

Michigan Conference of Teamsters Welfare Fund  
2700 Trumbull Avenue  
Detroit, Michigan 48216-1296  
313-964-2400 • 800-572-7687  
www.mctwf.org

**Compilation of Messenger Notifications  
Fall 2012 through Spring 2015**



The *Messenger* is a publication that is used to notify you of changes to your benefit package. Such notifications, in combination with your Summary Plan Description (SPD) booklet and Schedule of Benefits, form your complete SPD. Attached you will find a compilation of Messenger notifications from the Fall 2012 issue through the Spring 2015 issue, arranged chronologically by topic. It is vital that you read all notifications within a topic to ensure that you are aware of the latest change. Your SPD will continue to be updated by new issues of the *Messenger*.

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Fall 2012 through Spring 2015



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## **INTRODUCTION**

### **MCTWF Actives Plan and MCTWF Retirees Plan – Spring 2014**

Since inception, both the employee welfare benefit plan under which all MCTWF participants (actives and retirees) and their eligible family members have been covered and the tax exempt trust through which MCTWF's Trustees fund the benefit plan have operated under the name, Michigan Conference of Teamsters Welfare Fund. This is to inform you that **effective April 1, 2014**, the Trustees, pursuant to their authority under the Trust Agreement, will spin-off assets and liabilities from the current benefit plan to establish and maintain two separate benefit plans, the MCTWF Actives Plan and the MCTWF Retirees Plan, with corresponding sub-funds in which the interest of each benefit plan will be held. The assets of each benefit plan and sub-fund will be segregated on the books of the trust fund, the Michigan Conference of Teamsters Welfare Fund.

The Trustees chose to take this action to permit them to continue to offer MCTWF's retiree medical benefits without materially raising contribution rates. This would have been necessary had the retiree benefit package (with its \$220,000 annual limit on most benefits) remained subject to the Affordable Care Act's required phase out of annual limits on Essential Health Benefits (by March 31, 2014 for MCTWF). However, since the Affordable Care Act does not impose the annual limits prohibition on "retiree only" benefit plans, the Trustees opted to preserve the retiree medical benefit package and its contribution rate structure by the establishment of the MCTWF Retirees Plan for the provision of retiree benefits. Retirees will be receiving a MCTWF Retirees Plan summary plan description booklet later this spring.

## **ELIGIBILITY**

### **Dependent Children and Spouses – Spring 2013**

For the purpose of determining eligibility under the MCTWF's plans of benefits, the Summary Plan Description( subject to additional criteria) defines a dependent as including a participant's children and spouse. In order to conform to the definition of "dependents" under the Affordable Care Act, as recently determined by the U.S. Department of the Treasury, which limits "dependents" to children age 26 and below, MCTWF has removed the spouse from its definition of "dependent" and hereafter will refer separately to a participant's covered dependents and spouse, or together as the participant's "beneficiaries."

### **Benefit Bank Weeks Entitlement for New Participants – Fall 2013**

Currently, employees of newly participating employers do not become entitled to benefit bank weeks until contributions have been made on their behalves for 12 consecutive weeks, or 13 out of 17 weeks, whereas new employees of already participating employers become entitled to benefit bank weeks once contributions commence on their behalves.

**Effective January 1, 2014**, employees of newly participating employers and newly hired employees of already participating employers will become entitled to benefit bank weeks once contributions have been made on their behalves for 8 consecutive weeks, or 9 out of 13 weeks.

### **Benefit Bank Weeks Included in COBRA Coverage – Fall 2013**

Effective April 1, 2012, dental and optical benefits were restored to benefit bank weeks (for those who had dental and optical benefits while actively employed). This is to clarify that effective April 1, 2012 remaining benefit bank week benefits are applied prior to elected COBRA continuation coverage benefits and each benefit bank week is counted toward your statutory COBRA continuation coverage entitlement period.

### **Adult Dependent Children Up to Age 26 New Open Enrollment Window – Fall 2013**

In accordance with the Affordable Care Act, MCTWF has made coverage available to all dependent adult children through the end of their 26th birthday month. The temporary exception to this rule is that adult dependent children are not entitled to coverage if they are eligible to enroll in an employer sponsored health plan, other than that of their parents. This exception ends upon the earlier of April 1, 2014 or the cessation of the "grandfathered" status of the participant/parent's MCTWF health plan. Except for those children who already were covered or became covered under MCTWF's rules on or after February 27, 2011, eligibility for coverage on or after April 1, 2011 has been contingent upon submission to MCTWF of an *Adult Child Coverage Application for Enrollment* form during an authorized enrollment period. There have been three such enrollment periods; January to February 2011, November to December 2011, and November to December 2012.

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Despite our several efforts to communicate the enrollment requirements to affected participants and their eligible children, a few affected adult children still have failed to submit a timely Application. Accordingly, **the Trustees have authorized another enrollment period for those adult children, beginning November 1, 2013 and ending December 16, 2013, to permit eligibility for coverage commencing on or after January 1, 2014** (contingent upon the eligibility of the child's parent/participant and only if the child's age is less than 26 at that time).

To enroll, an *Adult Child Coverage Application for Enrollment* form must be fully filled out and received by MCTWF between November 1, 2013 and December 16, 2013. This form is available on the *Forms* page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org), or by contacting MCTWF's Customer Communications Department. **Please note that the Application must be timely submitted - (a) regardless of whether the adult child's participant/parent is eligible for coverage at the time of submission of the Application. If and when that participant/parent resumes covered employment, the adult child's eligibility will commence; or (b) regardless of whether the adult child is excluded from MCTWF coverage by virtue of his eligibility to enroll in an employer sponsored health plan, other than that of his parents.** In such case, the adult child's eligibility will commence on the earlier of April 1, 2014 or the date upon which his participant/parent's MCTWF health plan ceases to be "grandfathered" under the Affordable Care Act.

### Expanded Eligibility Rules for Retiree Plan Enrollment – Spring 2014

**Effective April 1, 2014** retiree medical benefit eligibility rules will be substantially expanded under the MCTWF Retirees Plan.

Currently, the retiree medical benefit rules condition eligibility, in part, on participation at the time of retirement in a MCTWF benefit package that includes the retiree coverage component (the Standard Eligibility Rules). Effective with Retirement Dates of 4/1/14 or after, a participant need not retiree in a MCTWF benefit package that includes the retiree coverage component. Sufficient prior participation in such a package also will trigger eligibility for MCTWF Retirees Plan benefits, as explained below (the Expanded Eligibility Rules). Self-contribution rates for participation in the MCTWF Retirees Plan retiree medical benefits package based on the Expanded Eligibility Rules are approximately 10% higher than the standard rates.

- For participants who retire at age 62 or greater while covered by a MCTWF medical benefits package that does not include the retiree coverage component, eligibility for MCTWF Retirees Plan benefits is conditioned on having accrued, at any time, 20 years of participation in any MCTWF benefit package that includes the retiree coverage component.
- For participants who retire at age 57 or greater while covered by a MCTWF medical benefits package that does not include the retiree coverage component, eligibility for MCTWF Retirees Plan benefits is conditioned on having accrued a minimum of seven of the immediately prior 10 years of participation in a MCTWF benefit package that includes the retiree coverage component, or a minimum of 10 of the immediately prior 15 years of participation in a MCTWF benefit package that includes the retiree coverage component. Once the requirements are met, the participant will not lose his eligibility to enroll in the MCTWF Retirees Plan solely by delaying his Retirement Date.

### Coverage for Adult Children with Other Available Coverage – Special Enrollment Period – Spring 2014

In the Spring 2011 *Messenger* we informed you that, in accordance with the Patient Protection & Affordable Care Act (the "Affordable Care Act" or "healthcare reform law") effective April 1, 2011, MCTWF made coverage available to dependent children through the end of their 26<sup>th</sup> birthday month. The temporary exception to this rule was that "adult children" (i.e. those age 19 or older) would not be entitled to coverage if they were eligible to enroll in an employer sponsored health plan, other than that of their parents, until the earlier of April 1, 2014, or until the participant/parent's MCTWF health plan is no longer "grandfathered" under the healthcare reform law. Due to the expiration of this temporary exception, effective April 1, 2014, the applicable section of MCTWF's definition of a dependent has been revised in part as follows:

- *your natural or step child, or child who has been placed with you for adoption, or whom you have adopted, age 19 through the end of his 26<sup>th</sup> birthday month.*

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Adult dependent children with birthdates of April 1, 1988 or later, who were not eligible for MCTWF coverage due to the availability of other employer sponsored health plan, may now enroll for coverage under their parent's MCTWF benefit package by completing an "Adult Child Coverage Application," which is available from the *Forms* page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org) or by contacting MCTWF's Member Services Call Center at 313-964-2400 or 800-572-7687, Monday through Friday, 8:30 a.m. through 5:00 p.m. The application **must be received by MCTWF no later than May 16, 2014** with coverage commencing the Sunday following MCTWF's receipt of the completed application. Applications received after May 16, 2014 will be held until the next scheduled open enrollment period beginning November 1, 2014 and ending December 13, 2014 with coverage commencing on January 1, 2015.

### **MCTWF Retirees Plan Deferral Rules – Spring 2014**

The current MCTWF Retirees Plan (Plan) participation deferral rules are as follows:

**Prior to Commencement of Plan Participation – Automatic Deferral** – "30-and-Out" Pensioners who are under age 50, whose application for enrollment for retiree medical benefits has been approved subject to attaining age 50, will be automatically deferred until age 50 or later. The retired individual must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retired individual at the commencement of participation.

Retired individuals who are ages 50 to 56, who are not "30-and-Out" Pensioners, and whose application for enrollment for Retiree Medical benefits has been approved subject to attaining age 57, will be automatically deferred until age 57 or later. The retired individual must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retired individual at the commencement of participation.

**Prior to Commencement of Plan Participation – Voluntary Deferral** – Retired individuals, whose application for enrollment for Retiree Medical benefits has been approved, may defer participation upon written request. The retired individual must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retired individual at the commencement of coverage.

**Following Commencement of Plan Participation – Automatic Deferral – Effective July 31, 2014**, if either a Retiree or retiree spouse participating on her own ceases Plan participation for any reason other than - (a) becoming Medicare eligible, or (b) in the case of a retiree spouse participating on her own, divorce or remarriage - but is otherwise eligible for participation, he or she will be placed in an automatic deferral status and, after no less than six months deferral, may request, in writing, re-enrollment. Also **effective July 31, 2014**, re-enrollment must occur during the MCTWF Retirees Plan annual open re-enrollment period from November 1<sup>st</sup> through December 10<sup>th</sup>. Participation will recommence thereafter on January 1<sup>st</sup> if the Retiree is not engaged in Prohibited Employment and the required self-contributions are timely made.

**Following Commencement of Plan Participation – Voluntary Deferral** – Retirees and retiree spouse participating on their own may defer coverage any number of times after commencement of Plan participation. **Effective July 31, 2014**, re-enrollment must occur during the MCTWF Retirees Plan annual open re-enrollment period from November 1<sup>st</sup> through December 10<sup>th</sup>. Participation will recommence thereafter on January 1<sup>st</sup> if the Retiree is not engaged in Prohibited Employment and the required self-contributions are timely made. However, if the deferral is for the purpose of employment as a bargaining unit member by an employer that contributes to the MCTWF Actives Plan for medical benefit coverage, the six month minimum deferral period and open enrollment window requirements will be waived for re-enrollment if MCTWF is notified in writing of the termination of that employment, within 45 days of such termination, coupled with a request to re-enroll. In such case, eligibility will recommence as of the first day of the month following MCTWF's receipt thereof.

If the deferral is for the purpose of resuming employment, the Retiree or retiree spouse participating on her own may continue Plan participation until the new, employer sponsored coverage commences, by continuing payment of monthly self-contributions.

### **Choosing Between Total and Permanent Disability and retiree Medical Benefits–Fall 2014**

This is to clarify that if a participant who is eligible for both MCTWF Total & Permanent Disability (TPD) benefits and MCTWF Retiree Medical benefits applies for TPD benefits and is issued a notification of approval, the participant irrevocably loses his eligibility for Retiree Medical benefits.

Similarly, if the same participant is approved for and makes his first contribution payment for Retiree Medical benefits, he irrevocably loses his eligibility for TPD benefits.

### **Eligibility for Extended Disability Medical Benefits – Spring 2015**

All MCTWF Actives Plan medical benefits provide for “Extended Disability”.

Extended Disability medical benefits may be available for MCTWF Actives Plan participants or beneficiaries who became disabled while covered under a MCTWF health benefit package and whose active coverage thereafter ceased. If eligible, Extended Disability coverage will be provided for medical and prescription drug benefits that were available during active coverage, but solely in connection with the disabling disability for a period up to the earlier of (a) 24 months, (b) the date the member becomes eligible for Medicare benefits or other group health coverage, or (c) the date the member is no longer totally disabled.

To qualify for Extended Disability medical benefits, ALL of the following conditions must be met:

- As determined by MCTWF’s Trustees, the participant or beneficiary was totally disabled when coverage ended and remained continuously totally disabled until the date the medical expense is incurred; and
- Within fifteen months from the date the active coverage ceased, documentation is provided to MCTWF by the physician verifying the total disability; and
- The treatment or services are received after active coverage ceases within the following period: the earlier of (a) 24 months, (b) the date the member becomes eligible for Medicare benefits or other group health coverage, or (c) the date the member is no longer totally disabled; and
- The treatment or services must be for the same injury or illness that existed on the date the coverage ended and caused the total disability.

For the first 90 days of the Extended Disability medical benefit period, the level of coverage is dependent upon whether the provider is in-network or out-of-network. For the last 21 months, coverage is limited to out-of-network levels of coverage regardless of whether the provider is in-network or out-of-network. Annual individual and family deductibles and coinsurances will apply based on the network affiliation and the specific MCTWF Actives Plan benefit package.

### **Notifying MCTWF of New Beneficiaries – Spring 2015**

New participants initially must inform MCTWF of their Beneficiaries (i.e., their spouse and children under age 26) and keep MCTWF informed of any changes (e.g., a divorce, a new spouse, a new child, etc.), within 60 days of the event, using MCTWF’s *Change in Family Status Form* (available on the Forms page of MCTWF’s website). Any such event may alter the required contribution rate paid on behalf of participants who have coverage under a tiered contribution rate structure, since it may cause a change in the participant’s contribution tier.

