.49**
2020	A	2	10.29	$4,142.82	$7,099.66		
	C	1	2.43	$485.71	$838.15		
	I	22	11.36	$49,714.05	$83,884.48		
		25	**10.92**	**$54,342.58**	**$91,822.29**	**69.0%**	**$37,479.71**
2021	A	1	18.29	$3,628.56	$6,291.09		
	C	1	6.57	$1,314.27	$2,267.95		
	I	18	7.41	$26,679.57	$45,497.00		
		20	**7.91**	**$31,622.40**	**$54,056.04**	**70.9%**	**$22,433.64**
2022	I	6	7.31	$8,771.37	$15,027.62		
		6	**7.31**	**$8,771.37**	**$15,027.62**	**71.3%**	**$6,256.25**
Total		139	10.07	$277,381.39	$471,920.44	70.1%	$194,539.05

Bakers Union and FELRA
Weekly Accident and Sickness Modeling

Year	Type of Claim	# of Claimants	Average Duration in Weeks	Paid Claim Dollars @ Current	Paid Claim Dollars @ Proposed	Percent Change from Current	Dollar Change from Current
2017-2021	A	18	16.17	$58,228.22	$96,654.01		
	C	2	4.50	$1,799.98	$3,106.10		
	I	113	9.35	$208,581.82	$357,132.71		
		133	**10.20**	**$268,610.02**	**$456,892.82**	**70.1%**	**$188,282.80**
2023 Estimate	A	3.6	16.17	$11,645.64	$19,330.80		
	C	1.0	4.50	$899.99	$1,553.05		
	I	22.6	9.35	$41,716.36	$71,426.54		
		27.2	**10.07**	**$54,262.00**	**$92,310.39**	**70.1%**	**$38,048.40**
Adverse Selection Load	10%	2.72	10.07	N/A	$9,231.04		
	20%	5.44	10.07	N/A	$18,462.08		
2023 with Adverse Selection	10%	29.92	10.07	N/A	$101,541.43	87.1%	$47,279.44
	20%	**35.36**	**10.07**	**N/A**	**$110,772.47**	**104.1%**	**$56,510.48**

Bakers Union and FELRA

Weekly Accident and Sickness Modeling

Notes

1. Assumed 433 Current Eligible based on Census provided by the Fund.
2. Assumed an average hourly rate of $18.61 based on census for proposed benefit calculations.
3. Assumed an average # of hours per week of 37.09 for proposed benefit calculations.

# Hours per Week Category	Eligible	Average Hourly Rate	Assumed Average # of Hours Worked per Week
28 hours or over	84	$15.32	30.00
40 hours	328	$19.66	40.00
Under 28 hours	21	$15.22	20.00
Total Census	433	$18.61	37.09

4. Projected 2023 utilization based on last 5 years experience (2017-2021), not including 2022 as immature and not credible.

Legend	Claim Type	Description
	A	Accident
	C	COVID-19
	I	Sickness

5. There is no adjustment for maternity claims in 2023, as there were none in the prior 5-year experience period.
6. Assumed benefit waiting period remains the same, 0 days for accident, and 7 days sickness.
7. Assumed a 10% or 20% increase in utilization due to increased weekly benefit amount.
8. The projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases.

9. The Coronavirus (COVID-19) pandemic continues to evolve and will likely continue to impact the US economy and health plan claim projections for most Health Plan Sponsors. As a result, projections could be significantly altered by emerging events. At this point, the full impact on Health Plan claim costs are uncertain. Unless specifically noted, this current report does not include any adjustments such as changes in eligibility, income, increases in healthcare costs or decreased investment returns. Additionally, the potential for federal or state fiscal relief is also not contemplated in these budget projections. Given the high level of uncertainty and fluidity of the current events, some plans may seek periodic updated estimates throughout the year to closely monitor health plan budget projections.

