HOT TOPICS

FIREFIGHTERS & PARAMEDICS LOCAL 22

HEALTH PLAN

SPRING 2018

WELCOME TO THE HEALTH PLAN'S NEWSLETTER

which we hope you will find interesting. We've tried to include answers to some of the most commonly asked questions we receive, as well as provide information on some benefits – new and not so new – that we want to be sure you're aware of.

We will be sending these newsletters throughout the year so, if there's a topic you'd like us to address, just let us know.

And check out the Health Plan's new website at **www.local22healthplan.org** for information on all the benefits available to you and your family.

ACT 111 ARBITRATION AWARD

The Award was announced on May 17th and we are pleased to announce the provisions of the Award that affect the Local 22 Health Plan:

- NO CHANGES to our benefit plans
  - No increased copays
  - No deductibles
  - No coinsurance
- NO MEMBER CONTRIBUTIONS to our Health Plan
- CITY AGREES TO PAY the Part B premium for Medicare-enrolled retirees in our Health Plan
- WELLNESS INCENTIVES continue for members and spouses
  - The deadline for completion and document submission for the 2017 incentive is extended to September 30, 2018.
- ONE-TIME WELLNESS INCENTIVE of $800 for members hired after January 1, 2017. Eligible members will be receiving a letter from the Health Plan with Incentives guidelines.

Under the Terms of the Award, the City will not be responsible for paying one month of Health Plan claims and expenses. The Health Plan will pay these expenses out of its reserves.

BUT, our active members will benefit from this provision, as per the following Award language "To allow bargaining unit employees to also reap the benefits of Local 22's management of its health fund and in light of the additional pension contributions being required of current employees by this Award, each non-probationary bargaining unit employee on the active payroll as of the date the Award is issued shall receive a one-time cash payment equal to the amount of the Health Fund expenses (claims and administration) for the month in question…"

BENECARD UPDATE

SHINGLES VACCINE

As of May 1, 2018 – Local 22 Health Plan Members ages 50 + can received the Shingles Vaccine through our prescription plan – Benecard – with $0.00 co-pay. *(At participating pharmacies)*

DIABETIC SUPPLIES

Effective 07/01/2018 Diabetic Supplies will be covered by Benecard. Local 22 Health Plan members will be able to use Benecard through their local participating pharmacy as an option for obtaining their Diabetic supplies.

WHAT'S INSIDE THIS ISSUE

MENTAL HEALTH CONSULTANTS

The employee assistance program (EAP) is a counseling, information, and referral service that helps you address personal problems on a confidential basis. The HealthPlan has contracted with Mental Health Consultants (MHC) to provide this benefit. All calls to MHC and any treatment received by MHC providers are strictly confidential.

MHC has a comprehensive network of quality healthcare professionals, including psychiatrists, psychologists, clinical social workers, certified nurse practitioners, and counselors who are available to help you 24 hours a day, 7 days a week, with issues like:

- Stress
- Depression
- Drug or alcohol abuse
- Relationship problems
- Marital problems
- Domestic violence
- Caring for an elderly parent

It's Confidential

All calls to MHC, and any treatment received from MHC providers, is strictly confidential. No one, including the Health Plan, knows that you made a call to MHC or that you used an MHC healthcare provider, unless you authorize it.

MHC participating practitioners will provide up to five (5) counseling sessions, per year, per issue. MHC defines an issue as the problem or circumstance that prompted the member to contact MHC. Although there is a limit on the number of counseling sessions you can receive, each year per issue, there is not a limit on the number of issues per year for which you can reach out to MHC. And, remember, these counseling sessions are at no cost to you. You do not pay a copayment for the 5 sessions, per issue, when you reach out to MHC.

This Health Plan EAP is available to all eligible members, their dependents, the member's parents and the member's spouse's parents. If you or a family member needs assistance, **call MHC at 1-800-255- 3081.**

VETERANS ADMINISTRATION HEALTH CARE

Many Veterans may be eligible for VA health care. Enrollment in VA health care satisfies your Affordable Care Act health coverage requirement—no add-on insurance plan is needed. The VA encourages you to explore your health care benefits.

VA Requirements

Military Service Requirements

- Veterans must have served in the active military, naval, or air service and separated under any conditions other than dishonorable.
- Most Veterans who enlisted after Sept. 7, 1980, or who entered active duty after Oct. 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty. This includes current and former members of the Reserve or National Guard called to active duty by a federal order.

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VA Application Process

Applying is easy: Submit an application form and VA will send you written notification of your enrollment status. Women do not self-identify as Veterans first, but in the women's clinic … most of the staff are female Veterans.

