FOR YOUR BENEFIT

THE LOCAL 295/LOCAL 851 EMPLOYER GROUP BENEFIT FUNDS NEWSLETTER
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COORDINATION OF BENEFITS Some participants have health care coverage under two plans. When this happens, the two plans will coordinate their benefit payments so that the combined payments do not exceed the actual expenses. This process, known as coordination of benefits ("COB"), establishes which plan pays first and which one pays second.

Primary plan and secondary plan….. The plan that pays first is known as the "primary" plan; the plan that pays second is known as the "secondary" plan. The primary plan will reimburse you first and the secondary plan will reimburse you for the remaining expenses up to the maximum of the allowable charges for the covered services. In no event, however, will the amount of benefits paid by the Local 295/Local 851 Employer Group Welfare Fund exceed the amount which would have been paid if there were no other plan involved.

Should file claims with both….. If you have coverage in two plans, you should file claims with both so that you receive all the benefits available to you. When you submit claims to the Local 295/Local 851 Employer Group Welfare Fund, you must include information about other coverage available to you. The Welfare Fund will then be able to coordinate your benefits with your other coverage.

When there is more than one coverage, the plan that is primarily responsible for paying a participant's medical expenses is the "primary" plan. As the primary Plan, it pays benefits first before any other insurer. Plans that pay after the primary plan are "secondary."

The primary/secondary rules….. Here are the rules for determining when a plan is primary or secondary:

- If one of the two plans does not have coordination-of-benefits provisions, it is the primary plan.
- The plan covering a person as an employee is the primary plan for that person.
- The plan covering a person as a dependent is the secondary plan for that person.
- The Local 295/Local 851 Plan is always the secondary plan for any eligible retiree or dependent who has coverage provided or available through their employer or another multiemployer welfare plan, even if they have to pay for the coverage.
- If a dependent child is covered by both parents' plans, the birthday rule applies. The plan of the parent whose birthday occurs earlier in a calendar year is the primary plan and the plan of the parent whose birthday is later in the calendar year is the secondary plan.
- When the parents are divorced and there is a court decree that states that one parent is responsible for the child's health care expense, the plan of that parent will be the primary plan.
- If the parents are divorced or separated and there is no court decree, the plan of the parent with custody is primary and the plan of the parent without custody is secondary.
- If the parent with custody of the child has remarried, the plans should pay in the following order: 1) the plan of the parent with custody; 2) the plan of the step-parent; 3) the plan of the parent without custody.

Automobile insurance coverage….. Group or individual automobile insurance coverage that provides medical coverage, including no-fault insurance, is always considered as primary coverage, and this Plan will only provide secondary coverage regardless of whether an individual actually enrolls in the automobile insurance medical coverage. This means that, even if an active employee or a retiree or a dependent opts out of the medical coverage available under his or her automobile insurance policy, the Plan will only provide coverage to that individual to the extent it would have if the individual had not opted out of the available automobile insurance medical coverage.

Coverage coordinated with Medicare….. The Welfare Plan applies the Medicare Secondary

(continued on page 2)

(COB – continued from page 1)
Payer program rules to determine how its benefits are coordinated with the benefits of Medicare. If a Medicare-eligible person is covered under the Plan during a period when Medicare is the individual's primary carrier, Medicare will pay its full benefits before any payment will be made under the Welfare Fund.

Medical benefits account….. Any benefits that may be paid from the Local 295/Local 851 Employer Group Pension Trust Fund will not be paid a second time by the Welfare Fund.

Questions….. Please contact the Local 295/Local 851 Employer Group Welfare Fund Office if you have any questions about the coordination of benefits regulations. The Fund Office is located at Sixty Broad Street, 37th Floor, New York, New York 10004. The telephone number is (212) 308 4200. ■

IS YOUR BENEFICIARY DESIGNATION UP TO DATE?

Most of the participants who are covered by the Welfare 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. When a covered member dies, however, the death benefit and life insurance proceeds have to be paid to the person who has been designated as the beneficiary.

Unfortunately, some of the covered members have not kept their beneficiary designations up to date. For example, a member may not have been married when originally enrolling in the Plan and designated a friend or a family member as beneficiary. If the member later gets married and doesn't change the beneficiary designation and dies, the Welfare Fund would have to pay the designated beneficiary instead of the spouse.

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. ■

HEALTH PLANS COVER ACTIVE & RETIRED UNIFORMED SERVICE MEMBERS & VETERANS

The United States Department of Veterans Affairs (VA) is responsible for the administration of a number of programs that range from Burial to Vocational Rehabilitation. Among the dozen or so programs are two health care plans. The plans are known as TRICARE and CHAMPVA. All uniformed services personnel and veterans should sign up for their VA health plan even if they have other coverage such as Medicare or an employer-sponsored plan. Everyone has to register to get the coverage and no premium payments are required. The coverage is free to everyone who qualifies.

