UFCW TRUST
Working For Your Benefit

FALL
2015
for Active
Members

The value of your benefits

This is the first of a three-part series of articles in which we compare your health benefits provided through the UFCW & Employers Benefit Trust (UEBT) with those available to other workers in the United States.

Part one examines the importance and cost of health benefits, how the Affordable Care Act has changed health care in America, as well as the number of Americans who don't have access to affordable, high-quality care at all.

Part two will look at what UEBT Members pay for specific Covered Services and compare those costs to what is paid by other covered workers across the country.

(Please see page 4)

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In This Issue

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 **UFCWTRUST.COM**.

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

Visite UFCWTRUST.COM, haga clic en el menú de Recursos y seleccione formas para elegir un tema. Visit **UFCWTRUST.COM**, highlight the Resources menu and select Forms to choose an issue.

Are you a PPO Participant who is also covered by an HMO plan?

If you or your covered Dependents have HMO coverage available through another employer and/or a previous employer, and receive services from an HMO provider within the HMO network, the UEBT Plan will **NOT** reimburse the HMO copayments or other out-of-pocket expenses required by the HMO.

In the case of a **Spouse/Domestic Partner covered by the UEBT PPO Plan** who is also covered by an HMO Plan, he or she is required to see an HMO provider for services. The UEBT Plan will not reimburse the HMO copayments or out-of-pocket expenses.

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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

Ambulatory Surgical Center

An Ambulatory Surgical Center is any freestanding outpatient surgical facility. It must be licensed according to state or federal laws and must meet all requirements and accreditation standards of an outpatient facility providing surgical services.

Custodial care

Custodial care is any care which does not require the services of trained medical or health professionals, such as helping a patient with walking, bathing, dressing, preparation of meals or supervision of medications.

Out-of-area

PPO level of benefits may be applied to services by a non-PPO provider **IF** there are no PPO providers within 40 miles of your home which could have performed the same service.

Is loneliness affecting you?

We live in a world where we are a click away from connecting with someone who is halfway around the planet, while connecting with others in our real-world communities can be more challenging than ever.

Loneliness affects people from all walks of life and at all ages. For many of them, this condition is more than an indication of an unfulfilling social life. It can be harmful for their physical health.

Lonely people tend to stay indoors and live sedentary lives in front of their television and computer screens. Prolonged sitting can lead to diabetes, high blood pressure and other health complications.

Fortunately, technology can provide an antidote for loneliness. Here are some useful online tools for breaking out of your shell:

- **Meetup.com.** Do you enjoy hiking or have a stamp or coin collection you want to show others? Would you like to meet up with other people who appreciate Star Wars as much as you do? **Meetup.com** is a place to find like-minded people in your city.
- **Craigslist.org.** The community forums on Craigslist also can help connect you with others in your town who enjoy the same activities. You can join groups, events and classes.
- **Social media.** Many communities have Facebook groups to help draw people together in the real world. It's easy to find a group or event and meet up with others for a night out.

Making other changes

As it is with most things in life, too much social media can be a bad thing. You may want to scale back your time spent with computers and gadgets and focus on how you interact with friends and relatives.

If you have a thought you'd like to share, you don't have to text it or post it. You can share it in a phone call or in person.

You can add meaning to your interactions by putting detail into your responses and encouraging conversation. For example, if someone asks how you're feeling, instead of saying "I'm good," try "My day is going great. How is yours?" Some interactions aren't meant to be long, but if it seems like the person you're talking to has the time, go for it.

Making the right choices with technology can alleviate loneliness in real life. Sometimes, the best choice can be to avoid technology altogether and strike up an old-fashioned conversation. It's up to you to choose the proper balance.

Sources

- **The Atlantic** (theatlantic.com)
- **Psychology Today** (psychologytoday.com)

Staying healthy with depression

If a doctor has diagnosed you with depression and you are taking medication to treat it, be sure you are getting the most from your treatment plan.

Here's some advice from experts:

- **Don't rush things.** Many of the antidepressant medications take time to produce results. This period can range from one month to nine months before you receive the maximum benefit.
- **Don't stop taking your medications once you start feeling better.** Unlike short-term drugs used to treat colds or allergies, your antidepressant medications require close adherence to the prescribed dosage and frequency.
- **Keep a schedule and keep in touch.** To ensure you get the most from your treatment plan, take your medications at the same time each day to avoid missing doses. Keep up with your routine therapy appointments, if applicable, and check in regularly with your doctors to update them on your progress.

The value of your benefits Part 1: Costs of coverage

(Continued from front page)

Part three will explore how your UEBT benefits compare to those offered at Affordable Care Act health exchanges or market places and look into the future of benefit plans in America.

A chronic illness can be devastating for individuals and their families. Depending on the severity of the diagnosis, it could lead to a long road of treatment and financial hardship.

Fortunately, Participants in the UFCW & Employers Benefit Trust (UEBT) are able to focus on their recovery knowing they have access to some of the best and most comprehensive health benefits available.

