UFCW TRUST

Working For Your Benefit

WINTER 2018/2019
Actives & Retirees

FOR YOUR BENEFIT: OFFICIAL PUBLICATION OF THE UFCW COMPREHENSIVE BENEFITS TRUST (UCBT)

PPO Explanation of Benefits (EOB) will soon be available online

Effective January 1, 2019, PPO Members and their covered Spouses/Domestic Partners will be able to view their Explanation of Benefits (EOBs) online!

To access your EOBs online, simply log into **UFCWTRUST.COM**. On your My Info page, select the My Claims button located at the bottom of your screen. You will be able to view your Health Claims' EOBs and your Sick Leave Claims' EOBs on each respective tab.

Please note if you are a Kaiser HMO Member, your EOBs will come from Kaiser, not the Trust Fund Office (TFO), and they will not display on the TFO website.

If you are covered under the PPO Plan, each time you take advantage of your health benefits and receive services,

(Please see page 2)

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.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 999-1999.

TRUST FUND OFFICE CORE VALUE: TRUST

WE DEMONSTRATE HONESTY AT EVERY LEVEL OF THE ORGANIZATION WHERE OUR WORDS AND ACTIONS ALIGN

UFCW Comprehensive Benefits Trust
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In This Issue

PPO Explanation of Benefits (EOB) will soon be available online

'It is very important to closely check your EOB for any notes or explanations of actions you may need to take.'

(Continued from front page)
whether it's an annual physical or a flu shot, the TFO creates an Explanation of Benefits.

The EOB is a statement explaining how your benefits were processed. It helps you stay informed about your benefits. **An EOB is not a bill.**

How to read your EOB

Carefully review your EOB to find a description of the services you received, the amount billed for those services, the amount the Plan paid, your co-insurance amount, and any amounts that may have been applied toward your calendar year deductible. It is important to closely check your EOB for any notes or explanations of actions you may need to take.

Participants should receive an EOB for every service they receive. Multiple EOBs will be issued to you if multiple providers were involved (for example: a surgery would involve the hospital, the surgeon, an anesthesiologist, one or more nurses, etc.). If you don't receive an EOB from the Trust Fund within four to six weeks of your service, contact your provider to make sure the claim is filed timely.

You may sometimes receive a bill from your provider before you receive your EOB, but your EOB will usually arrive first. If you receive a bill, compare what your provider billed to the amount listed on your EOB to make sure they match. If the two amounts don't match, contact the Trust Fund Office at (800) 552-2400.

The patient's portion on the EOB can include any amounts applied to deductible, co-pay, co-insurance and/or non-covered charges. You may be responsible for all or a portion of the charges for the services you receive if you visit an out-of-network provider or if you receive medical services not covered by the Plan, such as those considered experimental or investigational.

The following page has a guided tour through a sample EOB to help you understand all of the information available on these statements.

UFCW TRUST
Working For Your Benefit

For Your Benefit is the official publication of the UFCW Comprehensive Benefits Trust (UCBT). 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 Comprehensive Benefits 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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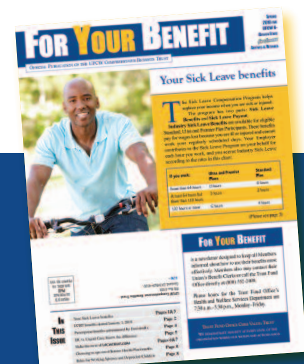


Share your stories and ideas with the Trust Fund Office

Would you like to share a story of how UCBT benefits made a difference in your life or for one of your loved ones? Do you have a benefit-related topic you would like to learn more about in a future issue of *For Your Benefit?*

Email your story or ideas to **MemberProfile@ufcwtrust.com**.
We may contact you for more information.

1 **Name and address** of the Trust Fund providing benefits.

