Michigan Conference of Teamsters Welfare Fund

# Messenger

Fall

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FALL 2005

**This issue contains descriptions of important changes to your medical networks and plan of benefits.**

## Message from MCTWF's Executive Director

Dear Teamster Families,

On January 17, 2006, a fundamental change will occur that will affect many of you covered by the Michigan Conference of Teamsters Welfare Fund. The Fund will replace the PPOM physician network with the Blue Cross Blue Shield (BCBS) PPO Network, a vast nationwide network of individual BCBS plan PPOs, including, of course, Blue Cross Blue Shield of Michigan's (BCBSM) Blue Preferred PPO, the largest preferred provider organization in the State, with roughly 25% more Michigan physicians than has PPOM. Not only will this change provide enhanced physician access within Michigan, but it will substantially improve access for most of you who seek services outside of Michigan; a matter of growing significance to the Fund. It will also greatly simplify participation. It will reduce the incidence of services unintentionally obtained from out-of-network providers while in a network facility and eliminate the difficulty of having to know which network affiliation is required for a given service. It will eliminate the confusion experienced by many providers in determining whether to bill BCBS or PPOM and which has resulted, on occasion, in unnecessary claim rejections, participant and provider frustration and improper pursuit of payment from participants.

There are many other good reasons to make this transition, but of course, any change of networks, even to a greatly improved one, will require everyone's attention and may cause inconvenience to some, especially to those whose current PPOM physician is not a BCBS PPO Network provider. Once the transition is completed, however, we believe that almost all will benefit by it.

Despite all the good reasons for change and the fact that over 90% of PPOM physicians currently utilized by Fund participants are BCBS PPO Network providers and over 85% of out-of-network physicians currently utilized by Fund participants are BCBS PPO Network providers, the Fund, until now, has not chosen to change its split network, BCBS/PPOM arrangement. Why not and why now?

PPOM, the second largest preferred provider organization in Michigan, has been a good partner, providing the Fund with an excellent and expanding network of physicians who accept deeply discounted fees, comparable to those of BCBSM and, until the last year or so, has provided reasonable access to all but a relative handful of Fund participants. Further, because PPOM simply "leases" its network to group health plans, it afforded the Fund complete control over benefits administration, whereas BCBSM, which will not lease its networks, has steadfastly insisted that as a condition of the use of its networks, the Fund must cede to it the processing of claims from network providers. Apart from the administration of hospital based claims, which, in our opinion, BCBSM handles better than anyone else in Michigan, the Fund has always believed that its participants are best served through the Fund's direct administration of their benefit plans, which not only permits flexibility and responsiveness, but ensures the care, focus, and individual attention that neither BCBSM nor any other insurance carrier or third party claims administrator ever could provide.

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But what has changed, in addition to a growing non-Michigan participant population with unsatisfactory physician network access, was advice from BCBSM that the Blue's national association would no longer accommodate the Fund's split network arrangement and, therefore, the Fund soon would be prohibited from continuing its access to non-Michigan Blue Cross hospital discounts. Since loss of such access would have been financially injurious both to the Fund and to participants and with time and viable alternatives limited, we entered into intensive negotiations with BCBSM. Our key goals were to gain full, low priced access to the BCBS national PPO network and to maintain our prominence in professional services claim processing with full responsibility for participant services and communications. With the invaluable support of Joint Council #43 Legislative and Community Affairs Director, Bill Black and the praiseworthy efforts of many BCBSM staff including senior management, we have succeeded in satisfying those goals through development of a unique arrangement which capitalizes on the strengths of both organizations.

Certain changes to the Fund's benefit plan designs, as detailed in this *Messenger*, are required for access to the BCBS PPO Network and to facilitate the arrangement, while others have been deemed by the Fund's Trustees to be appropriate to make in conjunction with them. I urge you to familiarize yourself with these changes. If you require clarification, or need help in determining your doctor's network affiliation, or in addressing any other transition issue, please contact the Fund's Customer Service Department. Our excellent staff of Customer Service representatives is ready to help you. You will receive your new BCBS PPO Network provider directory, Blue Cross ID card and MCTWF Networks Card by the first week of January for use effective January 17th. Thank you for your attention and patience with this transition.

