

ELIGIBLE FOR MEDICARE? NOT ENROLLING WILL BE EXPENSIVE

If you are covered by Medicare and the Welfare Fund, it is important that you tell the Fund Office about Medicare coverage being in force.

Whether you have qualified for a normal retirement or disability retirement, your eligibility for Medicare coverage changes the way your claims are paid.

If you're retired and eligible for Medicare coverage and reject it, you'll be at risk for a lot of your medical expenses. The Plan will process your claims as if you have Medicare coverage in force. You will only be covered for some of the Medicare deductibles and co-insurance.

You'll have to pay for most of your medical, surgical and laboratory bills out of pocket. If you don't enroll for Medicare coverage when you're first eligible, your Part B premium will cost you 10% more for each year you don't enroll.

DENTAL NETWORK OFFERS LESS OUT-OF-POCKET EXPENSE!

Much like the medical plan, the dental plan is composed of two options. One of the options is the Preferred Provider Organization (PPO) of DDS, Inc. The second option is to go to any out-of-network dentist.

Low out-of-pocket cost in the network

When you utilize the services of a DDS, Inc. network provider, your out-of-pocket cost will be only \$100 per unit for crowns, bridges and dentures. There will be no other out-of-pocket costs for your basic dental needs, including preventative maintenance, such as cleaning and X-rays.

If you go to a non-participating provider, you have to pay for the cost of the services and then file a claim with the Welfare Fund. You will be reimbursed based on a schedule. The out-of-network dentist could charge you much more than you will be reimbursed and you will have to pay the balance out of pocket.



REDUCED PRICES IN THE OPTICAL PLAN!



The Welfare Plan's optical providers offer savings to the patients who utilize the networks. For example, you can call the Fund Office and ask for an optical voucher and then go to any one of the five optical networks for an eye examination and a pair of glasses or contact lenses each calendar year. You will have no out-of-pocket expense whatsoever.

Out of network means out of pocket

You may instead choose to get your examination and glasses from a non-participating optical provider. If you do, however, you will have to pay for the services and then file a claim with the Fund Office. You will, most likely, have to pay a balance to the non-participating provider since the Welfare Plan limits the amounts of payments for the services of non-participating providers.

To get more information

If you need more information about the optical plan of benefits, contact the Welfare Fund Office at 212.308.4200.

FOR YOUR BENEFIT

THE LOCAL 295/LOCAL 851 EMPLOYER GROUP BENEFIT FUNDS NEWSLETTER

VOL. X, ISSUE 3, FALL, 2011

URGENT CARE CENTERS CAN SAVE YOU A LOT OF TIME AND EXPENSE

What do you do when you need medical care and can't see your doctor right away? The hospital emergency room (ER) is typically the first place where many people go when they have a minor injury or feel nauseous or have a head cold, the flu or a rash or other illness that isn't life threatening.

ERs are overloaded

The ERs are usually very busy and crowded places where you can wait for hours to be seen by a doctor. A lot of hospitals are experiencing "emergency room overload." The overload creates a disservice to all of the patients including the ones who have true emergencies such as chest pains or broken bones.

Urgent care centers are open in most cities

Urgent care centers have been opened up in most cities in the US. About 100 of them are located in New York City and the nearby metropolitan area.

These centers offer fast walk-in care to people who do not have life-threatening emergencies. The centers are similar to ERs. They have doctors and technicians on staff. Many of the doctors are board certified emergency medicine specialists. They have extended hours of operation and laboratory facilities and imaging equipment as well. You can locate a center that is in the network by calling



1.800.810.2583 or by going to the Blue Cross website at empireblue.com/eralt. You can also go to Yahoo, Google or Bing and type in "Empire NY Urgent Care" and you'll find urgent care centers located in your area. The link also tells you about when it's appropriate to use these ER alternatives.