Machine Readable Files and Pricing Tool Options

	Current carrier	What does the Fund need:	Notes:	*Option 1:* Exponent (Heel)	*Option 2:* medExpert (Basys partner)	*Option 3:* GreenUght	*Option 4:* HChange Healthcare	*Option 5:* Sapphire	*Option 6:* Zelis/Zenith
MRF	Cigna is handling the In-Network file only.	The Out-of-Network MRF File by July 1, 2022	They are handling the OON file, but not for Shared Administration clients.	Create/host MRF: $17,250 implementation fee per Fund, plus $779/month service fee for OON MRF	$492/month for both services for Bakers, assuming enough Funds opt in to meet min total of $3400/month. (based on how many Funds/ members opt in - see member counts at bottom of sheet) 0-0-0 up to 1000 members = $20,000 1000-5000 members = $15,000 5001-10000 member = $10,000 Over 10k members = No fee One time PS training fee of $5,100 across all Funds, not per Fund. (We can pro-rate per Fund, depending on how many Funds opt in.)	Create/host MRF Price for all Funds (not per Fund): $3,000 implementation fee; $1,200 monthly fee First month free	Host MRF only, not create it: $10,000/year (for all Funds). Add-on service to pricing tool. Assumes 3-year contract. **(they will not create the file).**	Awaiting pricing for MRF solution. **Call with Sapphire** postponed until **next week.**	Zelis will provide OON MRFs for free utilizing Sappire's product.
Pricing Tool	Cigna is providing a self-assessment pricing tool presenting at June 8, 2022 Board Meeting. $5 pmpm	Pricing Tool for INN/OON services by January 1, 2023	Tool requires personalized member cost- sharing for 500 services. Must allow members to compare INN & OON pricing, talc current accrued deductibles, visit limits, and other personalized factors. Our PS team must be able to navigate the tool for the member over phone and produce paper copy.	Pricing tool available, awaiting pricing.		Price for all AA Funds not per Fund $5,000 implementation fee, first month free, then $0.25 pmpm (members, not covered lives)	Price for all AA Funds. $30,000 implementation fee; $75,000 per year. **3-year contract required**	If membership across all Funds < 10k is: $20,000 implementation, $45,000 annual total for all Funds (not per Fund)	Sapphires product via Harbour Pricing Total Lives 0-999 $1.00 per pepm

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[Insert at top of newsletter]

Questions about your Benefits?
Call Participant Services at the Fund Office (866) 662-2537.
Press "2" for a representative or "#1" to use the automated system.

[Headline Article:]

Telehealth Services

As of June 30, 2021, the Plan **no longer** covers Telehealth Services. This was noted in the April 2021 FYB. If you use telehealth services after June 30, 2021, your claim(s) will not be covered.

New Claims Address for Cigna

Claims not filed electronically should now be sent to:

Cigna Payor 62308
PO Box 188004
Chattanooga, TN 37422-8004

New ID Cards have been issued. Please share this information with your provider the next time you have an appointment.

Your Over-the-Counter COVID-19 Test Coverage

Effective January 15, 2022 and continuing through the end of the federally-declared public health emergency, certain at-home COVID-19 diagnostic tests purchased without a prescription ("over-the-counter" or "OTC Tests") are now covered under the Plan's Prescription Drug Benefit.

The types of OTC Tests that are covered include at-home diagnostic tests approved, cleared, or authorized by the FDA for use without an order or individualized clinical assessment from a health care provider or the involvement of a laboratory under the applicable FDA authorization, clearance, or approval. Generally, at-home OTC tests that are available for purchase in pharmacies will meet this standard. Currently, these OTC Tests are covered with no cost sharing (including deductibles, co-payments, and co-premiums) and no requirement of prior authorization.

To obtain your OTC Tests from a Participating Pharmacy (Rite Aid, Sam's Club, Walgreens, or Walmart), first call the pharmacy to see if they have OTC Tests available. When you go to the pharmacy, take your OptumRx ID Card with you, and bring the COVID-19 test to the pharmacy counter, not the regular checkout lane. When you check out at the pharmacy counter with your OptumRx card, your test should automatically ring up at no cost to you. If you prefer to order your OTC Tests online at $0 copay and have them delivered to your home, visit www.optumrx.com to log into the OptumRx Store and place your order. Ordering 2 kits (containing 4 tests) or more in a single order will qualify for free standard shipping.

