FOR YOUR BENEFIT

THE LOCAL 295/LOCAL 851 EMPLOYER GROUP BENEFIT FUNDS NEWSLETTER
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WELFARE FUND CAN PAY FOR OBESITY SURGERY The Local 295/Local 851 IBT Employer Group Welfare Fund allows coverage for qualifying surgery to treat obesity.

The Trustees have adopted the following policy and criteria for evaluation of bariatric surgical cases.

- All proposed bariatric surgical cases must be submitted to the Fund Office for review in advance of the procedure being performed. Failure to obtain advance approval will result in denial of the claim in its entirety.
- The patient must be at least 18 years of age.
- The patient's body mass index (BMI) must be 40 or higher or the BMI must be 35 or higher with one or more co-morbidities such as severe sleep apnea, hypertension, obesity related cardiomyopathy, severe diabetes mellitus, pickwickian syndrome, serious musculoskeletal or neurological concerns and functional impairments that severely interfere with employment, family function and ambulation. Certification of the patient's BMI and co-morbidities, if any, must be provided by the attending physician.
- The patient must have a long standing history of obesity and must have undergone multiple unsuccessful attempts to lose weight using non-surgical methods (i.e. - regular exercise and an established weight loss program such as Weight Watchers, LA Weight Loss or Jenny Craig) for at least a one-year period with no sustained weight loss. The patient must provide proof of participation in the non-surgical or conventional weight loss programs within the 1 to 2 year period prior to the request for coverage of a bariatric surgical procedure.
- The patient must have the ability to comply with dietary and behavioral changes as recommended by the weight management team and must have undergone psychiatric evaluation with a statement attesting absence of psychiatric disorder.
- The patient must have undergone nutritional assessment and routine laboratory tests including a thyroid function test.

There are two different bariatric surgical procedures that can be covered by the Welfare Fund. They are CPT codes 43847 and 43846. The procedure names are gastric roux-en-y and gastric bypass.

If the claim is approved, no more than the preferred provider organization (PPO) allowed surgical charge will be processed for either of the two eligible surgical procedures. The payment for network claims will be the PPO allowed charge less the patient's co-payment.

Out-of-network claims will be processed under the major medical portion of the plan, subject to the annual deductible and 75% - 25% co-insurance. No more than the network allowed anesthesia expense will be covered on the same basis.

The usual hospital pre-admission certification rules apply to bariatric surgical cases. The patient or their physician must Contact MedReview. The toll-free telephone number is 800 553 9603. The hours are Monday through Friday, 8:30 A.M. to 5:00 P.M., Eastern Time.

Failure to pre-certify the hospital admission will result in a part of the hospital claim not being paid by the Welfare Fund.

Weight loss treatment options . . . For anyone who has considered treatment, there is certainly no shortage of choices. Most weight loss programs are based on some combination of diet/behavior modification, drug therapy and regular exercise. Unfortunately, even the most effective interventions have proven to be effective for only a small percentage of individuals. Published reports indicate that severely obese adults who participate in non-surgical weight loss programs often do not achieve medically significant long-term weight loss. Most of these patients regain all of the weight lost over the next five years. Sustained weight loss for patients who are morbidly obese is even harder to achieve.

Weight loss surgery provides longest period of sustained loss . . . Bariatric (or weight loss) surgery when compared to other interventions has provided

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the longest period of sustained weight loss in patients when all other therapies have failed. That is the key reason that more than 140,000 weight loss surgical procedures were performed in 2004. After 5 years, only 2% to 5% of the diet and exercise patients maintained their weight loss by comparison to 0% of the drug therapy patients and 70% of the weight loss surgical patients.

Before you have the surgery, you should know about the risks . . . While bariatric (or weight loss) surgery provides longer term sustained weight loss and marked improvement in the patients' co-morbid conditions, it was found that the chances of dying within a year after obesity surgery are much higher than previously thought. Some previous studies of people in their 30s to their 50s (the most common ages for obesity surgery) found death rates well under 1 percent. A study involving more than 16,000 Medicare patients who underwent obesity surgery between 1997 and 2002 was recently published in the Journal of the American Medical Association. It was noted in the Medicare patient study that more than 5 percent of men and nearly 3 percent of women in the age 35 to age 44 range were dead within a year following the surgery. Slightly higher death rates were noted in patients in the age 45 to age 54 range. Among the patients between the ages of 65 and 74, nearly 13 percent of men and about 6 percent of women died. Among the patients who were age 75 and older, half of the men and 40 percent of the women died. The study lumped together all of the deaths with no breakdown on the causes. Researchers said that one reason men may have higher post-surgery death rates is that men wait longer than women to get medical help and may be sicker when the weight loss operation is performed. ■

WANT TO SAVE ON YOUR EXPENSE FOR DRUGS? TRY THE MAIL AWAY PROGRAM!

