FOR YOUR BENEFIT

THE LOCAL 295/LOCAL 851 EMPLOYER GROUP BENEFIT FUNDS NEWSLETTER
VOL. VIX, ISSUE 3, OCTOBER, 2010

FREE COVERAGE IF YOU QUALIFY FOR FMLA LEAVE You may be entitled to have contributions made on your behalf while you are on an approved leave under the terms of the Family Medical Leave Act of 1993 (FMLA). Under FMLA you could be eligible for a maximum of 12 work weeks of unpaid leave during any twelve-month period because of:

- the birth of a child and to care for the child;
- placement of a child with you for adoption or foster care;
- the need to care for a parent, child or spouse with a serious health condition; or
- your inability to perform the functions of your position because of a serious health condition.

Must have 50 or more employees . . . This federal law applies to employers with 50 or more employees.

You must apply to your employer and provide the reason or reasons for requesting the leave. If your employer is covered by the FMLA and if the leave you wish to take is covered by the FMLA, the leave should be approved.

If you are approved for family medical leave, your employer must continue to make payments to the Welfare Fund on your behalf even if your leave is unpaid. Your benefits must be continued at the level of coverage that you would have received as an active employee.

If you should qualify for a leave and then inform your employer that you are not returning to work, the Welfare Fund will consider your employment as having been terminated, your coverage will cease and you will be eligible to begin COBRA continuation coverage. ■

MAIL ORDER PROGRAM SAVES TIME AND MONEY When you need to have a prescription filled, you have two choices.

Choice number one . . . You can take the prescription to any one of the more than 50,000 participating drug stores, pay a co-payment and get a thirty day supply of the drug.

Choice number two . . . You can order your prescription through the mail order program. The amount of your co-payment is the same. The difference is that you will get a ninety day supply of the drug instead of a thirty day supply.

The co-payments . . . Three levels of co-payment are in effect. If you get a generic drug, the co-payment is $10. If you get a preferred brand-name drug, the co-payment is $25 and if you get a non-preferred brand-name drug, you have to pay $40. Your co-payments are $2 more if you get your prescription filled at CVS, Eckards or Walgreens.

Remember, you get a thirty-day supply of your drug when your prescription is filled at a drug store and you get a ninety-day supply of the drug through the mail order program for the same amount of co-payment.

You save from $20 to $80 for a three-month supply of your drugs by using the mail order feature of your prescription drug plan and those three trips to the drug store get reduced to one trip to the mail box.

Specialty drug co-payment . . . Specialty drugs are high-cost medications for people with complex chronic conditions such as rheumatoid arthritis, hemophilia, cancer and multiple sclerosis. The prices of these drugs range from several hundred to several thousand dollars. Prior to the program change, patients needing specialty drugs had to buy the drugs and then file a major medical claim with the Welfare Fund. The covered expense was subject to the major medical deductible and the rate of payment was 75% after the $400 deductible was satisfied.

Now, the only patient out-of-pocket expense for a specialty drug is a $50 co-payment for a three-month supply.

Specialty drugs are only available through a pharmacy or through the pharmacy benefit manager. The pharmacy benefit manager is Broadreach Medical Resources, Inc. (BMRx). The address is 1350 Broadway, Suite 1901, New York, New York 10018. The Broadreach Medical Resources' telephone number is 1 866 718 2375.

(continued on page 2)

MAIL ORDER PROGRAM . . .
(continued from page 1)

If you need specialty drugs, call Broadreach toll free today and ask how they can save you money on your specialty drug needs. ■

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 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. ■

PENSION FUND REMAINS IN CRITICAL STATUS The Local 295/Local 851 Employer Group Pension Fund was again certified critical for the plan year of July 1, 2010 to June 30, 2011.

Critical is one of the several categories established by the Pension Protection Act of

2006 and the Pension Fund Equity Act.

The federal legislation changed the Funding rules and when that is added to the impact of an eroding and erratic investment market, the Plan has been pushed to the critical status.

Rehabilitation plan has been in place . . . The first report of critical status was for the plan year that started on July 1, 2008.

When the Pension Fund's status first became critical the Board of Trustees and the Fund's advisors were required to set up a rehabilitation plan. Keep in mind that it is a long-term plan that will be carried out over a period of up to thirteen years. The rehabilitation plan includes increases in the rates of employer contributions and some reductions in benefits. That rehabilitation plan is still in place. It will be reviewed and modified as necessary.

Retirees' and beneficiaries' benefit payments won't change . . . All benefit payments will continue unchanged for all of the retirees and beneficiaries who were on the payment rolls as of May 20, 2009. Payments will not be cut back for any of the persons who were receiving pension benefits as of that date.

Current assets are enough to pay benefits for fifteen or more years . . . The Pension Fund has enough assets to continue paying all of its monthly benefit obligations for at least the next fifteen years even if the Fund did not receive any more employer payments or earnings on investments.

And, the fund is *NOT* insolvent . . . A pension fund is considered to be insolvent in a year only if it doesn't have enough assets to pay benefits for that plan year. ■

COVERAGE NOW PROVIDED FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS We are pleased to announce that the Local 295/Local 851 Employer Group Welfare Fund provides coverage for Physician Assistants and Nurse Practitioners as of September 14, 2010. These two health care professions came into existence because of the shortage and uneven geographic distribution of primary care physicians in the United States.

Physician Assistant . . . A Physician Assistant or Physician Associate (PA) is a healthcare professional

(continued on page 3)

COVERAGE NOW PROVIDED . . .
(continued from page 2)

licensed to practice medicine with the supervision of a licensed physician.

A PA is concerned with preventing, maintaining and treating human illness and injury by providing a broad range of health care services that are traditionally performed by a physician. PAs conduct physical examinations, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery and write prescriptions.

