

Michigan Conference of Teamsters Welfare Fund

Messenger



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Message from the Fund's Executive Director, Richard Burker

Warm greetings from frozen Trumbull Avenue. The Fund's staff have been keeping busy working on a number of key projects while doing a fine job discharging their normal responsibilities. We've been focusing diligently on HIPAA Privacy and the new Claims/Appeal Regulations compliance; getting our forms completed, our procedures in place and completing our training. We've implemented and trained staff on a new, flexible billing/collection/eligibility system designed and built in-house as the front end to our claims processing system, which we are, in turn, well along in replacing with a far more functional and cost efficient claims system which will permit critical improvements in service to all of our constituents. We've also reconfigured our member services call center, giving resource priority to participants and beneficiaries over calls from providers. This has helped deal with the recent increase in member calls, due primarily to the many changes implemented of late. We apologize for any initial confusion or inconvenience caused to you.

This expanded Winter issue is once again primarily devoted to HIPAA Privacy, but also addresses a number of key issues including Retiree Plan and Military Leave provisions and the triennial benefit bank renewal.

In the Fall issue of the Messenger, we provided you with a brief summary of HIPAA Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) and published the Fund's Notice of Privacy Practices. In this Winter issue, we are following up with a series of frequently asked questions and their answers (FAQs) to further your understanding of the Privacy Rule, which becomes effective April 14, 2003. The source of the FAQs is the U.S. Department of Health and Human Services Office for Civil Rights (OCR). Its more expansive set of FAQs, from which we have excerpted, may be found directly at www.hhs.gov/ocr/hipaa/privacy.html, or by linking to that address from the home page of the Fund's website.

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HIPAA Privacy Rule — Frequently Asked Questions

General Overview

Q: What does the HIPAA Privacy Rule do?

A: Most health plans and health care providers that are covered by the new Rule must comply with the new requirements by April 14, 2003.

The HIPAA Privacy Rule for the first time creates national standards to protect individuals' medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records.
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights.
- And it strikes a balance when public responsibility supports disclosure of some forms of data – for example, to protect public health.

For patients – it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.

- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections.
- It empowers individuals to control certain uses and disclosures of their health information.

Q: Why is the HIPAA Privacy Rule needed?

A: In enacting HIPAA, Congress mandated the establishment of Federal standards for the privacy of individually identifiable health information. When it comes to personal information that moves across hospitals, doctors' offices, insurers or third party payers, and State lines, our country has relied on a patchwork of Federal and State laws. Under the patchwork of laws existing prior to adoption of HIPAA and the Privacy Rule, personal health information could be distributed—without either notice or authorization—for reasons that had nothing to do with a patient's medical treatment or health care reimbursement. For example, unless otherwise forbidden by State or local law, without the Privacy Rule patient information held by a health plan could, without the patient's permission, be passed on to a lender who could then deny the patient's application for a home mortgage or a credit card, or to an employer who could use it in personnel decisions. The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical information. State laws which provide stronger privacy protections will continue to apply over and above the new Federal privacy standards.

Health care providers have a strong tradition of safeguarding private health information. However, in today's world, the old system of paper records in locked filing cabinets is not enough. With information broadly held and transmitted electronically, the Rule provides clear standards for the protection of personal health information.

Q: Generally, what does the HIPAA Privacy Rule require the average provider or health plan to do?

A: For the average health care provider or health plan, the Privacy Rule requires activities, such as:

- Notifying patients about their privacy rights and how their information can be used.
- Adopting and implementing privacy procedures for its practice, hospital, or plan.
- Training employees so that they understand the privacy procedures.
- Designating an individual to be responsible for seeing that the privacy procedures are adopted and followed.
- Securing patient records containing individually identifiable health information so that they are not readily available to those who do not need them.

Q: Who must comply with these new HIPAA privacy standards?