Until recently, for participants who have coverage under a tiered contribution rate structure and who inform MCTWF of a new beneficiary more than 60 days from the date of that change in family status, the rule has been that if the addition of the beneficiary changed the participant’s tier, the beneficiary’s MCTWF benefits coverage would commence after receipt of such notification and the employer would be billed at the higher tier contribution rate prospectively. **Effective February 2, 2015**, in such instance, the beneficiary’s MCTWF benefits coverage will commence retroactively to the date 60 days prior to MCTWF’s receipt of such notification and the employer will be billed at the higher tier contribution rate retrospectively and prospectively.

### **Reminder – Entitlement to Retiree Benefits Ceases Upon Medicare Eligibility – Spring 2015**

In addition to the other causal events stated in your Summary Plan Description, entitlement to Retiree benefits cease as of the earlier of a) the first of the month in which the individual’s (i.e., the retiree’s or spouse’s) 65<sup>th</sup> birthday falls or b) the date that the individual becomes eligible for early Medicare Part A coverage. It is imperative that the individual immediately call to inform MCTWF of his or her early Medicare eligibility date and that the individual immediately cease the use of Retiree benefits. MCTWF will ask the individual for a copy of the Medicare card or letter from the Social Security Administration stating the effective eligibility date. MCTWF will pursue recovery from both individuals for any Retiree benefits paid for services incurred on or after the individual’s Medicare eligibility date.

### **Benefit Bank Weeks Renewal and Expansion of Entitlement – Spring 2015**

We are pleased to announce that the Trustees have renewed MCTWF's standard benefit bank week program for "Old" and "New" SOA, TIF, Key 1, Key 1a, Key 1b, Key 2, Key 2a, Key 2b, Key 2c, Key 2d, Key 3, and Key 3a, medical benefit packages for the 36 month period **commencing April 1, 2015** as follows:

- Eligible participants who are actively employed on or after April 1, 2015, will be allotted six benefit bank weeks for use during the period April 1, 2015 through March 31, 2018.
- Benefit bank week coverage includes the medical benefits, and any prescription drug, dental and vision benefits provided for in the participant's active benefit package. No short term disability ("Weekly Accident and Sickness"), total and permanent disability, or death benefits will be available when incurred during the period covered by benefit bank weeks.
- Participants who are not actively employed on March 31, 2015 and who are still covered by remaining benefit bank weeks from the 2012 through 2015 period will continue to be so covered until their benefit bank weeks are exhausted. Upon their return to active employment and the payment of contributions on their behalf, they will receive a new allotment of six benefit bank weeks through March 31, 2018.

**Effective 4/1/15, benefit bank week coverage will be available in the event of a termination or suspension** (MCTWF no longer will require that the termination or suspension be grieved to trigger benefit bank week coverage). **Benefit bank week coverage remains unavailable in the event of a quit.**

### **MEDICAL BENEFITS – ACTIVES & RETIREES PLANS**

#### **Provider Networks Change For Mental Health and Substance Use Disorder Benefits–Spring 2013**

**Effective April 1, 2013**, Blue Cross Blue Shield's PPO nationwide provider network will replace ValueOptions as MCTWF's mental health and substance use disorder provider network.

With this network change, outpatient services will no longer require prior authorization. However, providers must continue to receive prior authorization for inpatient services (including admissions and services for programs administered in connection with inpatient hospitalizations for mental health treatment, with partial hospitalizations for mental health treatment, with inpatient residential treatment for substance use disorder treatment) by contacting Blue Cross Blue Shield at 800-762-2382, Monday through Friday 8:30 a.m. to 11:30 a.m. and 12:30 p.m. to 5:00 p.m.

To determine whether a mental health or substance use disorder provider participates in the Blue Cross Blue Shield PPO network, you can link to the Blue Cross Blue Shield PPO provider search available on the *Provider Networks* page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org) and click on the Blue Cross Blue Shield Michigan or non-Michigan Physician, Hospital and Facilities search, or you can contact MCTWF's Customer Communications Department at 800-572-7687. For referrals after business hours, please contact Blue Cross Blue Shield at 800-810-BLUE (2583).

While the Blue Cross Blue Shield PPO network is extensive, not all ValueOptions outpatient network providers participate in it. To help facilitate the transition for those who are receiving ongoing authorized outpatient services after March 31, 2013 from a ValueOptions provider who does not participate in the Blue Cross Blue Shield PPO network, MCTWF will treat such services as "in-network" for patient copay or coinsurance purposes, until the earlier of July 1, 2013 or the exhaustion of the ValueOptions authorization. Please note, however, that you may be subject to balance billing if your ValueOptions provider does not accept MCTWF's new "in-network" reimbursement amount (plus your copay or coinsurance amount) as payment in full. Accordingly, should you seek outpatient services between now and April 1, 2013, we encourage you to select a provider who participates in both the ValueOptions and Blue Cross Blue Shield PPO networks. We have sent letters with the foregoing information to all individuals whom we believe to be receiving outpatient services currently. Copay/ coinsurance amounts will remain at the "in-network" level for all authorized inpatient services rendered by ValueOptions providers and the patient will have no exposure to balance billing.

In mid to late March, you will receive in separate mailings new BCBS ID Cards and MCTWF Network cards, which will provide the appropriate billing and prior authorization information needed for mental health and substance use disorder services. Your BCBS ID Card should be presented when utilizing any provider for mental health or substance use disorder services on or after April 1, 2013.

### **Compliance with Mental Health Parity and Addiction Equity Act – Spring 2013**

**Effective April 1, 2013** in accordance with the Mental Health Parity and Addiction Equity Act, mental health and substance use disorders must be covered with treatment limitations that are no more restrictive and at levels that are no lower than that would be the case for other medical benefits offered by a healthcare plan. Accordingly, all MCTWF Plan mental health and substance use disorder benefits outpatient and inpatient visit limits and all inpatient day limits will be eliminated. And with regard to coverage level for all Plans –

- For inpatient hospital services - coverage level is unchanged whether in-network or out-of-network.
- For inpatient professional visits - coverage level is unchanged if in-network; is changed to the medical benefit level if out-of-network (for example, coverage is increased from 50% of Maximum Allowable Benefits to 60%; or, in other words, coinsurance charges are reduced from 50% to 40%).
- For outpatient professional visits - coverage level is changed to the medical benefit level. All outpatient professional visits will be considered as primary care for copay determinations.

### **Applied Behavior Analysis Coverage – Spring 2013**

**Effective October 30, 2012**, eligible MCTWF participants and beneficiaries diagnosed with an autism spectrum disorder are covered by their medical benefits for applied behavior analysis services under certain conditions.

Autism spectrum disorders are neurobiological conditions which include Autistic disorder, Asperger's disorder and other pervasive developmental disorders. While MCTWF had covered a range of services to treat autism spectrum disorders, including physical, speech and occupational therapy, nutritional counseling and other mental health services, it had not covered applied behavior analysis to diagnose and treat autism spectrum disorders. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to provide significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

The conditions which must be satisfied for coverage of applied behavior analysis services for those diagnosed with autism spectrum disorder are –

- Confirmation of the autism spectrum disorder diagnosis by a Blue Cross Blue Shield of Michigan approved autism evaluation center. A list of approved autism evaluation centers can be found on the *Info Links* page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org);
- The provision by an approved autism evaluation center of a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for applied behavior analysis services; and
- The applied behavior analysis is provided by a board certified behavior analyst, subject to prior authorization. A list of applied behavior analysts can be found on the *Info Links* page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org).

Applied Behavior Analysis services are subject to the following annual limits based on the patient's age on January 1st of each year:

- \$50,000 through age 6
- \$40,000 through age 12
- \$30,000 through age 18

### **Appropriate Use of Emergency Room – Spring 2013**

Emergency room utilization by MCTWF participants and beneficiaries is about 50% higher than the average utilization throughout the country as reported to MCTWF by its benefits consulting firm, Towers Watson. Emergency room services are far more expensive than comparable services rendered in a physician's office or urgent care facility and should be used only when the need for emergency services is real and otherwise unavailable. MCTWF's extraordinary emergency room claim experience is not only driven by occasional indiscriminate usage by many participants and beneficiaries, but in large part by chronic users; mostly about a half dozen times per year and some with several dozen emergency room visits per year.

Accordingly, as a first step in curbing inappropriate usage, MCTWF's Medical Director is carefully reviewing for medical necessity all emergency room claims incurred by individuals in excess of three per 12 month period. If the use of the emergency room is determined to not have been medically necessary, the individual will bear the full cost of the billed services.

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All participants and beneficiaries are urged to consider whether their medical condition warrants emergency room attention (please consult your Summary Plan Description booklet), or whether it can be addressed appropriately by their physician or by a local urgent care facility.

**Required Notices of Waiver from the Annual Limit Requirement of the Affordable Care Act – Spring 2013**

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This calendar year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least \$2 million.

Your health coverage, offered by the Michigan Conference of Teamsters Welfare Fund’s Retiree Medical Program Plans 145 and 475 and Freight Industry “Daily Rate” Mini-Med Plan 330, do not meet the minimum standards required by the Affordable Care Act described above. Your Retiree Medical Program Plans’ coverage have annual limits of \$220,000 on all covered medical benefits and your Mini-Med Plan has an annual limit of \$100,000.

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around \$1,853 per day. At this cost, under your Retiree Medical Program Plans 145 and 475, your insurance would only pay for 119 days, and under your Freight Industry “Daily Rate” Mini-Med Plan 330, your insurance would only pay for 54 days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least \$2 million this calendar year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until March 31, 2014.

If you are concerned about your plan’s lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: [www.HealthCare.gov](http://www.HealthCare.gov).

If you have any questions or concerns about this notice, contact the Michigan Conference of Teamsters Welfare Fund Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. In addition, you can contact the Michigan Health Insurance Consumer Assistance Program (HICAP) which is run by the Michigan Office of Financial and Insurance Regulation at:

611 W. Ottawa Street  
 Lansing, MI 48933  
 (877) 999-6442  
<http://michigan.gov/ofir> (website)  
[OFIR-HICAP@michigan.gov](mailto:OFIR-HICAP@michigan.gov) (email)

**Retiree Medical Program Rates: April 2013 - March 2014 – Spring 2013**

**Effective April 2013**, the monthly self-contribution rates listed below apply to all those participating in MCTWF’s basic Retiree Medical Program, Plan 145. For those purchasing Plan 475, which includes the Retiree Supplemental Benefits Rider (MCTWF’s hearing, vision, and Dental Plan 2 benefits), add \$128.50 to the following Plan 145 monthly rates:

<b>April 2013 Plan 145 Monthly Self-Contribution Rate (Covers Both the Retiree and the Eligible Spouse)*</b>						
<i>Years Participating in MCTWF under a Plan with Retiree Medical Program Coverage</i>						
<b>Age at MCTWF Retirement Date</b>	<b>5 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
50 – 54	\$750	\$680	\$615	\$550	\$470	\$415
55 – 59	\$575	\$535	\$495	\$450	\$420	\$385
60 – 64	\$415	\$400	\$385	\$365	\$355	\$345
For eligible retirees whose active employment ceased prior to January 1, 2002: <u>\$345</u>						

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To drop the Retiree Supplemental Benefits Rider you must have been covered by it for a minimum of 12 months and you must notify MCTWF in writing 45 days prior to the calendar month for which the Rider coverage is to terminate. For example, to drop coverage as of January 1<sup>st</sup>, MCTWF must receive written notification by November 15<sup>th</sup>. Once the Retiree Supplemental Benefits Rider is dropped, it will not be available to you again.

\* Eligibility to participate in the Program ceases for the retiree or the spouse when he or she becomes eligible for Medicare Part A coverage or engages in prohibited employment (as defined by the Summary Plan Description Booklet). In the event that the retiree becomes eligible for Medicare Part A, the spouse may continue to participate in the Program at the retiree self-contribution rate until or unless such participation, from the date of commencement, exceeds eight years. Spouse participation then requires self-contribution at the Program's cost based rates. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate in the Program at the retiree's contribution rate, unless or until the later of a) eight years from the date that the retiree's Program coverage began or b) until the date the retiree would have attained age 65, after which, for so long as she remains eligible, the spouse may continue to participate at the Program's cost based rate as an "Extended Retiree Spouse."

### **"Grandfathered" Status Under The Affordable Care Act - Spring 2013**

Please be advised that this group health plan, the Michigan Conference of Teamsters Welfare Fund (MCTWF), believes that all current MCTWF medical plans not designated as "New SOA", "New Key"\*, "New I&S" or "New PEP" are "grandfathered plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the MCTWF Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

\* New Key Plans 1, 1a, 1b, 2, 2a, 2b, 2c, 2d, 3, and 4

### **Required Notice of "Grandfathered" Status Under The Affordable Care Act - Fall 2013**

Please be advised that this group health plan, the Michigan Conference of Teamsters Welfare Fund (MCTWF), believes that all current MCTWF medical plans not designated as "New SOA", "New Key"\*, "New I&S" or "New PEP" are "grandfathered plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the MCTWF Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

\* New Key Plans 1, 1a, 1b, 2, 2a, 2b, 2c, 2d, 3, and 4

### **Emergency Ambulance Benefits - Fall 2013**

Under all MCTWF medical benefit plans, eligible in-network and out-of-network expenses are reimbursed for ground, air or water ambulance services for basic and advanced life support and transportation to a medical facility for treatment of a medical emergency, or from one hospital facility to another for reasons of medical necessity. **Effective April 9, 2013**, MCTWF's coverage was broadened to hold harmless from out-of-network balance billing exposure, participants and beneficiaries who, in seeking emergency ambulance services, receive services from a non-participating ambulance provider, when no other reasonable choice is available.

