FOR YOUR BENEFIT

THE LOCAL 295/LOCAL 851 EMPLOYER GROUP BENEFIT FUNDS NEWSLETTER
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COORDINATION OF BENEFITS (COB) or, WHICH PLAN PAYS FIRST?

If you or your family members have coverage in more than one health plan you should be familiar with the term COB or coordination of benefits.

Coordination of benefits rules determine which health plan pays its benefits first and which plan pays second. COB was created to make sure that together the health plans do not pay more than 100% of any claim.

The COB rules are uniform throughout the United States and its territories. They were developed by the National Association of Insurance Commissioners.

Should I file claims with all of the plans...? If you have coverage in two or more health plans, you should file claims with all of them so that you receive all the benefits available to you.

When you file claims with the Local 295/ Local 851 Welfare Fund, we will always ask you for information about any other coverage being in effect so that it can be determined if the other coverage is primary or secondary. The Welfare Fund will then be able to coordinate its benefit payments with the other coverage.

When claims are filed for your spouse or any covered adult son or daughter, very often other coverage is in force and most of the time that other coverage is primary and will have to pay the claim before your Welfare Fund can process it.

This COB process saves your Welfare Fund a lot by coordinating its claim payments with the payments of other benefit programs.

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 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 your Welfare Fund 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 Fund applies the Medicare Secondary Payer program rules to determine how its benefits are coordinated with the benefits of Medicare. If you have any questions about coordination of benefits, please contact the Welfare Fund Office at 212.308.4200.

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 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.

THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (the Affordable Care Act or ACA) has been in the news almost every day recently. The Welfare Fund Office is getting some questions about how the ACA affects the persons who are covered by the Welfare Fund and whether or not they need to do anything to comply with the ACA. The answer to that question is: As long as you remain eligible in the Welfare Fund you do not have to do anything whatsoever to comply with the ACA.

Many of the ACA requirements don't begin until 2014. One component that's been in place since 2010 is the grandfathered and non-grandfathered health plan status. Your Welfare Fund is considered to be a grandfathered plan. Grandfathered plans are subject to some, but not all, portions of the ACA. Grandfathered plans are those that were in effect before March 23, 2010. They are allowed to offer the coverage they did before the ACA. A grandfathered plan might not include certain benefits or consumer protections that non-grandfathered plans are required to include. A few examples of this are:

- Grandfathered plans are not required to cover all preventive services without any cost sharing.
- Grandfathered plans are not required to cover all of the benefits the ACA has deemed to be "essential," such as certain types of testing and treatment.
- Grandfathered plans have different appeal rights. The ACA has added some benefits to both grandfathered and non-grandfathered status plans, including:
- No lifetime or annual dollar limit on benefits.
- Dependent coverage for adult children until they become age 26, subject to certain limitations.

Your Welfare Fund includes a number of valuable benefits that far exceed the ACA requirements.

For example, you and your dependents have an excellent dental program and coverage for eye glasses and routine examinations. You also have coverage for life insurance and death benefits.

You will not qualify for subsidy. Since the Welfare Fund is not one of the health benefit plans being offered through the ACA Marketplace, you cannot qualify for the ACA subsidy, even if you are paying for your Welfare Fund coverage out of pocket.

If you have any questions about grandfathered health plans you can call the Welfare Fund Office at 212.308.4200 or the Employee Benefits Security Administration, U.S. Department of Labor, at 1.866.444.3272. You can also go to the website of the Department of Labor. The address is: www.dol.gov/ebsa/healthreform

SOME CHANGES IN RETIREE COVERAGE AND COST

Earlier in 2013, the Welfare Fund mailed out Summaries of Material Modification (SMM) to all of the retirees who are covered by the Local 295/Local 851 Employer Group Welfare Fund.

One of the SMM's announced that certain changes would take place in the coverage of persons who are on Medicare and the other SMM announced that it has become necessary to increase the monthly cost of coverage for the retirees and eligible dependents who have not reached Medicare age. These changes go into effect on January 1, 2014.

The Board of Trustees and the professional staff in the Fund Office have constantly strived to control the rising costs of health care. Unfortunately, while the Consumer Price Index (CPI) was increasing at the rate of 2-1/2 or 3 percent a year, health care costs have been jumping up at the rate of 8 to 10 and even 12 percent per year. The skyrocketing medical costs have been cause for a lot of concern. Because of the dramatic cost increases, the Welfare Fund had to impose some monthly charges for retirees to continue their coverage. Originally, the cost was $200 per person per month for those who were also covered by Medicare and $300 per month for those persons who have not reached Medicare age.

