FOR YOUR BENEFIT

NEWSLETTER OF THE LOCAL 295 IBT EMPLOYER GROUP BENEFIT FUNDS
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CHANGE IN PRESCRIPTION DRUG PROVIDER

As many of you are aware, the Board of Trustees has selected OptumRx as the Fund's new provider for prescription drugs as of January 1, 2017. This is often referred to as a PBM ("Pharmacy Benefits Manager"). OptumRx was selected after an extensive review of many national and local PBM's. OptumRx, along with three other finalist PBM's, made presentations to the Board. At these presentations, and at follow-up contacts, OptumRx was selected due to their being the best based on a variety of factors.

This change in provider does not apply to those members who are retired and are on Medicare. If you are retired and on Medicare you will have been notified of the changes that affect you. OptumRx has a nationwide panel of pharmacies (more than 65,000!!) where you can fill your prescriptions. Virtually every pharmacy in the New York metropolitan area is in the OptumRx network. OptumRx also has a mail order program that is similar to the one in effect from your current PBM.

OptumRx was chosen after careful consideration because it was demonstrated that they would provide the best benefits at the best cost to the Fund. As you know, from following the news, prescription drug charges are one of the main reasons why the cost of providing medical coverage is increasing at rates well in excess of inflation. OptumRx was the PBM that had the best rates along with the greatest rebates (payments back to the Fund from Pharmaceutical companies). OptumRx also had an aggressive specialty drug program that will manage the cost to the Fund for these expensive, but very necessary prescriptions.

Even though prescription drug charges are increasing, the Board has determined that because they have selected OptumRx it will not be necessary to make any increases in your co-payments.

They will remain the same as they are now. The current co-pay amounts are $10 for a generic prescription, $25 for a "Preferred" or "Formulary" brand name drug and $40 for a non-preferred brand name drug. In addition, as you are aware, there is $2 added to your co-pay if you fill your prescription at one of the major retail chain stores such as Walgreens, Duane Reade, CVS or Rite Aid. Remember, always ask your doctor for prescriptions for generic drugs as this will save you money. If you insist on having a brand name drug when a generic drug is available, you will not only pay the higher co-pay for the brand name drug but, in addition, you will pay the difference in cost between the brand drug and the generic drug. This can be a very expensive choice for you.

Each PBM has its own list of "preferred" or "Formulary" medications. If you have a current prescription for a preferred medication that is not an OptumRx preferred medication, you will be contacted by OptumRx and be given your options to switch medications to the OptumRx preferred or to pay the higher co-pay if you wish to continue with your existing prescription. One of the reasons that OptumRx was elected was that, based on the actual prescriptions in effect, this "disruption" was among the least of all the PBM presenters. You will be receiving informational material from OptumRx in the next few weeks along with your new OptumRx prescription drug card. After January 1, 2017 you will need to show your new card to your pharmacist. If you have a prescription on mail order at the beginning of the year, it should be automatically transferred. Please look in your mail for further information on this change to OptumRx.

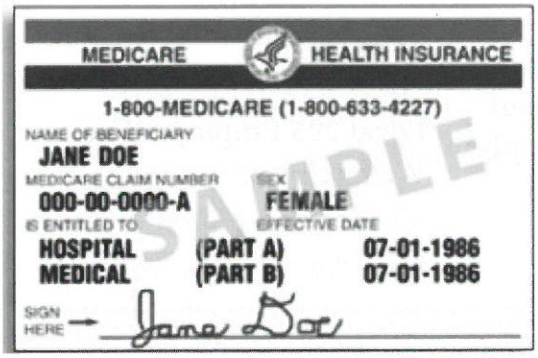
CHANGE IN COVERAGE FOR RETIREES WITH MEDICARE

As you were previously notified, effective January 1, 2017 the Board of Trustees is pleased to announce new and improved coverage for members who are retired and on Medicare.

In their continuing efforts to protect the integrity of your medical benefit, the Board has selected two major American insurers to provide your benefits. Your medical coverage will now be provided by United American Insurance Company and your prescription drug coverage will be provided by Aetna as of January 1, 2017.

Just as before, you can use any provider that accepts Medicare - there is no need to change your doctor. If your doctor accepted Medicare before and continues to accept Medicare then he or she can still be used.

Aetna is accepted at virtually every pharmacy in America so you may continue to get your prescriptions filled as you have been doing. There is also a mail order program with Aetna which is similar to what is now in effect.



There are many benefit improvements in the new Plan. Some of the main improvements are as follows:

- There are no deductibles, copays or coinsurance on all approved Medicare charges. You will have zero out-of-pocket expense for all covered services.
- There is enhanced foreign travel coverage should you need medical treatment outside the United States.
- Allowed Part B drugs, chemotherapy and durable medical equipment are now covered in full. You will no longer have any coinsurance amounts on these services.

This new medical benefit is what is known as a Medicare Supplement Plan F which is the finest Medicare Supplement plan available. You will need to use your Medicare card for the basic Medicare benefits and your new United American card when you see your doctor or are admitted to the hospital or have services performed by the hospital on an out-patient basis. You will use your new Aetna card at the pharmacy for your prescriptions.