**Emergency Room Benefits - Fall 2013**

As was announced in the spring 2013 *Messenger*, emergency room utilization by MCTWF participants and beneficiaries is about 50% higher than the average utilization throughout the country as reported to MCTWF by its benefits consulting firm, Towers Watson. As a result, MCTWF’s Medical Director reviews carefully for medical necessity all emergency room claims incurred by individuals in excess of three per 12 month period. Should the use of the emergency room be determined to not have been medically necessary, the individual will bear the full cost of the billed services.

All participants and beneficiaries are urged to consider whether their medical condition warrants emergency room attention. The Trustees have restated with examples the criteria that must be satisfied to qualify for emergency room benefits, as follows:

An emergency situation is a sudden and unexpected medical problem which if not immediately treated, might result in death or serious bodily harm.

Some examples of emergency illness are heart attack, stroke, loss of consciousness and convulsions.

Some examples of emergency injuries are severe eye or head injury, medication overdose, poison ingestion, severe allergic reaction, animal bite, burn, smoke inhalation, and frostbite.

In general, emergency room treatment for medical conditions that do not require immediate attention (to prevent death or serious bodily harm), including chronic medical problems, is not covered as a benefit.

We urge you, when possible, before deciding to go to an emergency room, to contact your primary care provider. If you have an unexpected medical problem requiring prompt attention that is not a true emergency as defined above, treatment should be sought from an urgent care facility.

**Immunizations - Fall 2013**

Immunizations received in accordance with MCTWF’s approved schedules (which follow the recommendations of the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices) are covered, subject to applicable limits, by all MCTWF medical plans. For children, all immunizations are covered in full if received from a network provider. For adults, coverage is subject to applicable limits (please refer to your schedule of benefits for specifics). Below are the *2013 Child and Adolescent Immunization Schedule* and the *2013 Adult Immunization Schedules*. The Centers for Disease Control and Prevention publish these schedules together with footnotes (which are too voluminous to print here) that must be read in conjunction with the schedules. Please refer online to the complete schedule and footnotes, as noted beneath the schedules below or on the *Info Links page* of our website at [www.mctwf.org](http://www.mctwf.org).

**2013 Child and Adolescent Immunization Schedule**

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16-18 yrs
Hepatitis B (HepB)	Dose 1	Dose 2		Dose 3												
Rotavirus (RV)		Dose 1	Dose 2	Dose 3												
Diphtheria, Tetanus, & acellular Pertussis (DTaP))		Dose 1	Dose 2	Dose 3	Dose 4			Dose 5								
Tetanus, diphtheria & acellular pertussis (Tdap)													(Tdap)			
Haemophilus Influenzae Type b (Hib)		Dose 1	Dose 2	Dose 3	Dose 3 or 4											
Pneumococcal conjugate (PCV13)		Dose 1	Dose 2	Dose 3	Dose 4											
Pneumococcal Polysaccharide (PPSV23)																
Inactivated Poliovirus (IPV)		Dose 1	Dose 2	Dose 3						Dose 4						
Influenza (IV, LAIV)				(IV only)						(IV or LAIV)						

**Michigan Conference of Teamsters Welfare Fund**

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16-18 yrs
Measles, Mumps, Rubella (MMR)							Dose 1					Dose 2				
Varicella (VAR)							Dose 1					Dose 2				
Hepatitis A (HepA)							2 Dose Series									
Human Papillomavirus (HPV2: females only; HPV4: males and females)														3 Dose series		
Meningococcal														Dose 1		Booster

- Range of recommended ages for all children
- Range of recommended ages for catch-up immunization
- Range of recommended ages for certain high-risk groups
- Range of recommended ages during which catch up is encouraged and for certain high-risk groups
- Not Routinely recommended

Please refer online to <http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-schedule.pdf>

**2013 Adult Immunization Schedule Based on Age Groups**

Vaccine	19-21 Years	22-26 Years	27-49 Years	50-59 Years	60-64 Years	65 Years and Older
Influenza	1 dose annually					
Tetanus diphtheria pertussis (Td/Tdap)	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 years					
Varicella	2 doses					
Human papillomavirus (HPV) Female	3 doses					
Human papillomavirus (HPV) Male						
Zoster						1 dose
Measles, Mumps, Rubella (MMR)	1 or 2 doses					
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses					1 dose
Pneumococcal 13-valent conjugate (PCV13)						
Meningococcal	1 or more doses					
Hepatitis A	2 doses					
Hepatitis B	3 doses					

- For persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)
- No recommendation

**2013 Adult Immunization Schedule Based on Medical and Other Indications**

VACCINE ↓ INDICATION →	Pregnancy	Immuno-compromising conditions (excluding human immune deficiency virus (HIV))	HIV Infection CD4 +T lymphocyte count		Men who have sex with men (MSM)	Heart disease, chronic lung disease, chronic alcoholism	Asplenia (including elective splenectomy and persistent complement component deficiencies)	Chronic liver disease	Kidney failure, end-stage renal disease, receipt of hemodialysis	Diabetes	Healthcare personnel	
			<200 cells/μL	>200 cells/μL								
Influenza			1 dose IIV annually		1 dose IIV or LAIV annually	1 dose IIV annually					1 dose IIV or LAIV annually	
Tetanus, diphtheria, pertussis (Td/Tdap)	1 dose Tdap each pregnancy	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs										
Varicella		Contraindicated										2 doses
Human papillomavirus (HPV) Female		3 doses through age 26 yrs				3 doses through age 26 yrs						
Human papillomavirus (HPV) Male		3 doses through age 26 yrs				3 doses through age 21 yrs						
Zoster		Contraindicated		1 dose								
Measles, mumps, rubella (MMR)		Contraindicated	1 or 2 doses									
Pneumococcal polysaccharide (PPSV23)		1 or 2 doses										
Pneumococcal 13-valent conjugate (PCV13)												
Meningococcal												
Hepatitis A						2 doses						
Hepatitis B						3 doses						

**Introducing MDLIVE™ Telehealth Consultations – Spring 2014**

MCTWF is pleased to announce that **effective April 1, 2014** it is making available to all medical plan participants, spouses, and dependent children a new and very convenient service for treatment of many non-acute medical conditions. This service, known as a “telehealth” (or “telemedicine”) consultation, is provided by MDLIVE™, which MCTWF has determined to be the best telehealth vendor in America. MDLIVE provides you with on-demand access to U.S. Board certified physicians and licensed therapists by secure video (between 7am and 9pm), or by phone or e-mail **anytime** and almost everywhere throughout the country. Your consultation generally will occur in less than 15 minutes from the time you request it. You also can choose a provider and schedule a consultation for a time that works best for you.

The goal is to connect you with the care you need, whenever you need it. Whether you are at home, at work, traveling, or you simply want the most convenient way to see a doctor, real-time video and phone consultations allow for the diagnosis and treatment of a wide range of medical conditions, regardless of your location, in a safe, secure and confidential environment.

MDLIVE physicians are state licensed and Board certified and are credentialed in family practice, internal medicine, pediatrics, or emergency medicine. MDLIVE physicians average 15 years of experience.

Each consultation with a MDLIVE physician or behavioral health therapist will cost you \$10, payable by debit or credit card. You can receive unlimited free e-mail advice. Prescriptions\* are sent electronically to your chosen pharmacy and MDLIVE’s on-line patient portal provides you with a secure way to store and access your MDLIVE electronic personal health records.

\* Prescriptions are issued only when clinically appropriate. No controlled substances may be prescribed and the availability of other prescriptions may be restricted by law.

**When To Use MDLIVE**

- If you are considering the ER or urgent care center for a non-emergency medical issue
- If your primary care physician is not available
- If you are traveling and in need of medical care
- During or after normal business hours, nights, weekends, and holidays

## **Common Conditions Treated**

### **Medical**

Acne	Allergies	Asthma
Bronchitis	Cold & Flu	Constipation
Diarrhea	Ear Infection	Fever
Headache	Infections	Insect Bites
Joint Aches	Nausea	Pink Eye
Rashes	Sore Throat	

### **Behavioral Health**

Child Behavior & Learning Concerns  
Coping with Loss & Grief  
Stresses & Challenges of Everyday Life

## **Getting Started - Registration**

Before seeking your first phone or video consultation, you and your eligible family members will need to register. Registration is easy and it will speed up the time it will take to arrange for your first consultation when you need it. You and your family can register by phone with the help of an MDLIVE health services specialist at **1-888-632-2738** or on-line at **www.mdlive.com/mctwf**, a link to which, as well as a guide for on-line registration, is available on the *Info Links* page of MCTWF's website.

### **When registering on-line -**

1. The participant must register before eligible family members can be registered. The participant must enter the last 4 digits of his social security number and his date of birth (the "Moniker"), continue to the next screen to select his name from among his listed family members, and then continue to each of the patient sign-up screens, creating a username and a password and filling in other requested information.
2. An e-mail confirmation will be sent to the participant. Once received, the participant will complete the registration process by clicking on the "Activation" link. He then will be prompted to login using his username and password. This will take the participant to his personal portal's "Dashboard."
3. The participant now may register each dependent minor child in the same manner that he did for himself by selecting each name from the dropdown next to the participant's name in the upper right hand corner of the Dashboard screen. The participant's spouse and children over age 18 may register by using the participant's Moniker and then following the above process for themselves.
4. Each registered person should fill out his medical history by clicking on the link, "You need to update your medical history" on the right hand side of their Dashboard page and then completing all of the tabs under "My Health."
5. Also to the right hand side of your Dashboard is the link, "You need to choose a pharmacy." Each registered person should select the network pharmacy to which he wishes his prescriptions sent. MDLIVE physicians have been asked to observe MCTWF's prescription benefit rules and limitations when prescribing medications.

### **Requesting a medical or behavioral health consultation, by phone or on-line -**

If arranging for a consultation **on-line**, sign in using the username and password you created to be directed to your Dashboard from where you can seek a phone consultation with the next available "on call" doctor or therapist available, or you can select from a number of family doctors, pediatricians, or therapists to schedule a phone or video consultation at a time that best fits your schedule (however, video consultations must occur between 7am and 9pm). For scheduled video consultations, sign in to the MDLIVE portal five minutes prior to your consultation. You will be prompted to update your health information and your pharmacy selection, and download "VSee", MDLIVE's proprietary secure video software; the provider will then connect with you. If you have any questions regarding "VSee" or regarding any other issue, contact MDLIVE Customer Services at 1-888-632-2738 and you will be assisted. MDLIVE will soon be making available an application that will permit video consultations using mobile devices such as iPhones, tablets or android devices.

You soon will be receiving by mail a welcome kit containing information about MDLIVE, an identification card and a key ring attachment stating MDLIVE's phone number and URL.

**Michigan Conference of Teamsters Welfare Fund**

We hope that you take advantage of this convenient and low cost alternative for treating non-acute medical conditions.

**Retiree Medical Benefit Package Rates: April 2014 - March 2015 – Spring 2014**

**Effective April 2014**, the standard and expanded monthly self-contribution rates listed below apply to all those participating in MCTWF’s basic Retiree medical benefit package 145. For those purchasing benefit package 475 (includes the Retiree Supplemental Benefits Rider - hearing, vision, and Dental Plan 2 benefits), add \$128.50 to benefit package 145 monthly rates:

<b>April 2014 Retiree Medical Benefit Package 145 Standard Eligibility Rules Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*</b>						
	<b>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</b>					
<b>Age at MCTWF Retirement Date</b>	<b>5 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
50 – 54	\$780	\$705	\$640	\$570	\$490	\$430
55 – 59	\$600	\$555	\$515	\$470	\$435	\$400
60 – 64	\$430	\$415	\$400	\$380	\$370	\$360
For eligible retirees whose active employment ceased prior to January 1, 2002: <u>\$360</u>						

<b>April 2014 Retiree Medical Benefit Package 145 Expanded Eligibility Rules Monthly Self-Contribution Rate (Covers Both the Retiree and the Eligible Spouse)*</b>						
	<b>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</b>					
<b>Age at MCTWF Retirement Date</b>	<b>7 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
57 – 59	\$660	\$610	\$565	\$515	\$480	\$440
60 – 64	\$475	\$455	\$440	\$420	\$405	\$395

To drop the Retiree Supplemental Benefits Rider you must have been covered by it for a minimum of 12 months and you must notify MCTWF in writing 45 days prior to the calendar month for which the Rider coverage is to terminate. For example, to drop coverage as of January 1<sup>st</sup>, MCTWF must receive written notification by November 15<sup>th</sup>. Once the Retiree Supplemental Benefits Rider is dropped, it will not be available to you again.

\* Eligibility to participate in the retiree medical benefit package ceases for the retiree or the spouse when he or she becomes eligible for Medicare Part A coverage or engages in prohibited employment (as defined by the Summary Plan Description Booklet). In the event that the retiree becomes eligible for Medicare Part A, the spouse may continue to participate in the retiree medical benefit package at the retiree self-contribution rate until or unless such participation, from the date of commencement, exceeds eight years. Spouse participation then requires self-contribution at the retiree medical benefit package’s cost based rates. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate in the retiree medical benefit package at the retiree’s contribution rate, unless or until the later of a) eight years from the date that the retiree’s medical benefit package coverage began or b) until the date the retiree would have attained age 65, after which, for so long as she remains eligible, the spouse may continue to participate at the retiree medical benefit package’s cost based rate as an “Extended Retiree Spouse.”

**Emergency Room or Urgent Care? – Spring 2014**

Your MCTWF plan pays for emergency room treatment of emergency injuries and emergency illnesses (“emergent conditions”). As addressed in the Fall 2013 *Messenger* and supported with examples, an emergent condition is a sudden and unexpected medical problem which if not immediately treated, might result in death or serious bodily harm. **If your condition does not meet this definition, your plan will not cover the costs incurred, so we urge you to make your decision carefully.** For conditions that require medical attention and cannot wait for an appointment with your physician, but are not “emergent,” treatment should be sought from an urgent care center. Emergency rooms should never be used as a matter of convenience.

Blue Cross Blue Shield of Michigan provides the following useful guidance:

## **Should I go to the emergency room or urgent care?**

This information can help you figure out where to go for medical treatment when you need it most. When you're sick or injured, the last thing you want to do is to have to decide whether to go to an emergency room or an urgent care center. Understanding the differences between the two options now will give you peace of mind later.

