Michigan Conference of Teamsters Welfare Fund

Messenger

VOLUME 23, ISSUE 1

WINTER 2004-2005

Message from the Fund's Executive Director

Dear Teamster Families,

Okay folks; we're well past Thanksgiving, Christmas celebrations, New Year's Eve and Super Bowl Sunday – the season of culturally incited gluttony is over. It's once again socially acceptable, for a while, to consider the impact of how much we eat and what we eat.

While for many of us, eating is a very personal and passionate matter, with deep, powerful connections to our childhood and feelings of self worth, we're adults now and capable of observing that our eating habits have not changed markedly since age thirteen, when, at least, we were burning it off.

Most of us are all too aware that our once solid bodies are getting softer, heavier, less capable, more susceptible to injury, illness and chronic disease as the years go by, but do little or nothing about it. We delude and undermine ourselves with rationalizations about genetic predisposition, culture, environment, stress, or about our inability to deal with the ever changing, endless deluge of information about nutrition. We take note of the frustration so many others have experienced with each newly promoted diet because of their inability to sustain their weight loss.

But what it comes down to is that if you really want to get healthier, you can, simply by relying on your common sense and your self awareness. You know that you'll lose weight if you burn off more calories than you ingest, so first you've got to reduce the size of your portions; you should still eat regularly, but cut down a bit, eat more slowly and stop when you begin to feel full. As a result, you'll feel less weighed down and more willing and able to exercise a little. Just taking a walk can do the trick. You'll know very quickly how much you're accomplishing by your appearance, the feel of your waist band and your energy level. If you want to accomplish more, consider what you're eating and drinking; you know the value of eating fruits and vegetables and drinking lots of water and you know which foods are high in calories and most of which are otherwise bad for you (we'll address the issue of saturated fats and trans fats in the Spring *Messenger*); and consider seizing more opportunities to exercise, even for just a few minutes here and there, during the course of your week. Small changes in behavior can make a large difference in the quality of our lives.

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This Winter *Messenger* contains a number of articles suggested by the Fund's staff regarding subjects which they find to be frequently misunderstood or forgotten by Fund participants. As always, I urge you to read the *Messenger* carefully and in its entirety so that you may get maximum use of your benefits with the lowest out-of-pocket expense. Also, please keep in mind that by going to the Fund's web site, you will have online access to your SPD booklet, Schedule of Benefits, *Messengers* dating back to 1998 and an easy to use *Compilation* of plan changes printed in the *Messenger* since the 2001 publication of the SPD booklet.

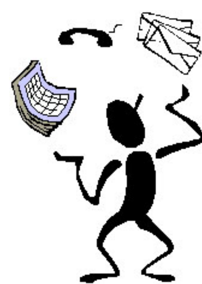
Finally, we belatedly welcome the many new groups that began participating in the Fund since our last such welcome in the Spring 2004 *Messenger*. Among the largest are **Affiliated Foods** (Omaha, Nebraska, Local 554), **April Steel** (Dearborn, Michigan, Local 247), **Menominee County Road Commission** (Menominee County, Michigan, Local 328) and **Indiana Sugars** (Gary, Indiana, Local 142). For the year, over 100 new groups, from nine states, comprising about 2,500 Teamsters joined the Fund. While transition is almost never free of issues, we hope that you have not been unduly inconvenienced and trust that all remaining issues are being addressed courteously and competently by the Fund's staff.

On behalf of the Trustees and staff, I wish you, for the rest of winter, the best of times and the best of health, and, on a more personal note, we wish a happy retirement to Local 406 Business Agent, Sharon Norton; a fine, thoughtful lady, a tireless activist and a friend and supporter of the Fund. Many people will miss you, Sharon.

Richard Burker

Electronic Funds Transfers for Retiree Self Contributions

The Fund is pleased to announce that effective January, 2005, it is making available to retirees a program for the electronic payment of self contributions (known as Automated Clearing House debits). With ACH debiting, monthly self contributions are automatically withdrawn from the retiree's checking or savings account on the date the payment is due, thereby eliminating the monthly concern about making timely payment.