A: As required by Congress in HIPAA, the Privacy Rule covers:

- Health plans.
- Health care clearinghouses.
- Health care providers who conduct certain financial and administrative transactions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

These entities (collectively called "covered entities") are bound by the new privacy standards even if they contract with others (called "business associates") to perform some of their essential functions. The law does not give the Department of Health and Human Services (HHS) the authority to regulate other types of private businesses or public agencies through this regulation.

Incidental Uses and Disclosures

Q: Can health care providers engage in confidential conversations with other providers or with patients, even if there is a possibility that they could be overheard?

A: Yes. The HIPAA Privacy Rule is not intended to prohibit providers from talking to each other and to their patients. Provisions of this Rule requiring covered entities to implement reasonable safeguards that reflect their particular circumstances and exempting treatment disclosures from certain requirements are intended to ensure that providers' primary consideration is the appropriate treatment of their patients. The Privacy Rule recognizes that oral communications often must occur freely and quickly in treatment settings. Thus, covered entities are free to engage in communications as required for quick, effective, and high quality health care. The Privacy Rule also recognizes that overheard communications in these settings may be unavoidable and allows for these incidental disclosures.

Q: Do the HIPAA Privacy Rule's provisions permitting certain incidental uses and disclosures apply only to treatment situations or discussions among health care providers?

A: No. The provisions apply universally to incidental uses and disclosures that result from any use or disclosure permitted under the Privacy Rule, and not just to incidental uses and disclosures resulting from treatment communications, or only to communications among health care providers or other medical staff. For example:

- A provider may instruct an administrative staff member to bill a patient for a particular procedure, and may be overheard by one or more persons in the waiting room.
- A health plan employee discussing a patient's health care claim on the phone may be overheard by another employee who is not authorized to handle patient information.

If the provider and the health plan employee made reasonable efforts to avoid being overheard and reasonably limited the information shared, an incidental use or disclosure resulting from such conversations would be permissible under the Rule.

Minimum Necessary

Q: How are covered entities expected to determine what is the minimum necessary information that can be used, disclosed, or requested for a particular purpose?

A: The HIPAA Privacy Rule requires a covered entity to make reasonable efforts to limit use, disclosure of, and requests for protected health information to the minimum necessary to accomplish the intended purpose. To allow covered entities the flexibility to address their unique circumstances, the Rule requires covered entities to make their own assessment of what protected health information is reasonably necessary for a particular purpose, given the characteristics of their business and workforce, and to implement policies and procedures accordingly. This is not an absolute standard and covered entities need not limit information uses or disclosures to those that are absolutely needed to serve the purpose. Rather, this is a reasonableness standard that calls for an approach consistent with the best practices and guidelines already used by many providers and plans today to limit the unnecessary sharing of medical information.

Personal Representatives

Q: Can the personal representative of an adult or emancipated minor obtain access to the individual's medical record?

A: The HIPAA Privacy Rule treats an adult or emancipated minor's personal representative as the individual for purposes of the Rule regarding the health care matters that relate to the representation. The scope of access will depend on the authority granted to the personal representative by other law. If the personal representative is authorized to make health care decisions, generally, then the personal representative may have access to the individual's protected health information regarding health care in general. On the other hand, if the authority is limited, the personal representative may have access only to protected health information that may be relevant to making decisions within the personal representative's authority.

There is an exception to the general rule that a covered entity must treat an adult or emancipated minor's personal representative as the individual. Specifically, the Privacy Rule does not require a covered entity to treat a personal representative as the individual if, in the exercise of professional judgment, it believes doing so would not be in the best interest of the individual because of a reasonable belief that the individual has been or may be subject to domestic violence, abuse or neglect by the personal representative, or that doing so would otherwise endanger the individual.

Q: How can family members of a deceased individual obtain the deceased individual's protected health information that is relevant to their own health care?