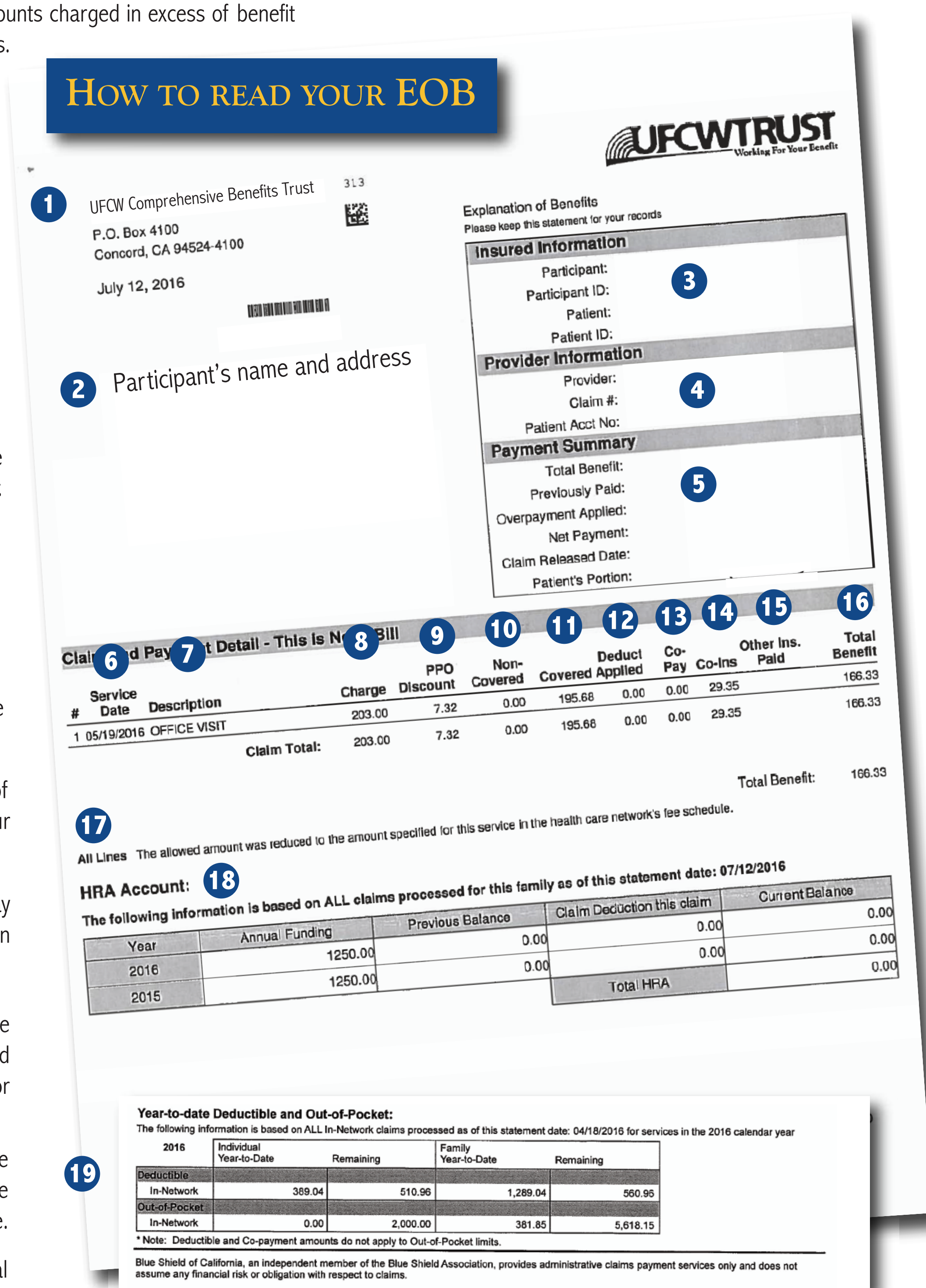
2 **Name and address** of the Participant. (Log into **UFCWTRUST.COM** to update your contact information at any time.)

3 **Insured Information** lists the name and ID number of the Participant and the name of the patient.

4 **Provider Information** shows the name of the health care provider, the Trust Fund claim number and the patient account number assigned by the provider.

5 **Payment Summary** summarizes the amount paid to the provider and/or the Participant. The patient's portion is the amount the patient owes to the provider. This amount includes any deductible, co-pay and/or patient co-insurance. It also includes any amounts charged in excess of benefit maximums or for non-covered services. The Claim Released Date is the date the payment was processed. This is not a bill.