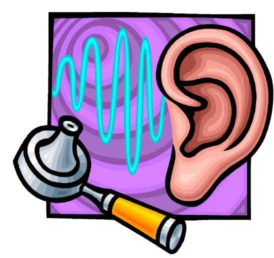
In December, 2004 all currently participating Retiree Medical Program participants received a letter announcing this service along with an explanation of the enrollment process and an Authorization Form to be filled out by those interested. In the first month of the ACH debit program more than twenty-five percent of eligible retirees successfully enrolled.

If you are a Retiree Medical Program participant now wishing to enroll -

1. Complete the Authorization Form and include a voided check (for checking account debiting) or a deposit slip (for savings account debiting) and return it to the Fund.
2. Once your bank information has been verified by the Fund you will receive a Confirmation Notice informing you when your ACH debiting will commence.
3. Once your monthly ACH debiting begins, it will continue until such time as you (or the authorizing party) instructs the Fund to cease.

The Fund encourages you to take advantage of this convenient method of payment. If you no longer have access to the materials mailed to you, please contact the Fund's Retiree Department.

Hearing Aid Benefit



The Fund has encountered problems with certain PPOM providers who have sought direct, non-discounted payment from participants prior to fitting them for hearing aids. Network providers are not entitled to do this and those that have come to our attention have been instructed accordingly. The Fund urges you to insist that the provider bill PPOM if you are asked to pay. Once the claim has been processed by the Fund, you will receive an Explanation of Benefits notifying you of your payment responsibility to the provider which includes any co-payment, deductible and allowed amounts owed in excess of the per person benefit maximum.

In summary, the Fund's hearing aid benefits are available once every two years up to $1,000 per person per hearing aid under all Fund medical benefit plans (with the exception of the UE and Retiree Plans).

Dependent Child Dental Sealant Coverage Clarification

As announced in the Summer 2004 issue of the *Messenger*, dental sealant coverage was made available under Class I services at 75%, with specific limitations, for dependent children ages 14 years or younger, effective September 1, 2004.

This coverage, which must be prior authorized, is limited to the first and second permanent molars of eligible children with high risk teeth. A child with high risk teeth is one who has caries (tooth decay) in one or more molar(s).

Dental sealant coverage is available only for permanent teeth, not for baby (deciduous) teeth.

Bariatric Surgical Procedures Benefit Requirement and Exclusion

Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity. During the course of treatment, surgery is sometimes necessary to obtain the best medical results. The Fund provides coverage for a variety of bariatric surgeries, subject to prior authorization by the Fund's Medical Director. Such requests must be submitted to the Fund's Utilization Review Department.

Effective January 27, 2005, among the other criteria considered for prior authorization for bariatric surgeries, **the patient must produce adequate documentation evidencing participation in a structured, professionally supervised weight reduction program for a minimum of two years immediately prior to the surgery authorization request.** Please note that the cost of such programs is not covered by the Fund.

Please take further note that **reconstructive surgical procedures of any kind, for any reason, occasioned directly or indirectly by the weight loss following bariatric surgery, are excluded from coverage under the Fund's plans**. Previously, reconstructive surgical procedures deemed by the Fund to be medically necessary had been a covered benefit. This new exclusion applies to any such procedure which follows bariatric surgeries authorized by the Fund, or otherwise occurring, after January 27, 2005.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law October 21, 1998. This law amended the Employee Retirement Income Security Act of 1974 and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Under the Women's Health Act, group plans offering mastectomy coverage must also provide for reconstructive surgery in a manner determined in consultation between the attending physician and the patient. Coverage must include:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

The Fund has provided this coverage, subject to Plan rules, for many years prior to the enactment of this law and continues to do so.

