



Always on call

MedExpert delivers
quality health care
advice over the phone

Doctors can't always be by your side when you need advice, but thanks to MedExpert, you can receive expert medical advice from on-call doctors right over the phone, in a matter of minutes.

MedExpert is a benefit available to PPO Members to help them and their families get answers to basic health questions at no extra cost. You can call to speak to a doctor regardless of your current health status.

(Please see page 4)

FOR YOUR BENEFIT

is a newsletter designed to keep all Members informed about how to use their benefits most effectively. Members also may contact their Union's Benefit Clerks or call the Trust Fund office directly at (800) 552-2400. Phone hours for the Trust Fund office's Health and Welfare Services Department are 7:30 a.m.-5:30 p.m., Monday-Friday. Or visit us online at www.ufcwtrust.com.

¿Le gustaría una versión en Español de este boletín de noticias? Would you like a Spanish version of this newsletter?

Visite www.ufcwtrust.com, haga clic en el menú de Recursos y seleccione formas para elegir un tema.

Visit www.ufcwtrust.com, highlight the Resources menu and select Forms to choose an issue.

UFCW TRUST
Working For Your Benefit
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Using your mental health and chemical

The Employee Member Assistance Program (EMAP) is available to help Members and their eligible dependents manage their personal issues. If you or a loved one is dealing with matters related to marriage or family, raising children, elderly care, chemical dependency, stress, depression, anxiety, legal, financial or other types of emotional or mental health issues, EMAP is here to help.

Benefits for all mental health and chemical dependency needs for PPO Participants are provided through Health Management Concepts (HMC). **For HMO Participants, mental health and chemical dependency treatment is provided by your HMO, not through HMC.**

How do I use EMAP benefits?

Please note: All information shared with EMAP is confidential and will

not be shared with a Member's Union or Employer.

To use your EMAP benefits, we strongly encourage you to first call an HMC/APS counselor at (877) 845-7440. A counselor is available 24 hours a day, seven days a week. The counselor will refer you to a qualified provider for your specific concern.

Remember: As of January 1, 2014, no Pre-authorization is required for Outpatient treatment and annual maximums have been removed. Pre-authorization is still required for Inpatient Treatment, Residential Treatment, Partial Day Treatment, Intensive Outpatient Treatment, Psychological Testing and Electroshock Therapy.

EMAP PROVIDER NETWORK

The HMC/APS network of providers should be used in order to receive the highest level of benefits



For Your Benefit is the official publication of the UFCW & Employers Benefit Trust. Every effort has been made to provide correct and complete information regarding particular benefits, but this newsletter does not include all governing provisions, limitations and exclusions, which may vary from Plan to Plan. Refer to the Summary Plan Description, Plan Document, Evidence of Coverage and/or Disclosure Form ("Governing Documents") for governing information. In the event of any conflict between the terms of this newsletter and the Governing Documents, the Governing Documents will control. As always, the Board of Trustees for the UFCW & Employers Benefit Trust retains the sole and complete discretionary authority to determine eligibility and entitlement to Plan benefits and to construe the terms of the Plans. The information in these articles is for general use only and should not be taken as medical advice. In an emergency, you are advised to call 9-1-1.

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Glossary

OUT-OF-NETWORK PROVIDER

A provider who doesn't have a contract with your health insurer or Plan to provide services to you. In most instances, you will pay more to see an Out-of-network provider.

OUT-OF-POCKET LIMIT

The most you pay during a policy period (usually a year) before your health insurance or Plan begins to pay 100 percent of the allowed amount for services.

PRE-AUTHORIZATION

A decision by your health insurer or Plan determining a health care service, treatment Plan, prescription drug or durable medical equipment is medically necessary. The terms prior authorization, prior approval or precertification are sometimes also used.

ical dependency benefits



through the EMAP program. When you use a provider outside of the HMC/APS network, including a Blue Shield PPO provider, you will receive Out-of-network benefits.

