

Michigan Conference of Teamsters Welfare Fund



Messenger



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Message from the Fund's Executive Director

Sunday, August 8th – The first day of Teamsters Joint Council No. 43 Fall Delegates Seminar.

I'm home with my family, restless with the low grade anxiety that always strikes me before my semi-annual presentations to the assembly of Teamster delegates. Nonetheless, I'm looking forward to speaking this time, not about the health of the Fund, but about the health (or more accurately, the ills) of America's health care system and what's going to have to change to ensure its future viability.

The target, of course, is controlling the paralyzing cost of health care which now dwarfs every other sector of our economy, including housing, food and defense. It undermines the ability of this nation to compete and excludes an ever growing number of citizens from health care services, most of whom are members of working families.

The extraordinary amount of underuse, overuse and misuse of our health care system is undeniable. The common wisdom calls for universal preventative health care, the rewarding of doctors and facilities for the quality rather than the quantity of their services, the elimination of waste caused by health care fraud, duplicative testing and inappropriate testing driven by the practice of defensive medicine, enlightened and enforced public policies addressing contaminants and pollutants which cause cancers and asthma and attention/learning disorders in our children and the harnessing of the Internet to securely compile all medical records and make them instantly available and interactive with the latest research and best practice guidelines to treat virtually any medical condition.

But perhaps more important than any other factor in controlling costs is the one over which we can exercise the most control; our own health. Chronic diseases, like asthma, diabetes and heart disease, account for 80% of hospital inpatient stays, 60% of physician visits, 55% of emergency room visits and 83% of prescription drug use. Most chronic diseases can be avoided and if not, they can be managed with great success (please read our article on BlueHealthConnection, which will soon be administering the Fund's disease management program). Yet we fail far too often to exercise the necessary control, or seek professional help, and fall prey to chronic illness. Obesity alone, which affects so many of us, can lead to diabetes, coronary artery disease, congestive heart failure, stroke, osteoarthritis, gallstones, sleep apnea and cancer. And the cost to America is staggering.

Solving this problem requires not only the commitment of the public will, but of the individual will as well. It must be done; our children's welfare is at stake.

Please review the full contents of this newsletter. As with every issue of the *Messenger*, it contains information you need to know to maximize your benefits and to minimize your expense.

On behalf of the Fund's staff and Trustees, I wish you and your families, for the rest of this summer, the best of times and the best of health.

Richard Burker

Inside this issue:

BlueHealthConnection	2
Eligible Dependent Coverage Amendment Totally and Permanently Disabled Coverage Children	3
Benefit Bank Week Entitlement New Rule for Employees of Newly Participating Employers	3
Establishing Eligibility Clarification	3
In-Office Diagnostic Testing Restrictions: Revision and Clarification	4
Dental Sealant Coverage Available Eligible Dependents Age 14 and Younger	4
Dental Limitations Amendment	5
Sanctioned Strike Coverage Rule Amendment	5
Prescription Drug Benefit Exclusion Reminder Non-Sedating Antihistamines and Proton Pump Inhibitors	6
Full-Time Student Eligibility Verification Form Reminder	6

BlueHealthConnection

Blue Cross Blue Shield of Michigan, the Fund's administrative services and network provider for hospital based services and its pharmacy benefit manager, offers to Fund participants and beneficiaries its **BlueHealthConnection** Program.

What's is it?

BlueHealthConnection is a comprehensive health care management program designed to help acutely ill and chronically ill participants get healthy, stay healthy and lead a better life.

BlueHealthConnection's registered nurse health coaches provide you with the information, assistance and decision-making tools you need to work with your doctor and take charge of your health care needs.

You can contact **BlueHealthConnection** on your own or by recommendation from your doctor, hospital or other health care professional. A nurse health coach may contact you directly, but under all circumstances **BlueHealthConnection** is provided at no cost to you, with absolute confidentiality.

What's in it for you?