TRICARE program…..TRICARE is the health plan of the U.S. Department of Defense. It is available to active duty service members and retirees of the seven uniformed services, their family members and survivors. The uniformed services include the U.S. Army, Air Force, Navy, Marines and Coast Guard and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Association.

TRICARE covers active duty service members and their families, children, dependent parents and parents-in-law, families of court martialed personnel and personnel missing in action, foreign force members and their families, medal of honor recipients and their families, National Guard and Reserve members and their families, retired service members and their families, including Medicare eligible persons. TRICARE provides coverage for medical care, prescription drugs, dental and vision care and mental health.

Eligible persons must register in the Defense Enrollment Eligibility Reporting System. Information about TRICARE and registering in the Defense Enrollment Eligibility Reporting System can be obtained on the TRICARE website at http://www.tricare.mil/. The office address is Skyline 5, Suite 810, 5111 Leesburg

(continued on page 3)

(Health Care – continued from page 2)
Pike, Falls Church, Virginia 22041-3206.

The CHAMPVA program….. The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries. All veterans are potentially eligible. Eligibility is based solely on active service in the Army, Navy, Air Force, Marines or Coast Guard (or Merchant Marines during World War II) and having been discharged other than dishonorably.

Reservists and National Guard members who were called to active duty by a Federal Executive Order may qualify for VA health care benefits. Returning service members, including Reservists and National Guard members who served on active duty in a theater of combat operations have special eligibility for hospital care, medical services and nursing home care for two years following discharge from active duty.

Veteran's health care is not just for service-connected injuries or medical conditions and the health care facilities are not just for men only. The VA offers full-service health care to women veterans. Also, some dependents of veterans may be eligible for CHAMPVA benefits. They are:

- The spouse or child of a veteran who has been rated by a VA regional office as permanently and totally disabled due to a service-connected disability;
- the surviving spouse or child of a veteran who died from a VA rated service connected disability;
- the surviving spouse or child of a veteran who was, at the time of death, rated permanently and totally disabled from a service connected disability; or
- the surviving spouse or child of a military member who died in the line of duty.

In general, the CHAMPVA program covers most health care services and supplies that are medically and psychologically necessary. Veterans are required to complete an annual means test or agree to pay the VA the applicable co-payments. The means test is based on the family's income and net worth.

Veterans are also requested to provide health insurance information. The VA is required to submit claims to insurance carriers for treatment of all non-service-connected conditions. All reimbursements from insurance carriers are retained at the VA health care facility where treatment was received. These funds are used to provide additional health care services to all veterans.

Veterans are never responsible for any unpaid balance that the insurance carrier does not pay except for co-payments that the veterans may have to make when they receive services.

CHAMPVA is managed by the United States Department of Veterans Affairs Health Administration Center. Call them, toll free, at 1 800 733 8387, Monday through Friday from 8:00 A.M. to 7:30 P.M., Eastern Time. You can also visit the VA's website at http://www.va.gov/ which is available 24 hours a day and 7 days a week. ■

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.

(continued on page 4)

(WHCRA – continued from page 3)

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 breast reconstruction. Your 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 under the terms of the Plan. ■

ELIGIBLE FOR MEDICARE? NOT ENROLLING CAN BE EXPENSIVE

If you are covered by Medicare and the Local 295/Local 851 Employer Group 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.

Higher Part B premium….. If you don't enroll for Medicare coverage when you're first eligible, your Part B premium can cost you 10% more for each year you delay. Delayed enrollment also delays the start of your coverage and increases the risk of paying for medical expenses out of pocket. You can postpone enrolling in Part B without penalties or a delay in the start of coverage only if you are active at work and still covered by an employer-sponsored plan.

Didn't enroll? You won't qualify for Part B reimbursement….. You will miss out on the Part B premium reimbursement if you don't accept Medicare coverage. If you are eligible for Part B of Medicare, you can apply for reimbursement of the Medicare premium up to $93.50 a month. Part B premium amounts that are higher than $93.50 per month cannot be reimbursed. The same rules apply to disabled persons on the retirement rolls as well as those who qualify for Medicare at age 65.

Still active at work….. If you are covered by the Welfare Fund because you are still active at work or because your spouse is still active at work, your employer-sponsored plan is the primary payer of claims and Medicare is the secondary payer. Medicare refers to these rules as the Medicare Secondary Payer Program. This means the employer plan will pay first on your covered bills and then Medicare will review the charges and payments to determine if any balances can be covered. ■

LOCAL 295/LOCAL 851 IBT EMPLOYER GROUP PENSION TRUST FUND AND EMPLOYER GROUP WELFARE FUND
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