



The value of your benefits

This is the second 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 examined the importance and cost of health benefits and how the Affordable Care Act changed health care in America.

In this issue, we'll look at the range of services covered by the UEBT and how the amount you pay for specific Covered Services compares to the amount paid by other covered workers across the country.

(Please see page 2)

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IN THIS ISSUE

Changes to Sick-Leave rules	Page 4
Extended Medical Benefits	Page 5
Know your deadlines to submit forms	Page 6
What is Form 1095-B?	Page 7
Learn more about your pension online	Page 8

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.



The value of your benefits **Part 2**

(Continued from front page)

Half of workers in the U.S. are not offered health insurance by their Employers. Members of the UEBT are fortunate to have benefits to prevent them from financial ruin in the event an illness affects them or their loved ones. Members work hard to earn these benefits in order to protect their families and provide for their future.

INDUSTRY-LEADING BENEFITS FOR PARTICIPANTS

Even among other workers with health insurance in the U.S., the affordability and breadth of benefits enjoyed by UEBT Members compare very favorably. See the comparisons listed on the next page for more details.

UEBT PPO Participants in the Health Care Partnership

(HCP) Program also receive a Health Reimbursement Account (HRA) funded by the UEBT at the start of each year. Members do not contribute to this account. This account can be used to pay for eligible medical Coinsurance payments, Deductibles and prescription drug copays. Unused HRA amounts are carried over and can be used in future years to reduce your UEBT medical and prescription drug expenses.

Preventive screenings, tests and exams are often fully covered for UEBT Participants, including your annual physical exam, flu shot and well-child care. You must visit a PPO Network provider for these services to be covered at 100 percent.

PPO Participants also have access to 24-hour expert medical advice on the phone via MedExpert, as well as extensive mental health and chemical dependency treatment through the Employee Member Assistance Program (EMAP). (HMO Participants receive mental health and chemical dependency treatment through their HMO).

ADDITIONAL BENEFITS

As part of their comprehensive health benefits, UEBT Participants have vision and dental benefits, which greatly reduce their out-of-pocket costs for these services.

Premier PPO and Kaiser Participants in the HCP Program pay only a \$5 deductible for their annual eye examination when using an in-network VSP provider. Frames and lenses coverage is also included, up to a maximum of \$165 for frames.

For dental benefits, Premier PPO and Kaiser Participants pay no calendar-year deductible with an annual \$2,500 benefit maximum. Expenses related to preventive and diagnostic services are completely covered.

Basic restorative services are covered at 80 percent of covered services, while major restorative services are covered at 70 percent. The orthodontic benefit also covers UEBT Participants for up to 75 percent of covered expenses, up to \$2,000 per person lifetime.

The benefits listed above are just part of the expansive benefit coverage enjoyed by UEBT Participants. Coverage for podiatry, chiropractic care, acupuncture and many other services is also available to Participants.



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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ENCOURAGING AND ENABLING WELLNESS

As the cost of health care continues to grow, health plans across the country are focusing on overall wellness programs to encourage participants to not only use the benefits available to them, but also use those benefits wisely.

Nearly a third of employers in the U.S. offer health risk assessments like the one you fill out when you complete your Health Risk Questionnaire (HRQ) – or Total Health Assessment (THA) for Kaiser Members – for the UEBT, and more than half take advantage of biometric screenings to identify ways Participants can get healthier.

Nearly all employers offer at least one wellness program (weight loss, smoking cessation, coaching, flu shots, etc.), and the UEBT offers several of these to its Participants and more, including an Individual Medical Decision Support Program through MedExpert and a Disease Management program.

UEBT Participants are also able to take control of their personal health and save money on their medical costs by taking part in the Health Care Partnership (HCP) Program. Members in the HCP Program have the lowest out-of-pocket expenses and are able to earn the most potential funding for their HRAs.

The benefits enjoyed by UEBT Members lead the industry in both the expansive amount of covered health services available as well as the low out-of-pocket costs Members pay to access these services.

In the final part of the Value of Your Benefits feature, we will look at how health care exchanges – created as part of the Affordable Care Act — will affect your benefits, and how the benefits currently offered by exchanges stack up against your benefits.

SOURCE

- **The Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits Annual Survey 2014**

Your benefits: How do they compare with other plans?

The average annual deductible amount for a single covered worker in the U.S. is \$1,217.

UEBT: The calendar-year Deductible for an employee can be as low as \$200 for both Premier PPO and Kaiser Participants in the Health Care Partnership (HCP) program. Premier PPO HCP Participants use their Health Reimbursement Account (HRA) funds to achieve this lower deductible.

The U.S. average for coinsurance for primary doctor's office visits is 18 percent.