If you or your covered dependents purchase OTC Tests at non-participating pharmacies, or other retailers, you may submit a request for reimbursement of up to eight (8) FDA-approved OTC Tests per covered person per 30-day period.

Be sure to obtain a receipt when you purchase the OTC Tests. To see a list of FDA-authorized tests that are eligible for reimbursement, visit https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/home-otc-covid-19-diagnostic-tests

Reimbursement will be capped at $12 per test. A testing kit containing two tests in one box will count as two tests toward this limit. To request reimbursement for the cost of OTC Tests, go to www.optumrx.com and log in for instructions on how to submit an online reimbursement claim form or download and print a paper claim form that you can mail to the address on the form for reimbursement. You may also call OptumRx at (888) 869-4600 to request a paper claim form. You must include a receipt for the purchase of the OTC Test with your claim form, and you will be required to submit an attestation that the test is for personal use, is not for employment purposes, and will not be reimbursed by another source or placed for resale.

Regardless of whether you obtain the tests at a participating pharmacy, from OptumRx online, or out-of-network, coverage is limited to eight (8) tests per covered participant or dependent per 30-day period. Please note, COVID-19 diagnostic tests performed at a provider's office, hospital, or clinic do not count toward this limit.

Important Notes:

OTC COVID tests may be in high demand. As an alternative to obtaining these tests at a pharmacy or retailer, you also can visit www.COVIDtests.gov to order 2 sets of 4 free at-home tests that will be mailed to you from the federal government. If you already ordered your first set, you can order a second set now. There also may be additional options in your local area for obtaining OTC COVID tests at no cost. If you have any questions, please contact the Fund Office at (800) 638-2537.

Free at-home COVID-19 tests

Every home in the U.S. is eligible to order two sets of four free at-home tests. To order your free at-home tests Call (800) 232-0233 (TTY (888) 720-7489) or online: www.COVIDtests.gov

Tests available for order:

- Are rapid antigen at-home tests, not PCR
- Can be taken anywhere
- Give results within 30 minutes (no lab drop-off required)
- Work whether or not you have COVID-19 symptoms
- Work whether or not you are up to date on your COVID-19 vaccines
- Are also referred to as self-tests or over-the-counter (OTC) tests

Reasons to take an at-home test:

- If you begin having COVID-19 symptoms like fever, sore throat, runny nose, or loss of taste or smell, or
- At least 5 days after you come into close contact with someone with COVID-19, or
- When you're going to gather with a group of people, especially those who are at risk of severe disease or may not be up to date on their COVID-19 vaccines.

Giant Employee Co-Premium Increase

Effective June 1, 2022, Giant employees will have a weekly co-premium increase. Full-time employees will have a $1.00 weekly increase in their current co-premium. Local 68 Plan 3 part-time employees with dependent coverage will pay 20% of the employer contribution rates in effect. Local 118 Plan 3 part-time employees with dependent coverage will have a $1.00 weekly increase in their current co-premium.

The co-premiums are set forth in the collective bargaining agreement for Giant employees and Giant will deduct the co-premium amounts from your paycheck starting June 1, 2022. If you have any questions, please contact the Fund Office at (800) 638-2537.

[Insert contribution rate chart. Attached as Word doc]

Your New Dental Plan – Delta Dental

Effective January 1, 2022, Delta Dental became the Fund's provider of dental benefits, replacing Group Dental Service.

Stay in network to save
Visit a dentist in the Delta Dental network to maximize your savings. These dentists have agreed to reduced fees and you won't get charged more than your expected share of the bill. Find a PPO dentist at **www.deltadentalins.com.**

Set up an online account
Get Information about your plan, check benefits and eligibility information, find a network dentist, and more. Sign up for an online account at **www.deltadentalins.com.**

Check in without an ID card
You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date, and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log into your account to view or print your card.