At the heart of **BlueHealthConnection** is your 24-hour connection to its registered nurse health coaches. They are available 365 days a year to assist you in the following ways:

- To provide you with general health information and educational materials you need on any health care subject;
- To talk to you about your symptom concerns and provide information on treatment options. Be sure to ask for your free copy of the **HealthWise Handbook**, a handy reference tool providing information on a wide range of symptoms and treatment options;
- To help you find ways to live a healthier life through appropriate lifestyle changes such as connecting you to the **Quit the Nic** smoking cessation program. Whether you're ready to quit or just thinking about it, the **Quit the Nic** program health coaches can help you plan and provide you with the tools and support to help you reach your goals;
- To learn to control chronic conditions such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease; following the best medical practice guidelines, the nurse health coaches will work with you one-on-one to help you understand your disease, avoid complications and follow your physician's plan of care;

- To take an active, decision-making role in your healthcare; the nurse health coaches can equip you with information so you can work more closely with your physician and other health care providers. For example, are you living with back pain and possibly facing surgery? The nurse health coach can send you a video to assist you in your decision-making. Nurse health coaches will follow-up to answer any questions you may have and help you with questions you may want to discuss with your physician;
- To refer you to case management services. The Case Management Program is a voluntary, comprehensive, short term program designed to help Fund participants address serious, or even terminal, illnesses. A case management nurse will work with you, your health care providers, and your family or caregivers to ensure there is a clear understanding of your condition, prognosis and treatment options. The Case Manager will assist in coordinating the services a participant requires involving several providers of care.

Accessing the Program

Call **1-800-775-Blue (2583)** and follow the prompts to reach a nurse health coach, an audio health library of over 1,600 topics, or the **Quit the Nic** Program.

Or

Go to the **BlueHealthConnection's** website at www.PersonalPath.com, to search for information on a number of health topics and related information and to obtain personalized health care information for you and your family.

You may receive occasional postcard reminders or health information in the mail. These mailings will offer information and suggestions for taking care of your health. The nurse health coaches may contact you following a mailing to offer additional information or support to help you manage your health.

Remember: There is no substitute for a doctor's care. While the nurse health coaches can help you with any health care questions or referrals, they cannot diagnose medical conditions or authorize medical care.

Please be advised effective October 31, 2004, the Fund's Disease Management Program will be provided by BlueHealthConnection. Participant's currently enrolled in the CareEnhance Disease Management Program will be contacted by BlueHealthConnection during the interim period.

Eligible Dependent Coverage Amendment ***Totally and Permanently Disabled Overage Children***

The current Fund rule for providing extended dependent coverage for an overage child who is totally and permanently disabled requires that the disability began while the child was covered under the Fund as an eligible dependent.

Effective August 1, 2004, this requirement has been eliminated for current participants. Coverage for eligible individuals will be applied prospectively, for claims incurred on or after August 1, 2004. Participants whose overage children are not covered by the Fund but have been determined by a licensed

physician, psychologist or psychiatrist to be totally and permanently disabled, must complete and sign a new enrollment card and submit it to the Fund with a letter from the physician verifying the child's disability.

For those who become participants on or after August 1, 2004, this rule change will apply provided that the participant can present adequate evidence that the overage child was covered under the health plan that immediately preceded Fund coverage. A letter from the physician verifying the child's total and permanent disability is also required.

Benefit Bank Week ***Entitlement*** ***New Rule for Employees of*** ***Newly Participating*** ***Employers***

If your plan of benefits provides for benefit bank weeks (please refer to your Schedule of Benefits), they will be applied to provide you and your eligible dependents with continued coverage when your employer does not make contributions to the Fund on your behalf in the event of:

- Illness
- Layoff
- Personal leave
- Military leave
- Sanctioned strike
- Transfer to another contributing employer (to cover the probationary period in the event you were to quit employment with Employer A to go to work for Employer B)



Effective June 27, 2004, employees of newly participating employers will not be entitled to benefit bank weeks until contributions have been made on their behalves for 12 consecutive (or 13 out of 17) weeks of active employment.

