

Benefits Basket

Food for thought from the UFCW Unions & Employers Midwest Benefits Funds

Fall, 2000

Using Your Benefits – 15 Top Tips

Health and pension benefits have been increased substantially over the past five years, including an increase in lifetime health benefits to \$1 million per person. In 1999, \$62 million in health benefits and \$33 million in retirement and disability pensions were paid. The vast majority of these claims and applications were processed quickly and participants were able to receive all the benefits they were due. But some claims were delayed due to a lack of information; and some claims were probably never filed even though a participant had benefits coming.

The purpose of this special edition of *The Benefits Basket* is to give you specific tips on how to help get your claim processed smoothly and how to get the most of the benefits you have coming. The employees of the Benefits Fund Office have identified 15 potential problem areas where claims can be delayed or benefits can go unclaimed. Look them over and, hopefully, you will find a few that will prove useful to you.

#1 Injury Claims Always Require a Health Claim Form

With the arrival of the BlueCross BlueShield PPO in 1994, much of the work for the patient and the Benefits Fund Office has been “paperless.” The doctor or hospital files your claim through the BlueCross system and your work is done. But, if the claim involves an injury—from a sprained ankle to a major accident—the Benefits Fund Office needs to have a claim form completed by you. The information you provide on the claim form helps us process benefits accurately. If this information is not received, it will delay processing while we send you a separate letter asking for the injury details.

You can help cut processing time for injury claims in half by filing a claim form after you get medical attention. Do this even though you don't have a bill to send in with the claim form. Don't worry—we'll know what to do with the information even if the medical bill has not yet reached us.

The Benefits Fund Office can mail you claim forms on request.

#2 Go to the Dentist

Each year several thousand people who are eligible for benefits never file a dental claim. Your health plan provides substantial benefits for preventive dental care—particularly for cleanings and diagnostic x-rays. Dental problems caught early are much easier to fix!

If you have not already done so, choose a dentist and schedule a visit. Then be sure to file a dental claim form and provide all information requested, particularly other employment or other medical coverage information. Failure to do so can delay the processing of your claim.

#3 You Can Get up to a 100-Day Supply of Certain Drugs

Your health plan covers a 34-day supply of most prescription drugs. But for certain drugs used for long-term conditions, a 100-day supply is allowed. If you use one of these drugs, take advantage of the

special provision—it is more convenient plus you pay your deductible only once every 100 days instead of once every 34 days.

The allowable drugs for the larger supply are:

- anti-asthmatic drugs and inhalers
- anti-convulsant drugs
- anti-gout drugs
- anti-hypertensive drugs
- anti-lipidemic drugs
- anti-Parkinson drugs
- blood glucose testing strips
- cardiovascular drugs
- estrogen supplements
- fluoride supplements (prescription only)
- hypoglycemic drugs
- methazolamide (Neptazine)
- Pentoxifylline (Trental)
- potassium supplements (prescription only)
- pre-natal vitamins (prescription only)
- Propylthiouracil
- thyroid supplements



#4 Call Us Later in the Week if Possible

Phone calls peak on Monday and gradually drop off to the lowest call volume on Friday. The later in the week that you call, the less likely you are to experience a delay in your call being answered. For some reason, even waiting from Tuesday to Thursday makes a difference!

Of course, some calls can't wait. But if you can delay, service should be faster later in the week.

#5 Make use of the PPO—Especially for Outpatient Surgery

When you use a PPO hospital or doctor, both you and the health fund save substantial dollars. Many prestigious and well-regarded medical centers are in the BlueCross BlueShield Preferred Provider Organization (PPO). There is no need to settle for anything less than the highest quality of healthcare just to get a discount.

If you are having outpatient surgery, it is especially important that you use a PPO hospital or surgical center. We have many "horror stories" of employee-members who had minor foot surgery that would have cost \$500 in a doctor's office but were charged \$5,000 at a non-PPO surgical center.

Ask the doctor or medical center if they are in the BlueCross BlueShield PPO. If you are unsure, you can check with us or call BlueCross BlueShield at 1-800-810-BLUE, web site www.bluecares.com.

Remember that you should not pay at the time of service when you use a PPO doctor or facility. The Benefits Fund Office needs to receive the discounted bill from the health care provider before any payment decisions are made. If you pay the full amount charged by the provider, you may not receive all of the reimbursement that you have coming.