Participating Providers

Where do I find a Participating Provider?

[Insert participating provider chart, attached as Word doc]

Vaccines

COVID-19 Vaccines Are Free to Anyone in the United States

COVID-19 vaccines are available for everyone (ages 5 years and older) in the United States at **no cost,** regardless of health insurance or immigration status.

- CDC does not require U.S. citizenship for individuals to receive a COVID-19 vaccine.
- Jurisdictions (state, tribal, local, and territorial) cannot add U.S. citizenship requirements or require U.S. citizenship verification as a requirement for vaccination.

To find out information regarding COVID-19 vaccines go to:

www.cdc.gov

Continuity of Care – Consolidated Appropriations Act

Beginning January 1, 2022, if you are receiving certain types of medical care from an in-network provider or facility and that provider or facility leaves the Cigna network, the Fund will notify you and will give you the option to continue your care with that provider or facility at the in-network coverage levels for up to 90 days. Under the Consolidated Appropriations Act, only certain types of medical treatment are subject to the continuity of care rules.

Eligible Medical Treatment for Continuity of Care

To be eligible for continuity of care, you must be an 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;
- Determined to have been terminally ill and receiving treatment for such illness from the provider or facility; or
- 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 care over a prolonged period of time.

What should they do if they have questions, don't know if they have a serious and complex condition? Call the Fund office?

What can the provider or facility charge me?

If you qualify for continuity of care, 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 from the Fund, 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 eligible for continuity of care, is there anything I need to do?

Yes. If you qualify for continuity of care protection, the Fund 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 eligible for continuity of care, would like to inquire whether you qualify, or experience difficulties with a provider or facility refusing to provide continuity of care at in-network copayment, coinsurance, and deductible amounts, please contact the Fund Office at (866) 662-2537.

MOBILE APPS to Help you Navigate your Health

OptumRx – Mobile App

Download the Mobile App today
You can download the OptumRx mobile app by searching for OptumRx in the App Store or Google Play.

Can I use both the full site and the mobile site?
Yes. If you make a change to your account or manage your prescriptions on the website or app, that information will be updated on the other as well.

The home screen looks different. What do I need to know?
OptumRx has made some smart changes to make managing your prescriptions more seamless. From this screen you can:

- Order now
- Check an Order status
- View a list of My drugs
- Search drug pricing
- Scan to refill
- Add prescription

Where can I access My ID card and other profile information?

You can click on the 3 dots and "More" at the bottom of the screen. This will bring you to the "My account" section. Here you can access "My profile," Home delivery settings, App settings, and information about OptumRx.

How to set up text message medication reminders

- Click "Tools" on the bottom of the home screen Click "My medication reminders." (If you are not logged in, you will have to do that first).
- Click the "New" button to set up a new reminder.
- Choose the medicine for which you want to set up a reminder.
- Choose the frequency of the reminder.

- Choose the time for the reminder. Click the "Save" button.

Delta Dental Mobile – Mobile App

Your oral health is important to the Fund — and to your overall health! Delta Dental has designed its mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, view ID cards, and more, right on your mobile device.

Getting started - The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download the app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental Mobile App.

What functions are available on the new mobile app?

- Member ID
- Dentist finder
- Cost estimator
- Account management functions

May is Mental Health Awareness Month

Make time for self-care.
Caretaker, parent, teacher, student, employee. Many of us juggle different responsibilities and roles in our lives, leaving not much "me time" in the day. This can lead to burnout, stress, and higher risk of illness.* So, in honor of Mental Health Awareness Month, here are five ways you can, and should, start practicing more self-care.

1. **Be happy with you.**
   Try not to compare yourself to others or their lifestyles. Focus on positivity and challenge unhelpful thoughts.