Establishing ***Eligibility*** ***Clarification***

Your Summary Plan Description states that "You are covered by the Plan on the first Sunday of the week after your employer has made contributions to the Fund on your behalf for eight consecutive weeks or nine weeks within a thirteen week period, provided that contributions are received for the ninth week. If no contributions are submitted for the ninth week, then coverage does not begin." The way in which this rule is stated not only makes it a challenge to grasp, but also results in its frequent mischaracterization as an "eight week eligibility rule", when, in fact, it requires nine weeks of contributions to trigger eligibility. Accordingly, the Trustees have clarified the rule as follows:

Eligibility under the Plan is established upon receipt of nine weeks of employer contributions on your behalf, during any consecutive 13 week period. Coverage is retroactive to the first day (Sunday) of the ninth week.

In-Office Diagnostic Testing Restrictions: Revision and Clarification

We advised you in the Summer 2003 *Messenger* that as of January 1, 2004, based on the recommendation of the Fund's Medical Director, the Fund ceased coverage or limited the frequency of certain diagnostic testing when performed in the office of a primary care physician. The Fund's Medical Director has reconsidered that policy and upon review, the Trustees adopted the following recommended revisions and clarifications:

Effective September 1, 2004, the Fund will no longer cover, or will limit the frequency of certain diagnostic testing (see below) when performed in the private practice setting (this includes both primary care physicians and specialists).

- Benefit plan coverage will be provided for the following diagnostic tests, only if they are performed in either a freestanding radiological diagnostic center, or a hospital based diagnostic unit (either on, or off a hospital campus):

- X-rays of the sinus and skull.
- Standard abdominal ultrasounds.¹

¹ Exception - Pelvic, trans-vaginal and obstetrical ultrasounds are allowed in the obstetrics/gynecology specialist's office.

- Benefit plan coverage will be provided for the following diagnostic tests on a limited basis, as noted, in the private practice setting. Otherwise such coverage will be provided only if they are performed in either a freestanding radiological diagnostic center, or a hospital based diagnostic unit (either on, or off a hospital campus):



- Echocardiography and stress testing (any form of echocardiography at rest, or with treadmill stress, with or without chemical assistance) not more than once annually.
- Bone density only for the purpose of establishing a baseline. Follow-up is permitted once every three years.
- Cardiac studies (any form of nuclear cardiography at rest, or under stress circumstances, with or without chemical assistance) not more than once annually.

Please note that in each case above, frequency limitations apply when the same doctor is performing the tests and prior written authorization is required for greater frequency.

Dental Sealant Coverage Available ***Eligible Dependents Age 14 and Younger***

Effective September 1, 2004, the Fund's Dental Benefit Plans will include Dental Sealants as a covered benefit under Class I services. Dental Sealants must be prior authorized. To obtain prior authorization, dentists must submit their requests to the Fund's Utilization Review Department in writing.

Coverage

- Sealants are limited to first and second molars of eligible dependent children who are age 14 years old or younger and whom the Fund considers to have high risk teeth. A child who has high risk teeth is one who has caries (tooth decay) in one or more molar(s).



- The participant is responsible for a 25% coinsurance charge.
- Benefits paid by the Fund will be applied to the annual \$2,000 dental maximum for that patient.

Limitations

- Repair or reapplication within three years from the sealant application date is not covered.
- Prior authorization is required for repair or reapplication beyond three years from the sealant application date.

Dental Limitations Amendment

In the Spring 2004 *Messenger*, we reviewed the five year limitation on replacement services, appliances and prosthetics. We quoted the SPD booklet, under Dental Expenses Not Covered, noting that the five year period runs from the last such service covered by the Fund's Plan or a predecessor plan. That rule is consistent with Delta Dental's claim system limitation, which starts its five year count from the last such service in its system; so if your predecessor (pre-Fund) plan used Delta Dental and, while covered under that plan three years ago, for example, you had a crown placement and now need a replacement, Delta Dental's system would reject coverage.

The Trustees have agreed to amend the Fund's rule so that all dental time limitations shall only apply to dental services received by a participant while covered by a Fund benefit plan.