Medicare covered persons... The cost for Medicare-covered persons is not increasing. The Board of Trustees, with the assistance of the Fund Actuary, has taken some steps to help keep that cost level. As of January 1, 2014 all of the retirees and eligible dependents who are on Medicare will be covered by the Blue Cross/Blue Shield Medicare Advantage Plan. The details of the coverage are listed on a chart that was sent out with the SMM. The Medicare-eligible retirees will also continue to be eligible for the full dental coverage provided through DDS, Inc., the prescription drug program provided though BMRx, and death benefits. Medicare covered persons must continue to pay their Medicare Part B premium.

Persons who are not on Medicare... For those persons who are not on Medicare, the cost, unfortunately, has to be increased from $300 per month to $375 per month. The plan of benefits remains the same. It includes Blue Cross/Blue Shield coverage for hospital, medical, surgical, laboratory and X-ray services, prescription drugs through BMRx, the full dental services plan through DDS, Inc., eyeglasses and routine examinations and death benefits.

You may opt out... Along with the SMM's the Welfare Fund Office provided opt-out forms. If any of the retirees wishes to opt out of the Welfare Fund's coverage he or she may do so by completing the form and sending it to the Welfare Fund Office. If you do opt out of the Welfare Fund's coverage, you can return to the plan at a later date. To do so, you will have to provide evidence that you had creditable coverage throughout the time you were not covered by the Welfare Fund.

Questions? If you have any questions about these changes, call the Welfare Fund Office at 212.308.4200

DID YOU ENROLL IN WELLNESS – THE RIGHT WAY – FOR YOUR BENEFIT?

You didn't enroll yet? Why are you waiting? You could have been getting the benefit of this innovative program for the past year!

Enrollment is easy...

You can enroll in "Wellness – The Right Way – For Your Benefit" by calling 1.877.834.4596 or you can enroll via the internet at: http://wellnesstherightway.hmcportal.com

Wellness – The Right Way – For Your Benefit will provide you with ways to maintain and improve your health.

You can get help with weight management, exercise and activity, smoking cessation, healthy eating and nutrition, stress management, heart disease prevention, diabetes education, blood pressure management, back care and managing high cholesterol.

It won't cost you anything. Even the telephone call is free. Go ahead – make the call while you're still thinking about it! Call 1.877.834.4596

LOCAL 295/LOCAL 851 IBT EMPLOYER
GROUP PENSION TRUST FUND AND
EMPLOYER GROUP WELFARE FUND
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HIGH BLOOD PRESSURE AND CHOLESTEROL OUT OF CONTROL – SILENT KILLERS

Every 39 seconds an adult dies from heart attack, stroke or other cardiovascular disease.

Nearly 68 million people have high blood pressure but 1 out of 2 doesn't have it under control. 71 million US adults have high cholesterol but 2 out of 3 don't have it under control.

Heart disease, stroke, and other cardiovascular diseases are among the leading causes of death and now kill more than 800,000 adults in the US each year. Of these, 150,000 are younger than age 65.

These diseases are also two of the leading causes of health disparities in the US. Treatment of these diseases accounts for 1 in every 6 US health care dollars spent. Two main reasons people have heart disease or stroke are high blood pressure and high cholesterol, which are common, very deadly and very preventable.

The number of adults with high cholesterol and high blood pressure who don't have their condition under control is increasing. Clearly, more steps are needed to gain control of these health risks.

Improved care could save more than 100,000 lives a year...

Why is control difficult to achieve? More than 80% of people who don't have their blood pressure or cholesterol under control actually have health insurance.

Not only do individuals need to be continually checked for these conditions, they also need good, affordable treatment along with regular follow-up care.

Many people, unfortunately, don't have regular access to medical care, prescription medications or lifestyle counseling. Your Welfare Fund provides coverage for all of these services.

Some people don't go back to the doctor when they should. This makes it difficult to control their blood pressure and cholesterol. About 1 out of 2 adults will stop taking cholesterol medicine.

People get 77% of their sodium (mostly salt) from eating processed or restaurant foods, which can raise blood pressure. Even people who want to eat low-salt foods may have trouble finding them in grocery stores or on restaurant menus.

Trans fat found in fried and processed foods such as cookies and donuts can raise cholesterol, contributing to heart disease and stroke. Only 1 in 5 Americans lives where there are policies that eliminate artificial trans fat from restaurant foods.

Everyday decisions can help keep a heart healthy. These include not smoking, eating right, exercising, and taking prescription medicines. One important decision is to make an appointment with your doctor.

How are your numbers? Do you know if your blood pressure is too high? Do you know if your cholesterol is too high? You can find out by paying a visit to your doctor.

Get your numbers checked and don't find out the hard way that you have high cholesterol and high blood pressure.

Neither of these health problems present any symptoms. When they get too far out of control, they simply sneak up on you and kill you.