How to read your EOB


UFCW Comprehensive Benefits Trust
313
P.O. Box 4100
Concord, CA 94524-4100
July 12, 2016

Participant's name and address

Explanation of Benefits
Please keep this statement for your records

Insured Information
Participant:
Participant ID:
Patient:
Patient ID:

Provider Information
Provider:
Claim #:
Patient Acct No:

Payment Summary
Total Benefit:
Previously Paid:
Overpayment Applied:
Net Payment:
Claim Released Date:
Patient's Portion:

Clai d Pay t Detail - This is N Bill

#	Service Date	Description	Charge	PPO Discount	Non-Covered	Covered	Deduct Applied	Co-Pay	Co-Ins	Other Ins. Paid	Total Benefit
			203.00	7.32	0.00	195.68	0.00	0.00	29.35		166.33
1	05/19/2016	OFFICE VISIT	203.00	7.32	0.00	195.68	0.00	0.00	29.35		166.33
		Claim Total:	203.00	7.32	0.00	195.68	0.00	0.00	29.35		166.33

Total Benefit: 166.33

All Lines The allowed amount was reduced to the amount specified for this service in the health care network's fee schedule.

HRA Account:
The following information is based on ALL claims processed for this family as of this statement date: 07/12/2016

Year	Annual Funding	Previous Balance	Claim Deduction this claim	Current Balance
2016	1250.00	0.00	0.00	0.00
2015	1250.00	0.00	0.00	0.00
			Total HRA	0.00

Year-to-date Deductible and Out-of-Pocket:
The following information is based on ALL In-Network claims processed as of this statement date: 04/18/2016 for services in the 2016 calendar year

2016	Individual Year-to-Date	Remaining	Family Year-to-Date	Remaining
Deductible				
In-Network	389.04	510.96	1,289.04	560.96
Out-of-Pocket				
In-Network	0.00	2,000.00	381.85	5,618.15

* Note: Deductible and Co-payment amounts do not apply to Out-of-Pocket limits.

Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

6 **Service Date** is the date the patient received services.

7 **Description** is a brief summary of the services rendered.

8 **Charge** is the amount billed by the provider for the service.

9 **PPO Discount** is the amount you and the Plan saved by using an in-network provider.

10 **Non-Covered** is the amount not covered by the Plan for a service or an amount which exceeds the allowed charges for an out-of-network provider. Your provider may be able to bill you for these charges.

11 **Covered** amount shows the Allowable Charges for covered services.

12 **Deduct Applied** is the amount of covered charges applied toward your calendar year deductible.

13 **Co-Pay** is a fixed dollar amount you pay for covered health care, usually when you receive the service.

14 **Co-Insurance** is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service.