PAs are educated in the medical model designed to complement physician training, rather than in the nursing model as Nurse Practitioners are. The profession is represented in the United States by the American Academy of Physician Assistants.

Nurse Practitioner . . . A Nurse Practitioner (NP) is an advanced practice nurse who has completed graduate-level education and training in the diagnosis and management of common as well as complex medical conditions.

To become licensed to practice, Nurse Practitioners hold national certification in an area of specialty (family practice, pediatrics, adult care, acute care, etc.) and are licensed through nursing boards rather than medical boards.

NPs see patients of all ages. The core philosophy of the field is individualized care. NPs treat both physical and mental conditions through comprehensive history taking, physical examinations, physical therapy and ordering tests and therapies for patients within the scope of their practice.

NPs can serve as a patient's primary health care provider and see patients of all ages depending on their designated scope of practice.

NPs' duties may include diagnosing, treating, evaluating and managing acute and chronic illness and diseases, obtaining medical histories and conducting physical examinations, ordering, performing and interpreting diagnostic studies, prescribing physical therapy and other rehabilitation treatments, prescribing drugs for acute and chronic illness and providing many other health care services that might ordinarily be performed by a primary care physician.

NPs are licensed by the state in which they practice and have national board certification. ■

DON'T JUST SIT THERE You may find this information so unusual that you feel inclined to sit down for a minute, but that's actually the opposite of what you should do. A study published in the *American Journal of Epidemiology* suggests people who spend more time sitting (specifically, more than six hours a day) during leisure time have an increased risk of premature death compared to those who sit for three hours or less, and the results are independent of exercise

When you sit for long periods of time, usually with little or no movement, it negatively affects circulation, metabolism, resting blood pressure and cholesterol, among other things. And more time sitting, especially in front of the TV, computer, etc., often contributes to excessive snacking (all too often the unhealthy variety) which can lead to obesity and weight-related disorders such as diabetes.

"Sit less, move more" is a great message to store in your memory bank and recall on a daily basis. Anytime you start to feel stuck to your chair, peel yourself away and add a little motion (and a few years) to your life.

Talk to your doctor about the health dangers associated with prolonged sitting (especially its impact on the spine and posture) and how you can sit less and live longer. ■

GET DIABETIC SUPPLIES FROM PARTICIPATING PROVIDERS TO SAVE TIME AND MONEY If you are diabetic and you are buying your supplies from the local drug store or other supplier, you have to shop for the supplies, pay for them and then file a claim with the Welfare Fund Office.

Diabetes supplies purchased at a drug store or other out-of-network supplier are covered by the major medical part of the Welfare Fund.

You first have to meet an annual deductible of $400 and then the Plan pays 75% of the covered charges that are over and above the deductible. If your total expense is $500, you would be reimbursed just $75 for $500 of cost.

If you use the network, your out of pocket expense is nothing . . . When you order your supplies from one of the network providers, there is no out-of-pocket expense. You do not have to pay a co-payment, you do not have pay an annual deductible, you do not have to pay a percentage of the cost and you do not have to file a claim.

(continued on page 4)

LOCAL 295/LOCAL 851 IBT EMPLOYER GROUP PENSION TRUST FUND AND EMPLOYER GROUP WELFARE FUND
Sixty Broad Street, 37th Floor
New York, New York 10004

GET DIABETIC SUPPLIES . . .

(continued from page 3)

There are numerous companies selling diabetes supplies that are part of the Blue Cross preferred provider network. Among the network suppliers are:

- Edge Park Surgical — 800 321 0591
- Liberty Medical Supplies — 800 705 5797
- Apria Healthcare, Inc. — 800 277 4288

You can still buy your diabetic supplies at a drug store but keep in mind that it will cost you some out of pocket expense for the major medical deductible and the 25% co-insurance. And, you'll have to file a claim for reimbursement.

Why aren't you saving some cost and getting your diabetic supplies from a Blue Cross participating provider? ■

THE COVERAGE GAP CONTINUES TO WIDEN FOR SERVICES OF EMERGENCY ROOM DOCTORS We reported in previous issues of this newsletter that most emergency room (ER) doctors are not in the Blue Cross preferred provider network. As a result, the charges of those ER doctors are paid as out-of-network claims under the major medical coverage. This leaves the patient to pay a part of the doctor's bill out of pocket.

The doctors' billings have continued to increase while the extent of coverage has been limited to a percentage of the permissible plan charges. If the case is not an emergency situation such as an accident, the patient is responsible for a $400 deductible and then the Welfare Fund pays 75% of the remainder of the permissible plan charges.

The Welfare Fund gets a lot of complaints and appeals about the balances the patients have to pay for the services of ER doctors. The choice is yours. If you go to the emergency room instead of your doctor, you should then be prepared to pay out of pocket. ■

NEED INFORMATION? If you need some information about your Welfare Fund or Pension Fund, call or visit the Fund Office. The Benefit Fund Office is located in the financial district of Manhattan at Sixty Broad Street, 37th Floor, New York, New York 10004. The telephone number is (212) 308 4200. The office hours are Monday through Friday, 9:00AM to 5:00 PM, except for holidays. ■

TRY DIRECT DEPOSIT Direct deposit or electronic funds transfer (EFT) is the way to make sure that you receive your pension benefit on time. Direct deposit eliminates the chances of lost or stolen checks.

You don't have to wait for the mail delivery, you don't have to fill out a deposit slip, you'll make less trips to the bank and you won't have to wait for cleared funds in your account.

Call the Pension Fund Office at 212 308 4200 and ask for a direct deposit form. After you sign up for direct deposit, you'll receive one more check in the mail while we send test information to your bank. After that, your benefit will be in your account on the first business day of every month. ■