### **The difference between an emergency room and an urgent care center**

#### **Emergency Rooms:**

- Treat severe and life-threatening conditions
- Hospital emergency rooms have specially trained doctors, paramedics, nurses, and other support staff that can recognize, diagnose and make recommendations on a wide variety of medical issues
- Emergency rooms are open 24 hours a day, seven days a week

#### **Urgent Care Centers:**

- Focus on diagnosing and treating conditions that aren't life-threatening yet they need to be taken care of right away
- Offer quality care on a walk-in basis
- Have extended evening and weekend hours
- Typically provide more complex services than a doctor's office

### **What are some common reasons to visit an emergency room?**

You may choose an emergency room if you're having:

- Chest pain
- Sudden or severe pain
- Abdominal pain
- Difficulty breathing
- Stroke
- Severe bleeding
- A head injury
- Other major trauma

### **What are some common reasons to visit an urgent care center?**

You may choose an urgent care center if you have:

- A sprained ankle
- Ear infections
- Fever or flu-like symptoms
- Allergic reactions
- Minor burns or injuries
- Broken bones
- Coughs, colds, sore throats
- Animal bites

### **What are the advantages of going to an urgent care center?**

In most situations, you'll find that you save time and money by going to an urgent care instead of an emergency room.

If you have an injury or illness such as a sprained ankle or an ear infection, you may end up waiting for hours in the emergency room and paying hundreds of dollars for your care.

Most urgent care centers are open for extended hours, and they are often able to accommodate you much more quickly. Also, you may end up paying lower copays at an urgent care center. Check your plan's benefits to find out your out-of-pocket costs.

If you're ever in doubt about which care facility to choose, it's a good idea to ask your primary doctor for guidance. And if you can't reach your doctor, you might want to call an urgent care center in your neighborhood.

## Michigan Conference of Teamsters Welfare Fund

MCTWF's Medical Director advises that "[p]articipants should understand that utilization of emergency rooms does not ensure superior medical care. Quite the opposite is frequently the reality. Persons with minor injuries and medical complaints are triaged to the lowest status and are justifiably placed in the back of the line to endure the longest wait times. Furthermore, if your presenting complaint is not of sufficient concern, an ER may assign you to receive treatment from a non-physician medical provider such as a Nurse Practitioner or Physician's Assistant.

*MCTWF does not in any way wish to discourage the use of ER services for participants involved in a true medical emergency. If you or a family member ever experiences a major traumatic injury, sudden severe chest pain, shortness of breath or loss of consciousness, please dial 911 immediately.*"

We soon will be mailing to you a list of in-network urgent care centers closest to your home. The phone number and office hours for each will be included. Of course, you can get this information by going to our website at [www.mctwf.org](http://www.mctwf.org) and following the search instructions on our Provider Networks page under Blue Cross Blue Shield, or by contacting MCTWF's Member Services Call Center during business hours at 313-964-2400 or after business hours at 800-810-BLUE (2583) for assistance.

Also please remember that your MCTWF medical benefits include use of the BlueHealthConnection 24-hour nurse line at 800-775-BLUE (2583), which is staffed with registered nurses who can help you assess the seriousness of your condition and the appropriate venue for treatment.

### **Required Notice of "Grandfathered" Status Under The Affordable Care Act - Spring 2014**

Please be advised that this group health plan, the Michigan Conference of Teamsters Welfare Fund (MCTWF), believes that all current MCTWF medical plans not designated as "New SOA", "New Key"\*, "New I&S" or "New PEP" are "grandfathered plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the MCTWF Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

\* New Key Plans 1, 1a, 1b, 2, 2a, 2b, 2c, 2d, 3, 3a, 4 and 4a.

### **Influenza Vaccination Coverage - Fall 2014**

It's that time of the year again; please don't forget to get your influenza vaccination. For adults and children covered under a MCTWF medical benefits package, the annual influenza vaccine is covered in full if received from a network provider.

### **Coverage for Emergency Room Facility and Physician Services – Fall 2014**

#### **Change to Copayments for Grandfathered Emergency Room Facility Charges**

Please refer to the following chart. **Effective January 1, 2015** the patient's copayment/coinsurance responsibility under all "grandfathered" benefit packages will be changed to the flat copayment amounts noted. Consequently, each of the affected benefit packages will lose its "grandfathered" status under the Affordable Care Act, resulting in the expansion of free preventive services and expanded appeal rights. As always, if the patient is admitted through the emergency room for inpatient services, the emergency room copayment is waived.

**Michigan Conference of Teamsters Welfare Fund**

<b>Base Medical Benefit</b>	<b>Emergency Room Facility Charges Copayment/Coinsurance Prior to 01/01/15</b>	<b>Emergency Room Facility Charges Copayment Effective 01/01/15</b>
<b>SOA, I&amp;S, PEP</b>	\$20	<b>\$75</b>
<b>Key 1, Key 1a</b>	10% of contracted charges	<b>\$75</b>
<b>Key 1b</b>	10% of contracted charges plus \$75 copayment	<b>\$75</b>
<b>Key 2, Key 2a</b>	15% of contracted charges	<b>\$100</b>
<b>Key 2b, Key 2c, Key 2d</b>	15% of contracted charges plus \$75 copayment	<b>\$125</b>
<b>Key 3</b>	20% of contracted charges	<b>\$100</b>
<b>Key 4</b>	20% of contracted charges	<b>\$125</b>

**New Coverage for Emergency Room Services for Treatment of Non-Emergent Conditions**

As repeatedly noted in recent issues of the *Messenger*, emergency room treatment of medical conditions that are not “emergent” (meaning sudden and expected and which if not immediately treated might result in death or serious bodily harm), are not covered as a MCTWF benefit and therefore are payable by the patient, in full, without benefit of Blue Cross Blue Shield (BCBS) negotiated discounts.

The Trustees remain determined to deny coverage for inappropriate usage of emergency rooms since, had the necessary medical services been obtained in an appropriate setting, there would be no facility charges and the same physician’s services would be charged at a substantially reduced rate. However, they have acknowledged their concern about member exposure to non-discounted charges for denied claims. Accordingly, MCTWF has made arrangements with Blue Cross Blue Shield of Michigan that will avail members of those BCBS discounts.

**Effective January 1, 2015**, MCTWF will “approve” emergency room facility claims and emergency room physician claims for treatment of non-emergent conditions, thereby triggering the BCBS discounts. MCTWF will continue not to pay any portion of the non-emergent emergency room facility claims, but will make payment toward the non-emergent emergency room physician claims in an amount approximately equivalent to what MCTWF would have paid if the services had been obtained from an urgent care clinic. Accordingly, both the facility and physician bills will be payable by the patient based on discounted charges rather than the full charges and, in addition, the physician bills will be reduced by MCTWF’s payment at the urgent care rate for those services.

For a realistic example, a patient obtains emergency room services for a non-emergent condition with facility charges of \$850 and physician’s charges of \$475. Under current benefit design, MCTWF would deny these claims and the patient would be responsible for full payment of the charges (\$1,325). Effective January 1, 2015 -

- MCTWF will approve the emergency room facility claim, but pay \$0 and so, instead of the patient having to pay \$850 in facility charges, he would pay the BCBS “allowed amount” of \$474.
- MCTWF will approve the emergency room physician claim and pay toward it the approximately equivalent BCBS urgent care allowed amount (to treat the patient’s condition) of \$98, less his benefit package’s urgent care level copay of \$35, for a total of \$63. The patient would pay the difference between MCTWF’s \$63 payment and the BCBS allowed amount for the emergency room physician claim of \$173. So, instead of the patient having to pay \$473 in physician charges, he would pay \$110.

In sum, in this example, the patient’s billing exposure for having utilized an emergency room to treat a non-emergent condition will be reduced by 56% from \$1,323 to \$584.

### **Bariatric Surgery – Revised Prior Authorization Guidelines – Fall 2014**

**Effective May 16, 2014**, the Trustees revised MCTWF's guidelines for prior authorization of bariatric surgery (gastric surgery for morbid obesity) in all medical benefit packages. MCTWF covers bariatric surgery for patients between the ages of 18 and 60 if all the below general prior authorization criteria are met. The same is true for patients below age 18 if satisfactory documentation is presented that appropriate consideration has been given to the risk of surgery on future growth, the patient's maturity level and ability to understand the surgical procedure and to comply with post-operative instructions, and the adequacy of family support. The same also is true for patients above age 60 if satisfactory documentation is presented that based on the patient's physiologic age and co-morbid conditions, a positive risk/benefit ratio exists. The general prior authorization criteria are as follows:

- The patient has a body mass index (BMI) of 40 or greater. If the patient's BMI is between 35 and 39, authorization will be granted if one or more co-morbid conditions also exist, including but not limited to:
  - degenerative joint disease (including degenerative disc disease)
  - hypertension
  - hyperlipidemia or coronary artery disease
  - other atherosclerotic diseases
  - type II diabetes mellitus
  - sleep apnea
  - congestive heart failure.
- The patient has been clinically evaluated by a physician (or authorized delegate) and the physician has documented the failure of non-surgical management including a structured, professionally supervised (physician or non-physician) weight loss program for a minimum of six consecutive months within the last four years prior to the recommendation for bariatric surgery. However, this requirement is waived for super morbidly obese individuals (i.e., those who have a BMI of 50 or greater). Documentation should include periodic weights, dietary therapy and physical exercise, as well as behavioral therapy, counseling and pharmacotherapy, as indicated.
- Documentation has been provided demonstrating that the physician and the patient have a good understanding of the risks involved and that the physician has a reasonable expectation that the patient will be compliant with all post-surgical requirements.
- The patient has had a psychological evaluation performed as a pre-surgical assessment by a mental health professional in order to establish the patient's emotional stability, ability to comprehend the risk of the surgery and to give informed consent, and ability to cope with expected post-surgical lifestyle.

Reconstructive surgical procedures of any kind, for any reason, occasioned directly or indirectly by the weight loss following bariatric surgery, are excluded from coverage.

### **Intra-Articular Cartilage Injections – Benefit Revision – Fall 2014**

**Effective July 15, 2014**, MCTWF's Trustees limited coverage in all medical benefit packages for intra-articular cartilage injections to members with the following conditions:

- Osteoarthritis, localized, primary, lower leg;
- Osteoarthritis, localized, secondary, lower leg; and
- Osteoarthritis, localized, not specified whether generalized or localized, lower leg.

Individuals with osteoarthritis of the knee who have obtained insufficient pain relief from conservative non-pharmacological therapy (such as physical therapy) and simple analgesics and who have failed conservative therapy with a non-steroidal anti-inflammatory drug (NSAID), or who have contraindications to NSAID therapy, are eligible for a course of treatment with intra-articular cartilage injections of from one to five weekly injections, once per three month period.

### **Required Notice of “Grandfathered” Status Under the Affordable Care Act – Fall 2014**

Please be advised that this group health plan, the MCTWF Actives Plan, believes that all current medical benefit packages not designated as “New SOA,” “New Key,”\*, “New I&S,” or “New PEP” are “grandfathered benefit packages” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your benefit

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package may not include certain consumer protections of the Affordable Care Act that apply to other plans for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the MCTWF Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

\* New Key Plans 1, 1a, 1b, 2, 2a, 2b, 2c, 2d, 3, 3a, 4 and 4a.

### **In-Lab Sleep Studies – Prior Authorization Required – Fall 2014**

All MCTWF medical benefit packages cover members for sleep studies for the following diagnoses:

- transient difficulty in initiating or maintaining sleep;
- somnambulism or night terrors;
- other dysfunctions of sleep stages or arousal from sleep; and
- cataplexy and narcolepsy.

In light of the significantly higher cost of in-lab sleep studies than home sleep studies and in accordance with Blue Cross Blue Shield of Michigan medical policy, **effective February 1, 2015**, MCTWF will require that all Michigan providers obtain prior authorization for in-lab sleep testing for MCTWF members by contacting AIM Specialty Health at (800) 728-8008. All non-Michigan providers must obtain prior authorization for in-lab sleep testing for MCTWF members by contacting MCTWF's Utilization Review Department at (800) 572-7687, extension 463. To obtain prior authorization, the provider must justify why an in-lab sleep test is more clinically appropriate for the patient than a home sleep test. If services are performed, but not prior authorized, the member may be responsible for full payment of charges.

### **Breast Reduction Mammoplasty – Revised Prior Authorization Guidelines – Fall 2014**

**Effective July 15, 2014**, the Trustees revised MCTWF's prior authorization guidelines in all medical benefit packages for breast reduction mammoplasty coverage. Each of the following requirements must be satisfied:

- The patient must be old enough to ensure that her breasts are fully developed.
- The amount of tissue to be removed must be greater than or equal to the 22<sup>nd</sup> percentile on the Schnur Sliding Scale.
- Two of the below requirements must be met:
  - Documented pain in the neck and/or shoulders, or postural backache, which must be of long-standing duration. Failure of conservative therapy, including an appropriate support bra, exercises, heat/cold treatments and appropriate non-steroidal anti-inflammatory agents or muscle relaxants.
  - Shoulder grooving.
  - Recurrent intertrigo between the breasts and the chest wall that has not responded to dermatologic treatment.

To obtain prior authorization the provider must contact MCTWF's Utilization Review Department at (800) 572-7687 extension 463. If services are performed without prior authorization, you may be fully responsible for payment of the provider's charges.

### **Elimination of Best Doctors Program – Fall 2014**

Despite the high quality and value and MCTWF's free provision of Best Doctors medical review and consulting services, after more than two years of extremely low member utilization and lack of response to our survey earlier this year, the Trustees decided that they could no longer justify the cost of this program to MCTWF and therefore terminated MCTWF's contract with Best Doctors effective September 6, 2014.

### **Echocardiography Services – Prior Authorization Required – Fall 2014**

**Effective January 1, 2015**, in accordance with Blue Cross Blue Shield of Michigan medical policy, MCTWF will expand its current radiology management program by requiring prior authorization of nonemergency outpatient echocardiography services performed in a physician's office, freestanding radiology center, or hospital outpatient setting (but not in a in the hospital inpatient, observation, or emergency room setting). Michigan providers must obtain prior authorization by contacting AIM Specialty Health at (800) 728-8008. Non-Michigan providers must obtain prior authorization by contacting MCTWF's Utilization Review department at (800) 572-7687, extension 463. If services are performed, but not prior authorized, the member may be responsible for full payment of charges.