2. **Do more of what makes you happy.**
   Whether it's cooking, reading, meditating, or working out, find the activity that's just for you and make it a priority – even if it's just 15 minutes a day.

3. **Stick to a sleep schedule.**
   Program your alarm for bedtime and wake-up time and stick to it. When it's time to sleep, minimize sleep disruptors such as lights, phones, and television.

4. **Eat to feel great.**
   Help improve your energy and focus each day by eating a balanced diet, drinking plenty of water, and limiting caffeinated beverages.*

5. **Know when to say no.**
   To be your best self, you have to set boundaries. That means making your health and happiness a priority, even if it means sometimes politely saying no to other requests or obligations.

**National Institute of Mental Health. "Caring for Your Mental Health." https://www.nimh.nih.gov/health/topics/caring-for-your-mental-health/. Page last revised April 2021.*

This is general health information and not medical advice or services. You should consult your doctor for medical advice or services, including seeking advice prior to undertaking a new diet or exercise program.

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Group Vision Service

Why should I have my eyes examined regularly?

Comprehensive eye exams are essential not just for detecting vision problems. They are also important as a preventive measure for maintaining overall health and wellness and can detect medical eye conditions, such as glaucoma. Your vision benefit is designed to protect and enhance your eyesight – your most important sense. Caring for your eyes should always be a part of your regular health care routine.

What is a comprehensive examination?

Network providers are contracted to perform comprehensive examinations as detailed in the Professional Provider Manual. These exams not only evaluate a member's vision, but they can also lead to the detection of many medical conditions that should be treated by the patient's medical doctor, such as hypertension, arteriosclerosis, glaucoma, macular degeneration, and diabetes. Ultimately, comprehensive eye exams contribute to an overall wellness program.

Some of the tests and procedures performed with these exams include:

- Case History
- Evaluation of visual system's status
- Refractive Status
- Binocular Function
- Assessment, diagnosis, and treatment plan

The tests performed during examinations may vary according to age, type, and severity of the conditions present or other contributing factors.

Is dilation included in the comprehensive examination?

Dilation is covered by the comprehensive examination when the network provider determines it is appropriate for

the member. The decision to dilate is left to the professional judgment of the provider, subject to state law requirements, and may be critical to the final diagnosis in a thorough eye examination. Dilation allows the doctor to better view the back of the eye, as well as important components and structures – such as blood vessels, nerves, and other related tissues. In fact, it is dilation that makes an eye exam a key part of an overall wellness program because it allows doctors to detect early signs of serious illnesses such as diabetes, hypertension, and heart disease.

What is the difference between a routine eye exam and a contact lens exam?

Routine eye exams are designed to detect vision problems and determine overall wellness.

Contact lens exams are designed to evaluate your vision and comfort wearing contacts lenses. Although your vision may be clear and you feel no discomfort from your lenses, there are potential risk factors with improper wearing or fitting of contact lenses that can affect the overall health of your eyes. The contact lens exam assures proper fit of contact lenses.

How frequently should I have my eyes examined?

The American Optometric Association, as a rule, recommends that you not go beyond two years to have your eyes examined. Those with a family history of eye diseases, diabetic patients, and anyone whose general health is poor may need to have their eyes examined twice a year.

How frequently should children's eyes be examined?

As with adults, children's eyes should be examined every two years – or more frequently if there is an eye or vision problem or a family history of eye disease. School children use their eyes more frequently than adults to read and perform other school activities, so it's extremely critical for them to have regular eye exams. Also, it is important to remember that an eye screening typically offered at school only tests distance. Screenings will not detect some vision

problems. Your child can have problems with near vision, eye coordination, and focusing and still have 20/20 distance vision. If left untreated, these problems can cause learning disabilities, headaches, and other visual discomforts.

Do I need a special eye exam as I get close to, or past, age 40?

You don't need a special eye exam over age 40, but it's critical that you have your regular eye exam at least every two years. As we get older, we are more susceptible to certain eye diseases such as cataracts, glaucoma, and macular degeneration. Getting your eyes regularly examined enables your eye care provider to uncover the first signs of disease and prescribe the appropriate treatments to prevent vision loss.