The ER costs a lot more

Using the ER instead of an urgent care center or doctor's office can be much more expensive for you. If a trip to the ER is not for the care of a true medical emergency, as defined by the prudent lay person rule, the ER claim will not be covered by the Welfare Fund. You will have to pay the entire cost out of pocket. That could cost you one or two thousand dollars.

\$20 co-payment at the urgent care center

When medical treatment is received at a network urgent care center, your financial responsibility is just a \$20 co-payment which is the same amount of co-payment that's required for a network doctor's office visit.

Emergency room rule of thumb

Anyone with a life-threatening emergency such as chest pains, shortness of breath or difficulty breathing, broken bones, lacerations or other major injuries should call 911 or go directly to the nearest hospital emergency room for treatment without delay.



MORE ABOUT COVERAGE OF YOUNG ADULT CHILDREN

In the last two issues we reported on how health plan coverage is being provided to sons and daughters up to the age of 26 through the Patient Protection and Affordable Care Act (PPACA). The Welfare Fund Office sent out a letter to all of the eligible plan participants in May with forms and instructions on how to register young adult sons and daughters for this special coverage. The Fund Office received a lot of registration forms and the coverage was put into effect for the young adults who met the requirements.

The PPACA extended coverage is limited to those

young adult children under age 26 who do not have other coverage in force or available to them. Claims are now being received in the Fund Office and more paper work has to be completed before any of these claims can be processed. Each time a claim is filed for any of the PPACA covered young adults, the Fund Office is sending out a form to check as to whether other coverage is either in force or available to the young adult. All claims are put on hold until the fully completed other-coverage form is received. Call the Fund Office at 212.308.4200 if you have any questions about your claims.

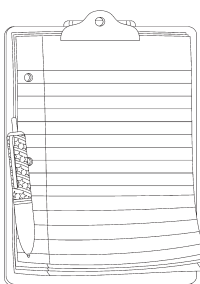
IS YOUR BENEFICIARY DESIGNATION UP TO DATE?

Most of the participants who are covered by the Welfare Fund plan of benefits have life insurance and/or death benefit coverage in force.

When a covered dependent dies the Welfare Plan regulations provide that the death benefit amount is automatically paid to the member.

Designated beneficiary is paid when a member dies

When a covered member dies, the death benefit and life insurance proceeds are paid to the designated beneficiary. Unfortunately, some of the beneficiary designations aren't up to date. The Welfare Fund had a recent case where the member wasn't married when he first enrolled and he named his mother as his beneficiary at that time. The member later got married and never changed his beneficiary. Then, he died and the Welfare Fund had to pay the death benefit and life insurance to the mother instead of the wife.



How to update your beneficiary

Updating your beneficiary designation is easy to do. You may change your beneficiary at any time without the consent of your spouse or beneficiary. Simply contact the Welfare Fund Office at 212.308.4200 to request a change form.

Fully complete the form and mail it to the Local 295/Local 851 IBT Employer Group Welfare Fund, Sixty Broad Street, 37th Floor, New York, New York 10004. All changes become effective when your form is received at the Fund Office.

You can find out more about the death benefit and life insurance coverage of your Welfare Plan in your Summary Plan Description booklet. If you have any questions after reading the booklet, contact the Welfare Fund Office.

DO YOU HAVE AN INCREASED RISK OF A HEART ATTACK?

If you have had a heart attack or if you have been hospitalized for heart-related chest pain, you're at increased risk of having a future heart attack, or even a stroke. In fact, research shows that people who have had a heart attack face a five times greater risk of another heart attack and a three times greater risk of a stroke. That risk never goes away.

What causes a heart attack?

About 80% of all heart attacks occur when platelets in the blood stick together and form clots. Here's why:

- Most people at risk for a heart attack have plaque buildup in their arteries.
- When there is a rupture in this plaque, platelets in the blood rush to the rupture and stick to the damaged area, much like a scab on the skin.
- As platelets continue to stick together, they form clots that can restrict blood flow.
- If these clots form in an artery, they can cause a heart attack.