#6 Call to Pre-Certify Surgery, Hospitalization or Major Testing

Your health plan requires pre-approval of surgery, inpatient hospitalization, and advanced testing (such as an MRI), unless treatment is given on an emergency basis. Remember to call the Benefits Fund Office (not BlueCross BlueShield) when such treatment is planned. Very often your doctor's office will offer to make the call—and they should do so since they have the most detailed and up-to-date information about your medical treatment. But even if your doctor's office is calling us, *you* should call also. This way, in case their call is delayed, your call will be on record at the Benefits Fund Office.

#7 Keep us Advised of your College Student's Enrollment in School

Dependent children up to age 23 may be covered under your health plan if they are enrolled full-time in a college or vocational school. At the beginning of each semester or term, the Benefits Fund Office must be provided with proof of school registration. The registrar's office at most schools is happy to provide this or you can use a copy of the confirmation of enrollment. If we don't receive verification, coverage ends at the beginning of the next semester.

If you have a college student, make it a habit to update his or her student status with the Benefits Fund Office every semester. This will assure continued coverage, especially for their prescription drug benefits, while they are away at school.

#8 Keep us Informed of your Correct Address—Even if you are no Longer Employed

Now that the vesting requirement for a pension has been lowered from

10 to 5 years of service, many people will be eligible for a pension at retirement age. This is true even though they may leave the grocery industry relatively early in life, many years before they would draw their pension.

When people aren't actively employed or aren't covered under the health plan, there is a tendency to not worry about keeping address data current. But it is to your benefit to keep us informed! Over the years, many valuable plan upgrades are made (like the lowering of the vesting requirement). We can't send you information on these important upgrades if we don't have your correct address.

So, remember to keep the Benefits Fund Office informed of your correct address.

#9 File Work-Related Claims through the Employer—File Non-Work-Related Claims with us

The number one topic of health claim appeals is whether or not a condition is work-related. Your health plan, like all group health plans, does not cover work-related injuries. Claims for injuries that occur because of the job should be filed through the employer's workers' compensation insurance plan.

As difficult as it is at times, the patient and doctor should assess the condition and make a determination as to whether the patient's job is the cause or a contributing factor. Then file the claim with either the employer or with us. Remember, if you advise the Benefits Fund Office that a condition is work-related, we must deny benefits and cease any involvement in the claim or treatment.

#10 Act Promptly to Protect Health Coverage that is about to End

Federal law gives you certain rights to make payments to continue health coverage after it would otherwise



end. The law that governs these rights is commonly referred to as “COBRA.” If you wish to elect continuing coverage under COBRA, you must act within 60 days of the date the coverage would end.

Coverage ends for most employee-members when they quit their job, work less than the minimum required hours, or do not return to work from a disability leave at the end of the free extension of coverage provided by the health plan (either 2 months or 6 months, depending on your plan of benefits). Dependent coverage can end when the employee-member’s hours drop, when there is a divorce, when a child turns 19 or 23, or when a student drops out of college.

We know when you are no longer actively at work or when your hours drop below the minimum for coverage. We send you a notice advising you of your COBRA rights. But we do not know when personal events happen in your life—you must notify *us* of personal events and, under the law, you must do it within 60 days if you want to elect continuing coverage under COBRA.

If you are on a disability leave, contact the Benefits Fund Office from time to time to confirm your continuing coverage. If a dependent is about to lose eligibility under the plan, contact us—we’ll let you know exactly when the dependent coverage ends and the cost to you of continuing the coverage under COBRA. It can be a terrible event for health coverage to lapse without your realizing it. Don’t let this happen to you.

#11 Provide Other Employer and Insurance Info on Claims for your Dependents

To process a claim for your husband, wife or child, we need to know about any other employment or health coverage. The first time you have medical expenses for a family member, be sure to file a claim form to provide the information requested about other employment or other medical coverage.



#12 Sign the Release Form at your Doctor’s Office or Clinic

When you fill out the “intake” forms at a doctor’s office or medical facility, there are usually two sections on the form that need your signature. One is a section that assigns any benefit payments to the treatment provider. The other is a paragraph in which you authorize the doctor or facility to release information to your health plan. If we need information and this section has not been signed, most doctors will not talk to us. Since we sometimes need additional information on the claim, this slows the process down while we mail you a release form to be signed. So sign the release on the first day and you won’t have to worry about it causing a delay.

#13 Provide Info on Payments by Other Insurance— And be Sure to File with us for another Plan’s Co-Payment!