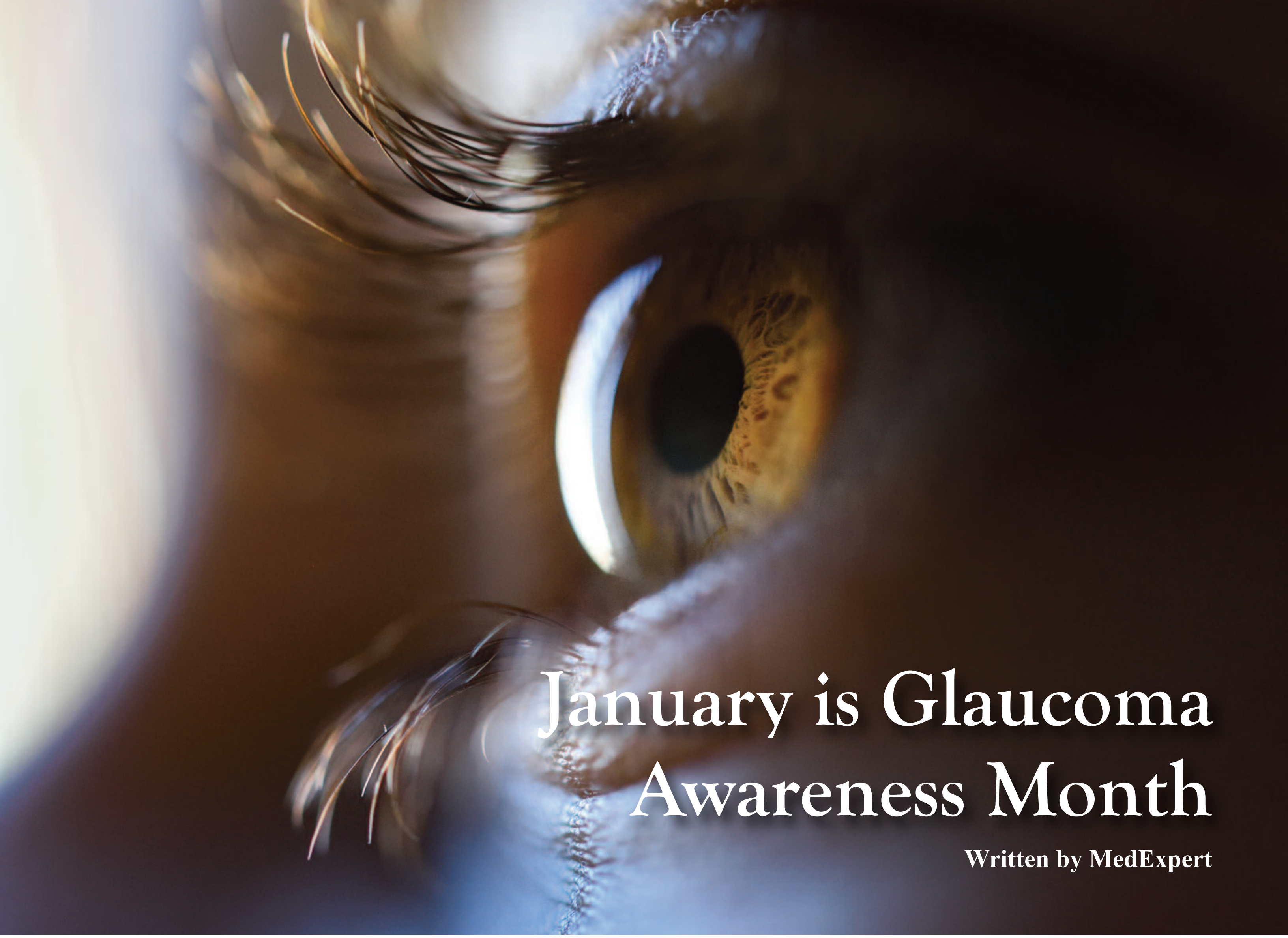
15 **Other Insurance Paid** shows the amount paid by a primary carrier if the Patient was covered by other insurance.

16 **Total Benefit** indicates the total amount paid by the Plan.

17 **All Lines** provide additional information about how the claim was processed. This information is important and may include a request for further action by a provider or the Participant.

18 **HRA Account** summarizes the Active Participant's Health Reimbursement Account (HRA) for the current year (if the Participant is covered under an HRA Plan). It shows the previous balance, the amount applied based on the current claim, and the amount remaining in the HRA account as of the date the EOB was printed. HRA accounts only apply to Active Members unless you retire with a balance left in your HRA bank, after which the balance can be used for services until it is exhausted.

19 **Year-to-Date Deductible and Out-of-Pocket** summarize the patient's and family's year-to-date accumulation of deductible and out-of-pocket amounts as of the date the EOB was printed.



January is Glaucoma Awareness Month

Written by MedExpert

Glaucoma is an eye disease with specific characteristics such as optic nerve damage and visual field loss. While it is usually associated with Increased pressure inside the eye, identified as intraocular pressure (IOP), some patients with normal-range IOP can develop glaucoma.

Normal eye pressure ranges from 12-22 mm Hg, (millimeters of mercury) and eye pressure of greater than 22 mm Hg is considered higher than normal. Ocular hypertension is the diagnosis when the pressure is higher than normal but the person does not show signs of glaucoma.

While high eye pressure alone does not cause glaucoma, it is a risk factor. Individuals diagnosed with high eye pressure should have regular comprehensive eye examinations by an eye care professional to check for signs of the onset of glaucoma. Early diagnosis and treatment of glaucoma is the key to preventing vision loss.

Vision loss from glaucoma occurs when the eye pressure is too high for the specific individual and damages the optic nerve. Any resulting damage cannot be reversed. The peripheral (side) vision is usually affected first. The changes in vision may be so gradual that they are not noticed until a lot of vision loss has already occurred.

In time, if the glaucoma is not treated, central vision will also be decreased and then lost; this is how visual impairment from glaucoma is most often noticed.

If detected early, glaucoma can be managed and, with medical and/or surgical treatment, most people with glaucoma will not lose their sight.