The Fund's Trustees, staff and I send our best wishes to you for a happy holiday season.

Richard Burker

## Introducing
## The Blue Cross Blue Shield PPO Network

The Michigan Conference of Teamsters Welfare Fund (MCTWF) is pleased to announce that effective January 17, 2006, the Blue Cross Blue Shield PPO nationwide provider network (BCBS PPO Network) will become the medical network for <u>all</u> MCTWF medical plans, both active and retiree, replacing the PPOM Network. MultiPlan will remain MCTWF's complementary network.

Virtually all BCBS plans maintain a "Traditional" network, as well as a "PPO" network, in which most Traditional providers also participate. To receive MCTWF "in-network" level medical benefits, you must use a BCBS PPO Network provider, unless you qualify for a "non-access" exemption (we're happy to note that the Non-Access Rule has been expanded to include specialists; please see page 7 of this *Messenger*), or unless you use a provider to whom you're referred by a BCBS PPO provider (please see page 4 hereof); otherwise, your benefits will be subject to "out-of-network" limitations. This includes your use of BCBS Traditional Network and MultiPlan Network providers, although because those providers' allowable charges are fixed by contract, you will have no balance billing exposure.

The first thing to do is to contact your current primary care physician and specialists and ask whether they participate in the Blue Cross Blue Shield PPO Network. If they do not, you may continue to use them and be covered at out-of-network benefit levels as discussed above, or you may refer to (1) your BCBS PPO Network provider directory (which you will receive by the first week in January), (2) MCTWF's website for linkage to the appropriate BCBS website (please see page 4 hereof), or (3) call MCTWF's Customer Service Department for BCBS PPO Network providers near you (24/7 provider referral phone numbers will be provided on your Fund Networks Card and Blue Cross ID card, which you'll receive, separately, by the first week in January).

Call for referrals, as well, when you are traveling. However, it is wise always to check with your doctor that he or she is still participating in the network, before you receive services.

Also available to you is BlueCard Worldwide, which gives you access to medical care when you are outside of the United States. For non-emergency inpatient medical care, you must call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week. By making arrangements through the Service Center your medical services will be covered at in-network benefit levels. If you need emergency medical care, you may seek reimbursement by completing an International Claim Form and sending it to the BlueCard Worldwide Service Center for emergency level benefits. The Claim Form is available by contacting MCTWF's Customer Services Department or from MCTWF's website at www.mctwf.org and clicking on the Forms page.

The below listed provider categories do not participate in the BCBS PPO Network, but do participate in the BCBS Traditional Network. Services obtained from BCBS Traditional Network providers in these categories will be covered at in-network benefits levels:

- Ambulance providers
- Ambulatory surgical centers
- Certified nurse anesthetists
- Certified nurse midwives
- Certified nurse practitioners
- Durable medical equipment suppliers
- ESRD facilities
- Hearing aids suppliers
- Home health care providers
- Hospice providers
- Independent licensed physical therapists
- Private duty nursing providers
- Prosthetic and orthotic suppliers

ValueOptions will continue to serve you as MCTWF's provider network for mental health and substance abuse services. Please remember; these services must be prior authorized by calling ValueOptions at 1-800-457-8540.

## *Which identification card should I present ?*

To ensure your full coverage, please present your new MCTWF Networks Card and your new Blue Cross ID card when receiving medical services. The cards will evidence your coverage, including restrictions, and provide billing instructions. Only your new Blue Cross ID card is necessary to receive services at participating pharmacies and hospitals.

You will receive these two new cards separately by the first week in January. The new cards will no longer reflect the participant's social security number. Instead, a personal contract number has been assigned for privacy protection.

## *How do I locate a BCBS PPO Network provider?*

By the first week in January 2006, you will receive a new provider directory specific to the area in which you reside. You may also link to the appropriate BCBS website for the most up-to-date information on providers participating in the BCBS PPO Network through MCTWF's website at www.mctwf.org on the "Provider Networks" page.

