TWIN HORSE CRIER

November 2014 Volume 42, No. 2

Having trouble understanding your Explanation of Benefits?

MOST OF US HAVE AT LEAST SEEN AN EXPLANATION OF Benefits (EOB), but may not really understand it means. Here's some information to give you a better understanding of why you receive EOBs and how to interpret them.

Any time you receive services from a medical, dental or vision provider, and a claim is filed and processed by the Fund, you will receive an EOB. An EOB is not a bill, but an explanation of how your benefits were paid for the particular claim.

EOBs identify the following information, as well as the information provided in the example below:

* the member's name and ID number
* the patient's name and birth date
* the provider's name

In compliance with HIPAA laws, spouses and dependent children 18 and older will receive EOBs addressed specifically to them, while underage dependent children's EOBs will be mailed to the participant.

See the example below which explains how in-network benefits were paid for an out-patient x-ray. The numbers in red are defined in the legend below the Explanation of Benefits.

If you're still having trouble understanding your Explanataion of Benefits, feel free to contact the Claims Department at the Fund Office for more information.

MEMBER	SERVICE DESCRIPTION	MEMBER ID	PATIENT	ALLOWED AMOUNT	BIRTH DATE	PROVIDER NAME		PLAN %	PREPAID	PAYABLE AMOUNT	RMK CD	
FROM DATE THRU DATE		SUBMITTED CHARGES	DISCOUNT		COPAY AMOUNT	NOT PAYABLE	DEDUCTIBLE				PATIENT RESPONSIBLE	CLAIM #
BEN E. FITZ		80109999	ELLIE FITZ		11/20/1998	MEDICAL IMAGING OF RICHMOND						A
10/4/2014	RAD OUT PAT	$118.00	$66.86	$51.14	$0.00	$66.86	$26.57	90	$0.00	$22.11	$29.03	AA1111
1	2	3	4	5	6	7	8	9	10	11	12	13 14
TOTALS		$118.00	$66.86	$51.14	$0.00	$66.86	$0.00		$0.00	$22.11	$29.03	
Comments/Denial:												
A. Your 2014 annual deductible has been satisfied.												
Total Payment:										$22.11		

1. From Date/Thru Date - dates in which service was performed
2. Service Description - type of service that was provided, i.e., out-patient radiology
3. Submitted Charges - dollar amount billed by the provider
4. Discount - dollar amount to be written off by the provider for participating in the Anthem BlueCross BlueShield PPO Network
5. Allowed Amount - difference between the submitted charges and the discount; amount considered for payment by the Fund
6. Copay Amount - dollar amount specified in the Schedule of Benefits payable by the patient
7. Not Payable - dollar amount not considered for payment by the Fund
8. Deductible - dollar amount applied towards the annual deductible
9. Plan % - payment based on the percentage specified in the Schedule of Benefits, after the deductible is satisfied
10. Prepaid - dollar amount paid by the primary carrier, in cases where the Fund is the secondary carrier
11. Payable Amount - payment made by the Fund
12. Patient Responsible - the submitted charges less any discount, deductible, copays, co-insurances, primary carrier payments (if applicable) and payment by the Fund
13. Remark Code - refers to any pertinent information relating to the claim such as deductible information or non-covered charges
14. Claim # - combination of letters and numbers assigned by the Fund Office to identify the claim

In this Edition:

H&W NEWS

Need to file an out-of-network claim?

If you have visited an out-of-network provider that refuses to file a claim on your behalf, you must submit the claim yourself. The form and addresses for filing your claim are available at the following web address: www.tjc83funds.org/medical.asp

Optum Rx Complies with COPPA

Optum Rx, your prescription benefit manager, complies with the Children's Online Privacy Protection Act (COPPA). This Act states that parents or guardians of dependents age 13 and older cannot legally access their dependents' accounts on OptumRx.com unless the dependent grants Caregiver Access to his/her parent or guardian.

Maternity Management Program Reminder

If a Participant or their Dependent is within the first trimester of pregnancy, she must join and successfully complete the maternity management program provided by Carewise Health. The maternity management program is deemed successful when the 28 week survey is completed. A $500 penalty will apply if the program is not completed.

Disease Management Program Reminders

If you are identified for the Disease Management Program provided by Carewise Health, you will receive both phone calls and letters to enroll in the program. Participation in the program allows you to enjoy free generic drugs. If you choose not to participate, your copays will be increased.