WHAT ARE MY EMAP BENEFITS?

- **Initial Outpatient assessment visits**

Initial assessment visits are visits to assess your condition and the need for care. There is no cost to you for using up to three assessment visits when you use an HMC provider. Benefits for Assessment Services from a psychiatrist and/or non-HMC provider will be paid as an outpatient mental health “session” subject to your deductible and coinsurance.

- **Outpatient mental health and chemical dependency coverage**
Subject to your annual calendar year deductible and coinsurance; no Pre-authorization is required.

- **Inpatient mental health and chemical dependency coverage**

Paid as any other hospital admission, subject to annual calendar year deductible and coinsurance; Pre-authorization is required.

- **Medication management**

Benefits for mental health medication management visits for the following conditions are paid outside of the EMAP program when provided by an Out-of-network HMC provider:

- Children with Attention Deficit Hyperactivity Disorder (ADHD)
- Adults with chronic, mild depression and anxiety
- Women with post-partum depression who received short-term anti-depressant medication from the obstetrician during a post-partum visit
- Adolescents with bulimia or anorexia nervosa who are prescribed anti-depressants by their treating physicians

This means if you are seen by a Blue Shield primary care physician for medication management for any of the above conditions, the Plan will pay at the in-network level of benefits. Out-of-network benefits will apply to Out-of-network providers.

ONLINE RESOURCES

You can access the EMAP site through the Trust Fund’s health management website, ufcwtrust.com, under “Resources” and “Find A Provider.” The EMAP site offers many additional resources for Members. It has articles dealing with adoption, caring for infants and toddlers, personal growth, grief and loss, and more.

Members with aging parents can find materials on senior health, adults with disabilities, and housing options for seniors, and other topics. When visiting the site, enter the code UFCWEBT.

Reminder: Sick-Leave payouts

If you have the maximum of 360 hours in accumulated Sick-Leave as of December 31 in any calendar year, you may be eligible for a payout. The maximum payout is \$400 per year, less \$10 for each hour of Sick-Leave used in the calendar year.

To be eligible for the payout, **you must be employed as an Active Member on December 31 of the calendar year for which the payment is made.** Even though you receive the payout, no Sick-Leave hours are deducted from your account.

You do not need to file a claim for the Sick-Leave payout – the payout will be made to eligible Members as soon after the end of the year as is administratively feasible, usually by March 31.

Please note: Payout checks will be held if a Member who is required to complete Open Enrollment has not yet done so, or if a Member’s address has not been updated.

MedExpert: Health advice over the phone

(Continued from front page)

MedExpert is an Individual Medical Decision Support (IMDS) service providing current, accurate and unbiased information on more than 22,000 recognized medical conditions and more than 16,000 pharmaceuticals.

The qualified MedExpert staff is happy to help with any health matter, large or small, and can help interpret test results, access medical research or assist with any type of inquiry.

Considering treatment options? Not sure about surgery? They're here to help.

MEDEXPERT SUCCESS STORIES

A Trust Fund Member learned he had a blood clot in his lung and needed help interpreting test results. He called MedExpert and his doctor networked with other physicians to discuss treatment options.

"To know you have a valuable resource like this at your disposal is invaluable," the Member said. "It enabled my wife and me to make decisions regarding my treatment based on facts."

Another Member had severe dizzy spells, which impaired her ability to drive. She contacted a MedExpert doctor who then gained access to her medical files. He consulted with neurologists and determined her dizzy spells were caused by chronic dehydration.



"I was struck by his compassion," she said. "It's unbelievable. It worked and now I only have problems on the days I forget to drink enough water."

Don't speak English? No problem. MedExpert is available in other languages as well.

MedExpert is not a substitute for treatment and should be used in

conjunction with a treating physician.

MedExpert is a safe and secure option for you and your family's medical needs. You can call them at (800) 999-1999 from 7 a.m. to 7 p.m., Monday through Friday, or email support@medexpert.com. You can also visit them online at medexpert.com.

