



## WELFARE AND PENSION FUNDS

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December 30, 2013

### IMPORTANT NOTICE – CHANGE TO YOUR HEALTH PLAN BENEFITS EFFECTIVE MARCH 1, 2014 CHANGES TO FULL-TIME PLAN

To All Eligible Full-Time Participants:

The Trustees of the U.F.C.W. Local 1500 Welfare Fund (the "Fund") announce the following changes to your health plan ("the Plan"). The first two changes listed below are effective January 1, 2014. The remaining changes are effective March 1, 2014. We are committed to keeping you informed and making you aware of benefit changes to the Plan, most of which are a result of the passage of the Patient Protection and Affordable Care Act ("ACA"). As of March 1, 2014, the Plan will no longer be a grandfathered plan within the meaning of ACA.

#### **I. Annual Maximum Eliminated Effective January 1, 2014**

The \$2,000,000 annual maximum on covered services is eliminated. There will be no annual maximum for medical and prescription drug benefits provided by the Fund.

#### **II. Dependent Eligibility Expanded Effective January 1, 2014**

The Fund will no longer exclude from health coverage eligible children under age 26 who have access to their own employment-based health coverage. If your eligible child has been excluded from coverage for this reason, contact the Fund Office at 1-800-522-0456 for instructions on how you may enroll your child for coverage, effective January 1, 2014.

- **NOTE: You must enroll your newly eligible children for this coverage. In order for such coverage to be effective as of January 1, 2014, you must enroll your newly eligible child by January 31, 2014. Contact the Fund Office for enrollment information.**
- As a reminder, the following children under age 26 are eligible for coverage under the Plan: your biological or legally-adopted child (including a child legally placed for adoption); a stepchild; a child for whom you have been appointed legal guardian (provided the child is claimed by you as a dependent on your federal income tax return); and a child for whom you have been designated as the responsible party under a Qualified Medical Child Support Order (QMSCO).

#### **III. Spousal Coverage Effective March 1, 2014**

Effective March 1, 2014, any spouse who has access to other coverage through his or her employer, will not be eligible for coverage under the Plan. The "access to other coverage exclusion" applies regardless of the premium charged by the spouse's employer or the level of benefits provided by the spouse's employer. Coverage for spouses currently covered under the Plan who have access to other coverage will terminate February 28, 2014.

#### IV. Plan Design Changes Effective March 1, 2014

	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Deductible</b> (Single/Family)	\$150 single/\$300 family	\$500 single/\$1,000 family
<b>Co-Insurance</b> Paid by the Fund  Paid by the Patient	80% of the In-Network Fee Schedule  20% of the In-Network Fee Schedule,	70% of the Usual & Customary Rate  30% of the Usual & Customary Rate
<b>Out-of-Pocket Maximum</b> (Single/Family) (includes deductibles, co-insurance and co-pays for covered charges)	\$1,500 single/\$3,000 family	\$4,000 single/\$8,000 family
<b>Primary Care Physician Copay</b>	\$25	
<b>Specialists Physician Copay</b>	\$40	
<b>Emergency Room Copay</b> (waived if admitted)	\$100	\$100
<b>Prescription Drug Benefit</b>	20% Co-insurance, up to a maximum of \$10 generic, \$25 preferred brand, \$50 non-preferred brand	20% Co-insurance, up to a maximum of \$10 generic, \$25 preferred brand, \$50 non-preferred brand

#### V. Preventive Care Benefits Effective March 1, 2014

The Fund will cover certain preventive care visits, without cost to you, when you use In-Network providers only. If you use an out-of-network provider for preventative care services when an in-network provider is available, your claim for benefits will be treated like any other out-of network claim. This means that if you use an out-of-network provider for preventative care, when an in-network provider is available, you will be responsible for applicable copayments. Participants and their eligible dependents covered under this Plan will be eligible for certain types of free screenings and tests, if they use in-network providers. Covered preventive services will include services with an “A” or “B” recommendation from the U.S. Preventive Services Task Force (USPSTF), vaccines recommended by the Centers for Disease Control and Prevention (CDC), and services outlined in the Bright Futures guidelines developed by the American Academy of Pediatrics.