### **Gastric Electrical Stimulation Therapy – New Benefit – Fall 2014**

Gastric Electrical Stimulation (GES) Therapy is a treatment option for those who suffer with chronic nausea and vomiting associated with gastroparesis, a common gastrointestinal motility disorder. This most commonly occurs in diabetic patients and may require frequent hospitalization due to hypoglycemia or hyperglycemia, electrolyte imbalance or other complications of this disease.

**Effective June 5, 2014**, MCTWF is covering GES Therapy under all of its medical benefits packages for members suffering from both diabetes and gastroparesis. Physicians must obtain prior authorization by contacting MCTWF's Utilization Review Department at (800) 572-7687, extension 463. If services are performed, but not prior authorized, the member may be responsible for full payment of charges.

### **ABA Coverage for Autism Spectrum Disorders – Revised Benefit – Fall 2014**

Effective October 30, 2012, dependent children diagnosed with an autism spectrum disorder became eligible under their MCTWF medical benefits package for coverage of Applied Behavior Analysis (ABA) services up to a calendar year limit of \$50,000 for patients through age 6, \$40,000 for patients through age 12, and \$30,000 for patients through age 18, with such limits being based on the patient's age as of January 1<sup>st</sup> of each year.

In accordance with the Affordable Care Act's prohibition on annual dollar benefit limits for essential health benefits, **effective April 1, 2014**, MCTWF's calendar year dollar limits for ABA services were actuarially converted to hour limits, as follows:

- 1,300 hours limit through age 6 (subject to service limitations below)
- 1,040 hours limit through age 12 (subject to service limitations below)
- 780 hours limit through age 18 (subject to service limitations below)

In accordance with Blue Cross Blue Shield of Michigan (BCBSM) medical policy, the requirements which must be satisfied for coverage of ABA services are as follows:

- Services in Michigan – An approved Blue Cross Blue Shield of Michigan (BCBSM) autism evaluation center must make or confirm the autism spectrum disorder diagnosis and provide a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for ABA services, before treatment begins. If ABA treatment is recommended, the services must be obtained from a board-certified behavior analyst for the treatment to be payable. The analyst must obtain prior authorization from BCBSM to provide ABA services. The board-certified behavior analyst may be non-participating but must be registered with BCBSM. A link to Approved Autism Evaluation Centers and Board-Certified Behavior Analysts is available on the *Info Links* page of MCTWF's website.
- Services Outside of Michigan – The participant must obtain a multidisciplinary evaluation from an academic medical center or a hospital based facility (participating with the Blue Cross Blue Shield plan in the state where services will be provided) that makes or confirms the autism spectrum disorder diagnosis and provides a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for ABA services. If ABA treatment is recommended, the services must be obtained from a board-certified behavior analyst for the treatment to be payable. The analyst must obtain prior authorization from BCBSM to provide ABA services. The board-certified behavior analyst must be a participating provider in the Blue Cross plan in the state where services will be provided. A link to Blue Cross Blue Shield Non-Michigan Physician, Hospital and Urgent Care Searches is available on the *Provider Networks* page of MCTWF's website.

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<b>ABA Services</b>	<b>Limitations</b>
Initial Assessment	Once per patient
Reassessment	No limitation
Line Therapy	Limited to 25 hours per patient per 7 days (Sunday-Saturday) in combination with skills training services
Skills Training	Limited to 25 hours per patient per 7 days (Sunday-Saturday) in combination with line therapy services
Supervision	Limited to 3 hours per patient per 7 days (Sunday-Saturday)
Caregiver Training	Limited to 3 hours per patient per 7 days (Sunday-Saturday)

**MDLIVE™ Telehealth Consultations Mobile App – Spring 2013**



## Introducing the MDLIVE App

Sick in bed? Sick at work? Got a smartphone?  
 Doctor visits are easier than ever with the MDLIVE App.

- Access to a doctor anywhere: at home, at work, or on the go
- Choose doctors from one of the nation's largest telehealth networks
- Available 24/7 by video or phone
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Activate your account online or over the phone at:

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1-888-632-2738

**No Cost Tobacco Cessation Interventions – Spring 2015**

Pursuant to the Affordable Care Act’s mandate for the provision of preventive services at no cost to the patient, all MCTWF “non-grandfathered” health benefit packages provide members who use tobacco products with coverage, at no cost and without prior authorization, for in-network tobacco cessation interventions, including tobacco use and tobacco caused disease counseling and FDA approved, physician prescribed tobacco cessation medications. As of January 1, 2015, all MCTWF Actives Plan health benefit packages are non-grandfathered and in compliance. The number of covered, appropriate, in-network counseling sessions for those diagnosed with tobacco use disorder is unlimited. Coverage for FDA approved, physician prescribed tobacco cessation medications purchased from an in-network pharmacy fall into two categories, Nicotine Replacement Products (patch, gum, lozenges, Nicotrol inhalation system, and Nicotrol NS nasal spray) and Nicotine Deterrent Products (Chantix or Bupropion). No cost coverage for any physician prescribed product or combination of products in each category is limited to 168 days per calendar year.

### **MDLIVE Telehealth Services - Free for One Year – Spring 2015**

A year ago, MCTWF introduced a convenient service for treatment of many non-acute medical conditions through the use of telehealth consultations provided by MDLIVE. MDLIVE provides on-demand access to U.S. Board certified physicians and licensed therapists by secure video (between 7am and 9pm), or by phone or email, anytime and almost everywhere throughout the country. Real-time video and phone consultations allow for the diagnosis and treatment of a wide range of medical conditions, regardless of the patient's location, in a safe, secure and confidential environment. Members who have used MDLIVE services almost uniformly have expressed surprise with the ease of the process and satisfaction with the telehealth consultation. Currently, each consultation with a MDLIVE physician or behavioral health therapist costs a member only \$10. However, telehealth consultations are a relatively new concept in healthcare delivery and many people are reluctant to try it.

In an effort to encourage members to register and try out MDLIVE, **MCTWF's Trustees have decided to waive the \$10 copay per consultation for the plan year April 1, 2015 through March 31, 2016.**

In addition, as promoted by the following "flyer," MDLIVE will conduct a drawing from the names of all those who register to utilize MDLIVE services (at [www.mdlive.com/mctwf](http://www.mdlive.com/mctwf), or by calling MDLIVE at 1-888-632-2738) between March 15<sup>th</sup> and April 30<sup>th</sup> (plus those who previously have registered and who send their full name and email address to [promotions@mdlive.com](mailto:promotions@mdlive.com). by April 30th). The winner will be given a "GetFit Pack" that includes a Samsung Galaxy Tab, a Fitbit Flex and a Sport Water Bottle. Good luck!

### **Out-of-Pocket Cost Limits – Spring 2015**

In accordance with the Affordable Care Act, **effective January 1, 2015**, all MCTWF Actives Plan medical and prescription drug benefits combined in-network out-of-pocket costs are subject to calendar year limits. Out-of-pocket costs refer to deductibles, copay and coinsurance amounts (but not contribution payments, or out-of-network cost-sharing or balance bill payments). Once a calendar year limit is reached, coverage must be provided for the balance of the year without further out-of-pocket costs for in-network medical and prescription drug benefits. The limits for 2015 are \$6,600 per individual and \$13,200 per family. Member accumulations toward these statutory out-of-pocket cost limits are tracked on each MCTWF Explanation of Benefits (EOB) form and in each MCTWF *Participant Portal* account.

In addition, MCTWF continues to separately administer and similarly track the out-of-pocket cost limits specific to each medical benefit package (for instance the Key I benefit has a \$1,000 per family in-network out-of-pocket maximum and a \$2,000 per family out-of-network out-of-pocket maximum). As always, the member costs that are accumulated against these out-of-pocket cost limits are medical (not prescription drug) copay and co-insurance (not deductibles) amounts only. Once a cost limit is reached, in-network or out-of-network coverage, as appropriate, is provided without further copay or co-insurance costs.

Therefore, in addition to the annual in-network and out-of-network out-of-pocket cost limits built into each MCTWF Actives Plan benefit package, MCTWF now administers the Affordable Care Act required annual in-network, medical and prescription drug combined out-of-pocket cost limits for individuals and families, which may result, for the first time, in a limitation on your out-of-pocket costs for prescription drugs.

## MDLIVE Register for Chance to Win an MDLIVE GetFit Pack – Spring 2015

**MDLIVE**

The Future of Healthcare is Here

### Get Active This Month!

Start this month off with a big win for your health!



#### Get 24/7 Access to Doctors Anytime, Anywhere.

We are happy to offer you MDLIVE, a health benefit that allows you to have doctor's appointments via your phone or mobile device, for convenient care when you're not at your best. And best of all? It's free to sign up!

### SIGN UP FOR FREE

Sign Up from March 15th to April 30th for a chance to Win a GetFit Pack to boost your heart health this month. (\$500 approx. value)

If you are already an MDLIVE member and wish to participate, please send your full name and email address to [promotions@mdlive.com](mailto:promotions@mdlive.com)



Samsung Galaxy Tab



Fitbit Flex



Sport Water Bottle

GET STARTED NOW. Activate your account by phone or go online.

1-888-632-2738

[www.mdlive.com/mctwf](http://www.mdlive.com/mctwf)

Download the free MDLIVE app



NO PURCHASE OR PAYMENT OF ANY KIND IS NECESSARY TO ENTER OR WIN. Purchase and payment of any kind will not increase your chances of winning. Prizes are not intended to treat or diagnose any health conditions. Odds of winning will depend on the total number of entries received. Void in PA and where prohibited or restricted by law. By entering (or otherwise participating in) the sweepstakes, you agree to MDLIVE's official rules, which are a contract; so read them carefully before entering. Without limitation the contract includes indemnification to the sweepstakes entries from you and a limitation of your rights and remedies. For official sweepstakes rules go to [www.mdlive.com/legal/promotions008.html](http://www.mdlive.com/legal/promotions008.html)

See terms of use for more details: [www.mdlive.com/pages/terms.html](http://www.mdlive.com/pages/terms.html) 010113

## Air Ambulance Benefit Usage Criteria – Spring 2015

MCTWF's medical benefit packages cover eligible expenses for ground, air, or water ambulance services for basic and advanced life support and transportation to a medical facility for treatment of a medical emergency (i.e., when transport by any other means would endanger the patient's health, or the injury requires immediate first aid to stabilize the patient before transport to a hospital), or from one hospital facility to another for reasons of medical necessity. MCTWF will hold harmless from balance billing, members who, in seeking emergency ambulance services, receive services from a non-participating ambulance provider when no participating ambulance provider is available.

However, air ambulance services are payable only when ALL of the following criteria are met:

- the use of an air ambulance is medically necessary and ordered by a physician;
- the physician must have a reasonable expectation of significant time savings by the use of air ambulance transport as compared to ground or water ambulance transport time and that such time savings will reduce the risk of loss of life, limb or bodily function;
- the patient is transported to the nearest medical facility capable of treating his condition; and
- the provider is a licensed air ambulance service, not a commercial air carrier.

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**Retiree Health Benefit Package Rates: April 2015 – March 2016 – Spring 2015**

**Effective April 2015**, the standard and expanded monthly self-contribution rates listed below apply to all those participating in MCTWF's basic Retiree Health Benefit Package **145**. For those purchasing Benefit Package **475** (which includes the Retiree Supplemental Benefits Rider - hearing, vision, and Dental Plan 2 benefits), **add \$115.70** to Benefit Package 145 monthly rates:

<b>April 2015 Retiree Health Benefit Package 145 Standard Eligibility Rules Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*</b>						
	<b>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</b>					
<b>Age at MCTWF Retirement Date</b>	<b>5 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
50 – 54	\$785	\$710	\$645	\$575	\$495	\$435
55 – 59	\$605	\$560	\$520	\$475	\$440	\$405
60 – 64	\$435	\$420	\$405	\$385	\$375	\$365
For eligible retirees whose active employment ceased prior to January 1, 2002: <u>\$365</u>						

<b>April 2015 Retiree Health Benefit Package 145 Expanded Eligibility Rules Monthly Self-Contribution Rate (Covers Both the Retiree and the Eligible Spouse)*</b>						
	<b>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</b>					
<b>Age at MCTWF Retirement Date</b>	<b>7 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
57 – 59	\$665	\$615	\$570	\$525	\$485	\$445
60 – 64	\$480	\$460	\$445	\$425	\$415	\$400

To drop the Retiree Supplemental Benefits Rider you must have been covered by it for a minimum of 12 months and you must notify MCTWF in writing at least 45 days prior to the end of the last calendar month for which you wish to be covered. For example, to drop coverage as of January 1<sup>st</sup>, MCTWF must receive written notification by November 15<sup>th</sup>. Once the Retiree Supplemental Benefits Rider is dropped, it will not be available to you again.

\*Eligibility to participate in the Retiree Health Benefit Package (i.e., 145 or 475) ceases for the retiree or the spouse when he or she becomes eligible for Medicare Part A coverage or engages in prohibited employment (as defined by the Summary Plan Description Booklet). In the event that the retiree becomes eligible for Medicare Part A, the spouse may continue to participate in the Retiree Health Benefit Package at the retiree self-contribution rate until or unless such participation, from the date of commencement, exceeds eight years. Spouse participation then requires self-contribution at the retiree health benefit package's cost based rates. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate in the Retiree Health Benefit Package at the retiree's self-contribution rate, unless or until the later of (a) eight years from the date that the retiree's health benefit package coverage began or (b) until the date the retiree would have attained age 65, after which, for so long as she remains eligible, the spouse may continue to participate at the Retiree Health Benefit Package's cost based rate as an "Extended Retiree Spouse."

**Increase in Covered Mastectomy Bras per Calendar Year – Spring 2015**

MCTWF's breast reconstruction benefit has provided coverage for two mastectomy bras per calendar year. **Effective 12/4/14**, MCTWF has increased coverage to four mastectomy bras per calendar year. Reimbursement is at the scheduled amount for Medical Supplies, subject to any deductible, coinsurance and co-payment amounts.