How to Apply

- **Apply Online** — www.vets.gov
- **Apply in Person** — Visit the nearest VA medical center or clinic.
- **Apply by Phone** — Call 1-877-222-8387 - M-F, 8 a.m. – 8 p.m. EST.
- **Apply by Mail** — Print, fill out, and mail VA Form 10-10EZ to Health Eligibility Center
  Enrollment Eligibility Center
  2957 Clairmont Road, Suite 200
  Atlanta, GA 30329-1647

Struggling with a healthcare issue?

CALL GUARDIAN NURSES HEALTHCARE ADVOCATES

The Health Plan introduced Guardian Nurses last year and we are happy to announce that we now have one of the Guardian Nurse team who is dedicated solely to the members of Local 22 and their families. Call Linda Clark, our own Guardian Nurse, if you or one of your dependents is ill or injured (non-IOD), or needs long-term care. Linda can help you with all kinds of medical issues, including:

- VISIT YOU AT HOME or in the hospital to assess your care needs.
- BE YOUR GUIDE, coach and advocate for any healthcare issue.
- MAKE APPOINTMENTS so you can be seen as quickly as possible.
- GO WITH YOU to see doctors, to ask questions and to get answers.
- IDENTIFY PROVIDERS for all care needs and second opinions.
- GET THINGS YOU NEED such as healthcare equipment.
- PROVIDE DECISION SUPPORT when you are thinking about treatment options
- EXPLAIN A NEW DIAGNOSIS to help you make informed decisions.
- COACH AND SUPPORT YOU through the challenges of chronic disease

Guardian Nurses services are available to anyone eligible under the Local 22 Health Plan. You do not need to use your Blue Cross card, any benefits provided through Guardian Nurses are free and confidential.

If you or your loved one could use some help, call Linda Clark at 484-803-2198 (cell); 215-836-0260x119 (office) or email her at Linda@GuardianNurses.com.

OBSTRUCTIVE SLEEP APNEA

Do you snore at night? Are you sleepy during the day? Have you been told that you stop breathing in your sleep? Then you may have obstructive sleep apnea. Obstructive sleep apnea is a common sleep disorder where the upper airway repeatedly closes off during sleep.

It is estimated that up to 52 million people in the United States have obstructive sleep apnea, with the majority remaining undiagnosed. Symptoms include loud snoring, daytime sleepiness, difficulty concentrating, irritability, getting up to urinate during the night, and nighttime sweating. Often the bed partner will note periods where the patient stops breathing in their sleep.

Sleep apnea places an individual at risk for accidents associated with sleep deprivation, and has-d been linked to significant cardiovascular disease. This includes hypertension, stroke, coronary artery disease and heart failure.

DIAGNOSIS

- To diagnose obstructive sleep apnea a patient needs to undergo a sleep study which monitors breathing, snoring, heart rate and oxygen level during the night.
- These studies are primarily completed at home in what's called a home sleep test where the patients wear a small monitoring device in the comfort of their own bed.
- It is simply taken home during the normal sleep cycle and then returned the next day for analysis.

TREATMENT

- Treatment of obstructive sleep apnea is individualized, with the most common treatment being continuous positive airway pressure (CPAP).
- A CPAP device consists of a small mask that is worn over the nose or nose and mouth and it blows air into the airway to act like an air splint to keep the airway open at night. Snoring is eliminated as well as the abnormal breathing events.
- Approximately 25% of patients with obstructive sleep apnea are purely positional, where the abnormal breathing events occur predominantly when they are sleeping on their back. In these cases, a positional device to keep the patient from sleeping on their back is very effective in treating her obstructive sleep apnea.
- Other treatment options include the use of an oral appliance, weight reduction or surgical intervention - including those that increases size of the upper airway or the use of a stimulator that when turned on at night will stimulate the tongue muscle to keep the airway open.

PROGRAM

- The Health Plan is excited to partner with Temple Health to introduce Temple's obstructive sleep apnea program for the Local 22 Health Plan. The program is run through the Temple University Sleep Disorder Center, which is located at Temple's Jeanes Hospital campus.
- Members with symptoms suggestive of obstructive sleep apnea can undergo a simple haome sleep test for diagnosis and the appropriate treatment can then be initiated, including CPAP therapy or positional therapy.
- Follow-up with a board-certified Sleep Specialist at Jeanes Hospital will be scheduled after treatment is initiated.
    - This benefit is available to all those covered under the Health Plan – both members and spouses can take advantage of this program
    - You simply call the Sleep Disorder Center at 215-728-2148 and let them know you're part of the Local 22 Health Plan. There is no co-payment .
    - Completion of the sleep apnea will count as 1 incentive in the FY18 Wellness Incentive Program

If you think you may have sleep apnea, make the call. You (and your spouse!) will be happy you did.