UEBT: Coinsurance for doctor's office visits is as low as 15 percent for PPO Premier Participants in the HCP Program and Kaiser HCP Participants (after annual Deductible is met).

The U.S. average copayment for prescriptions ranges from \$11 to \$83 for certain medications.

UEBT: Premier PPO and Kaiser HCP Participants pay as little as \$7 for a 30-day supply of generic drugs.

The U.S. average coinsurance for hospital visits and outpatient surgery is 19 percent.

UEBT: Premier PPO and Kaiser HCP Participants pay only 15 percent of these costs when visiting in-network hospitals and providers (after annual Deductible is met).

More than half of U.S. workers with single coverage are in plans with an out-of-pocket maximum of \$3,000 or more for medical services.

UEBT: Premier PPO and Kaiser Participants in the Health Care Partnership (HCP) program have an out-of-pocket maximum of \$2,200 for employee-only coverage. Premier PPO HCP Participants use their Health Reimbursement Account (HRA) funds to achieve this lower out-of-pocket.

Changes to Sick-Leave rules

As of January 1, 2016 changes have been made to how Sick-Leave/Pay is administered for Employees of Employers which participate in the UEBT Sick-Leave Plan:

The following are the criteria for which Sick-Leave will be accrued, used and administered for the **first 24 hours or 3 days** (whichever is greater) of paid Sick-Leave:

- The Employee may accrue and use accrued paid sick days beginning on the 90th day of their employment.
- The Employee may request paid sick days in writing or verbally.
- The Employee can take paid leave for their own or a family member for the diagnosis, care or treatment of an existing health condition or preventative care or specified purposes for an Employee who is a victim of domestic violence, sexual assault or stalking.

- Sick-Leave/Pay can be requested/paid in 2 hour increments.
- The Employee **MUST CONTACT THEIR EMPLOYER** for the first 24 hours or 3 days of Sick-Leave/Pay.

Once the first 24 hours or 3 days (whichever is greater) of Sick-Leave/Pay is depleted, the twenty-fifth (25th) hour/fourth (4th) day of Sick-Leave/Pay, whichever is greater, will be provided **BY THE TRUST FUND OFFICE** in accordance with previously established rules as outlined in the UEBT Summary Plan Description (SPD).

The following are some of the

criteria for which Sick-Leave will be accrued, used and administered:

- The Member will continue to accrue paid sick days monthly as outlined in the SPD, but no more, to include the first twenty-four (24) hours/three (3) days of Sick-Leave/Pay accrued.
- The Member may request Sick-Leave Benefits in writing only by completing the UEBT Sick-Leave form.
- The Member can request Sick-Leave Benefits only for their own sickness or disability.
- Sick-Leave Benefits can be requested for any day in which the Member failed to work at least 50% of their scheduled straight time hours due to sickness or disability.
- The Member must be seen by a physician during their disability to receive Sick-Leave Benefits for the first day of disability.

MONTHLY SICK-LEAVE ACCRUAL

Monthly Work Hours	Premium and Ultra	Standard
Less than 64 hours	0 hours	0 hours
At least 64 hours but less than 120 hours	3 hours	2 hours
120 hours or more	6 hours	4 hours

IMMUNIZATIONS REMINDER FOR ALL PARTICIPANTS

For all UEBT PPO Active Plan Participants and their Spouses/Domestic Partners and Dependent children, most immunizations are covered at 100% (\$0 copay) under Preventive Care. Coverage is provided when you obtain the immunization at your local UEBT network pharmacy or by an in-network Blue Shield provider. Check with your local UEBT network pharmacy as to which immunizations are available.

You can log onto the Trust Fund website at UFCWTRUST.COM. Under the Resources tab, select

Find a Provider and you will be taken to a selection of providers. From here you can link to a pharmacy provider to search for participating UEBT pharmacies.

In addition to your annual flu shot, common immunizations include those for Hepatitis A and B, Tetanus, Chickenpox and HPV. Consult your Summary Plan Description (SPD) for a complete list and schedule, including specific pediatric immunizations and those suggested for Participants older than age 60.

PPO Members: Talk to your doctor before receiving medical services

Consider yourself a consumer, as well as a patient, during your doctor visits. It is your responsibility to ensure the care you receive is covered by your health plan.

IN-NETWORK?

Always be sure to ask the doctor if he or she is “a current contracting provider with the Blue Shield of California network.” Do not simply ask if he or she will accept your insurance.

Using an in-network Blue Shield PPO provider ensures you receive the in-network discount and prevents the provider from billing you the difference between the in-network discount and the actual billed charges on covered expenses. Additionally, if you have elective admissions, be sure the hospital is an in-network hospital with Blue Shield in order to keep your costs down.