OPEN ENROLLMENT REMINDER

Open Enrollment (OE) for the 2015 Plan Year ended on September 30, 2014. If you made changes during the OE period, your new Plan benefits will go into effect on January 1, 2015. If you did not make any changes, your current coverage elections will carry forward into the 2015 Plan Year.



ER vs. Urgent Care: Know the difference

Emergency rooms exist to help people when they suffer a major traumatic event like a heart attack, stroke or accident. It is not appropriate to visit an ER for less-serious reasons.

The misuse of ERs can be costly for Members and for the Fund. The average cost of an ER visit is much higher than a regular visit to a doctor. Fortunately, timely and affordable care for non-emergencies is available elsewhere.

If you suffer a minor cut or burn, or if a child is experiencing an earache, call your primary care doctor. Many have extended hours and same-day appointments to treat ailments quickly.

Urgent Care centers are also available to provide fast care, and they too are often at convenient locations.

In an emergency situation, you should always call 9-1-1 or visit an emergency room. However, if you feel your condition could be treated by your primary care provider or at an Urgent Care center, take advantage of those options to keep our Fund healthy for the future.

If you are not sure whether a primary care physician, Urgent Care or ER is the right place to be seen, call your primary care or after-hours advice nurse or on-call doctor.

If your primary care physician does not have an on-call advice line, Blue Shield PPO members can obtain advice by visiting ufcwtrust.com. Select "Find A Provider" from the "Resources" pulldown menu on the homepage, and select the appropriate link under "Blue Shield of California." Kaiser members can call (800) 464-4000.





Reminder of Plan changes for Kaiser members

As of January 1, 2014, Kaiser Members should have noticed changes in how their Plan covers the cost of common medical events.

Prior to 2014, Members usually paid a fixed copay amount for common events such as a visit to their primary care doctor for an illness or a visit to a specialist. Beginning January 1, 2014, Members started to pay a certain percentage of coinsurance for these visits and others.

Coinurance is your share of the costs for a Covered Service, calculated as a percentage of the allowed amount for the service. For example, if the Plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. Health Care Partnership and Personal Direction Plan Members will be subject to a \$15 copay for acupuncture and chiropractic visits.

Note: You must pay for all of the costs for medical care up to your deductible before the Plan begins to pay for Covered Services you use. The deductible for Kaiser Health Care Partnership Plan Members is \$200 for

an individual and \$600 for a family. The deductible for Kaiser Members in the Personal Direction Plan is \$900 for an individual and \$1,850 for a family.

Here are some examples of costs for services with a commencement date of January 1, 2014:

HEALTH CARE PARTNERSHIP PLAN MEMBERS

HEALTH CARE PROVIDER OFFICE OR CLINIC VISIT

- **Primary care visit to treat an injury or illness**
Your cost is 15% coinsurance per visit, once your deductible has been met. Non-Plan Provider visits are not covered.
- **Specialist visit**
Your cost is 15% coinsurance per visit once your deductible has been met. Non-Plan Provider visits are not covered.
- **Preventive care, screenings and immunizations**
There is no cost for these services if you visit a Plan Provider, and the deductible is waived. Age and frequency guidelines apply to covered preventive care. Non-Plan Provider visits are not covered.

TESTS

- **Diagnostic tests (X-ray, blood work)**
Your cost is 15% coinsurance per encounter for X-rays and lab tests, once your deductible has been met. Non-Plan Provider visits are not covered.
- **Imaging (CT/PET scans, MRIs)**
Your cost is 15% coinsurance per procedure, once your deductible has been met. Non-Plan Provider visits are not covered.

