FOR YOUR BENEFIT

THE LOCAL 295/LOCAL 851 EMPLOYER GROUP BENEFIT FUNDS NEWSLETTER
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FUNDING NOTICE IS ONCE AGAIN THE CAUSE OF SOME CONCERNS The Local 295/Local 851 Employer Group Pension Fund recently mailed out a funding notice as required by federal legislation. The federal legislation is PL109-280, the Pension Protection Act of 2006. In 2007, a similar type of funding notice was mailed out to comply with a previously enacted federal law known as the Pension Fund Equity Act.

Once again, the members of the U. S. Congress who supported this new pension legislation thought that pension plan participants were not being provided with enough information about their plans. Once again, the funding notice has raised concerns among the participants and employers. These are some of the questions being asked by callers to the Fund Office.

Q. The notice said the Pension Fund is in critical status. What does that mean?

A. Critical is one of the several categories established by the new law. We now have to follow some new funding rules that are mandated by legislation. Using the mandated funding rules, the Plan is projected to have an accumulated funding deficiency for the July 1, 2011 plan year.

Q. What caused the critical status?

A. The primary cause of the Pension Fund being in "critical status" is the decrease in the value of the Fund's invested assets. There has been a dramatic decline in the value of investments that began earlier in this calendar year and it has continued to date. This recent market loss follows the prior period of investment decline that began in the 2000 plan year and lasted until 2003. Although the Fund had some investment gains during the next four years, these gains did not fully make up for the losses incurred. It is this series of assets losses, the current market decline plus the remaining loss from the prior market downturn, that caused the Fund to be in "critical status".

Q. Is my pension benefit going to be stopped?

A. Absolutely not! The Plan currently has enough assets to continue paying all of its obligations for the next 15 years even if there were no further contributions or earnings on investments.

Q. Is the Pension Fund insolvent?

A. It is not! A pension fund is considered to be insolvent in a year if it doesn't have enough assets to pay benefits for that plan year.

Q. I saw in the notice that a rehabilitation plan could include some reductions in benefits.

A. That's correct, but the benefit reductions, if any, can only apply to the so-called adjustable benefits and they can only apply to participants and beneficiaries whose benefit payments begin on or after October 26, 2008. Persons who are currently on the pension benefit payment rolls will not be affected in any way by any benefit reductions.

Q. What are the adjustable benefits?

A. Some examples of the adjustable benefits are the Rule-of-70 Pension, the 25-Year Service Pension and the 15-Year/Age-50 Early Retirement Pension being provided under the Pension Plan's current rules.

Q. How have the recent market nose dives affected the Pension Fund valuation?

A. The valuations are done each year as of the close of the fiscal year. The fiscal year runs from July 1st of one calendar year to June 30th of the next calendar year. The valuation is a snapshot as of each June 30th. Subsequent events are taken into account as of the end of the next fiscal year end. The next fiscal year ends on June 30, 2009. If the markets have worsened or improved by next June, that will be taken into account for the next valuation.

Q. Are you working on a rehabilitation plan?

A. Yes. The Board of Trustees and the Fund's advisors are putting together a plan to bring the Pension Fund out of critical status. Keep in mind that it will be a long-term plan that will be implemented over a period of up to ten years. ■

MEDICARE SECONDARY PAYER PROVISIONS If you are still active at work and your Medicare coverage begins, Medicare will not be the primary payer of your claims.

If you are covered by the Local 295/Local 851 Employer Group Welfare Fund as an active employee or if you are the dependent of an active-at-work employee and you are also eligible for Medicare, the Welfare Fund is the primary payer of your claims and Medicare is the secondary payer.

Medicare refers to these procedures as the Medicare Secondary Payer Program. This means that the Welfare Fund will pay first on hospital and medical bills and for other covered services. Medicare will then review what the Welfare Fund paid for Medicare-covered health care services and determine if any balances can be covered.

The Welfare Fund has to tell Medicare who's covered… Medicare needs to identify all of the persons who have group health plan coverage and Medicare so that Medicare can properly pay its claims.

Early in 2009, Medicare will require the Welfare Fund to provide Social Security Numbers and other information for persons who are eligible for Medicare and also covered by the Welfare Fund.

If you receive a request for information from the Welfare Fund Office, please cooperate by fully completing the form and promptly returning it. ■

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. ■

OUT OF NETWORK MEANS OUT OF POCKET All hospital, medical, surgical, diagnostic and other health care services are being provided through the Empire Blue Cross/Blue Shield Preferred Provider Organization (PPO). This PPO plan is provided to all active plan participants and their dependents as well as all of the eligible retirees and spouses who are not covered by Medicare.

Don't assume that all health care providers are in the PPO… Be sure to ask each of your health care providers if they are in the Blue Cross/Blue Shield network. Signs or literature announcing that all insurance is accepted can be misleading.

If the health care provider is not in the Blue Cross/Blue Shield network, their claims have to be processed under the major medical part of the Local 295/Local 851 Employer Group Welfare Fund. That's when your out-of-pocket costs will suddenly increase.

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Deductible and co-insurance… Major medical claims are subject to an annual deductible. After the annual deductible is met, the Welfare Fund payment rate is 75% of the remaining covered charges that are over and above the deductible amount. The 75% - 25% cost sharing is referred to as the co-insurance rates.

The deductible amount is $400 per individual per calendar year and the family maximum is $1,200 per calendar year. When three persons in the family have met the annual deductible ($1,200), the deductible for other family members is $0 for the rest of that year.