When there are two group health plans in a family, each plan pays the claims in a certain order—this is referred to as “Coordination of Benefits” (COB). Usually this occurs when both a husband and wife have coverage. Generally, we pay first for you as an employee-member—and your spouse’s plan pays first for his or her expenses. Dependent children are covered first by the plan of the parent whose birthday occurs first in the year.

There are two things you can do to speed COB claims and maximize your benefits.

The first thing is to be sure to send in an itemized bill and your other plan’s explanation-of-benefits (EOB) when we are the secondary plan. This will help speed your payment because we need both items.

The second thing is often overlooked and can, in fact, save you money. When your spouse or child uses the other plan’s prescription drug benefit card, the small co-payment made at the pharmacy can be submitted to our plan for reimbursement. Call the Benefits Fund Office and ask for a “Direct Reimbursement” form for prescription drug claims. Recently an employee-member filed such a claim with us and received over \$500 in reimbursement. This is unusually high, but we know there are dollars out there that are never claimed. Be sure to apply for all you have coming!

#14 Beware of “Free” Medical Care Offers

Over the years we have seen claims from patients who went for “free” medical exams, foot exams or chiropractic check-ups. But later, either the Benefits Fund Office is billed for large expenses or the patient is faced with recommendations for invasive, expensive medical care. The best place for you to receive medical care and advice is from a family practice doctor, internist or pediatrician with whom you have developed a trusting doctor-patient relationship. If you do not have such a doctor, work with a local hospital’s doctor referral service to select a BlueCross BlueShield PPO physician.

“Free” physical exams are not a good place to receive health care (and neither is the emergency room in many non-emergency cases!). Building a lasting doctor-patient relationship is far more healthy and productive.

#15 Reconsider Whether you Need to Buy School Insurance or Other Special Event Insurance

If your children are covered under this health plan, their coverage applies regardless of where an injury might occur. If you buy insurance offered by a school or sports group,



you are buying coverage over and above what this plan would pay for medical care. This could be advantageous to you, because the school plan may cover your out-of-pocket expenses with us or may pay above some limits included in this plan.

But the existence of special event insurance can also lead to disputes as to which plan is primary

(meaning, which plan should pay first). Your plan has decades-old, proven, fair language that if there is such a dispute, each plan should pay one-half of the costs. But other plans usually don't have this language. This can actually lead to your receiving lower benefits than you would get if you hadn't purchased the special plan. We don't want to advise you whether or

not to buy such coverage, but all of the factors should be considered before you make such a purchase.

Similar issues arise when you purchase "medical payment" insurance as part of your automobile policy. This is not the same as school coverage, since automobile medical payment insurance covers persons in your car who are not covered under this health plan. But you might want to ask your agent about the need for medical payment coverage since you have group health coverage from your UFCW union and employer.

Need to contact the Benefits Fund Office?

Call us 1-847-384-7000 ♦ 1-800-621-5133 ♦ TDD 1-847-384-0199

FAX us 1-847-384-0197

Write us 1300 Higgins Road, Suite 300, Park Ridge, IL 60068-5713

(Note: Some readers are not covered under the Pension Plan)

United Food and Commercial Workers Unions and Employers Midwest Health Benefits and Pension Funds

Board of Trustees

Employer Trustees

Sid Abrams, Safeway, Inc.
Byron Magafas, Eagle Food Centers
Rex Mudge, Illinois Food Retailers Association

Alternate Employer Trustees

John Dougherty, Supervalu
Brian Jordan, Illinois Food Retailers Association
Stan Schwartz, Dominick's Finer Foods

Fund Administrator: Daniel W. Ryan

Union Trustees

Robert C. Hooker, UFCW Local Union 1540
Ronald E. Powell, UFCW Local Union 881
Steven M. Powell, UFCW Local Union 881
D. Troy Pruitt, UFCW Local Union 536
Robert H. Vaughn, UFCW Local Union 546

Alternate Union Trustees

Joseph Blatner, Jr., UFCW Local Union 1540
Wallace Evans, UFCW Local Union 881
Maynard Jerome, UFCW Local Union 881
Terry Kramer, UFCW Local Union 1540
Clarence O'Connor, UFCW Local Union 546
Walter Wojciechowski, UFCW Local Union 1540

Editor: Margi Devoe

United Food and Commercial Workers
Unions and Employers Midwest
Health Benefits and Pension Funds
1300 Higgins Road, Suite 300
Park Ridge, Illinois 60068-5713