**For Michigan Physician Search -** Click on the BCBSM logo and locate "Find a Participating Provider". Click on "physician search". In Step 1, under the "Choose a plan" drop down menu, select "Community Blue/Blue Preferred PPO" (starting in mid December 2005, the same network will be available under the title "MCTWF PPO"), then complete Step 2 and search.

**For Michigan Hospital and Facilities Search -** Click on the BCBSM logo and locate "Find a Participating Provider". Click "hospital and facilities search" and select the "Facility type" you are searching for, then select "Community Blue/Blue Preferred PPO" in the "Plan type" section and complete the remaining search criteria.

**For Non-Michigan Provider Search -** Click on the Blue Cross Blue Shield Association logo, click on "Member", enter TMI as your "Identification Prefix" and complete the remaining search criteria.

You may also contact MCTWF's Customer Service Department for assistance in locating a provider. If you need to locate a BCBS PPO Network provider by phone after business hours, call 800-810-BLUE (2583). We encourage you to determine at your earliest convenience whether your provider participates in the BCBS PPO Network so that you have sufficient time to choose another provider; if you wish, that is, to have coverage at in-network benefit levels.

If you are traveling, contact MCTWF's Customer Service Department at 313-964-2400 or 800-572-7687 for a referral to the nearest BCBS PPO Network provider. For BCBS PPO Network provider referrals after business hours, call 800-810-BLUE and, when you have no access to BCBS PPO Network providers, call 800-672-2140 for a MultiPlan Network provider referral.

## *If I am in treatment for a condition on January 17, 2006 and my doctor or other professional service provider is not in the BCBS PPO Network, can I continue treatment without additional out-of-pocket expense?*

The **Transitional Care Program,** which applies to all Plans, permits those being treated by a non-BCBS PPO Network provider for the following listed conditions at the time of the BCBS PPO Network implementation, to continue receiving treatment at in-network benefit levels and therefore incur no additional out-of-pocket costs (other than for non-BCBS Traditional Network or non-MultiPlan Network charges in excess of MCTWF's maximum allowable benefit schedule). First, confirm that your provider does not participate in the BCBS PPO Network. Then, submit to MCTWF a Transitional Care Form filled out by your physician. Submission must be made in no more than 45 days following the January 17, 2006 effective date of MCTWF's transition to the BCBS PPO Network. This form is available by contacting MCTWF's Customer Service Department or from MCTWF's website at www.mctwf.org on the "Forms" page. Upon approval by MCTWF, the conditions and length of time covered are as follows:

- **Pregnancy** – Up to 6 weeks after delivery.
- **Dialysis** – Up to 3 months from January 17, 2006
- **Chemotherapy and Radiation Therapy** - Up to 3 months from January 17, 2006.
- **Inpatient Care** – For the entire admission, including the usual surgical postoperative care plus one follow-up medical visit following discharge.
- **Neonatal Care** - For the entire admission plus one follow-up visit following discharge.
- **Neonatal Intensive Care** - For the entire admission, plus the usual post hospital care and follow-up visits.
- **Terminal Care** - For up to 6 months from January 17, 2006. Exception requests to extend the 6 month period will be considered.

## *What if my doctor refers me to a provider outside the BCBS PPO Network?*

The BCBS PPO Network is designed to meet all plan participants' health care needs, including care by specialists. However, in the event a particular service or specialty is not available in the BCBS PPO Network, your BCBS PPO Network doctor may decide to refer you outside the BCBS PPO Network. Your doctor must complete a referral form and the non-BCBS PPO Network provider must submit the referral with the claim to ensure coverage at in-network benefits levels. If the provider does not participate in the BCBS Traditional Network or MultiPlan Network, you will be subject to balance billing for charges in excess of MCTWF's maximum allowable benefit schedule.

## *How are my claims processed within the new BCBS PPO Network?*

When you go to a provider for services, you will present your new MCTWF Networks Card and new Blue Cross identification card. These cards explain to providers how to bill for services. All medical service providers, BCBS PPO Network or non-BCBS PPO Network, must bill the local BCBS Plan. The claim is then processed and paid as appropriate. You will receive an Explanation of Benefits from MCTWF stating amounts paid and any remaining financial responsibility you may have, along with an explanation of how the claim was processed.