Summary Annual Report for the Teamsters Joint Council No. 83 Health & Welfare Fund

This is a summary of the annual report of the Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund, EIN 54-0556299, Plan No. 501, for period January 01, 2013 through December 31, 2013. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

TEAMSTERS JOINT COUNCIL NO. 83 OF Virginia Health & Welfare Fund has committed itself to pay all claims incurred under the terms of the plan.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $59,540,361 as of December 31, 2013, compared to $57,921,244 as of January 01, 2013. During the plan year the plan experienced an increase in its net assets of $1,619,117. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $43,395,111, including employer contributions of $35,586,196, employee contributions of $1,623,147, earnings from investments of $6,149,215, and other income of $36,553.

Plan expenses were $41,775,994. These expenses included $3,511,697 in administrative expenses, and $38,264,297 in benefits paid to participants and beneficiaries.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

* an accountant's report;
* financial information;
* assets held for investment;
* transactions in excess of 5% of the plan assets;
* information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund at 8814 Fargo Road, Suite 200, Richmond, VA 23229, or by telephone at (804) 282-3131. The charge to cover copying costs will be $3.05 for the full annual report, or $0.05 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund, 8814 Fargo Road, Suite 200, Richmond, VA 23229) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Carewise Health Provides Disease Management Program that Delivers Powerful Results

RECENTLY, ONE OF OUR participants completed the Disease Management Program provided by Carewise Health. This 59 year old, who we will refer to as John Doe in order to protect his identity under HIPAA law, was quite pleased with the results of the program.

Several factors led to John's condition. Admittedly, he was overweight and made poor choices when it came to food and was guilty of snacking late at night. His lifestyle was mainly sedentary due to his job and exercise was not part of his daily routine. Not surprisingly, John was diagnosed with hyperlipidemia, also known as high cholesterol and high blood pressure.

After receiving notification from Carewise Health of their disease management program, John decided to participate and set a few goals to improve his health. He wanted to lose weight, specifically around his midsection and reduce his cholesterol.

The disease management program provided by Carewise Health offers participants an array of resources and the opportunity to work one-on-one with a health coach. John's health coach made regular phone calls to him and provided him with information regarding his disease as well as self-care skills to help achieve the goals he had set.

"I was a little skeptical at first but it's been such a positive experience working with everyone from Carewise and I really enjoyed the encouragement and accountability of the programs."

After completing the program, John had lost 7 pounds and had incorporated interval training four days a week for 20 minutes. He was able to motivate his wife to exercise as well. As a result, she lost 15 pounds. Finding the right balance of decreasing his intake of junk food and increasing the amount of fruits and vegetables he consumed also played a key role in his weight loss. John plans to follow up with his health coach after he receives his next lab results to report on how his lifestyle changes have impacted his health.

Carewise Health provides health coaches to help you improve your chronic condition

What can I do if I disagree with the Fund's payment or non-paymentof my claim?

IF YOU DISAGREE WITH THE FUND'S decision on the payment or nonpayment of a claim, you may ask to have it reviewed. Your written request for review must be received by the Fund Office within 180 days from the date you receive an "Adverse Benefit Determination", which is defined as a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for, a benefit. This is typically the EOB described in the article on the cover of this newsletter. Please note that if your appeal is not filed within the required 180 day period, you lose your right to a review of the denial and the decision of the Fund Office will become final and binding. Also, your request must be addressed to the Board of Trustees in care of the Fund Office and must state the following:

* your name and address;
* the fact that you are appealing a decision of the Fund Office and the date of the decision;
* the basis of your appeal
* the provisions of the Plan on which you base your claim.

If you are appealing an urgent care claim, a claim that, if not addressed within 15 days of receipt, could seriously jeopardize the life or health of the person for whom the appeal relates, your appeal request may be made by phone call, in person or in writing.

If you are unable to submit an appeal on your own, you may have someone else submit on your behalf, as long as you notify the Fund Office in writing the name of your "authorized representative".

Along with your appeal you may submit written comments, documents, records and any other information you feel is important to your claim for which you are appealing;

The Board of Trustees, or a subcommittee of Trustees, reviews and rules on appeals. In doing so, they will take into account all comments, documents, records and other information submitted, whether or not such information was considered when the claim was originally processed by the Fund Office.

The Trustees will not consider the original decision reached by the Fund Office when making a determination on the appeal.

Unless you have additional information that was not initially submitted to the Board, or you elect to take the matter to court, the Board's decision is final and binding.

COBRA Benefits and How You Can Qualify for Coverage After Your Benefits Terminate

THE CONSOLIDATED OMNIBUS BUDGET Reconciliation Act of 1985, allows you and/or your eligible dependents the option to temporarily extend health coverage if benefits terminate. The maximum amount of time you can extend your health coverage varies and depends on the reason coverage is terminated.