**WEEKLY ACCIDENT AND SICKNESS BENEFITS**

**Short-Term Disabilities – Spring 2013**

Participants who suffer a non-occupational, or non-auto related accident or sickness, and who otherwise meet MCTWF's requirements, are entitled to ongoing coverage for themselves and their beneficiaries in accordance with the terms of their medical plan of benefits. The duration of such ongoing full plan coverage may be only for the period of additional employer contributions required by the participant's collective bargaining agreement (but, in accordance with MCTWF's rules, not less than four weeks) or, if their benefit plan includes Weekly Accident & Sickness benefits, then up to a maximum of 26 weeks of disability.

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MCTWF's Trustees have resolved that for non-occupational and non-auto related disabilities that commenced (in accordance with MCTWF's rules) on or after April 1, 2013 and through April 2, 2016, full plan coverage will continue for the period of the disability, not to exceed 26 weeks, regardless of whether the participant's plan provides for Weekly Accident & Sickness benefits. Thereafter, such ongoing full plan coverage beyond the period of additional employer contribution, up to a maximum duration of 26 weeks of disability, will be limited to participants whose plan includes Weekly Accident & Sickness benefits.

### **Weekly Accident and Sickness Benefits – Fall 2013**

Participants who suffer a non-occupational, or non-auto related accident or sickness, and who otherwise meet MCTWF's requirements, are entitled to ongoing coverage for themselves and their eligible beneficiaries in accordance with the terms of their schedule of benefits. Weekly accident and sickness benefits are not payable if the disability commences during a period of time the participant would not otherwise be working if the disability had not occurred. Your Summary Plan Description provides as an example, that if a disability occurs during a layoff, weekly accident and sickness benefits are not payable. MCTWF's Trustees have determined that other such examples are when a participant is not working due to a personal leave or temporary work stoppage (e.g., strikes and lockouts).

Additionally, Weekly Accident and Sickness benefits entitlement is conditioned, in part, upon a determination of disability by a physician. The Trustees have resolved that **effective January 1, 2014**, physicians who are authorized to make such determination under a MCTWF plan of benefits must be either a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M), or an Oral Surgeon. Accordingly, **effective January 1, 2014**, MCTWF no longer will accept a determination of disability by a chiropractor (D.C.).

### **Weekly Accident and Sickness Benefits – Fall 2014**

The MCTWF Summary Plan Description (SPD) currently states in relevant part that, "[o]nce the Participant establishes eligibility, weekly accident and sickness benefits may begin on –

- the first day following Medical Attention after the last day worked in the event of an Accidental Injury,...; or
- the eighth day following Medical Attention after the last day worked in the event of a Sickness...."

The SPD defines "Accidental Injury" as "a bodily injury that is the direct result of an Accident and is not related to any cause other than the Accident" and it defines a "Sickness or Illness" as "any disorder of the body or mind (but not an injury) and pregnancy (including abortion, miscarriage, or childbirth)." MCTWF's Trustees have amended these definitions to more clearly reflect their intent. Effective immediately –

- An "Accidental Injury" is defined as "any disabling disorder of the body or mind that is the direct result of an occurrence that is not a sickness."
- A "Sickness or Illness" is defined as "any disabling disorder of the body or mind (other than an Accidental Injury as above defined) and pregnancy (including abortion, miscarriage, or childbirth)."

## **PRESCRIPTION DRUG BENEFITS**

### **New CVS Caremark Programs– Spring 2013**

In an effort to assist participants in improving their health and safety as well as reducing costs, the following CVS Caremark programs were implemented as part of MCTWF's prescription drug program for prescriptions filled on or after January 1, 2013:

#### **Specialty Preferred Drug Program**

If you are newly prescribed a "non-preferred" specialty medication for certain autoimmune diseases (rheumatoid arthritis, crohn's disease or psoriasis) or for multiple sclerosis, the program requires that you be treated with the most common clinically effective medication. If you are not effectively treated with that medication, you will be provided authorization for use of a "non-preferred" medication. This process is referred to as "step therapy." If you were being continuously treated for any of these diseases prior to January 1, 2013 you will not be subject to this Program. Specialty medications are sent to you by mail. If you go to a retail pharmacy, the pharmacist will ask you to contact CVS Caremark at 800-237-2767 to initiate the direct relationship with Specialty Pharmacy Services. CVS Caremark will communicate directly with your prescribing physician regarding your treatment plan.

### Pharmacy Advisor Support Program

If you are taking medications for any of the following chronic conditions and you do not refill your prescription timely, the Pharmacy Advisor Program will reach out to you in writing, by telephone, or face-to-face through your CVS pharmacist to remind you to refill your prescription and, in certain cases, provide disease treatment counseling:

Benign prostatic hypertrophy (BPH)  
Coronary artery disease/ischemic heart disease  
Diabetes  
Heart failure  
High Cholesterol  
Hypertension  
Osteoporosis  
Parkinson's disease  
Respiratory diseases  
Rheumatoid arthritis

The goal of the Program is to drive favorable behavior changes in the short term and improve clinical outcomes over the longer term by encouraging adherence with your physician's prescribed drug treatment of your chronic condition

### “Dispense as Written” Rule

MCTWF encourages the use of generic drugs by covering them at much lower patient cost than it does for brand name drugs. A generic drug must have the same active ingredients as its brand name counterpart and are considered by the U.S. Food and Drug Administration identical in dose, strength, route of administration, safety, efficacy, and intended use.

If a generic version of your prescribed brand name drug is available, your MCTWF prescription drug benefit plan only will cover the generic version, regardless of whether your physician instructs the pharmacy to “Dispense [the brand name drug] as Written” (“DAW”). If you insist on receiving the prescribed brand name drug, you will be responsible for payment of the difference in the applicable charges (the “allowed amounts”) between the generic and brand name drug and for payment of the generic copay or coinsurance amount.

The only exception to this rule is if, through a prior authorization request, your physician presents to CVS Caremark, or, where applicable, to MCTWF, adequate evidence of medical necessity for use of the brand name drug. In such case, you will be responsible only for the payment of the brand name drug copay or coinsurance amount.

### Glucose Monitoring Supplies Now Also Covered As a Prescription Drug Benefit– Spring 2013

For those who are covered under a MCTWF medical plan, the purchase of glucose monitoring supplies have been covered solely as “Medical Supplies” benefits for lancets and test strips and as “Durable Medical Equipment” benefits for glucose meters (so long as they are prescribed and certified as medically necessary by a licensed physician and obtained from a provider whom Blue Cross Blue Shield has certified as a medical supply or durable medical equipment provider).

**Effective February 1, 2013** you also may obtain your prescribed lancets, test strips and glucose meter from any participating in-network pharmacy, at your Plan's brand copay or coinsurance level. *Accu-Chek* and *One Touch* test strips and lancets are the preferred brand products and do not require prior authorization. Freestyle test strips do require prior authorization.

You also may be qualified to receive a free *OneTouch* or *Accu-Chek* glucose meter through the CVS Caremark mail service program. To qualify, your prescription must state that you are diabetic and it must provide for a 90-day supply of *OneTouch* or *Accu-Chek* test strips (or you must inform CVS Caremark mail service pharmacy that you wish to switch to *One Touch* or *Accu-Chek*) and you must not have received a free meter through the program within the last 365 days. To see if you qualify, you can contact CVS Caremark toll-free at 1-800-588-4456.

### Brand Drugs Requiring Prior Authorization– Fall 2013

As was first announced in the winter 2011-2012 *Messenger*, MCTWF's pharmacy benefit manager, CVS Caremark, made prior authorization of certain brand name prescription drugs a condition of coverage. The following list reflects each drug requiring prior authorization, its therapeutic class, the common medical condition that the class treats, and the alternative drugs in that therapeutic class (i.e., those not requiring prior authorization). Those drugs stated in red print have been newly added by CVS Caremark to the list requiring prior authorization **effective January 1, 2014**. Please note that generic drugs are in *lowercase italics* font and brand drugs are in UPPERCASE font. Those who are utilizing any of the listed brand name drugs in red print will be notified, along with their prescribing physician, directly by CVS Caremark and will be provided with a list of covered alternative drugs that are equally or more efficacious

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<b>Common Condition/ Therapeutic Class</b>	<b>Drug Subject to Prior Authorization</b>	<b>Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)</b>	
<b>Allergies</b> Nasal Steroids/Combinations	BECONASE AQ OMNARIS QNASL	RHINOCORT AQUA VERAMYST <b>ZETONNA</b>	<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</i>
	<b>DYMISTA</b>		<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX WITH azelastine or ASTEPRO</i>
<b>Allergies</b> Ophthalmic	<b>LASTACAPT</b>		<i>axelastine, cromolyn sodium, ALREX, PATADAY</i>
<b>Asthma</b> Beta Agonists, Short-Acting	MAXAIR <b>VENTOLIN HFA</b>	XOPENEX HFA	PROAIR HFA, PROVENTIL HFA
<b>Asthma</b> Steroid Inhalants	<b>ALVESCO</b>		ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR
<b>Asthma or Chronic Obstructive Pulmonary Disease (COPD)</b> Steroid/Beta Agonist Combinations	<b>BREO ELLIPTA</b>		ADVAIR, DULERA, SYMBICORT
<b>Chronic Obstructive Pulmonary Disease (COPD)</b> Anticholinergics	<b>TUDORZA PRESSAIR</b>		SPIRIVA
<b>Depression</b> Antidepressants	OLEPTRO		<i>trazodone</i>
<b>Diabetes</b> Biguanides	GLUMETZA RIOMET		metformin, metformin ext-rel
<b>Diabetes</b> Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	NESINA ONGLYZA		JANUVIA, TRADJENTA
<b>Diabetes</b> Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations	<b>KAZANO</b> KOMBIGLYZE XR	<b>OSENI</b>	JANUMET, JANUMET XR, JENTADUETO
<b>Diabetes</b> Insulins	HUMALOG		APIDRA, NOVOLOG
	HUMALOG MIX 50/50		NOVOLOG MIX 70/30
	HUMALOG MIX 75/25		NOVOLOG MIX 70/30
	HUMULIN 70/30		NOVOLIN 70/30
	HUMULIN N		NOVOLIN N
	HUMULIN R		NOVOLIN R
	NOTE: Humulin U-500 concentrate will be subject to removal and will continue to be covered.		
<b>Diabetes</b> Supplies	<b>BREEZE 2 STRIPS AND KITS</b> <b>CONTOUR STRIPS AND KITS</b> <b>CONTOUR NEXT STRIPS AND KITS</b> <b>FREESTYLE STRIPS AND KITS</b>		ACCU-CHEK STRIPS AND KITS, ONETOUCH STRIPS AND KITS
<b>Erectile Dysfunction</b> Phosphodiesterase Inhibitors	LEVITRA		CIALIS, VIAGRA
<b>Glaucoma</b> Prostaglandin Analogs	LUMIGAN		<i>latanoprost, TRAVATAN Z, ZIOPTAN</i>
<b>Growth Hormones</b>	GENOTROPIN NUTROPIN/NUTROPIN AQ TROPIN OMNITROPE	SAIZEN TEV-	HUMATROPE, NORDITROPIN
<b>High Blood Pressure</b> Angiotensin II Receptor Antagonists	EDARBI		<i>candesartan, eprosartan, irbesartan, losartan, BENICAR, DIOVAN, MICARDIS</i>
<b>High Blood Pressure</b> Angiotensin II Receptor Antagonist/Diuretic Combinations	EDARBYCLOR TEVETEN HCT		<i>candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, valsartan-hydrochlorothiazide, BENICAR HCT, MICARDIS HCT</i>
<b>High Cholesterol</b> HMG Co-A Reductase Inhibitors (HMGs or Statins)	ALTOPREV LIVALO <b>LESCOL XL</b>		<i>atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, CRESTOR</i>
<b>High Cholesterol</b> HMG Co-A Reductase Inhibitor Combinations	ADVICOR		<i>atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, SIMCOR</i>
	<b>LIPTRUZET</b>		<i>atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, VYTORIN</i>

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<b>Common Condition/ Therapeutic Class</b>	<b>Drug Subject to Prior Authorization</b>	<b>Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)</b>
<b>Inflammatory Bowel Disease (IBD), Ulcerative Colitis</b> Aminosaliclates	<b>ASACOL HD</b> <b>DELZICOL</b>	<i>balsalazide, sulfasalazine, sulfasalazine delayed-rel, APRISO, LIALDA, PENTASA</i>
	<b>SUBOXONE FILM</b>	<i>buprenorphine/naloxone sublingual tablets</i>
<b>Overactive Bladder/Incontinence</b> Urinary Antispasmodics	DETROL LA TOVIAZ OXYTROL	<i>oxybutynin ext-rel, tolterodine, trospium, trospium ext-rel, GELNIQUE, VESICARE</i>
<b>Pain and Inflammation</b> Nonsteroidal Anti-inflammatory Drugs (NSAIDs)	FLECTOR	<i>diclofenac, meloxicam, naproxen</i>
<b>Pain and Inflammation</b> Corticosteroids	<b>RAYOS</b>	<i>dexamethasone, methylprednisolone, prednisone</i>
<b>Prostate Condition</b> Benign Prostatic Hyperplasia Agents/Combinations	JALYN	<i>finasteride or AVODART WITH <i>alfuzosin ext-rel, doxazosin, tamsulosin, terazosin</i> or RAPAFL0</i>
<b>Sleep</b> Hypnotics, Non-benzodiazepines	INTERMEZZO ROZEREM	<i>zolpidem, zolpidem ext-rel</i>
<b>Testosterone Replacement</b> Androgens	ANDROGEL TESTIM	ANDRODERM, AXIRON, FORTESTA
<b>Transplant</b> Immunosuppressants, Calcineurin Inhibitors	Hecoria	<i>tacrolimus</i>

To obtain prior authorization, your physician must contact CVS Caremark at 800-626-3046

**Drugs Requiring Prior Authorization – Fall 2014**

As was first announced in the winter 2011-2012 *Messenger*, MCTWF’s pharmacy benefit manager, CVS Caremark, made prior authorization of certain prescription drugs a condition of coverage. The following list reflects each drug requiring prior authorization, its therapeutic class, the common medical condition that the class treats, and the alternative drugs in that therapeutic class (i.e., those not requiring prior authorization). Those drugs stated in red print have been newly added by CVS Caremark to the list requiring prior authorization **effective January 1, 2015**. CVS Caremark will notify current utilizers of the newly added drugs and their prescribing physician and will provide them with a list of covered alternative drugs that are equally or more efficacious. Please note that generic drugs are in *lowercase italics* font and brand drugs are in UPPERCASE roman font.