Traditional glaucoma surgery such as trabeculectomy and glaucoma drainage devices are effective but are associated with risks such as double vision, eye infections, swelling of the cornea and low IOP. As a result, many surgeons delay glaucoma surgery until less invasive treatment, such as medications and laser treatment, are not effective.

Glaucoma experts are seeking alternative surgeries to treat glaucoma. Minimally Invasive Glaucoma Surgery (MIGS) is defined by a micro-invasive approach which causes minimal tissue trauma. MIGS is considered much safer and patients recover rapidly. Medical literature continues to debate whether MIGS or traditional trabeculectomy are superior.

Final treatment decisions depend on the expertise of the physician and patient characteristics.

For more information call MedExpert at (800) 999-1999.

Keeping mental health and eating in check during holidays

Written by MedExpert

The holiday season should be filled with joy and excitement! Here are some tricks to avoid holiday stress, anxiousness and overeating:

Maintain a positive outlook. Much of what contributes to health problems during the holidays can be attributed to a lack of sunlight and bad habits rather than the time of year.

Get outside. No matter the weather, get outside to take a walk or run. Soak up sun to avoid the pitfalls of Seasonal Affective Disorder (SAD), a disorder which affects nearly one in five people during the winter months.

Give of your time. Volunteer at your local church or community program. Social interactions lift everyone's spirits. If family is not around, go to your neighbor's homes and start your own "Holiday Potluck Because We Can" group.

Repeat, "I'm a good person." Don't slip into old family dynamics. You are a good mom or dad or brother or sister or son or daughter.

And, eat and drink for merriment and not regret. Start a holiday party with a festive glass filled with water. Create a goal of having at least one glass or even two glasses of water before you begin drinking alcohol. Most people are naturally nervous when a party begins and consume alcohol to feel more comfortable. If you begin with water, you will quench your thirst, give yourself a chance to relax, fill your stomach a bit, slow down on the hors d'oeuvres and consume fewer calories by night's end.

Health Reimbursement Accounts for Active PPO Members

A Health Reimbursement Account (HRA) is an account to help eligible Active members pay for their portion of health care expenses not paid by the Plan.

HRAs will be established for eligible PPO Premier, Ultra and Standard Members on January 1, 2019, in the following amounts:

Standard Plan

Individual employee, $250; Employee with enrolled Dependents, $350.

An additional credit of $150 will be added to your HRA in 2019 if you complete an online Health Risk Questionnaire (HRQ) between February 1, 2019, and March 15, 2019.

Ultra Plan

If you are participating in the wellness program (HCP): Individual employee, $550; Employee with enrolled Dependents, $800.

If you are not participating in the wellness program (HCP): No HRA credits for Ultra Members who are not participating in the wellness program.

Premier Plan

If you are participating in the wellness program (HCP): Individual employee, $700; Employee with enrolled Dependents, $1,250.

If you are not participating in the wellness program (HCP): No HRA credits for Premier Members who are not participating in the wellness program.

The Trust Fund Office (TFO) will administer the HRAs and allocate credits to each eligible account annually. Active Participants and Spouses/Registered Domestic Partners in the Ultra or Premier PPO Plans must choose to participate in the wellness program (HCP) and complete all of their required Action Steps in order to receive HRA credits.

What can my HRA balance be applied to?

Your HRA balance will be applied to covered benefits incurred under your UCBT Plan to pay for medical* deductibles, co-insurance, medical co-pays and preferred prescription drug co-pays. If you have a question about whether an expense is reimbursable, call the TFO.

Unlike a regular bank account, you cannot make deposits into your HRA or withdraw funds from it. Your HRA does not earn interest and cannot be invested. HRA contributions are tax-free to you.

Unused HRA credits roll over into the next year, provided you remain eligible under the Plan.

If you retire and have coverage under the UCBT Retiree Health and Welfare plan, your balance of HRA credits accumulated as an Active Member will be used to pay for eligible expenses until your HRA is exhausted.

Exclusions

Your HRA may not be used to reimburse the following expenses:

- Premium payments (such as COBRA)
- Expenses excluded from the Plan's medical and prescription drug program (such as cosmetic procedures and co-pays for non-preferred drugs)
- Amounts which exceed the Plan's annual dollar limits (for example, if your Chiropractic benefit has a $500 annual limit, you cannot use your HRA credits to pay for additional chiropractic care.)

* Non-duplication of Benefits states the Trust Fund will not issue payment when the primary allowed amount exceeds the Trust Fund allowed amount.