Active-at-work employees and dependents and eligible retirees and spouses who are not covered by Medicare have a prescription drug coverage through the Local 295/Local 851 Employer Group Welfare Fund. The drug plan is provided through General Prescription Programs.

More than 50,000 retail pharmacies . . . The General Prescription Programs card can be used at any one of more than 50,000 pharmacies nationwide to get the needed prescription drugs. When prescriptions are filled at the participating pharmacies a $10 co-payment is required for each generic drug. The co-payment is $20 for most brand-name drugs and it is $25 for any one of about 40 specific brand-name drugs that are on the non-preferred listing. All co-payments are an additional $2 for prescriptions that are filled in any of the drug stores that are part of the Walgreen's, Eckerd or CVS chains.

When you buy your drugs at a retail store you may only get a 30-day supply and your prescription may be refilled two times. Your out-of-pocket expense for the co-payments on three 30-day supplies will range from a low of $30 to a high of $81.

Of course, if you enjoy going to the drug store every month, waiting in line and paying higher costs, then you should continue getting your prescriptions filled at the retail store. Otherwise, you may want to consider using the mail away program.

Mail-away program will reduce your cost . . . For the price of a stamp and a $10 co-payment you can get a 90-day supply of your prescription drug. The $10 single co-payment applies to all generic, brand-name and non-preferred brand name drugs that you purchase through the Mail Away Program. Your co-payment savings will range from $20 to $71. And, you will save even more money and a lot of time since you only have to take your Mail Away Program form to the mail box instead of making three trips to the drugstore.

Make the call to get a form . . . If you are interested in changing to the Mail Away Program, call the Fund Office at (212) 308 4200 and ask for a prescription order form. Complete and easy-to-follow instructions are printed on the form. You can make your $10 co-payment by check or money order or you can authorize a charge to your Master Card or Visa credit card. ■

PPO NETWORKS – IF YOU CHOOSE NOT TO USE THEM YOU'LL PAY OUT OF POCKET

An important part of the Welfare Plan of benefits is its Preferred Provider Organizations. We refer to a Preferred Provider Organization as a PPO. The PPOs for your Welfare Fund are networks of facilities and practitioners who are under contract with Empire Blue Cross and

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Horizon Health Care/Beechstreet. The network providers have been screened by the PPOs to assure quality services.

In network services means lower out of pocket expense for you . . . Each of the PPO facilities and practitioners has agreed to provide all covered services with little or no out-of-pocket expense to our covered participants and their families.

PPOs provide medical, surgical, laboratory and X-ray services to you and your dependents for reduced fees. Other than a co-payment for some medical and surgical services, you will have no out-of-pocket expense.

Be sure that your provider is in the network . . . If you are in need of medical, surgical or laboratory and X-ray services check your Horizon Health Care/Beechstreet directory. Select a provider and call the provider you have selected to make an appointment.

When you make an appointment with a provider it is to your advantage to confirm that the provider is still participating in the PPO. Do not assume that a provider is in the network or that a PPO doctor will use a PPO laboratory or X-ray facility or refer you to other PPO providers.

When you arrive at the network facility, show your identification card and make the required co-payment, if any. You do not need a claim form for PPO providers.

Out of network means you have to pay more . . . Out of network claims are paid according to the Plan's reimbursement rate and the charges will be subject to the annual major medical deductible and co-insurance. The claim will cost you some out-of -pocket expense.

The major medical deductible is $300 for each covered person each year. That means that the first $300 of permissible plan charges are not paid at all by the Plan. After the deductible has been met, the rate of payment is 75% of the amount of permissible plan charges that are over and above the deductible.

Out of pocket costs could be several hundred dollars or several hundred thousand dollars . . . If, for example, an out-of-network provider charges you $1,000 for surgery, the permissible plan charge may be only $500. $300 of the $500 would satisfy the deductible and the payment would be 75% of $200. The total payment would be only $150 and you would have to pay the provider $850 out of pocket.