Because of Delta Dental's system limitation, Delta Dental will provide a quarterly report of such rejections to the Fund for review and determination. The Fund will reverse those rejections and cover the service. However, if you receive a rejection that you believe is based on pre-Fund services, please contact our Member Services Department so that the Fund may address the matter more quickly.

Sanctioned Strike Coverage Rule Amendment

Effective August 1, 2004, the extended coverage provided by the Fund for participants on sanctioned strike will be limited to eight weeks following the exhaustion of the participants' benefit bank weeks.

The following conditions must be met in order for the Fund to provide extended coverage to participants who are absent from employment due to a strike –

- The strike must be sanctioned by the International Brotherhood of Teamsters (IBT);
- The Teamsters Local Union involved must provide the Fund with the inception date of the strike, confirmation of the IBT sanctioning, the name of the Employer, a list of affected participants, and the termination date of the strike; and
- The Employer must not be more than 30 days delinquent in making legally required contributions at the commencement of the sanctioned strike.

The following limitations will apply when extended coverage is granted –

- Coverage will not be provided to participants whose employment status as of the date the sanctioned strike begins is due to one of the following – leave of absence, sick leave, layoff, or termination.
- Unused benefit bank weeks will be applied from the inception date of the sanctioned strike.

- Upon exhaustion of available benefit bank weeks, coverage shall continue for a maximum of eight weeks, subject to the participant's ongoing compliance with the Local Union's requirements for strike duty.
- The COBRA coverage continuation period commences on the date of the COBRA qualifying event (the strike) and will be offset by the number of benefit bank weeks used following the commencement of the strike plus the number of weeks of extended Fund strike coverage.

Here is an example of how coverage will be applied to a participant who is on sanctioned strike.

Example: The sanctioned strike commences on August 1, 2004 and ends on December 1, 2004. The participant has six remaining benefit bank weeks, which are applied through September 11, 2004. The Fund extends coverage for eight additional weeks through November 6, 2004, after which the Fund coverage ceases, subject to the participant's election of COBRA coverage.

COBRA notices will be sent to participants prior to the cessation of the Fund's extended strike coverage. As noted, the COBRA period runs from the "qualifying event" (i.e., the strike) and is reduced by the number of benefit bank weeks used thereafter plus the weeks of extended strike coverage provided by the Fund. In the above example, the standard 18 month COBRA period would be reduced by 14 weeks.



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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Prescription Drug Benefit Exclusion Reminder Non-Sedating Antihistamines and Proton Pump Inhibitors

All prescription non-sedating antihistamines (Allegra®, Clarinex® and Zyrtec®) and proton pump inhibitors (Aciphex®, Nexium®, Prevacid® and Protonix®) are excluded under the Fund's prescription drug program, due to the fact that Claritin® (and Claritin-D®) and Prilosec® are available without prescription (also referred to as over-the-counter).

However, your physician may obtain an exemption from this exclusion based on medical necessity by submitting a prior authorization request to the Fund's Utilization Review Department. The Fund will consider the below criteria in its review. You and your physician will be notified in writing of the Fund's determination.

Non Sedating Antihistamines -

- Documented failure of treatment (minimum of 2 week trial) with OTC Claritin or OTC Claritin-D.
- An adverse reaction or intolerance to OTC Claritin or OTC Claritin-D.
- An adverse drug interaction or potential adverse drug interaction.

Proton Pump Inhibitors -

- Documented failure of treatment (minimum of 8 week trial) with Prilosec OTC.
- An adverse reaction or intolerance to Prilosec OTC .
- An adverse drug interaction or potential adverse interaction with Prilosec OTC.

Full-Time Student Eligibility Verification Form Reminder

As summer vacation is nearing its end, we would like to remind all participants who have eligible dependents age 19 or above who are attending a degree or certification program offered by an accredited academic institution or vocational school, to submit a completed Full-Time Student Eligibility Verification Form.

You may obtain a form by contacting us at the Fund office or by printing one from the Fund's website at www.mctwf.org and clicking on the Forms button from any page on the site.