COLLEGE TUITION REIMBURSEMENT ANNOUNCEMENT

In July 2016 Local 22 announced a new benefit available to you as a Health Plan member.

Independence Blue Cross has introduced a College Tuition Benefit Rewards program that is available to all their subscribers. This program is offered *at no cost to you.*

To register for this program log on to www.ibx.CollegeTuitionBenefit.com. **When you log on to this program you must use CID 6045** and the member ID from your Blue Cross card - numbers only. Do not use any letters.

Some of the highlights of the program include:

- Members enrolled in the program automatically earn $2,000 in annual Tuition Rewards
- One Tuition Rewards point = $1 guaranteed minimum reduction in full tuition
- The Tuition Rewards can be used at over 350 institutions across the county, including over 50 college and universities in Pennsylvania
  - A full list of the participating colleges and universities is on the website and we expect even more educational institutions to be added
- You can provide this benefit to your child, step-child, niece, nephew, grandchild
  - You can enroll more than 1 child in the program
  - This program is not available to you or to your spouse
  - This program is not available to a child who is already in college or who is starting 12th grade this year
  - This benefit is for undergraduate study only

Important Deadline

Students must be added to the program by August 24th of the year that the student begins 11th grade. If you are interested in this free enrollment and the child you wish to enroll will be starting 11th grade this year, make sure you log on to www.ibx.CollegeTuitionBenefit.com and enroll.

Independence Blue Cross

PHILLY FIRE'S MOTIVATED FITNESS

Local 22's Health Plan is dedicated not only to providing our members with the best healthcare but also to assisting our members with leading and maintaining a healthier lifestyle.

In order to educate and guide our members to a healthier lifestyle we are proud to offer our members the **Philly Fire's Motivated Fitness Program.**

Philly Fire's Motivated Fitness is dedicated to our Health Plan members' health and well-being. The program includes a group of motivated and certified personal fitness trainers, all of whom are firefighters or paramedics, whose main objective is to help you achieve your personal healthy lifestyle goals. This is accomplished through personal one-on-one training, small group fitness programs, and nutrition education. The goal of the trainers is to provide our members with not only strength and physical conditioning but also the nutritional knowledge to lead a healthier, well-balanced life.

We encourage all Local 22 Health Plan members to take advantage of the programs developed by the Philly Fire Motivated Fitness staff. The programs are setup for members and dependents of all ages and physical conditions. For more information on the Philly Fire's Motivated Fitness programs visit our website at www.pfmfitness.com or call 215-440-4433.

SOME OF OUR MOST **FREQUENTLY ASKED QUESTIONS**

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What documents do I need to add a new dependent?

- Spouse - copy of your marriage certificate and the spouse's Social Security Number (we don't need to see the Social Security card)
- Biological Child – copy of your child's birth certificate showing you as the biological parent and the child's Social Security Number (we don't need to see the Social Security card)
  - ○ If you don't have the state-issued birth certificate within 30 days of the baby's birth, we will accept the hospital-issued certificate until you receive the state document
- Adopted Child – copy of the child's birth certification, Social Security number, and legal documents indicating the child has been placed with you for adoption
- Handicapped Dependent - you must provide medical or other documentation of the child's handicap. Examples of documentation include a statement from a treating physician that the child is handicapped; or a determination from the Social Security Administration that the child is handicapped.
  - ✓ the child must have been handicapped and an eligible dependent under the Plan prior to reaching their 26th birthday

What happens to my spouse's coverage if we divorce?

It is your responsibility to notify the Health Plan immediately when you are divorced and to provide a copy of your divorce decree. If you don't let us know you're divorced, and your ex-spouse continues to use Health Plan benefits, it is YOUR responsibility to repay the Plan for benefits used by a non-eligible dependent.

Do our Healthcare providers issue ID Cards?

You receive an ID card for medical from Independence Blue Cross and you receive an ID card from Benecard for your prescription drug benefits. You DO NOT receive ID cards for either dental (Aetna) or vision (VBA). When you or any of your eligible dependents need to use the dental or vision benefit, they simply use your (the member) Social Security number.

And don't forget that you can find important phone numbers for all our carriers on our website at www.local22healthplan.org and on the back of your Local 22 calendar.

How do I get prescriptions filled for Maintenance medications?

If your physician prescribes a maintenance medication (prescription drugs that you are expected to take for an extended period of time) you fill your first prescription AND the next 2 refills at any participating retail pharmacy.