Mastectomy Bra Benefit

Instead of electing reconstructive surgery after a mastectomy, some patients prefer to wear a prosthesis, which requires the use of a mastectomy bra. Since this can be obtained over-the-counter it has been considered an exclusion under the Fund's plan of benefits.

Effective January 27, 2005, mastectomy bras are no longer excluded, but are subject to the following limitations:

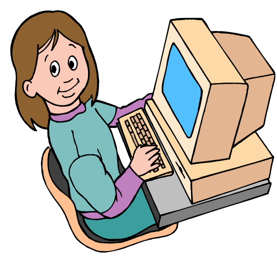
- ⇨ A maximum of two bras are reimbursable per calendar year.
- ⇨ Reimbursement will be made up to the Plan's scheduled amount subject to deductibles, coinsurance and co-payments .

Introducing the ValueOptions Achieve Solutions Website

ValueOptions, the Fund's behavioral health partner, is pleased to offer you a new resource, *Achieve Solutions,* a confidential website filled with educational information and content for you and your family. We encourage you to access this site. Log on to *Achieve Solutions* -

- To access a comprehensive library of educational materials, including information on depression, anxiety, stress, addiction and relationship issues;
- For complete self-assessment tools and interactive trainings; and
- To read news briefs and feature stories, which are updated weekly.

How to Access Achieve Solutions



Logging on to Achieve Solutions is easy. Simply follow these steps:

1. Go to the Fund's website at www.mctwf.org and click on the *Achieve Solutions* link on either the "Provider Networks" or "Info Links" page.
2. On the left hand side of the page, under "First Time Visitor?" click on "click here." This will take you to the next page.
3. On the next page, you will see "Step 1: Verify your eligibility." Enter the following username and password:

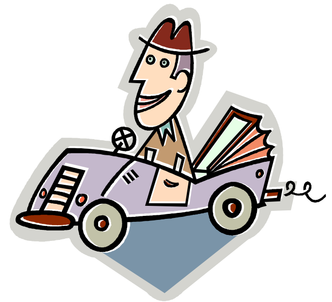
   User name: mctwf
   Password: solutions

4. Next, complete Step 2: Create your own personal user name and password. Your password must be at least 6 characters and include one symbol (for example !,@,#, $).

Reminder

In order to access your benefits for treatment of mental & nervous disorders and substance abuse, you first must receive authorization from ValueOptions. Simply call 1-800-457-8540 for authorizations and network referrals. Also call that number for 24-hour emergency assistance.

Non-Access Exemption



In the event that you live further than 20 miles from any primary care network physician (i.e., family practice, internal medicine, general practice, pediatrics or obstetrics/gynecology - **specialists are not covered by this exemption**) or Delta Premier dentist, or 25 miles from a Delta Premier orthodontist, the Fund's Non-Access Exemption permits your claim to be administered as if it were incurred in-network with respect to deductibles and co-payments. However, because non-network provider fees are not limited by contract, you remain responsible for sums charged in excess of the Fund's maximum allowable benefit schedule.

To obtain your Non-Access Exemption, you must fill out an application form before, or within 60 days following, the date services are rendered and mail it to the Fund. A form can be obtained by contacting the Fund's Member Services Department or by printing it from the "Forms" page of the Fund's website. Once your application has been approved, that approval will continue for six months from the date that the first non-access services were rendered. Any services beyond the six month period must be approved for continued exemption through a new application.

COBRA Rules

COBRA provides you and your eligible dependents with the right to continue your healthcare benefits in the event that your group health coverage ends due to certain qualifying events.

Two-tier Rate Structure

For all COBRA qualifying events occurring on or after April 1, 2004 the Fund offers COBRA Plan rates using a two-tier structure that permits you or your eligible dependents to choose single or family coverage. **However, whether you choose single or family coverage, you may not thereafter change your coverage selection under any circumstance**.