A: The HIPAA Privacy Rule recognizes that a deceased individual's protected health information may be relevant to a family member's health care. The Rule provides two ways for a surviving family member to obtain the protected health information of a deceased relative. First, disclosures of protected health information for treatment purposes—even the treatment of another individual—do not require an authorization; thus, a covered entity may disclose a decedent's protected health information, without authorization, to the health care provider who is treating the surviving relative. Second, a covered entity must treat a deceased individual's legally authorized executor or administrator, or a person who is otherwise legally authorized to act on the behalf of the deceased individual or his estate, as a personal representative with respect to protected health information relevant to such representation.

Q: Does the HIPAA Privacy Rule allow parents the right to see their children's medical records?

A: Yes, the Privacy Rule generally allows a parent to have access to the medical records about his or her child, as his or her minor child's personal representative when such access is not inconsistent with State or other law. There are three situations when the parent would not be the minor's personal representative under the Privacy Rule. These exceptions are: (1) when the minor is the one who consents to care and the consent of the parent is not required under State or other applicable law; (2) when the minor obtains care at the direction of a court or a person appointed by the court; and (3) when, and to the extent that, the parent agrees that the minor and the health care provider may have a confidential relationship. However, even in these exceptional situations, the parent may have access to the medical records of the minor related to this treatment when State or other applicable law requires or permits such parental access. Parental access would be denied when State or other law prohibits such access. If State or other applicable law is silent on a parent's right of access in these cases, the licensed health care provider may exercise his or her professional judgment to the extent allowed by law to grant or deny parental access to the minor's medical information.

Business Associates

Q: Does the HIPAA Privacy Rule require a business associate to provide individuals with access to their protected health information or an accounting of disclosures, or an opportunity to amend protected health information?

A: The Privacy Rule regulates covered entities, not business associates. The Rule requires covered entities to include specific provisions in agreements with business associates to safeguard protected health information, and addresses how covered entities may share this information with business associates. Covered entities are responsible for fulfilling Privacy Rule requirements with respect to individual rights, including the rights of access, amendment, and accounting. With limited exceptions, a covered entity is required to provide an individual access to his or her protected health information in a designated record set. This includes information in a designated record set of a business associate, unless the information held by the business associate merely duplicates the information maintained by the covered entity. Therefore, the Rule requires covered entities to specify in the business associate contract that the business associate must make such protected health information available if and when needed by the covered entity to provide an individual with access to the information.

A covered entity must amend protected health information about an individual in a designated record set, including any designated record sets (or copies thereof) held by a business associate. Therefore, the Rule requires covered entities to specify in the business associate contract that the business associate must amend protected health information in such records (or copies) when requested by the covered entity. The covered entity itself is responsible for addressing requests from individuals for amendment and coordinating such requests with its business associate.

The Privacy Rule requires a covered entity to provide an accounting of certain disclosures, including certain disclosures by its business associate, to the individual upon request. The business associate contract must provide that the business associate will make such information available to the covered entity in order for the covered entity to fulfill its obligation to the individual.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

Q: What is the difference between "consent" and "authorization" under the HIPAA Privacy Rule?

A: The Privacy Rule permits, but does not require, a covered entity voluntarily to obtain patient consent for uses and disclosures of protected health information for treatment, payment, and health care operations. Covered entities that do so have complete discretion to design a process that best suits their needs. By contrast, an "authorization" is required by the Privacy Rule for uses and disclosures of protected health information not otherwise allowed by the Rule. Where the Privacy Rule requires patient authorization, voluntary consent is not sufficient to permit a use or disclosure of protected health information unless it also satisfies the requirements of a valid authorization. An authorization is a detailed document that gives covered entities permission to use protected health information for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual. An authorization must specify a number of elements, including a description of the protected health information to be used and disclosed, the person authorized to make the use or disclosure, the person to whom the covered entity may make the disclosure, an expiration date, and, in some cases, the purpose for which the information may be used or disclosed.

Q: Does a physician need a patient's written authorization to send a copy of the patient's medical record to a specialist or other health care provider who will treat the patient?

A: No. The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual.