Non-panel providers are not limited as to amounts they can charge for any of their services and amounts billed by non-panel providers that are over and above the Fund's payment are the responsibility of the patient.

One claim could cost the patient $250,000 . . . A recent claim for kidney dialysis services was received from an out-of-network provider. The total expense is almost $300,000 and the patient is faced with having to pay more than $250,000 of the bills. If the patient had gone to a network provider there would have been no out-of-pocket cost. ■

DIABETIC SUPPLIES SHOULD BE PURCHASED THROUGH NETWORK PROVIDERS

The Fund Office staff has noticed an increase in the number of out-of-network claims that are being filed for diabetic supplies. The Plan does provide coverage for certain diabetic supplies such as lancets, test strips, glucose meters and insulin pumps. While these items are available through the PPO network, some of the patients are purchasing the items at retail outlets and then filing their claims with the Fund Office.

Out of network means out of pocket expense . . The Fund Office has to process the out-of-network charges under the major medical coverage. That means no payment for the first $300 of charges (that's the amount of the annual deductible) and the rate of payment is 75% of the covered charges that are over and above the deductible. As a result, the diabetes patient will receive no payment whatsoever for the first $300 of expense and payment will be made at the rate of 75% of the remainder of the covered expense. A $400 claim would result in a payment of just $75.

Many of the claims received in the Fund Office have to be returned to the diabetes patients for better information. Either the claim form is not fully completed or the documentation isn't acceptable. Some of the patients are filing cash register receipts or photocopies of billings with their claims and the Fund requires itemized original billings.

Network providers file claims for you . . . Diabetes patients can avoid the claim filing problems and out-of-pocket expense by ordering the

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covered supplies from a PPO network provider. Check your PPO directory under the heading of Ancillary Providers, DME. DME is the abbreviation for Durable Medical Equipment. The Fund Office staff has verified with Horizon Healthcare that at least two of the DME providers have diabetic supplies available. The providers are:

Pharmacy Distributors, 801 Maplewood Drive, Suite 18, Jupiter, Florida 33454. Telephone: 800 440 2427 Facsimile: 800 590 3441 Website: webmaster@pharmacydistributorservices.com

Edgepark Surgical, 1810 Summit Commerce Park, Twinsburg, Ohio 44087 Telephone: 800 321 0591 Facsimile: 330 425 4355
Website: www.edgepark.com

The providers will ship your order directly to you and directly file a claim with the Welfare Fund on your behalf. The deductible and co-insurance do not apply when you buy from a network provider. ■

REDUCED PRICES IN THE OPTICAL PLAN! The Welfare Plan's optical providers offer savings to the patients who utilize the networks. For example, you can call the Fund Office and ask for an optical voucher and then go to any one of the five optical networks for an eye examination and a pair of glasses or contact lenses each calendar year. You will have no out-of-pocket expense whatsoever. You may instead choose to get your examination and glasses from a non-participating optical provider. If you do, however, you will have to pay for the services and then file a claim with the Fund Office. You will, most likely, have to pay a balance to the non-participating provider since the Welfare Plan limits the amounts of payments for the services of non-participating providers.

If you need more information about the optical plan of benefits, contact the Fund Office at (212) 308 4200. If you are covered by a Medicare Risk HMO you should contact the HMO to inquire about their procedures to get optical services. ■

DENTAL NETWORK OFFERS LESS OUT-OF-POCKET EXPENSE! Much like the medical plan, the dental plan is composed of two options – the DDS, Inc. PPO or non-participating providers. When you utilize the services of a DDS, Inc. provider, your out-of-pocket cost will be only $100 per unit for crowns, bridges and dentures and there are no out-of-pocket costs for your basic dental needs, including preventative maintenance, such as cleaning and X-rays.

If you go to a non-participating provider, you have to pay for the cost of the services and then file a claim. You will be reimbursed based on a schedule. The out-of-network dentist could charge you much more than you will be reimbursed and you will have to pay the balance out of pocket. ■

NEED INFORMATION ABOUT THE WELFARE OR PENSION PLAN? Call or visit the Fund Office. The Fund Office is located in mid-town Manhattan at One Dag Hammarskjold Plaza, 20th Floor, New York, New York 10017. (Second Avenue between 47th and 48th Streets). The telephone number is (212) 308 4200. Office hours are 8:30 AM to 5:30 PM Eastern Time. ■

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