After your 2nd refill, your prescription must be filled through Benecard Central Fill. For your convenience, you can also fill your maintenance medications at your local Rite-Aid retail pharmacy. After your initial fill and two refills, the Plan will cover maintenance medications only if you use Benecard's Central Fill or Rite-Aid retail pharmacy. You can order your mail order refills online at www.benecardpbf.com or directly from your local Rite-Aid. You will need to have your doctor write a new prescription for a 90 day supply of your maintenance medication with up to 3 refills. You want to do this before you are finished your second refill from your retail pharmacy.

F.A.Q.

What do I do if my prescription is rejected and I can't get it filled?

Ask the pharmacist why it's not being processed. They can tell from what they're seeing on the message from Benecard why it's not going through. Sometimes it's a clinical issue and your doctor needs to contact Benecard; sometimes you may be trying to refill a prescription too soon. If you aren't able to fill a prescription you should contact the Health Plan at 215-440-4421 for help.

I'm in the PPO Dental Plan and I know that dental implants are covered. Why am I being billed for part of the procedure?

The Dental PPO plan provides a benefit of $5,500 per person per year and does include coverage for dental implants. In most cases, all of the work that's done is covered. However, your dentist may perform a procedure that Aetna does not cover. ANY time you have dental work done, particularly if it's expensive, we suggest you ask your dentist's office to pre-authorize the treatment with Aetna to confirm what Aetna is going to pay. That way you know going into the procedure whether you'll end up with any out of pocket expense.

Can I go to any provider I want for vision benefits?

While you can use any provider you want, your out-of-pocket expense is generally less when you use a VBA- participating provider. For a list of participating providers in your area, contact VBA at 1-800-432-4966 or log on to the VBA website at www.visionbenefits.com

How does the telemedicine benefit work?

The Health Plan offers a telemedicine benefit through MeMD. This program allows you to reach a medical provider via telephone or web when access to your regular doctor is not available. MeMD provides a national network of US licensed physicians who are available any time, day or night, 365 days a year. You will receive a personal diagnosis and a personalized treatment plan, including prescriptions for common medications. You can access MeMD by calling 1-844-800-7110; online at www.memd.me/ha/firefighters-union . The Health Plan pays the entire cost. Your copayment is $0.00. This benefit is offered to members and dependents.

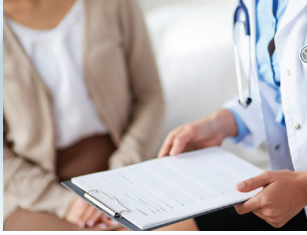
I'm retired but still covered under the Local 22 Health Plan. Do I need to enroll in Medicare when I'm 65?

The Health Plan does not require that you enroll in Medicare; however, Medicare does impose a Late Enrollment Penalty (LEP) for retirees (not active members) who qualify for Medicare but do not enroll. Because of that, the Health Plan – beginning in 2017 – starting reimbursing retirees who are still covered under the Health Plan for the Part B premium that they pay. For those retirees, Medicare pays first and the Health Plan picks up the deductibles and co-insurance that Medicare doesn't pay. And the retiree doesn't need to worry about any penalty with Medicare when their coverage with the Health Plan finally ends.

For more information about how Medicare works with the Health Plan, including how to enroll, see the "Retirees" section of our website at www.local22healthplan.org

If you (or your spouse) are covered under the Health Plan, as a retiree, you are on Medicare, and you have not let us know what you're paying for Part B coverage, contact the Health Plan office.

SOME OF OUR MOST **FREQUENTLY ASKED QUESTIONS**



How do I add a dependent to the Health Plan?

You need to come into the Health Plan office to add a dependent. Your enrollment card needs to be updated by you and there is documentation that's required (see below).

When can I add a dependent to the Health Plan?

- If you get married, you need to add your spouse within 30 days of the date of your marriage
- If you have a new baby, you need to add the baby within 30 days of the date of birth
- If you adopt a child, you need to add the child within 30 days of when the child was placed in your home for adoption

If you don't add a new dependent within 30 days of the marriage/birth/placement, you will have to wait until the Health Plan's annual Open Enrollment, which is November each year.

EXCEPTION: If your dependent is covered under another health plan and loses that coverage, you can add that dependent any time throughout the year as long as you do it within 30 days of when they lost their other coverage.

Coverage for you dependent will start on the 1st day of the month after we receive your documentation

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What dependents are covered under the Health Plan?

- Legally married spouse
- Biological and adopted children under age 26
- Handicapped children of any age
- Qualified Medical Child Support Order (QMCSO): children under age 26 for whom you are required to provide health care under a QMCSO
- Stepchildren under age 26 (there is generally a cost of $65 per stepchild per month to provide coverage: contact the Health Plan for additional details)

Firefighters & Paramedics
Local 22 Health Plan
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