Q: Can a patient have a friend or family member pick up a prescription for her?

A: Yes. A pharmacist may use professional judgment and experience with common practice to make reasonable inferences of the patient's best interest in allowing a person, other than the patient, to pick up a prescription. For example, the fact that a relative or friend arrives at a pharmacy and asks to pick up a specific prescription for an individual effectively verifies that he or she is involved in the individual's care, and the HIPAA Privacy Rule allows the pharmacist to give the filled prescription to the relative or friend. The individual does not need to provide the pharmacist with the names of such persons in advance.

Marketing

Q: Does the HIPAA Privacy Rule expand the ability of providers, plans, marketers and others to use my protected health information to market goods and services to me? Does the Privacy Rule make it easier for health care businesses to engage in door-to-door sales and marketing efforts?

A: No. The Privacy Rule's limitations on the use or disclosure of protected health information for marketing purposes do not exist in most States today. For example, the Rule requires patients' authorization for the following types of uses or disclosures of protected health information for marketing:

- Selling protected health information to third parties for their use and re-use. Thus, under the Rule, a hospital or other provider may not sell names of pregnant women to baby formula manufacturers or magazines without an authorization.
- Disclosing protected health information to outsiders for the outsiders' independent marketing use. Under the Rule, doctors may not provide patient lists to pharmaceutical companies for those companies' drug promotions without an authorization.

Moreover, under the "business associate" provisions of the Privacy Rule, a covered entity may not give protected health information to a telemarketer, door-to-door salesperson, or other third party it has hired to make permitted communications (for example, about a covered entity's own goods and services) unless that third party has agreed by contract to use the information only for communicating on behalf of the covered entity. Without the Privacy Rule, there may be no restrictions on how third parties re-use information they obtain from health plans and providers.

Q: May covered entities use information regarding specific clinical conditions of individuals in order to communicate about products or services for such conditions without a prior authorization?

A: Yes, if the communication is for the individual's treatment or for case management, care coordination, or the recommendation of alternative therapies. The HIPAA Privacy Rule permits the use of clinical information to the extent it is reasonably necessary for these communications. Similarly, population-based activities in the areas of health education or disease prevention are not considered marketing when they promote health in a general manner. Again clinical information may be used for such communications, such as in targeting a public education campaign.

We refer you directly to the complete set of OCR FAQs regarding issues of less interest, including Disclosures for Public Health Activities, Research, Workers' Compensation Purpose, Notice of Privacy Practices for Protected Health Information and Restrictions on Government Access to Health Information.

Please note that you may obtain any of the Fund's HIPAA Privacy forms from the Fund's HIPAA Privacy Officer by phone, letter, e-mail request, or by downloading the form from the Fund's website. Those forms include individual requests regarding PHI for Access, Restrictions on Use/Disclosure, Confidential Communication, Amendment, Accounting of Disclosures, Authorization to Release and Revocation of Authorization to Release PHI.

Disclosures to Plan Sponsor under HIPAA Privacy Regulations

The Michigan Conference of Teamsters Welfare Fund (the Plan) may disclose protected health information to the Trustees of the Michigan Conference of Teamsters Welfare Fund (the Plan Sponsor) for the purposes of plan administration functions, as permitted by law. The Plan only may disclose such information upon the receipt of any necessary certifications from the Plan Sponsor, as required by law. Only persons involved with plan administration functions shall have access to any information disclosed under this section. If the persons to whom information is disclosed violate this section, or applicable law, the Plan shall cease disclosing such information.

Extended Retiree Spouse Contribution Rates

The Fund has adopted new monthly self-contribution rates for all Extended Retiree Spouses (Plans SOA, TIF and I&S). These rates are effective April 1, 2003 through March 31, 2004 and are determined by the spouse's age on April 1st or if thereafter, on the date of first coverage as an extended spouse.