<b>Common Condition/ Therapeutic Class</b>	<b>Drug Subject to Prior Authorization</b>	<b>Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)</b>
<b>Allergic Reaction</b> (Anapylaxix) Treatment	<b>ADRENACLICK</b>	AUVI-Q, EPIPEN, EPIPEN JR
<b>Allergies</b> Nasal Steroids/Combinations	BECONASE AQ RHINOCORT AQUA OMNARIS VERAMYST QNASL ZETONNA	<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</i>
	DYMISTA	<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX WITH azelastine spray or PATANASE</i>
<b>Allergies</b> Ophthalmic	LASTACFT	<i>azelastine, cromolyn sodium, PATADAY, PATANOL</i>
<b>Anti-infectives, Antivirals</b> Herpes Agents	VALTREX	<i>acycovir, valacyclovir</i>
<b>Asthma</b> Beta Agonists, Short-Acting	<b>PROVENTIL HFA</b> XOPENEX HFA VENTOLIN HFA	PROAIR HFA
<b>Asthma</b> Steroid Inhalants	<b>AEROSPAN</b> ALVESCO	ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR
<b>Asthma or Chronic Obstructive Pulmonary Disease (COPD)</b> Steroid/Beta Agonist Combinations	<b>SYMBICORT</b>	ADVAIR DULERA
<b>Attention Deficit Hyperactivity Disorder Agents</b>	<b>ADDERALL XR</b>	<i>amphetamine-dextroamphetamine mixed salts ext-rel</i>

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<b>Common Condition/ Therapeutic Class</b>	<b>Drug Subject to Prior Authorization</b>	<b>Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)</b>
<b>Cardiovascular Antilipemics</b> HMG Co-A Reductase Inhibitors (HMGs or Statins) / Combinations	ADVICOR ALTROPREV LESCOL XL  <b>LIPITOR</b> LIPTRUZET LIVALO	atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, CRESTOR, SIMCOR, VYTORIN
<b>Chronic Obstructive Pulmonary Disease (COPD)</b> Anticholinergics	TUDORZA	SPIRIVA
<b>Dermatology Skin Inflammation and Hives</b> Corticosteroids	<b>APEXICON E</b>	desoximetasone, fluocinonide
<b>Diabetes</b> Biguanides	GLUMETZA RIOMET	<i>metformin, metformin ext-rel</i>
<b>Diabetes</b> Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	NESINA ONGLYZA	JANUVIA, TRAJENTA
<b>Diabetes</b> Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations	KAZANO KOMBIGLYZE XR  OSENI	JANUMET, JANUMET XR, JENTADUETO
<b>Diabetes</b> Injectable Incretin Mimetics	<b>BYETTA</b>	BYDUREON, VICTOZA
<b>Diabetes</b> Insulins	<b>APIDRA</b> HUMALOG	NOVOLOG
	HUMALOG MIX 50/50	NOVOLOG MIX 70/30
	HUMALOG MIX 75/25	NOVOLOG MIX 70/30
	HUMULIN 70/30	NOVOLIN 70/30
<b>Diabetes</b> Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitors	<b>FARXIGA</b>	INVOKANA
<b>Diabetes</b> Supplies	<b>ACCU-CHEK STRIPS AND KITS</b> BREEZE 2 STRIPS AND KITS CONTOUR STRIPS AND KITS CONTOUR NEXT STRIPS AND KITS FREESTYLE STRIPS AND KITS	ONETOUCH ULTRA STRIPS AND KITS, ONETOUCH VERIO STRIPS AND KITS
<b>Erectile Dysfunction</b> Phosphodiesterase Inhibitors	LEVITRA	CIALIS, VIAGRA
<b>Glaucoma</b> Prostaglandin Analogs	LUMIGAN	<i>latanoprost, travoprost, TRAVATAN Z, ZIOPTAN</i>
<b>Growth Hormones</b>	GENOTROPIN NUTROPIN AQ OMNITROPE  SAIZEN TEV-TROPIN	HUMATROPE, NORDITROPIN
<b>High Blood Pressure</b> Angiotensin II Receptor Antagonists	EDARBI	<i>candesartan, eprosartan, irbesartan, losartan, telmisartan, BENICAR, DIOVAN</i>
<b>High Blood Pressure</b> Angiotensin II Receptor Antagonist/Diuretic Combinations	EDARBYCLOR TEVETEN HCT	<i>candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide, BENICAR HCT</i>
<b>High Blood Pressure</b> Calcium Channel Blockers	<b>NORVASC</b>	amlodipine
<b>Inflammatory Bowel Disease (IBD), Ulcerative Colitis</b> Aminosalicylates	ASACOL HD DELZICOL	<i>balsalazide, sulfasalazine, sulfasalazine delayed-rel, APRISO, LIALDA, PENTASA</i>
<b>Multiple Sclerosis Agents</b>	<b>REBIF</b>	AVONEX, COPAXONE, EXTAVIA, GILENYA, TECFIDERA
<b>Musculoskeletal Agents</b>	<b>AMRIX</b>	<i>cyclobenzaprine</i>
<b>Opioid Dependence Agents</b>	SUBOXONE FILM	<i>buprenorphine-naloxone sublingual tablet, ZUBSOLV</i>

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Common Condition/ Therapeutic Class	Drug Subject to Prior Authorization	Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)
<b>Osteoarthritis</b> Viscosupplements	<b>EUFLEXXA</b> <b>ORTHOVISC</b>	GEL-ONE, HYALGAN, SUPARTZ
<b>Overactive Bladder/Incontinence</b> Urinary Antispasmodics	DETROL LA OXYTROL	TOVIAZ  <i>oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, GELNIQUE, VESICARE</i>
<b>Pain and Inflammation</b> Corticosteroids	RAYOS	<i>dexamethasone, methylprednisolone, prednisone</i>
<b>Pain and Inflammation</b> Nonsteroidal Anti-inflammatory Drugs (NSAIDs)/ Combinations	<b>VIMOVO</b> <b>DUEXIS</b>	<i>CELEBREX; diclofenac, meloxicam, or naproxen WITH lansoprazole, omeprazole, omeprazole/sodium bicarbonate, pantoprazole, DEXILANT, or NEXIUM</i>
	FLECTOR <b>PENNSAID</b>	<i>diclofenac, diclofenac sodium solution, meloxicam, naproxen, VOLTAREN GEL</i>
	<b>NAPRELAN</b>	<i>diclofenac, meloxicam, naproxen, CELEBREX</i>
<b>Prostate Condition</b> Benign Prostatic Hyperplasia Agents/Combinations	JALYN	<i>finasteride or AVODART WITH alfuzosin ext-rel, doxazosin, tamsulosin, terazosin or RAPAFLO</i>
<b>Sleep</b> Hypnotics, Non-benzodiazepines	INTERMEZZO ROZEREM	<b>LUNESTA</b>  <i>eszopiclone, zolpidem, zolpidem ext-rel</i>
<b>Testosterone Replacement</b> Androgens	<i>testosterone gel</i> <b>NATESTO</b> <b>VOGELXO</b>	ANDROGEL TESTIM  ANDRODERM, AXIRON, FORTESTA
<b>Transplant</b> Immunosuppressants, Calcineurin Inhibitors	Hecoria	<i>tacrolimus</i>

To obtain prior authorization, your physician must contact CVS Caremark at 800-626-3046

### Notice of Creditable Coverage – Fall 2013

The following Notice is published in accordance with regulations promulgated by the Centers for Medicare and Medicaid Services, pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003:

#### Important Notice from the Michigan Conference of Teamsters Welfare Fund (MCTWF) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with MCTWF and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. MCTWF has determined that the prescription drug coverage offered by the above stated Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

#### When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15<sup>th</sup> through December 7<sup>th</sup>. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

#### What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, under MCTWF rules you nonetheless may not drop your MCTWF prescription drug coverage. If you have both MCTWF prescription drug coverage and Medicare prescription drug coverage, MCTWF prescription drug coverage will be primary and your Medicare prescription drug plan will be secondary. If you are a COBRA beneficiary you may drop your MCTWF coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug plan. However, you will not be able to get your MCTWF COBRA coverage back later. If you do elect COBRA continuation coverage, your COBRA prescription drug coverage will be secondary to your Medicare

## Michigan Conference of Teamsters Welfare Fund

prescription drug plan coverage. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current prescription drug plan provides comprehensive coverage for eligible prescription drugs, subject to preauthorization requirements for non-sedating antihistamines, proton pump inhibitors, selective serotonin reuptake inhibitors, anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), oral acne, topical acne (age 26 and above) and oral anti-fungal drugs with both retail and mail order availability, subject to generic and brand copays, as detailed in your Summary Plan Description booklet. Your current coverage pays for other health expenses, in addition to prescription drugs, and you still will be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

### **When will you pay a higher premium (penalty) to join a Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with MCTWF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### **For more information about this notice or your current prescription drug coverage...**

Contact MCTWF's Customer Communications Department at (313) 964-2400 or (800) 572-7687. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MCTWF changes. You also may request a copy of this notice at any time.

### **For more information about your options under Medicare prescription drug coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

September 1, 2013

Michigan Conference of Teamsters Welfare Fund

## **Notice of Creditable Coverage – Fall 2014**

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1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. MCTWF has determined that the prescription drug coverage offered by the above stated Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When can you join a Medicare drug plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15<sup>th</sup> through December 31<sup>st</sup>. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What happens to your current coverage if you decide to join a Medicare Drug Plan?**

If you decide to join a Medicare drug plan, under MCTWF rules you nonetheless may not drop your MCTWF prescription drug coverage. If you have both MCTWF prescription drug coverage and Medicare prescription drug coverage, MCTWF prescription drug coverage will be primary and your Medicare prescription drug plan will be secondary. If you are a COBRA beneficiary you may drop your MCTWF coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug plan. However, you will not be able to get your MCTWF COBRA coverage back later. If you do elect COBRA continuation coverage, your COBRA prescription drug coverage will be secondary to your Medicare prescription drug plan coverage. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current prescription drug plan provides comprehensive coverage for eligible prescription drugs, subject to preauthorization requirements for certain brand name prescription drugs and for prescription drugs within the following drug classifications: non-sedating antihistamines, proton pump inhibitors, selective serotonin reuptake inhibitors (brand name only), anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs with both retail and mail order availability, subject to generic and brand copays, as detailed in your Summary Plan Description booklet. Your current coverage pays for other health expenses, in addition to prescription drugs, and you still will be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

**When will you pay a higher premium (penalty) to join a Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with MCTWF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage...

Contact MCTWF's Member Services call center at (313) 964-2400 or (800) 572-7687. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MCTWF changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
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**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

September 1, 2014

Michigan Conference of Teamsters Welfare Fund

**Removal of Walgreens from Pharmacy Network, January 1, 2014 – Fall 2013**

This is to inform you that effective January 1, 2014 and until further notice, Walgreens will be excluded from the Caremark retail pharmacy network for all MCTWF participants and beneficiaries.

MCTWF's Trustees have taken this step in light of Walgreens' decision to replace UPS with FedEx as its package delivery vendor. As a result, The IBT estimates that as many as 2,000 full-time and part-time Teamsters will be laid off.

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While we regret any inconvenience caused to you, the Caremark network has over 60,000 other participating retail pharmacies nationwide, so it is likely that you will find an equally accessible network pharmacy. To determine the network pharmacies in your area, please contact MCTWF's Customer Communications Department, or access [www.caremark.com](http://www.caremark.com) directly or through MCTWF's web site at [www.mctwf.org](http://www.mctwf.org). If a Walgreens pharmacy has your prescription with remaining refill entitlement, simply ask your new pharmacist to arrange for it to be transferred.

As with any non-network pharmacy, if you continue patronizing Walgreens after December 31, 2013, you risk incurring additional out-of-pocket expense, since you will be reimbursed only up to the discounted amount that MCTWF would have paid a network pharmacy, less the applicable copay.

### **Kroger and Walgreens – Spring 2015**

**Effective April 1, 2015**, all Kroger and Walgreens retail pharmacies will be reinstated in MCTWF's CVS/Caremark provider network.

### **New CVS/Caremark Programs – Spring 2015**

In an effort to assist members in improving their health and safety, as well as to reduce costs, the following recommended strategies from MCTWF's pharmacy benefit manager, CVS/Caremark, are being implemented as part of MCTWF's prescription drug benefit effective June 1, 2015:

#### **Compound Drugs**

In general, compounding is defined as a practice in which a licensed pharmacist combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient. Some compounds are medically indicated, such as liquid doses compounded from solids to permit pediatric use and those that are free of dyes or other ingredients that cause allergic reactions, whereas many of the higher priced compounds contain excessively priced bulk powders and proprietary compounding bases that, in addition, may be lacking documented evidence of clinical efficacy. The average cost for each compound prescription has increased over 300% between 2013 and 2014.

In an effort to promote the use of safe, effective compounds, **effective June 1, 2015** all compound drug claims exceeding \$300 will be subject to review for medical appropriateness by CVS/Caremark (i.e., through consideration of physician prior authorization requests) and all compound drug fills, regardless of the charge, will be limited to one fill of the same compound per 34 days. Those members who are currently utilizing a compound medication will be notified directly of this benefit rule change, as will their prescribing physician. To obtain prior authorization for compound medications that exceed \$300, your physician must contact CVS/Caremark at 800-626-3046.

#### **Maintenance Choice**

Currently, members that are covered by MCTWF's prescription drug benefit designs Rx1a, New Rx1a, New Rx1b, New Rx2a, and New Rx2b are allowed one retail fill at any participating network pharmacy for maintenance medications. Thereafter, fills of that maintenance drug must be obtained from the CVS/Caremark mail order pharmacy.