If your doctor orders a blood test, be sure to ask why the lab test is needed and only use a Blue Shield in-network laboratory. Standard blood work can cost anywhere from \$150 to \$2,000. You may lower your out-of-pocket expenses if you use an in-network freestanding lab facility versus the lab at the outpatient department of a hospital or other medical facility.

Diagnostic lab tests are subject to your deductible and coinsurance. The costs for preventive screening tests covered under the Affordable Care Act (ACA) are 100% covered by your Plan, with no cost to the Member.



QUESTIONS FOR YOUR DOCTOR

Here are some additional questions to ask your doctor at your next visit. The answers to these questions could make a big difference when it comes to your out-of-pocket expenses.

“You have prescribed a brand-name drug which is not listed on my Preferred Drug List. Do I need this specific drug?”

“You have referred me to a specialist. Is the specialist you are recommending a current Blue Shield in-network provider?”

EXTENDED MEDICAL BENEFITS

PPO Members and/or their Dependents who are Totally Disabled have 60 days to apply for Extended Medical Benefits after losing earned coverage.

“Earned coverage” is coverage as a result of Employer contributions to the Fund (hours worked or compensated), Family Medical Leave Act (FMLA) or Disability Extension. COBRA and Self-Pay are not earned coverage, and will run concurrently with this extension of medical benefits.

These Extended Medical Benefits are available to PPO Members only who apply for the extension within 60 days. Kaiser HMO Members are not eligible for extended medical benefits.

Extended Medical Benefits will end at the earliest of:

- the date you or your Dependent is no longer Totally Disabled;
- 12 months from the termination of earned coverage; or
- the date you or your Dependent becomes covered under another plan which provides similar benefits for the disabling illness or injury.

Know your deadlines to submit forms on time and save money

In order to best take advantage of the industry-leading benefits you have as a UEFT Member, you must submit the necessary paperwork to the Trust Fund Office (TFO) when you experience a life event. Knowing the deadlines to submit important forms can help you avoid out-of-pocket expenses and loss of coverage.

The following deadlines apply to Premier, Ultra and Standard Participants:

- **New Spouse or Domestic Partner:** Notify the TFO within 90 days (Kaiser Members: 60 days).

- **Loss of Spouse or Domestic Partner coverage:** Notify the TFO within 30 days from the loss of your Spouse or Domestic Partner's other group coverage.

- **Newborn:** Notify the TFO and submit the County Issued Birth Certificate within 90 days of the date of birth (Kaiser Members: 60 days). If you do not have the County Issued Birth Certificate by these deadlines:

- Submit the Hospital Issued Birth Certificate and proof you applied for your child's County Birth Certificate within 60 days of the date of birth (for both PPO and HMO) for six months of temporary coverage beginning at date of birth.
- The County Issued Birth Certificate must be received by the TFO no later than 6 months after the date of birth.

If the County Issued Birth Certificate is not submitted timely, coverage for the newborn will end on the last day of the sixth month following the newborn's date of birth and you will have to wait until the next Open Enrollment to enroll your child.

Due to possible delays in obtaining the County Issued Birth Certificate, be sure to apply for the official Certificate as soon as possible, and NO LATER than 60 days after the date of birth, and keep a copy of proof of your application.

- **New adopted child or foster child:** PPO Members must notify the TFO within 90 days from the date of placement of the adopted or foster child, and Premier HMO Members must notify the TFO within 60 days.

- **Loss of Dependent Child coverage:** Notify the TFO within 30 days from the loss of other group coverage for your Dependent child.

SUBMIT IMPORTANT FORMS ON TIME TO AVOID OUT-OF-POCKET EXPENSES AND LOSS OF COVERAGE.



- **COBRA Coverage Election:** Notify the TFO within 60 days from your loss of coverage notice, 60 days from loss of eligibility or 60 days from the date extended eligibility ends, whichever is later.

NOTICE:

WHAT IS FORM 1095-B AND WHAT DO I NEED TO DO FOR MY 2015 TAXES?

Under the Affordable Care Act, all non-exempt taxpayers must prove they have minimum qualifying health insurance coverage during a calendar year in order to avoid an individual shared responsibility payment, also known as an income tax penalty.

The Form 1095-B is a tax reporting form which generally indicates the type of health insurance coverage you have, the enrolled Dependents on your health insurance plan, and the period of coverage for the 2015 calendar year for you and each of your enrolled Dependents. This form will provide the basic information you will need to verify, on your tax return, that you and your enrolled Dependents have at least minimum qualifying health insurance coverage during the calendar year.

The Trust Fund Office will mail you a copy of your Form 1095-B in early 2016. You may also receive an additional Form 1095-B from your Medical Carrier (HMO), if applicable. Form 1095-B is also electronically reported to the IRS directly, but make sure you keep the copy of Form 1095-B for your records.