IMMEDIATE MEDICAL ATTENTION

- **Emergency room services**
Your cost is 15% coinsurance per visit, once your deductible has been met. Non-Plan Provider visits are covered at the same rate.
- **Emergency medical transportation**
Your cost is 15% coinsurance per trip, once your deductible has been met. Non-Plan Provider trips are covered at the same rate.
- **Urgent care**
Your cost is 15% coinsurance per visit, once your deductible has been met.

Non-Plan Provider visits are covered at the same rate when outside the service area.

PERSONAL DIRECTION PLAN MEMBERS

HEALTH CARE PROVIDER OFFICE OR CLINIC VISIT

- **Primary care visit to treat an injury or illness**
Your cost is 20% coinsurance per visit, once your deductible has been met. Non-Plan Provider visits are not covered.
- **Specialist visit**
Your cost is 20% coinsurance per visit, once your deductible has been met. Non-Plan Provider visits are not covered.
- **Preventive care, screenings and immunizations**
There is no cost for these services if you visit a Plan Provider, and the deductible is waived. Age and frequency guidelines apply to covered preventive care. Non-Plan Provider visits are not covered.

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Your cost is 20% coinsurance per visit, once your deductible has been met. Non-Plan Provider visits are covered at the same rate when outside the service area.

For more information and to review additional coverage examples, Kaiser Members can review their most recent Summary of Benefits and Coverage.



OTHER INSURANCE INFORMATION

Enrolled Spouses* are required to enroll in their Employer's Group Health Plan

**Note: The term "Spouse" implies "Spouse or Domestic Partner" unless otherwise specified in this article.*

Open Enrollment for your Spouse's Employer Group Health Plan may begin soon. Therefore, keep in mind your Spouse enrolled in this Plan must enroll in their employer's group medical, prescription, vision and dental coverage if it is available through his or her own current or former employer. Your Spouse must enroll in the Plan most comparable to the UEBT Plan, regardless of the cost.

For the 2015 Plan year, if your Spouse is employed and does not have access to other group insurance, a signed letter on your Spouse's employer's letterhead must be mailed or faxed to the Fund Office before November 15, 2014. The employer letter must state what insurance (medical, prescription, dental or vision) is not offered to your Spouse. If the employer letter is not received at the Trust Fund office by November 15, 2014, this Plan will reduce the Spouse's benefits by 60% for the 2015 Plan year. This is also true if the Spouse declines the other group health insurance. Furthermore, claims for your Spouse will not have any Out-of-pocket maximum, even if they receive services from a PPO provider.

When enrolling a Spouse who has other group health insurance, the UEBT Plan is the secondary payer, and will coordinate with the primary Plan applying "Non-Duplication of Benefits" as the secondary payer. Please keep in mind the Trust Fund does not pay as the secondary payer on a HMO Plan. In general, the Plan will never pay more than if the Plan was primary. The Plan will pay the Plan's regular benefit minus the primary Plan's payment.



Dangers in your medicine cabinet

How to safely dispose of unwanted or expired prescription medications

Each year, more than 15,000 people in the United States die from overdoses of prescription painkillers. Teenagers are among those who abuse prescription medication most often, and about half of these teenage abusers obtain their drugs from friends or family members.

Sometimes, all it takes is opening a medicine cabinet.

Concerned parents and other family members can help control this hazard by becoming more aware of what is in their medicine cabinets and who has access to them.

Unfortunately, the presence of unused and expired medications can make this task more difficult. If you live in a household where a family member takes a large number of prescription medications, chances are some of the medications in your cabinet are no longer needed.

The Drug Enforcement Administration's National Take-Back Initiative helps people dispose of unwanted and expired medications.



“ Each year, more than 15,000 people in the United States die from overdoses of prescription painkillers. ”

Visit www.deadiversion.usdoj.gov/drug_disposal/takeback for more information. You can also visit www.awarerox.org/get-local/california for details on disposal locations near you.

Local law enforcement agencies also have databases to help you find the nearest collection sites to safely dispose of your medications.

Be aware, dispose of unwanted medication appropriately.