Extended Spouse Self-Contribution Rates — 04/01/03 through 03/31/04		
Age Range	Monthly Rate — Male	Monthly Rate — Female
50 — 52	\$294.95	\$362.30
53 — 55	\$373.65	\$395.30
56 — 58	\$457.30	\$410.30
59 — 61	\$537.65	\$424.85
62 — 64	\$598.45	\$449.00

Extended Retiree Spouse coverage was implemented in 1990 to accommodate eligible spouses who lose entitlement to coverage under the Retiree Medical Program upon the later of five years of Program coverage or the Retiree's loss of coverage .

Entitlement to Extended Retiree Spouse coverage may continue until the earlier of the spouse's re-marriage or attainment of age 65 (or if earlier than age 65, upon commencement of Medicare eligibility).

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. Please refer to your Summary Plan Description for further details.

Retiree Medical Program - Deferral Rule

As announced in the Summer 2002 issue of the *Messenger*, a retiree may defer coverage in the Retiree Medical Program any number of times after he/she has commenced participation in the Program, upon presentation of proof of other medical coverage, subject to the requirements that the retiree must defer coverage for no less than 12 months each time and upon re-election of Retiree Medical Program coverage, provide proof of loss of that other medical coverage.

The Trustees have further modified the deferral rule to state:

- ◆ If the deferral is for the purpose of employment as a bargaining unit member by an employer that contributes to the Fund for a plan that includes retiree benefits, the 12 month minimum deferral period will be waived.
- ◆ If the deferral is for the purpose of resuming employment, there likely will be a period of time before eligibility is established for the new coverage (minimally eight weeks if it is with an employer that contributes to the Fund). Therefore, the deferring retiree may continue coverage under the Fund's Retiree Medical Program by making his monthly self-contribution until eligibility for the new coverage is established.
- ◆ At such time as the deferring retiree re-elects to participate in the Fund's Retiree Medical Program, the self-contribution rate will be the same rate fixed for the retiree at the time of deferral. However, if by virtue of active Fund participation during the deferral period, the re-electing retiree can newly satisfy the initial eligibility rule of 5 out of 5 or 7 out of 10 years of Fund participation immediately preceding re-election, the self-contribution rate will be recalculated to reflect the additional year(s) of service earned and the age of the retiree at the time of re-election.

Affinity Rx Prescription Drug Program Renewal

The Fund is pleased to announce the renewal of the Affinity Rx Prescription Drug Program for calendar year 2003. **Please note that the Fund will be changing the payment cycle from monthly to quarterly (once every 3 months) commencing with the May 2003 invoice, which will cover June, July and August. We will remind you of this change on the invoices issued in March and April.** Under this program, all retired Medicare eligible participants are entitled to annual prescription drug benefits of \$1,000, subject to a retail co-pay of \$5 for generic drugs and \$15 brand name drugs and a mail order co-pay of \$10 for generic drugs and \$30 for brand name drugs for each 35-90 day prescription filled.

To enroll in the program a retiree or eligible spouse must file a completed application form with the Fund within 90 days following the date the retiree or spouse becomes Medicare eligible. The Fund will determine eligibility and send an election form to the retiree or spouse. The Retiree or spouse must respond within 30 days after receipt of the election form. Coverage will begin on the first of the month following the month in which the election form and first contribution payment are received.

The required contribution rate schedule has been slightly increased by 10% (as reflected in the chart) and will go into effect April 1, 2003. Current program participants will be individually notified of their new rates.

Years of Fund Participation	Quarterly Rate Per Person
05 - 10	\$65.40
11 - 15	\$58.05
16 - 20	\$50.85
21 Plus	\$36.30

Retiree Medical Program - Uniformed Services (Military Leave) Credit

The Fund will credit military leave time, of up to five years, towards satisfying Fund participation requirements for establishing Retiree Medical Program eligibility (i.e., 5 out of 5 or 7 out of 10 years of participation immediately preceding the Retirement Date and 20 years under a Teamster collective bargaining agreement if retiring before age 57) and for determining the Retiree Medical Program self-contribution rate.