Please review your Form 1095-B carefully and verify the information on the form is accurate. If information needs to be updated, please contact the organization that issued the 1095-B to request an updated form. For instance, if the 1095-B mailed to you by your HMO needs to be updated, you must call your HMO to receive an updated form. If you believe corrections are needed on the Form 1095-B sent to you by the Trust Fund Office, please call the Trust Fund at (800) 552-2400.

The information from Form 1095-B is electronically reported to the IRS. All communications and forms you receive in the mail from the Trust Fund Office in connection with any tax reporting forms under the Affordable Care Act, including this notice, are not intended to serve as tax advice. Please contact your tax advisor with questions regarding your individual tax liability. For additional information on the Form 1095-B and 1095-C, you can log onto the IRS website at: <https://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-about-Health-Care-Information-Forms-for-Individuals>.



Prenatal benefits for surrogates

If you are a UEBT Participant who is a surrogate mother, the Plan will cover some of your preventive care screenings – including necessary prenatal care services – in compliance with the Affordable Care Act.

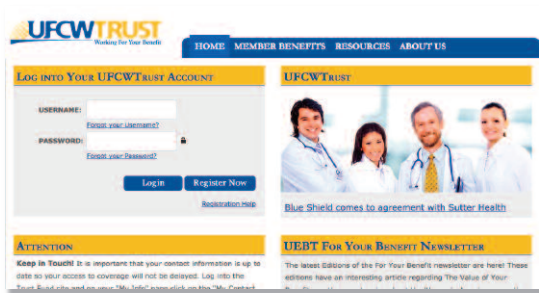
All other related expenses for surrogate pregnancies, (regardless of whether the surrogate mother or the intended mother is a participant under this Plan), including childbirth and coverage for the child following birth, are not covered as part of your health plan (unless the intended mother is a participant under this Plan).

Kaiser HMO Participants should contact Kaiser directly for their surrogacy coverage information.

Learn more about your pension benefits online at ufcwtrust.com

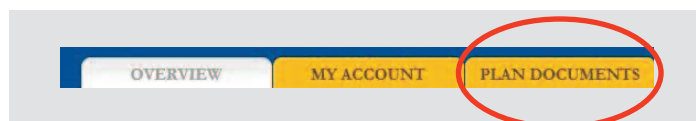
UEBT members have access to information about their Retirement Benefits and Pension at UFCWTRUST.COM.

Access your personalized information by following these steps:



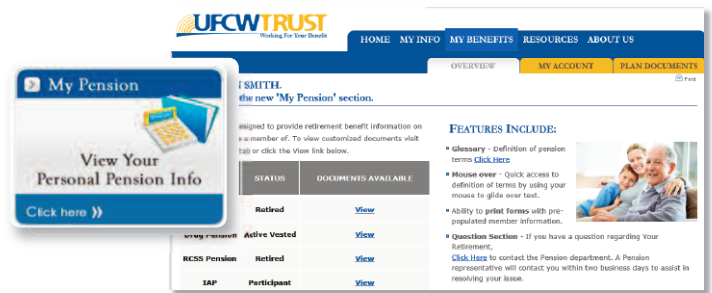
1. LOG INTO UFCWTRUST.COM. YOU WILL LAND ON YOUR “MY INFO” PAGE.

Your personal information will be displayed. Confirm your personal information is accurate and, if it is not accurate, please take the time to update it. If you need to update your street address, phone numbers or email address, you can click on the My Contact Info box on the bottom right of the page to fill out an online Change of Contact Information form. If you need to update your name, birth date, Social Security Number or marital status, you can contact the Trust Fund Office to update your details as necessary.



3. SELECT THE “PLAN DOCUMENTS” TAB.

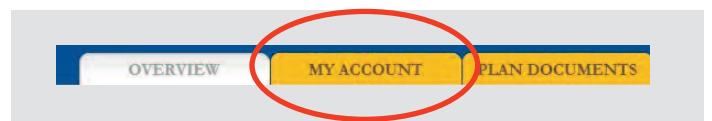
You will have access to all of the documents related to the plans in which you are a Member. These include updates and notices about changes to your benefits, as well as your Summary Plan Description and Annual Funding Notices.



2. SELECT THE “MY PENSION” ICON.

You will see an overview of your Retirement Benefit information, including the funds in which you are a Member, as well as your status and links to personalized documents.

You can also access a glossary of pension terms and submit a question to the Pension Department online. You will be contacted by a Pension representative within two business days to assist in resolving your issue.



4. SELECT THE “MY ACCOUNT” TAB.

You can access your Pension Estimate here by clicking on “View” next to “Pension Estimate.” If you are a Member in an Individual Account Pension Plan, you will also find your Annual Statement on this page.