Members have been treated for breast cancer, meningitis, diabetes and many other illnesses with care made affordable thanks to the superior Benefit Coverage offered by UEBT. Treatment plans sometimes span years and are still covered.

Benefits provide peace of mind

As a UEBT Member, you have access to health benefits which lead the industry in offering broad doctor and hospital choices (including some of the top-ranked physicians and hospitals in the country). These benefits provide valuable peace of mind for more than a hundred thousand people each year.

For most in-network care, after you meet your deductible you are then only responsible for a modest coinsurance. There is no lifetime or annual individual limit to the amount the UEBT Plan pays for the medical care you require, and once your total network out-of-pocket expenses are met, all network care is paid at 100 percent.

Covered preventive care, such as annual physical exams, flu shots and age appropriate screenings, is provided without any charge to you. The UEBT pays the costs. In addition, most prescription drugs only require a small copay to obtain.

Coverage & costs in the U.S.

Not all Americans are so fortunate. A recent survey by the Kaiser Family Foundation and Health Research & Educational Trust shows only 55 percent of employers in the U.S. offer health insurance to all of their workers. This is a decrease of five percent in the past five years.

Among those employers who do offer coverage, nearly a quarter of the workers are deemed ineligible for benefits (i.e. not a full time employee). The study also found some employers offer incentives for workers not to enroll in coverage.

Meanwhile, the costs of coverage continue to escalate. The average monthly premium for family health care in the United States is $1,403 (or $16,836 annually), reflecting an increase of more than $400 in the past five years and a 69 percent increase compared to 10 years ago. The average premium for single coverage is more than $502 per month (or $6,024 annually). If you focus exclusively on the Western Region/States and the types of plans UEBT offers (PPO and HMOs), these costs are even higher.

For most in-network care, after you meet your deductible you are then only responsible for a modest coinsurance.

These are for benefits which are far less than the level of benefits you enjoy as a Participant in the UEBT.

The Impact of the Affordable Care Act (ACA)

The Affordable Care Act (ACA), signed into law in 2010 by President Barack Obama, extended health insurance to millions of previously uninsured Americans and put an end to some of the worst practices in the health care industry.

The many goals of the legislation included enabling all Americans to purchase affordable health insurance — both as a matter of principle and as a way to curb the high costs of treating the uninsured — and to improve the administration of benefits for those who were already covered.

Those in need no longer can be dropped unexpectedly or denied coverage due to preexisting conditions, nor can insurers place annual or lifetime dollar limits on coverage. Men and women up to the end of the month in which they turn age of 26 can now also remain as Dependents on their parents' health plans, whereas before the law they were often dropped by the age of 21.

The far-reaching implications of the law have made it a topic for continued debate, even inside the Labor Movement, where even though it is praised for its best aspects, it's often seen as needing further adjustment so as to not unfairly harm multiemployer health plans or prevent them from continuing to provide the same high level service to their memberships.

The ACA continues to change the landscape of health care in America as different aspects of the legislation are implemented each year, and those changes will continue to affect UEBT Members. The Trustees of the UEBT will continue to decide how best to design its benefits to meet ACA mandates.

The presence of health exchanges will also continue to factor heavily into benefit-related negotiations between your union and your employer since they offer an alternative to the current multiemployer plan. However, studies have shown the the most commonly selected health plan selections from health exchanges offer substantially lower benefits at a much higher member cost than the benefits currently offered by the UEBT to Active Members and Retirees.

Part 3 of this series will take a closer look at how your UEBT Plan benefits stack up to what is offered by health care exchanges.

Sources

- **The Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits Annual Survey 2014**
- **UC Berkeley Labor Center Affordable Care Act Resources**
- **whitehouse.gov** ("Health Care In America")

Coverage for Retirees

Affordable access to high-quality health care is a benefit Members of the UEBT shouldn't take for granted, especially when they continue to receive excellent coverage after they stop working and become Members of the Retiree Health Plan.

The Kaiser Family Foundation survey found Retiree health benefits are offered by only 25 percent of employers who employ more than 200 workers. This number is down from 35 percent in 2004.

All Beneficiaries of the UEBT enjoy health benefits allowing them to take care of themselves and their families. Many of our fellow workers in California and across the country don't have the same stability, so our Members continue to be thankful for benefits on which they can rely.

In the next issue, we'll compare what you pay for many of the health-related goods and services you receive — such as doctor visits, prescriptions and hospital admissions — to what is paid by other covered workers in the United States.

Is other group health insurance available to you?

What you need to do and how your benefits are calculated

If your enrolled Spouse/Domestic Partner is offered group health insurance through another employer, current or former, he or she is required to enroll in the other insurance, regardless of the cost. Otherwise their benefits will be reduced by 60 percent.

If other group health insurance is not offered, a letter from the employer (on company letterhead) must be submitted to the Trust Fund Office explaining other insurance is not offered. A reduction of benefits will be applied if this letter is not submitted. The letter can be mailed to the Trust Fund Office or faxed to (925) 746-7549.