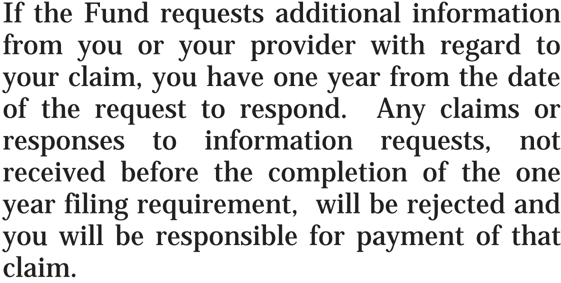
Medicare Eligible Participants Electing COBRA

Under Federal law, if you or your eligible dependent elects COBRA coverage while enrolled in Medicare, COBRA coverage is deemed secondary to that of Medicare. While Medicare Part A (hospital) enrollment is automatic, Part B (medical) enrollment is voluntary. Consequently, COBRA becomes primary for medical benefits if the participant or dependent does not enroll in Medicare Part B.

Effective April 1, 2005, the Fund requires that participants and dependents who are eligible for Medicare Part A benefits and who thereafter elect COBRA coverage, must be enrolled in Medicare Part B to be eligible for COBRA medical benefits. If the Medicare Special Enrollment Period has expired for the participant or dependent by April 1, 2005, the COBRA coverage will remain primary only through December 31, 2005, at which point Medicare's General Enrollment Period opens through March 31, 2006.

One Year Claim Filing Requirement

The Fund requires that all claims for benefits be filed within one year after -



- the date of loss;
- the date the eligible expense is incurred;
- the date the accident or sickness occurs; or
- the end of your active coverage for total and permanent disability claims.

If the Fund requests additional information from you or your provider with regard to your claim, you have one year from the date of the request to respond. Any claims or responses to information requests, not received before the completion of the one year filing requirement, will be rejected and you will be responsible for payment of that claim.

For purposes of administering this time limitation, the one-year period commences on the day of the event and ends one year later, on the prior calendar day. For example, to meet the one year claim filing requirement, if the date of service is July 1, 2004, the claim must be received no later than June 30, 2005.

Using Your ID Cards for Services

When you become a Fund participant with group health coverage, you receive a Michigan Conference of Teamsters Welfare Fund (MCTWF) identification (ID) card and a Blue Cross Blue Shield of Michigan (BCBSM) ID card. Since the Fund contracts with various provider networks, it may be confusing to know when to use each of your ID cards and who the provider should bill for payment.

Hospital & Prescription Drug Services

Services	Michigan	Outside of Michigan
Hospital There are two types of services charged for by a hospital; facility (inpatient, outpatient and emergency room services) and staff physician.	Present your BCBSM ID card for all hospital services. The hospital must bill BCBSM.	Present both your MCTWF ID card and BCBSM ID card at the hospital. The hospital must bill BCBSM for facility charges. The staff physician charges must be billed to PPOM (if PPOM provider) or MCTWF (if MultiPlan or non-network provider) at the billing address located on the MCTWF ID card. **These staff physician services should never be billed to BCBSM.**
Physician All independent physician services other than surgical and inpatient visits (e.g. anesthesia, pathology, lab charges etc.).	Present your BCBSM ID card for all independent physician services. The independent physician must bill BCBSM.	Present your MCTWF ID card for all independent physician services. The independent physician charges must be billed to PPOM (if PPOM provider) or MCTWF (if MultiPlan or non-network provider) at the billing address located on the MCTWF ID card. **These independent physician services should never be billed to BCBSM.**
Prescription Drugs	Present your BCBSM card to a MedImpact participating pharmacy. The pharmacist will process your claim through MedImpact using BIN 003585 and Rx PCN 23615.	Present your BCBSM card to a MedImpact participating pharmacy. The pharmacist will process your claim through MedImpact using BIN 003585 and Rx PCN 23615.