- Examples of preventive services that will be provided free of charge in-network include screening for colorectal cancer (including polyp removal during a preventive colonoscopy), cervical cancer, osteoporosis, cholesterol abnormalities, high blood pressure, diabetes, sexually transmitted diseases, depression, obesity and tobacco use.

In addition, aspirin will be covered, but *only* when prescribed by a physician. Other in-network preventative pediatric services will also be provided for children (*e.g.*, well-child care until age 21) and newborns, free of charge.

## **Additional Preventive Services for Women**

The Fund will also provide coverage for certain Preventive Services for women, as required by ACA. Coverage will be provided in-network with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the services recommended in the Health Resources and Services Administration (HRSA) guidelines, including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women. If you use an out-of-network provider for preventative care services when an in-network provider is available, your claim for benefits will be treated like any other out-of-network claim. This means that if you use an out-of-network provider for preventative women's care when an in-network provider is available, you will be responsible for applicable copayments.

Covered Preventive Services for women include, but are not limited to, well-woman visits, contraceptive methods and counseling for all FDA-approved methods (including, but not limited to, barrier methods, hormonal methods, implanted devices, and sterilization), human papillomavirus (HPV) testing, counseling for sexually transmitted infections, screening and counseling for HIV, screening and counseling for interpersonal and domestic violence, screening for gestational diabetes, and breast-feeding support, supplies and counseling (including equipment rental and/or purchase). In addition, the Fund will cover screenings for women whose family history are associated with an increased risk of mutations in the BRCA 1 and BRCA 2 genes, to include both genetic counseling and BRCA testing, if recommended by a health care provider.

A copy of the full rules regarding the scope of the Plan's Preventive Services coverage for adults and children is available by calling Associated Administrators at 1-855-266-1500.

## **VI. Out-of-Network Emergency Services Covered Same as In-Network Effective March 1, 2014**

In cases of medical emergencies outside of the Fund's network service area (New York, New Jersey and Connecticut), the emergency room benefit will be the same whether the emergency room used was in-network or out-of-network.

## **VII. New Claims and Appeals Procedures Effective March 1, 2014**

The Fund's claims and appeals procedures will comply with ACA, including the requirement to provide an external review by an independent external review organization, known as an Independent Review Organization (IRO), for certain claims, after the Fund's internal appeals processes are exhausted. The decision of the IRO will be binding on the Fund. A copy of the Fund's full claims and appeals procedures, including the new external review procedures, is available.

## **VIII. Participation in Approved Clinical Trials Effective March 1, 2014**

### **A. Benefit Description**

Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease, will be covered, provided the charges are those that are:

- (a) Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Fund if the individual were not participating in the Approved Clinical Trial; and
- (b) Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

You and your eligible dependents are eligible for payment of charges for participation in an Approved Clinical Trial if:

- (a) You satisfy the protocol prescribed by the Approved Clinical Trial provider; and
- (b) Either: (1) The individual's network participating provider determines that participation in the Approved Clinical Trial would be medically appropriate; or (2) the individual provides the Fund with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

An Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease. The Approved Clinical Trial's study or investigation must be:

- (a) Approved or funded by one or more of: (1) the National Institutes of Health (NIH), (2) the Centers for Disease Control and Prevention (CDC), (3) the Agency for Health Care Research and Quality (AHCRO), (4) the Centers for Medicare and Medicaid Services (CMS), (5) a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (6) a qualified non-governmental research entity identified by NIH guidelines for grants; or (7) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
- (b) A study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- (c) A drug trial that is exempt from investigational new drug application requirements.

**B. Limitations and Exclusions for Clinical Trial Coverage**

No benefits will be paid for:

- Expenses incurred due to participation in an Approved Clinical Trial that are:
  - (1) Investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial;
  - (2) Items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- Expenses at an out-of-network provider if an in-network provider will accept the patient in an Approved Clinical Trial

This notice is intended to serve as a Summary of Material Modifications ("SMM") for the U.F.C. W. Local 1500 Welfare Fund Full-time Plan, as required by the Employee Retirement Income Security Act of 1974 (ERISA). It describes changes to information presented in your Summary Plan Description (SPD) booklet, Fund communications, and any previous SMMs. Please keep it with your SPD and other benefits materials for future reference.

If you have any questions regarding any of the information in this notice, please contact Associated Administrators at 1-855-266-1500.

Sincerely,

The Board of Trustees