In order to earn up to five years of Uniformed Services Credit, all of the following conditions must be met:

- ◆ The participant must have entered the Uniformed Services while working for an Employer that was making contributions to the Fund (Contributing Employer) on his behalf for a benefit plan that included retiree benefits; and
- ◆ The participant's military leave does not exceed five years (except due to circumstances addressed in that section of USERRA entitled "Employment Rights of Persons Who Serve in the Uniformed Services"); and
- ◆ The participant must have applied for return to work with a Contributing Employer within the following time frames:
 - ✓ Within 90 days a military leave of more than 180 days.
 - ✓ Within 30 days a military leave of 31 to 180 days.
 - ✓ Within 5 days after a military leave of up to 30 days.

Military Leave Rule Benefit Bank Week Application

When active participants are called to military duty, available benefit bank weeks are automatically applied immediately following the employer's 30-day military leave contribution obligation.

The Fund has revised this rule to allow participants the option of when to apply their benefit bank weeks. The benefit bank weeks will no longer be automatically applied, as described above, if a participant submits to the Fund written instruction not to do so prior to commencement of military leave. If so instructed, the Fund will delay application of the available benefit bank weeks until discharge from military duty.



Custodial Care Services

As noted in your Summary Plan Descriptions, Custodial Care is **not** a covered benefit. The following description of Custodial Care is provided for further clarification:

Custodial Care can be delivered by either an individual, specialized or not, trained or not, related or not, to the patient in the delivery of that care. The complexity of the care is such that either because of its simplicity or the stability of the patient, it can be competently delivered by anyone trained or not, in the various specialties of medical service. The skills required, in general, are simply those that do not require special decision making processes (of a medical nature), special medical judgment in terms of a changing medical condition, or a unique experience only available to those specially trained in medical services. The delivery of care and the nature of this care in terms of the custodial definition has nothing to do with the importance of the care or to the survival of the patient, but only to the skill necessary to deliver it in a competent fashion.

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Eight-Week Benefit Bank Renewal

We are pleased to announce the renewal of the eight week benefit bank for the 36-month period beginning April 1, 2003 for Medical Plans SOA, TIF, UE, Key I and Key II as explained below:

- On April 1, 2003, eligible participants who are actively employed as of that date, and on whose behalf company contributions are being made, will receive up to a maximum of eight benefit bank weeks for use during the period April 1, 2003 through March 31, 2006.
- Participants who were in the process of using their current benefit bank weeks at the March 31, 2003 expiration date may continue to use those weeks until they are depleted. Upon their return to active employment, these participants shall then receive an additional eight benefit bank weeks for the period April 1, 2003 through March 31, 2006.
- Participants who are not actively employed and who have already exhausted their benefit bank weeks at the March 31, 2003 expiration date, upon their return to active employment shall receive up to a maximum of eight benefit bank weeks for the period April 1, 2003 through March 31, 2006.

Post Treatment Return to Work After Testing Positive for Alcohol/Drug Termination

For the defined period of April 1, 2003 through March 31, 2006, active participants subject to contractual work place alcohol and drug testing who are terminated due to testing positive for alcohol or drugs shall be eligible for retroactive use of available benefit bank weeks upon meeting the following conditions:

- Completion of an approved course of evaluation/rehabilitation by the Fund's Behavioral Healthcare Program;
- Documentation is submitted from the evaluation/rehabilitation facility that the treatment has been satisfactorily completed and/or the member is capable of returning to work;
- Return to active employment with employer contributions made on his/her behalf.

Disputed/Grieved Termination

Under the Fund's rules, benefit bank weeks are forfeited in the event of voluntary or involuntary termination of employment. However, the Fund will allow an exception to this rule if the termination is formally grieved. Upon receipt of written verification from the local union, which must include a copy of the formal grievance, the Fund will apply available benefit bank weeks retroactive to the last coverage date.