In an effort to increase convenience for members without significant cost increase to MCTWF, we are pleased to announce that **effective June 1, 2015** MCTWF will implement CVS/Caremark's Maintenance Choice program for all members covered by the above stated prescription drug benefit designs (including members from YRC, Holland Motor Express, Inc., ABF, Farmer Brothers Coffee, Stafford Transport of Michigan, Alexander Distributing, Central Warehouse Operations, Libra Industries, and Wiltfong Moving & Storage, Inc.). Under the Maintenance Choice program, members may obtain two retail fills of 34 days or less of a maintenance medication at any participating network pharmacy. Thereafter, members are given the choice of obtaining fills of that maintenance drug from the CVS/Caremark mail order pharmacy or from any CVS retail pharmacy.

## **DENTAL BENEFITS**

### **Bone Grafts for Dental Implants – New Benefit – Fall 2014**

**Effective October 2, 2014**, MCTWF benefit packages covering dental services will cover, as Class III major restorative services, certain bone graft procedures in conjunction with dental implants.

### **Pediatric Dental and Vision Benefits – New Limits – Fall 2014**

Pediatric dental and vision benefits are deemed “essential health benefits” by the Affordable Care Act and therefore are subject to the Act’s market reform requirements unless they are “excepted,” meaning that they are not an integral part of the group health plan. In such case, among other market reform provisions, they are not subject to the Act’s prohibition on annual dollar benefit limits. Recently, final regulations were issued by the applicable federal regulatory agencies under which MCTWF’s dental and vision benefits are deemed “excepted” effective January 1, 2015. Accordingly, MCTWF’s Trustees have determined that the unlimited pediatric dental and vision benefits that have been in effect since April 1, 2014 in all benefit packages that include dental and vision benefits, will be subject to the same annual dollar benefit limits as adult dental and vision benefits effective January 1, 2015.

## **VISION BENEFITS**

### **Introducing MCTWF’s New Vision Network – Davis Vision – Spring 2015**

We are pleased to announce that, **effective April 1, 2015**, MCTWF’s new vision network is *Davis Vision*, a nationwide network of quality eye care professionals. With *Davis Vision*, you will enjoy an improved vision benefit program, including better frame choices for less out-of-pocket expense with the exclusive *Davis Vision Collection* (available at most independent provider locations) and better retail access through retail stores such as SVS Vision (Teamster represented), Costco, Henry Ford OptimEyes, Sam’s Club, Walmart, America’s Best, Shopco, Eye Mart Express, Co-Op Optical, and VisionWorks.

The *Davis Vision* network includes more than 46,000 providers across the country, including optometrists and ophthalmologists in both private practice and in many retail optical settings. We have worked with *Davis Vision* to replicate or improve upon the current vision plan benefits. A summary of MCTWF’s *Davis Vision* benefits are below.

In late March, you will receive new MCTWF Networks cards bearing a *Davis Vision* imprint (in early April you also will receive replacement Blue Cross Blue Shield ID cards with the current reference to *VSP Choice* eliminated). Please destroy your current cards upon your receipt of these new cards. Your new MCTWF Networks card should be presented to *Davis Vision* network providers to ensure that your coverage is at the network benefit level. Also in late March you will receive a *Davis Vision* welcome letter summarizing the benefits and providing a list of network providers in your area. If you need a broader list of network providers, or if you wish to determine whether an unlisted provider is in the *Davis Vision* network, you can call MCTWF’s Member Services Call Center, or link to a complete *Davis Vision* network provider search from the *Provider Networks* page of MCTWF’s website. If you choose to use a non-*Davis Vision* provider, reimbursement of billed charges, subject to plan limits, will be made directly to the participant.

**Note:** If you utilize an ophthalmologist (medical doctor specializing in diseases of the eye) and do not have a medical eye condition, services will be covered under the vision portion of your benefit package. To receive network-level benefits, the ophthalmologist must participate in the *Davis Vision* network.

If you are being treated by an ophthalmologist for a medical condition, services will be covered under the medical portion of your benefit package. To receive network-level benefits, the ophthalmologist must participate in the BCBS PPO network.

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VISION BENEFITS	DAVIS VISION NETWORK COVERAGE	NON DAVIS VISION NETWORK COVERAGE																								
<b>EXAMINATION</b>	In full	Up to \$50																								
<b>FRAMES</b>	<p>Davis Vision Collection frames are covered subject to the following member copays:</p> <p><i>Fashion</i> frames - \$0  <i>Designer</i> frames - \$15  <i>Premier</i> frames - \$40</p> <p>Non-Davis Vision Collection frames are covered up to a retail value of \$125 on any frame. You are responsible for any charges in excess of \$125 after a discount of 20% of the excess is applied. Discounts do not apply to products purchased from Costco, Wal-Mart, or Sam's Club.</p> <p><b>Note:</b> All Davis Vision Collection frames and lenses and all frames and lenses purchased from a network provider that does not carry Davis Vision Collection frames come with <u>a free one-year breakage warranty.</u></p>	Up to \$75																								
<b>LENSES (clear plastic) - Per Pair:</b> <b>Single Vision</b> <b>Bifocal</b> <b>Trifocal</b> <b>Lenticular</b>	<p>In full  In full  In full  In full</p> <p><b>Note:</b> For lenses other than clear plastic, there may be an additional charge, both in-network and out-of-network.</p>	<p>Up to \$50  Up to \$60  Up to \$70  Up to \$70</p>																								
<b>OPTIONAL LENS TREATMENTS AND MATERIALS - Per Pair</b>	<p>Covered subject to the following member expenses:</p> <table border="1" data-bbox="444 1094 1154 1774"> <tr> <td>Anti-Reflective: <i>Standard/Premium/Ultra</i></td> <td>\$40/\$55/\$69</td> </tr> <tr> <td>High-Index</td> <td>\$60</td> </tr> <tr> <td>Oversize</td> <td>\$0</td> </tr> <tr> <td>Photochromic (plastic only)</td> <td>\$70</td> </tr> <tr> <td>Polarized (plastic only)</td> <td>\$75</td> </tr> <tr> <td>Polycarbonate lenses under age 19</td> <td>\$0</td> </tr> <tr> <td>Polycarbonate lenses age 19 or greater</td> <td>\$35</td> </tr> <tr> <td>Progressive: <i>Standard/Premium/Ultra</i></td> <td>\$42/\$82/\$117</td> </tr> <tr> <td>Scratch Protection Plan: single vision/multifocal</td> <td>\$20/\$40</td> </tr> <tr> <td>Scratch-resistant</td> <td>\$0</td> </tr> <tr> <td>Tinting (plastic only)</td> <td>\$15</td> </tr> <tr> <td>Ultraviolet (plastic only)</td> <td>\$15</td> </tr> </table>	Anti-Reflective: <i>Standard/Premium/Ultra</i>	\$40/\$55/\$69	High-Index	\$60	Oversize	\$0	Photochromic (plastic only)	\$70	Polarized (plastic only)	\$75	Polycarbonate lenses under age 19	\$0	Polycarbonate lenses age 19 or greater	\$35	Progressive: <i>Standard/Premium/Ultra</i>	\$42/\$82/\$117	Scratch Protection Plan: single vision/multifocal	\$20/\$40	Scratch-resistant	\$0	Tinting (plastic only)	\$15	Ultraviolet (plastic only)	\$15	No coverage
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<b>CONTACT LENSES – Per Pair</b>	Up to \$120. You are responsible for any charges in excess of \$120 after a discount of 15% of the excess is applied. Discounts do not apply to products purchased from Costco, Walmart, or Sam's Club.	Up to \$80																								
<b>Contact Lens Fitting</b>	You are responsible up to the first \$60.	No coverage																								

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<b>VISION BENEFITS</b>	<b>DAVIS VISION NETWORK COVERAGE</b>	<b>NON DAVIS VISION NETWORK COVERAGE</b>
<b>LASER VISION CORRECTION</b>	Up to \$250 per eye per lifetime. For charges in excess of \$250, additional discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials (whichever is lower) is available.	Up to \$250 per eye per lifetime.
<b>BENEFIT FREQUENCY</b>	One exam and one vision correction option per person per calendar year. A vision correction option is defined as either (a) one pair of lenses and frames, whether purchased together or separately, (b) contact lenses and fitting, or (c) laser vision correction for one or both eyes. <b>Note:</b> Coverage for one such annual vision option cannot be later replaced with coverage for another vision option.	

**ACTIVES DEATH BENEFITS**

**Survivor Health Benefits – New Benefit – Fall 2014**

MCTWF’s Trustees are pleased to announce a new benefit, Survivor Health Benefits, available **effective October 1, 2014** for all eligible spouses and dependent children of participants who die while actively covered under a MCTWF medical benefits package. Survivor Health Benefits, as defined below, provides up to 36 months of free medical and prescription drug coverage.

**Key Definitions:**

With respect to this benefit rule –

- “Survivor(s)” refers to the spouse and dependent children (as defined by your Summary Plan Description, including unborn children) of the deceased participant who were eligible for MCTWF benefits on the date of the participant’s death.
- “Survivor Health Benefits” refers to the same base medical and prescription drug benefits that the deceased participant’s MCTWF participating group is covered for during the period of the survivors’ Survivor Health Benefits eligibility.
- “Active Coverage” refers to the participant’s eligibility for MCTWF Actives Plan base medical and prescription drug benefits while -
  - actively employed;
  - utilizing MCTWF’s strike benefits;
  - utilizing benefit banks; or
  - utilizing Weekly Accident and Sickness benefits.

**Eligibility – Initial and Ongoing:**

- Upon receipt of notification of the death of a participant who had Active Coverage on the date of his death, MCTWF will notify the participant’s Survivors of their automatic eligibility for Survivor Health Benefits following the exhaustion of any remaining benefit bank coverage, for a maximum period (including the benefit bank coverage period) of 36 months following the coverage week in which the participant died. Each Survivor, in the alternative, may elect COBRA continuation coverage.
- For each Survivor who does not elect COBRA continuation coverage, Survivor Health Benefits eligibility will continue as follows:
  - For the surviving spouse, for the earlier of 36 months or –
  - remarriage;
  - enrollment in the MCTWF Retirees Plan (**Note:** the spouse may defer enrollment until expiration of her Survivor Health Benefits coverage, but must comply with MCTWF rules for timely application for MCTWF Retirees Plan coverage); or
  - Medicare eligibility.

For each surviving child, for the earlier of 36 months or –

- the end of the month in which the child turns age 26; or
- the date of the child’s adoption by anyone other than the surviving spouse.

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- The deceased participant's MCTWF participating group's medical and prescription drug benefits are suspended or terminated for any reason, the Survivor Health Benefits also will be suspended or terminated. MCTWF will require periodic status statements to ensure that each Survivor remains eligible.

### **Benefit Design:**

Survivor Health Benefits always will mirror the design of the then current base medical and prescription drug benefits provided to the deceased participant's MCTWF participating group. If the group's base medical and prescription drug benefits change, so too will the Survivor Health Benefits.

### **Coordination of Benefits:**

If a Survivor also is covered under another group health plan (including another MCTWF benefit package) or health insurance policy, Survivor Health Benefits coverage always will be secondary to that other plan or policy.

## **HOW TO FILE A CLAIM**

### **Death Benefit Filing Limitation– Spring 2014**

**Effective March 6, 2014** the Trustees have extended the claim filing deadline for active participant deaths and retiree/retiree spouse deaths to three years following the date of death. Previously, the Trustees had extended the claim filing deadline for spouse and dependent child deaths to three years following the date of death.

## **RIGHT TO RECOVERY**

### **Recovery of Benefit Overpayments– Fall 2013**

ERISA requires plan fiduciaries to use all reasonable means to recover benefits payments made to or on behalf of participants and beneficiaries who were not eligible for such benefits. This is to remind you that MCTWF has the right and obligation to recover such overpayments from any person to whom payments were made, from any person for whom payments were made, from any insurance company or organization to which payments were made, **as well as directly from you.**

## **COORDINATION OF BENEFITS**

### **Coordination of Benefits (COB) Rules for Employee, Spouse, and Retiree Coverage– Fall 2013**

If you and/or your eligible beneficiaries have coverage under another group health plan as well as under an MCTWF Plan, benefits entitlement will be coordinated between the two plans.

The primary plan is the plan that pays benefits first and the secondary plan is the plan that pays those benefits not covered or not completely covered by the primary plan. When the patient is covered by one plan as an active employee and another plan as a spouse, or by one plan as an active employee, or the spouse thereof, and by another plan as a retiree, or the spouse thereof, the following coordination of benefits rules apply if both group health plans have a COB provision:

The plan covering the patient as an actively working employee is primary to the [secondary] plan that is covering the patient as a spouse.

The plan covering the patient as an actively working employee is primary to the [secondary] plan covering the patient as a retiree.

The plan covering the patient as a spouse of an actively working employee is primary to the [secondary] plan covering the patient as a spouse of a retiree.

If the primary plan cannot be determined based on these rules, the plan that has covered the patient for the longest period of time will be deemed the primary plan.

## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

### **HIPAA Notice of Privacy Practices– Spring 2013**

**Effective September 23, 2013**, modifications to the HIPAA privacy, security and enforcement regulations went into effect, as reflected in the following amended Notice of Privacy Practices (and which also can be found on the *HIPAA Privacy Rule* page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org)):

### **Notice of Privacy Practices for Protected Health Information Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

#### **Your Rights**

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### **Your Choices**

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friend
- Provide disaster relief
- Market our services and sell your information

#### **Our Uses and Disclosures**

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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### Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).

### We will not retaliate against you for filing a complaint

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*

**Pay for your health services**

We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety.

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers’ compensation claim
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We never share your health information for marketing purposes. We never sell you health information.

Under the HIPAA privacy and security rules, the Plan is required to comply with State laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

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### Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

*This Notice is effective September 23, 2013*

*Privacy Officer: Cory Buchanan*

*(313) 964-2400 ext. 260*

*privacyofficer@mctwf.org*