Associated-Admin.com - Your website for valuable information about the Fund.

You may access this website at any time to view or download forms and information by logging onto www.associated-admin.com and clicking "Your Benefits" at the top of the page and selecting "Bakers Union/FELRA" from the drop down items. The following information is available:

1. Current and past notifications
2. Important forms relating to accident and sickness, covid-19 test kit reimbursement forms and other enrollment forms.
3. All past ***For Your Benefit*** newsletters
4. Summary Plan Description Booklet and all Summary Material Modifications (benefit changes)
5. Current Formulary Drug Lists
6. Useful provider links and phone numbers
7. No Surprises Billing Notice: Rights and Protections Against Surprise Billing
8. Link to In Network Negotiated Rates between the Plan and In Network Providers beginning July 1, 2022.

Use Quest or LabCorp for All Lab Work

Generally, you must use either Quest Diagnostics Patient Service Centers ("Quest") or Lab Corporation ("LabCorp") for all laboratory services in order for services to be covered by the Plan.

Inform Your Doctor
Before the lab work is performed, please tell your doctor that you will receive coverage for lab work only if the bill comes to the Fund **from either a LabCorp or Quest facility**. Even if your doctor has a contract with LabCorp to perform lab work in his/her office, explain that only lab work performed at a Quest or LabCorp facility will be covered. **Your Plan coverage does not include lab work performed and billed from your doctor's office.**

To find the most current list of Quest or LabCorp facilities, log onto their websites or call them:

- www.questdiagnostics.com/appointment or by telephone at (866) 697-8378
- www.labcorp.com/psc/index.html or by telephone at (888) 522-2677

Most participants in the Fund have a LabCorp or Quest facility within 5 miles of their homes.

Mail Service Saver Drug Program from OptumRx for Maintenance Drugs

Enroll and save

You now have the choice of using the OptumRx Mail Service Saver Program to receive your maintenance medications.* The Mail Service Saver Program allows you to receive a 90-day supply of maintenance medications at a lower copay. If you continue to receive maintenance medications at a retail pharmacy, you will pay an additional copay after two 30-day supply refills. This change does not impact non-maintenance medications.

*Maintenance medications are prescriptions that are taken regularly, commonly used to treat chronic or long-term conditions such as high blood pressure, asthma, heart disease, diabetes, etc.

Associate Contribution Rate Increase June 1, 2021

Local 68 - Giant Associates				
Associate Contribution	Full-time Associate Hired prior to April 2, 2009	Full-time Associate Hired after April 2, 2009	Plan 3 Part-time Associate	Plan 4
Current	$9.82	$5/$10/$15	$5/$10/$15	No Associate Contribution
6/1/2021	$10.82	$6/$11/$16	$6 Single/ $25.60 Dependents	Required
6/1/2022	$11.82	$7/$12/$17	$7 Single/ 20% of employer contribution rate	
6/1/2023	$12.82	$8/$13/$18	$8 Single/ 20% of employer contribution rate	

Full- time Associate - Effective June 1, 2021, $1 increase in the current associate contribution rate. Single/Two-Party/Family
Part-time Associate Dependent Coverage - 20% of monthly employer contribution rate in effect. Current Plan 3 Part-time Employer Contribution Rate is $128
No Spousal Coverage for Plan Three

Local 118 - Giant Associates				
Associate Contribution	Full-time Associate Hired prior to April 2, 2009	Full-time Associate Hired after April 2, 2009	Plan 3 Part-time Associate with Dependents	Plan 4
Current	$9.82	$5/$10/$15	$5/$10/$15	No Associate Contribution
6/1/2021	$10.82	$6/$11/$16	$6/$11/$16	Required
6/1/2022	$11.82	$7/$12/$17	$7/$12/$17	
6/1/2023	$12.82	$8/$13/$18	$8/$13/$18	