$400 out-of-network claim? No payment… No payment will be made for the first $400 of allowed charges of an out-of-network claim. The entire $400 will be applied to the annual deductible. For a claim of $500 of allowed charges, the Welfare Fund will issue payment of $75. For a claim of $5,000, the Fund will pay just $3,450 and the patient will have to pay $1,550 out of pocket.

Major medical coverage is limited…The major medical maximum coverage is $250,000 per illness. Out-of-network expenses that are over and above the $250,000 maximum are the patient's responsibility. With the costs of medical care at an all time high, the maximum major medical coverage could be quickly exhausted.

Make sure that your health care provider is in the network by calling 1 800 810 BLUE (2583) or go to the Blue Cross site on the internet. The address is www.empireblue.com. ■

GLAUCOMA – TAKING A CLOSER LOOK

Glaucoma is a disease of the optic nerve – the part of the eye that carries the images we see to the brain. The optic nerve is made up of many nerve fibers, like an electric cable containing numerous wires. When damage to the optic nerve fibers occurs, blind spots develop. These blind spots usually go undetected until the optic nerve is significantly damaged. If the entire nerve is destroyed, the result is blindness.

Early detection and treatment by your ophthalmologist are the keys to preventing optic nerve damage and blindness from glaucoma. Glaucoma is a leading cause of blindness, especially for older people. Loss of sight from glaucoma can be prevented with early treatment.

How glaucoma is treated… As a rule, damage caused by glaucoma cannot be reversed. Eye drops and surgery are used to help prevent further damage. In some cases, oral medications may also be prescribed.

Periodic examinations are very important to prevent vision loss. Because glaucoma can progress without your knowledge, adjustments to your treatment may be necessary from time to time.

Eye drops usually provide control…Glaucoma is usually controlled with eye drops taken daily. These medications lower eye pressure, either by decreasing the amount of aqueous fluid produced within the eye or by improving the flow through the drainage angle.

Surgery can be helpful…Surgery may be recommended if your ophthalmologist feels it is necessary to prevent further damage to the optic nerve. The surgery improves or creates a drainage channel for the aqueous fluid to leave the eye. The surgery is typically an outpatient procedure.

Examinations are necessary…Regular eye examinations by an ophthalmologist can help prevent the loss of vision. The recommended examination intervals for persons under age thirty is every 3 to 5 years and every 2 to 4 years for persons between the ages 30 and 64. After age 64, an annual examination is recommended.

To locate a network ophthalmologist, call Empire Blue Cross toll free at 1 800 810 BLUE (2583) or go to www.empireblue.com on the internet. ■

ONE CARD IS ALL THAT YOU NEED Now plan participants need only one identification card to use at the doctor's office, hospital, pharmacy or other health care provider. New identification cards were mailed out last year for all active participants and retirees who are not on Medicare. The new identification card has all of the Empire Blue Cross/Blue Shield and the Broadreach Pharmacy Plan information on it.

This new combination card is all you need to get health care services from the Blue Cross/Blue Shield providers or a prescription drug at any of

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the more than 56,000 participating pharmacies.

Blue Cross/Blue Shield coverage is valid everywhere…If you live or travel outside of the Empire Blue Cross/Blue Shield twenty-eight county operating area, benefits are provided through three programs known as Blue Card PPO, Blue Card Program and Blue Card Worldwide. Empire Blue Cross/Blue Shield is affiliated with all of the other Blue Cross and Blue Shield networks throughout the United States, its territories and many foreign countries.

No claim form is required….. You don't have to fill out a claim form if you are treated by a participating provider any where in the U.S. When you need any health care services, simply show your new Blue Cross/Blue Shield identification card and your claim will be filed directly with Blue Cross/Blue Shield by the provider. All providers may now file your claims electronically. If your provider is not equipped for electronic filing, claims can be mailed to the local Blue Cross Office.

More details about covered services, exclusions and limitations can be found in your summary plan description. ■

DENTAL PLAN PREFERRED PROVIDER ORGANIZATION The Local 295/Local 851 Employer Group Welfare Fund Dental Plan is provided through DDS, Inc.

Much like the health plan of benefits, persons needing dental services can choose between the PPO participating dentists or dentists who do not participate in the PPO.

If you receive covered services from dentists who are not in the DDS PPO, your out-of-pocket expense will be much higher.

Finding a PPO dentist… Contact DDS, Inc. to find a participating PPO dentist or to verify if your dentist is on the panel of participating dental providers.

You should also contact DDS, Inc. to obtain benefit allowance information or to check on the status of a claim.

The DDS, Inc. address is 1640 Hempstead Turnpike, East Meadow, NY 11554.

The telephone numbers are (516) 794-7700 and (800) 255-5681.

The DDS, Inc. office hours are Monday through Friday, 9:00 A.M. to 4:30 P.M., Eastern Time, except holidays. ■

NEED INFORMATION ABOUT YOUR PENSION PLAN OR YOUR WELFARE PLAN COVERAGE? If you need information about your benefits, contact the Fund Office by calling (212) 308 4200.

The Fund Administrator is Savasta and Company, Inc. and the Fund Office is located at Sixty Broad Street, 37th Floor, New York, New York 10004. Office hours are Monday through Friday, 9:00 A.M. to 5:00 P.M., Eastern Time, except holidays. ■

You'll be looking much better . . . . . if you contact the Welfare Fund Office and ask for an optical benefits voucher. You and your eligible dependents can get an eye examination, new lenses and frames once each year with no out-of-pocket expense. ■

LOCAL 295/LOCAL 851 IBT EMPLOYER GROUP PENSION TRUST FUND AND EMPLOYER GROUP WELFARE FUND
SIXTY BROAD STREET, 37TH FLOOR
NEW YORK, NEW YORK 10004