Non-Hospital Physician Services

Service	In-Network (PPOM & MultiPlan)	Out-of-Network
Physician All Physician services rendered in a non-hospital setting (e.g. office, free standing clinic, urgent care, etc.) and all surgical & hospital visit services rendered in a hospital.	Present your MCTWF ID card for physician services. The physician charges must be billed to PPOM (if PPOM provider) or MCTWF (if MultiPlan provider) at the billing address located on the MCTWF ID card. **These physician services should never be billed to BCBSM.**	Present your MCTWF ID card for physician services. Non-network physicians must be billed to the Fund at the billing address located on the MCTWF ID card. **These physician services should never be billed to BCBSM.**

Miscellaneous Services

Service	In-Network (Delta Dental)	Out-of-Network
Dental	Present your MCTWF ID card for dental services. The dental charges must be billed to MCTWF at the billing address located on the MCTWF ID card.	Present your MCTWF ID card for dental services. The dental charges must be billed to MCTWF at the billing address located on the MCTWF ID card.
Vision	Present your MCTWF ID card for vision services. The Fund does not contract with a network for vision services, therefore the vision charges must be billed to MCTWF at the billing address located on the MCTWF ID card.	
Mental Health and Substance Abuse	You must call 1-800-457-8540 for authorization prior to the service date. Present your MCTWF ID card for mental health and substance abuse services at the time of service. The mental health and substance abuse charges must be billed to MCTWF at the billing address located on the MCTWF ID card.	

Benefits will be determined based on the participating status of the physician/facility and the participant's residence according to the following:

BCBSM is the nationwide network for all hospital facility services, prescription drugs and some professional services rendered in Michigan. PPOM is the primary network for participants residing in MI, OH and IN for physician services. MultiPlan is the complimentary nationwide network for participants residing inside MI, OH and IN and the primary nationwide network when traveling or residing outside those states for physician services. Delta Dental is the nationwide network for all participants for dental services. ValueOptions is the nationwide network for all participants for mental health and substance abuse services.

The *Messenger*, published quarterly, notifies you of changes to your plan of benefits. Please retain all issues of the *Messenger*, along with your SPD booklet and other plan materials, for future reference.

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313-964-2400

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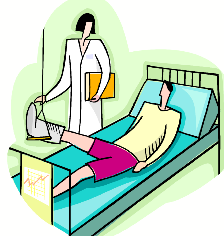
Reminders

Medical Benefit Co-payments

As a reminder, effective March 1, 2004 the following co-payments were put in place for office visits, emergency room visits and hospital admissions and apply to plans SOA, TIF, I&S, PEP and UE :

- ⇨ **In-Network Office Visit Co-payment** - $20 per visit. This includes primary care physicians, specialists and clinic visits (at a physician's office or outpatient at the hospital) and **does not include mental health and substance abuse visits**.
- ⇨ **In-Network and Out-of-Network Emergency Room Visit Co-payment** - $20 per visit.
- ⇨ **In-Network and Out-of-Network Hospital Admission Co-payment** - $250 per admission up to a maximum of three hospital admission co-payments per calendar year, **including mental & nervous and substance abuse admissions.**



Remember, the $20 emergency room visit co-payment is waived if the patient is admitted into the hospital, in which case only the $250 co-payment applies. If the patient is re-admitted to the hospital within 30 days from the prior discharge for the same condition, the $250 for the re-admission is waived.

HIPAA Privacy Rule

As initially introduced and explained in 2002, the Privacy Rules under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 went into effect April 14, 2003. These rules impose strict conditions on the use and disclosure of health information relating to the patient's past, present or future health condition, the provision of care, or the payment for that care.

In accordance with these rules, please remember that when you wish the Fund to share your Protected Health Information (PHI) with anyone, including your spouse or other family member, you must complete the Fund's Individual Authorization to Release PHI Form. This form is available by contacting the Fund's Member Services Department or by printing it from the "Forms" page of the Fund's website.

If you are married please be sure to share this communication with your spouse.