When electing COBRA coverage, you may choose the benefit plan under which you were last covered or you may move to a less costly plan. While life insurance and disability are not included in the COBRA benefits, you may choose to purchase either medical benefits only or medical benefits plus dental and vision, as the plan provides. The cost to extend health coverage depends on the plan and package you select.

If one of the following "qualifying events" occurs, you and/or your dependent must notify us. We will accept notice of termination of employment or a reduction in hours from your employer through a timely filed contribution report. Notification of the qualifying event must be in writing (email or fax accepted) and received by the Fund Office within 60 days of the date the event took place. If we do not receive notification within the 60 day time limit, the right to COBRA continuation coverage for this "qualifying event" is no longer available.

Qualifying Events for Active Participants

* Termination of Covered Employment for reasons other than gross misconduct;
* Reduction of hours of employment; and
* Absence from employment because of service in the uniformed services of the United States;
* Termination of Direct Pay benefits.

Qualifying Events for Active Dependents:

* Divorce
* Loss of Qualifying Child Status (i.e., turns age 26)
* Death of Participant

Qualifying Events for Participants Under Plan Schedule ZR:

* Divorce
* Separation (in cases involving a Participant's stepchild)
* Loss of Dependent Status (i.e., at age 19 or age 23 if a full time student)
* Retiree spouse's death (for eligible dependents)
* Retiree spouse's entitlement to Medicare (for eligible dependents)

For rates, questions regarding qualifying events or additional information regarding COBRA, contact the Fund Office. Please note: COBRA payments are due the first day of the month for which coverage is purchased. However, there is a 30 day grace period.

Women's Health and Cancer Rights Act

IF YOU HAVE HAD OR ARE GOING TO have a mastectomy, you may be entitled to certain benefits under the Women's Health Act and Cancer Rights Act of 1998 (WHRCA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

* reconstruction of the breast that was removed by mastectomy;
* surgery and reconstruction of the other breast to make the breasts look symmetrical or balanced after mastectomy;
* any external breast prostheses (breast forms that fit into your bra) that are needed before or during the reconstruction; and
* any physical complications at all stages of mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Consult your Schedule of Benefits for specific information regarding your coverage.

If you would like more information on WHCRA benefits, contact the Fund Office.

1 in 8 women will be diagnosed with breast cancer in their lifetime

Disk damage: Watch your Back

Consult your Schedule of Benefits to see if chiropractic benefits are covered.

A HERNIATED SPINAL disk can cause severe pain. Spinal disks act as cushions between your vertebrae, and if they become damaged or slip out of place, they can irritate surrounding nerves. The result: weakness, numbness, and/or pain in arms, legs, or back. Watch for these risk factors to assess your vulnerability:

- Age. Spinal disks degenerate over time, becoming less flexible and more likely to tear as you grow older.
- Weight. Extra weight puts more of a strain on your lower back.
- Lifting. If your job (or your personal life) requires you to do a lot of heavy lifting, be sure to pick objects up properly and safely to avoid injury.
- Genetics. The Mayo Clinic website points out that some people inherit a tendency to develop disks that herniate easily.

Courtesy of First Draft, November 2014

Federal Income Tax Withholdings for Pensioners

WHEN YOU FIRST applied for pension benefits, you were given the opportunity to have federal income taxes withheld from your monthly payment. If we did not receive instructions from you in regard to the taxes you wanted withheld, taxes were withheld as though you were married and eligible for three (3) exemptions.

We can also withhold Virginia State taxes and provide you with the necessary forms to have this tax withheld. However, we cannot withhold state taxes from any other state.

Federal Law requires federal income tax be withheld from pension and survivor benefits unless you elect an exempt status. The Internal Revenue Service may penalize you for not withholding enough federal taxes.

If you would like to change your withholdings, please contact the Fund Office.

Disqualifying Employment and Suspension of Benefits

ARE YOU RETIRED AND considering returning to work? If so, be sure to submit a Post-Retirement Employment Approval Form to the Fund Office, as certain jobs are considered Disqualifying Employment under the Pension Plan. Your monthly benefit will be suspended and permanently withheld for any month in which you are employed or self-employed in Disqualifying Employment. The following defines what is considered Disqualifying Employment at certain ages:

Before Normal Retirement Age (usually 65 years old):

- Employment with an Employer who pays into the Plan (a Contributing Employer), unless
  - you work less than 40 hours in a calendar month for a Contributing Employer that pays contributions at or above the prevailing National Master Freight agreement casual rate for each day your work, or
  - you become permanently disabled to perform the duties of your covered occupation while working in Covered Employment, you may return to work for your former Contributing Employer in non-covered employment, or
- Employment with an employer who competes with a Contributing Employer.