Coordination of Benefits with the other group health insurance is based on Non-Duplication of Benefits. This means if the other insurance is the primary payer, then the UEBT Plan will only provide additional payment if the other insurance pays less than what the UEBT Plan would have paid if it was the Primary Plan.

How Non-Duplication of Benefits works

For example, if Robin (a UEBT Plan Participant and Spouse of a PPO Member) had a medical procedure and a non-UEBT Plan was going to be the primary payer for the procedure, the claim would be processed as follows:

Amount billed for Robin's procedure:	**$8,500**
Primary Plan allowed amount:	$8,100
UEBT Plan allowed amount:	$7,500
Primary Plan payable at 70%:	$5,670
UEBT Plan payable at 85%:	$6,375

In this example, because the UEBT Plan would have covered more of the cost of Robin's procedure (85% versus 70%), the UEBT Plan will pay the difference.

UEBT Plan payable amount:	$6,375
Minus Primary Plan payable amount:	-$5,670
Equals (UEBT Plan will pay):	$705

Robin's remaining responsibility is $1,725, based on this calculation:

Primary Plan allowed amount:	$8,100
Minus Primary Plan's payment:	-$5,670
Minus UEBT Plan payment:	-$705
Equals (Robin's responsibility):	$1,725

If the UEBT payable amount was lower than the Primary Plan's payable amount, then the UEBT Plan would pay zero.

Deductibles, coinsurance and out-of-pocket maximums vary for each Plan (Premier, Ultra, Standard, or Retiree), so refer to your Summary of Benefits and Coverage.

Log into **UFCWTRUST.COM** to review your Benefit Coverage for you and your Spouse/Domestic Partner. This will help avoid confusion and could help you avoid paying for unnecessary out-of-pocket expenses.

Kaiser HMO Participants may request to pay later for medical services

In 2013, the Kaiser Permanente Plan structure was modified from a copayment plan design to a deductible and coinsurance design.

Participants going to a Kaiser Permanente plan provider who are not able to pay the estimated charges (such as the deductible or coinsurance) at the time of registration may request to be billed by Kaiser Permanente.

This will result in zero immediate out-of-pocket costs. You will then receive a bill from Kaiser for services within 30 days, giving you the ability to review the bill and services prior to making the payment.

If, as a UEBT Member, you are denied the request to be billed, please call the number on your Kaiser Permanente ID card: (800) 464-4000. If you have questions about your bill or how your out-of-pocket costs were calculated, call Kaiser at (800) 390-3507.

Flu shot reminder

Flu season is here. Protect yourself and your family against the flu by getting a flu shot at either your in-plan pharmacy or your physician's office.

If you would like to get your flu shot at your pharmacy, log into MyCatamaranRx.com.

Use the pharmacy locator search and be sure to mark "show in-plan pharmacies only." Call your pharmacist to confirm the pharmacy administers flu shots. If the in-plan pharmacy administers flu shots, then the shot will be covered and there will be no out-of-pocket expense for you or your covered Dependents.

An alternative to your pharmacy is your physician. A flu shot is considered a preventive benefit – therefore your flu shot will be covered at no expense to you as the Member.

It's never too late or too early to get a flu shot, so make sure you take advantage of your benefits and protect yourself from the flu this season.

Members now receive pharmacy benefits through OptumRx

OptumRx and CatamaranRx have recently merged. As of October 1, 2015, the company is referred to as OptumRx.

Members will now receive their pharmacy and prescription benefits through OptumRx. Therefore, you will see the OptumRx name on communication material and online and hear a transition message on the phone lines.

Your pharmacy benefits will not change and you can continue to use the same in-plan pharmacy you are currently using. You will be notified if any changes are made to the pharmacy network.

New ID cards for existing Members will not automatically be issued, although newly enrolled Members will receive OptumRx-branded IDs and welcome kits.

However, take a moment and look at the address on the back of your ID card. If you do NOT have the following address for submitting manual claims on your ID card or if you need a replacement card, call (866) 635-6906 and order a new card:

This is the correct address:

P.O. Box 968021
Schaumburg, IL 60196-8021

Members can continue using the **myCatamaranRx.com** website/portal and mobile app to manage their prescriptions as well as search for pharmacies in their area.

For more information, you can call OptumRx directly at (866) 635-6906.

What is changing?

Benefits

Your pharmacy benefits will not change as a result of the switch to OptumRx. Coverage and medication copays – as well as any specialty medications you receive – remain the same.

Pharmacies and ID card

You can continue to use the in-plan pharmacy you are currently using. You will be notified if any changes are made to the pharmacy network. You can still search for pharmacies near you by logging into **myCatamaranRx.com** or calling the phone number on the back of your ID card.

Prior authorization

You do not need to obtain prior authorization for any medications again as a result of the change to OptumRx. Current authorizations will remain active until they expire.

Home delivery

Your current home delivery prescriptions will continue to be filled through the same mail order pharmacy. There are no changes to how you order home delivery prescriptions, and you can still place new orders and request refills online, on the phone or through your physician.