New cards, new network for PPO Medicare Retirees

Good news! The Trust Fund Office (TFO) is changing the way your Medicare claims are processed. It's a simple change with minimal impact to you. In addition, there are no changes to your benefits.

Beginning January 1, 2019, all Medicare Retirees' claims will be submitted to Medicare, which then sends claims to the Trust Fund Office (TFO) for secondary payment processing. Not only will this save your Retiree Fund money, but claims will be processed faster!

Medicare Retirees will no longer access the Blue Shield of California or BlueCard network and instead will use the Medicare provider network. We anticipate little to no provider impact as the two networks are very similar. The Medicare provider network can be accessed from this web address: **medicare.gov/physiciancompare/**

New Participant Cards will be issued to Medicare Retirees, Spouses and Dependents. Members, Spouses and Dependent Children not eligible for Medicare will remain with Blue Shield of California and can use the same card they have now in the Member's name.

What's changing, what's not

Prescription coverage for Medicare members will not be affected by these changes.

The Trust Fund will continue to use the Non-Duplication of Benefit payment methodology for all claims. Note: Under the rules of Non-Duplication of Benefits, the Trust Fund will not issue payment when the primary (Medicare) allowed amount exceeds the Trust Fund's allowed amount.

All secondary payments will now be made by the Trust Fund instead of Blue Shield of California.

Mental health and chemical dependency benefits will be available through the Medicare provider network.

Find a mental health provider on ufcwtrust.com (for non-Medicare Retirees)

Here's how to contact Blue Shield of California to use your benefits for help with mental health and substance abuse:

1. Visit ufcwtrust.com.

2. Click the "Resources" tab.

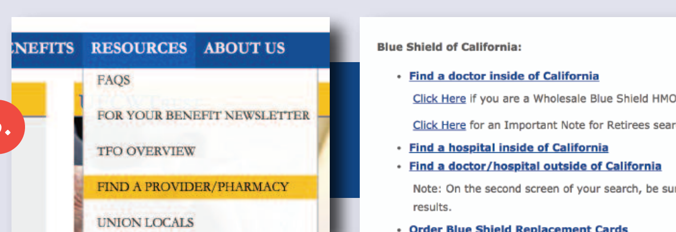
3. Select "Find a Provider/Pharmacy" and choose one of the Blue Shield of California options to find a provider near you.

4. Click on "Find a Doctor Inside of California," click on the "Mental Health" button, then enter your ZIP code.

1.

2.

3.



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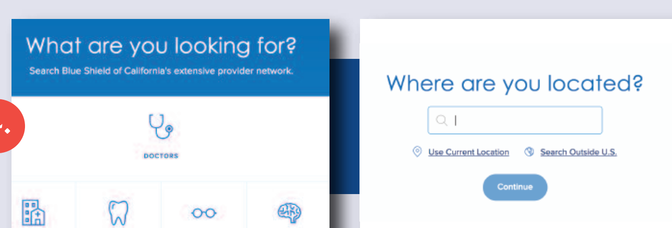

Ask your provider if services are medically necessary

Medical Necessity is defined as "accepted health care services and supplies provided by health care entities appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care."

Certain medical services are not routine. These services require a health care provider to submit medical reasons to Blue Shield of California (BSCA) and for Blue Shield of California to determine whether a requested medical service meets predetermined criteria for a disease, condition, illness or injury.

If Blue Shield determines that the services are not medically necessary, the claims for those services will be denied.

Medical review is completed by BSCA trained Medical Management staff. This staff is overseen by a Medical Director who makes the final decision on the appropriateness of treatments.

Pre-authorization and more

For certain services and treatments, providers will request preauthorization from BSCA to ensure once the approval is received, the services are rendered and payment for the services can be expected.

For any claim where an authorization was required but not obtained – or if the services exceeded an authorization in terms of length of stay or level of treatment – the claims for those non-authorized days or services will have their claim denied and no payment for this portion of the claim will be issued.

Providers have the right to appeal Medical Necessity denials with BSCA. Again, the Medical Director makes the final determination on the validity of these appeals.

Members may appeal negative determinations from Blue Shield of California by following the appeal process.

If your health care provider has questions about whether a treatment is medically necessary or requires preauthorization, contact the Blue Shield of California Medical Management Department at (800) 541-6652.