After Normal Retirement Age but before 70½ years old (usually between 65 and 70½)

- Working 40 or more hours per month:
  - in an industry whose employees were covered by the Plan as of the date you retire or your Normal Retirement Age, and
  - in the geographic area covered by the Plan as of the earlier of the date you retired or your Normal Retirement Age, and
  - in a trade or craft, including supervisory work in which you were working at any time under the Plan.

After age 70½ years old

There is no employment that is considered disqualifying after age 70½.

You must notify the Fund in writing within 15 days after starting any job that may be Disqualifying Employment, regardless of how many hours you plan to work or have worked. The Fund has the right to request additional information before making a ruling. As always, if you disagree with the Fund's ruling, you have the right to appeal to the Board of Trustees.

The applicable United States Department of Labor Regulations may be found in 29 C.F.R., Section 2530.203-3. You may also refer to Sections 4.11 through 4.13 of the Pension Plan Document.

Uniformed Services Employment Reemployment Rights Act

IF YOU, AS A PARTICIPANT OF THE PENSION Plan, leave Covered Employment to serve in the military, you will continue to earn Benefit Accrual Service as if you had continued to work in Covered Employment. Under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, your employer must pay your pension contributions if you return from active duty and apply for reemployment within 90 days.

In the event you are reemployed by a different Covered Employer, then each employer is liable to the Pension Fund for half of the required contributions.

Please be sure to contact the Fund Office if you are called to serve in active duty or are the beneficiary of a Participant who dies as a result of serving in active duty.

Fund Retirees

The Fund would like to recognize the following Participants on their recent retirement:

Fund Office
Florence D. Edberg

Local 22
Ricky A. Davis
James D. Gillie
Teresa A. Smith

Local 29
Howard D. Banjoman, Jr.
Paul E. Harris, II
William R. Johns
David T. Landram
John A. Price

Local 171
Dennis K. Brown
Charles S. Haynes
Richard J. Keen
Stephen Linton
Richard A. Oakes
Ralph E. Short
Charles L. Williams

Local 322
Kenneth Crawford
Glenn T. Davis
Jeffrey S. Flinchum
Harold P. Hardy, Jr.
Karl A. Hartman
Wynonnie G. Johnson
Arthur W. Markland
John M. Owens
William E. Thomas
John F. Totty

Local 592
Steven G. Hayes, Sr.
Richard A. Martin

Local 822
Michael L. Bell
Earle R. Mize
Jerry R. Robinson
Arthur A. Tynes

Fund Office Contact Info

Phone:
(804) 282-3131 - local

800-852-0806 - toll free

Fax:
(804) 288-3530

Web:
www.tjc83funds.org

Email questions and comments:
yourfund@tjc83funds.net

Email documents and forms:
documents@tjc83funds.net

Teamsters Joint Council No. 83 of Virginia
Health & Welfare and Pension Funds
8814 Fargo Road
Suite 200
Richmond, VA 23229

Happy Thanksgiving! Avoid stress with this advice

Whether you're hosting the dinner or just visiting, remember these tips for staying calm and sane

THANKSGIVING IS A TIME FOR FAMILY TOGETHERNESS. Of course, sometimes too much togetherness breeds tension, stress, arguments, and the occasional blowup. Whether you're hosting the dinner or just visiting, remember these tips for staying calm and sane:

- Plan early. Start thinking about Thanksgiving well before the big day so you don't have to rush to get everything done at the last minute. Check in with guests, or your host, a few days ahead of time to confirm everyone's plans.
- Get people involved. Don't try to do all the work yourself. Invite guests to bring dishes (if you're a guest, volunteer). Recruit your kids to set the table and clear away the dishes. A team effort will make the day more fun for everyone.
- Mix up the guest list. Most families behave a little better if outsiders are present. Include a few neighbors or friends; ask if you can bring a co-worker. A "buffer" will encourage people to be on their best behavior.
- Get out of the house. No rule says you have to hold Thanksgiving at someone's house. A public setting like a restaurant or hotel can defuse tensions and take the load off. If you are at home, encourage guests to take walks or play outside while waiting for dinner to start.
- Take time to relax. Don't overschedule yourself. Build some extra time into your day so you can talk to family and friends, enjoy your meal, and genuinely give thanks for being together.

Courtesy of First Draft, November 2014