These changes in carriers were necessary because the existing insurance carrier demanded a very large increase in premium (almost 70%!!) to provide your coverage. The Board used its consultants to survey the market and find good, solid American companies to get you your coverage. Unfortunately, as you are aware if you follow the news, insurance premiums are increasing everywhere. In order to protect the ongoing viability of your Fund, due to the fact that there was still a substantial increase in the cost of providing your benefits, the Board had no choice but to raise your monthly contribution amount by $50 to $350 per month.

If you are entitled to Medicare and are enrolled in this coverage in 2016, you should have already received information about this new program from the Fund Office. If you have not received this information, please contact the Fund Office so it can be resent to you. Included in this package from the Fund Office are opt-out forms if you wish to no longer receive this coverage from the Welfare Fund. As always, you can opt back into the coverage at a later date, if you provide evidence that you maintained creditable coverage during the time you were not covered by the Welfare Fund.

The Board takes its responsibility to Retirees very seriously and will continue to make every effort to preserve, protect and defend the ongoing integrity of the Fund so these valuable benefits can continue to be provided in the future.

ANNUAL NOTICE ABOUT THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

A federal law known as the Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy related benefits or services to persons covered by the Welfare Fund.

This Plan has historically provided the benefits required under the WHCRA and continues to make these benefits available to eligible persons. This notice is a brief overview of the benefits required under the WHCRA and your rights under the law.

Under the provisions of the WHCRA, a group health plan eligible person who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy is entitled to coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of mastectomy, including lymph edema.

Coverage for these benefits or services will be provided in a manner determined in consultation with the eligible person's attending physician.

If you are eligible in the Plan and currently receiving, or in the future receive benefits under this

Plan in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event that you elect reconstruction of the affected breast.

Eligible dependents are also entitled to coverage for these benefits or services on the same terms. Coverage for the mastectomy-related services or benefits required under the WHCRA will be subject to the same deductibles and coinsurance or co-payment provisions, if any, that apply to any other medical or surgical benefits provided by the Welfare Fund.

YOUR PRIVACY IS PROTECTED BY LAW

The privacy of your medical records is important! Under a law called the Health Insurance Portability and Accountability Act (HIPAA), the Local 295 Employer Group Welfare Fund has rules and procedures for how it protects your records. For a brief explanation of these rules and procedures and also an explanation of your HIPAA rights, you can refer to the Notice of Privacy Practices.

For example, the Notice of Privacy Practices explains how to request a copy of your claims history from the Fund Office, how you can designate someone to speak to the Fund on your behalf, and how you can file a complaint.

The Notice of Privacy Practices is available in your SPD, beginning on page 70. You can also request a copy by calling the Fund Office at 212.308.4200 or by writing to:

HIPAA Privacy Officer

Local 295 Employer Group Welfare Fund

60 Broad Street, 37th Floor

New York, NY 10004

IN MEMORY

It is with great sadness that we advise you of the passing of Robert Beres. He was a full-time employee of Savasta and Company, Inc. until his retirement in 2006. He continued to provide services on a consulting basis after that and worked on many projects for the Local 295 Funds. Bob has been the editor of "For Your Benefit" since it began in 2002. Bob dedicated his entire working career to services related to the labor movement. He will be sorely missed by all.

LOCAL 295 IBT EMPLOYER
GROUP PENSION TRUST FUND AND
EMPLOYER GROUP WELFARE FUND
Sixty Broad Street, 37th Floor
New York, New York 10004

MORE FORMS!?

If you are an active participant, COBRA participant or covered retiree under the age of 65, you might remember receiving a Form 1095-B from the Welfare Fund in January earlier this year. Be on the lookout for your 2016 form to arrive in the mail in the next few months. The Form 1095-B provides you with information about your health coverage and the health coverage of your dependents from the Welfare Plan. Please keep this important document in a safe place because it is needed to file your tax returns. As long as you are covered by the Welfare Plan, you will receive a Form 1095-B every year.

The Form 1095-B will show which months in the year you and your dependents were covered by the Welfare Plan during 2016. If you don't receive a 1095-B from the Fund by the middle of February of 2017, please contact the Fund and we will make sure you get one.

Accuracy Counts!!...

It is important that the information on your 1095-B matches the information on your tax return. If you notice that your name or Social Security number appears differently on the 1095-B and your tax returns, please contact the Welfare Fund to sort out the discrepancy. Otherwise, we may contact you in the future to correct the discrepancy.

OUT OF NETWORK FACILITIES

In our last issue, we indicated that Bayonne Hospital is no longer participating in the Blue Cross network. Since that issue, we also learned that Christ Hospital and Hoboken University Medical Center do not participate in the Blue Cross network either. These facilities are all part of the Care Point Health System and none of them participates with Blue Cross. In order to avoid any out-of-pocket expenses, you should use a participating network facility.