Some of your risks can be managed

Age and family history are risk factors for heart attack and stroke that you can't do anything about. There are, however, risk factors that you can manage by making some lifestyle changes, such as:

- Keeping your blood pressure under control.
- Watching your cholesterol.
- Exercising regularly. This helps manage high blood pressure and high cholesterol, both of which are risk factors for a heart attack. Consult with your doctor before you begin an exercise program.
- Watch your diet. Choose foods that are low in fat, cholesterol and sodium. Losing as little as 10% of your current weight will help reduce your risk.
- Quitting smoking. If you smoke, your risk of heart attack is more than twice that of non-smokers. If you stop smoking, your risk for a heart attack will begin to drop.



Medications that help

Medications your doctor may prescribe can help reduce your blood pressure and your cholesterol. Other drugs such as antiplatelet medications help to prevent clots from forming in your arteries..

Early diagnosis and treatment pays off

See your doctor regularly to have your blood pressure checked and get some basic diagnostic tests. The early detection of diseases will help you to feel better sooner and that will save you a lot of time and money in the long run.

MAIL ORDER DRUGS

Earlier this year, the Pharmacy Benefit Manager of the Welfare Fund, Broadreach Medical Resources (BMR), announced that the Duane Reade mail order program would be discontinued and that MedVantx Pharmacy Services will be the new mail order drug provider.

Transition was to be seamless

All valid refills were transferred to MedVantx by Duane Reade and we announced that it will not be necessary for you to get new prescriptions. We reported that your payment information will not be transferred and we recommended that you contact MedVantx to furnish that information.

Some problems cropped up

The Fund Office received some complaints about the MedVantx services and all of the complaints were relayed to BMR. BMR reported that they held some meetings with MedVantx and have resolved the service issues.

BMR also reported that the relationship with Duane Reade came to an end due to the company permanently closing down its mail order business. BMR carried out a long and extensive search to find a suitable replacement and MedVantx was chosen for several reasons including outstanding customer service. BMR works closely with MedVantx on a daily basis to ensure that members are provided the best service. MedVantx's state-of-the-art home delivery pharmacy operates out of Sioux Falls, South Dakota and serves as a full-time mail service prescription drug and information provider. The hours of operation are Monday through Friday, 7am to 10pm and Saturday, 8am to 5pm, Central Time. Call toll-free at 1.866.744.0621 or you can log on to their website at www.MedVantxRx.com where you can register and request new prescriptions. You can also order new prescriptions by mail. Call the Fund Office to get a form.

Call BMR with your concerns or any problems

For any concerns or issues about MedVantx regarding a new prescription or refill, contact BMR at 1.866.718.2375, extension 4. If a medication requires prior authorization, contact BMR to initiate the prior authorization.



PURCHASE DIABETIC SUPPLIES THROUGH NETWORK PROVIDERS

The Welfare Fund provides coverage for certain diabetic supplies such as lancets, test strips, glucose meters and insulin pumps. While these items are available through the PPO network, some of the patients are purchasing the items at retail outlets and then filing their claims with the Fund Office.

Out of network means out of pocket expense . .

The Fund Office has to process the out-of-network charges under the major medical coverage. That means no payment for the first \$300 of covered charges (that's the amount of the annual deductible) and the rate of payment is 75% of the covered charges that are over and above the deductible. As a result, a diabetes patient will receive no payment whatsoever for the first \$300 or less of covered charges and payment will be made at the rate of 75% of the remainder of the covered expense over and above the deductible. A \$400 claim would result

in a payment of just \$75 or less.

Network providers file claims for you . . .

Diabetes patients can avoid the claim filing problems and out-of-pocket expense by ordering the covered supplies from a PPO network provider. The providers will ship your order directly to you and file a claim with the Welfare Fund on your behalf. The deductible and co-insurance do not apply when you buy from a network provider.

Contact the Welfare Fund Office for more information about network providers.