If a non-network physician does not accept an assignment of your benefits and you pay directly for services, please send the paid receipt and itemized bill to MCTWF for appropriate reimbursement.

## *What benefit changes will occur in connection with the transition to the BCBS PPO Network?*

Upon the January 17, 2006 implementation of MCTWF's transition to the BCBS PPO Network, the following changes will be made to MCTWF's plans of benefits:

- **Usage of Non-BCBS PPO Network Providers -** Except where BCBS Traditional Network providers are used upon referral (please see page 4 of this *Messenger*), or because the services are not provided by the BCBS PPO Network (please see page 6 hereof), or except in the case of mental health and substance abuse services, use of the non-BCBS PPO Network provider will be subject to the following coinsurance sanctions:

  - **SOA, TIF, I&S and PEP Plans –** All Basic Benefit services from non-BCBS PPO Network providers will be subject to a 10% coinsurance charge (except for those hospital based services over which the patient has no control, non-BCBS PPO Network physician visits and chiropractic care - please see below; also mental health and substance abuse services - please see page 3 hereof) up to an annual out-of-pocket maximum of $2,000 per family. Basic Benefits do not include Extended Benefits (please see page 6 hereof) and Additional Services and Supplies.

    Also, subject to the relevant exceptions noted above, I&S plan participants will be subject to an additional 10% coinsurance charge (for a total of 30%) on charges from non-BCBS PPO Network providers for services covered under the Extended Benefits category.

  - **Key I and Key II Plans -** Except as noted below with respect to chiropractic care, there will be no additional coinsurance charges. There also will be no change to the current annual out-of-pocket maximums.

  - **Retiree Medical Program -** The current coinsurance charge of 20% will be reduced to 15% for all BCBS PPO Network services up to an annual out-of-pocket maximum of $1,000 per person. The coinsurance charge will be increased to 25% for non-BCBS PPO Network services up to an annual out-of-pocket maximum of $2,000 per person.

- **Prior Authorizations Required - All Plans -** Prior to obtaining the following services, patients must verify that their provider has received prior authorization from MCTWF, or the claim will be rejected. If services are performed, but not prior authorized, the patient will be responsible for full payment of charges. Those services are:

  - Blepharoplasty and Ptosis Repair; Upper Lid
  - Breast Reduction
  - Breast Reconstruction
  - Durable Medical Equipment – Purchase
  - Growth Hormone Stimulation
  - Home Health Care
  - Hospice
  - PET Scans

- **Hospital Services from Non-BCBS PPO Providers - All Plans -** Certain inpatient and outpatient hospital services are covered at in-network benefit levels, despite the provider's non participation in the BCBS PPO Network. These services are characterized by the fact that the patient has little or no control over which provider performs the service, as follows:

  - Ambulance
  - Anesthesiology
  - Radiation Therapy
  - Radiology
  - Laboratory
  - Pathology
  - Emergency Room Physician
  - Nuclear Medicine

  If the provider does not participate in the BCBS Traditional Network or MultiPlan Network, the participant will be subject to balance billing for charges in excess of MCTWF's maximum allowable benefit schedule.

- **Non-BCBS PPO Network Physician Visits -** For the SOA, TIF, I&S and PEP Plans, non-BCBS PPO Network physician visits and consultations will be subject to a 40% coinsurance charge and will be covered as a Basic Benefit. The coinsurance charges are limited by the annual out-of-pocket maximum of $2,000 per family. Previously, this benefit was covered under Extended Benefits, subject to an annual deductible, coinsurance charges and a lifetime benefit maximum.

- **Chiropractic Care - All Plans –** Services provided by non-BCBS PPO Network chiropractic providers will be subject to an additional 10% coinsurance charge (for a total of 30%) . Chiropractic care coinsurance charges are not limited by annual out-of-pocket maximums.

- **Wellness Benefit/Non-BCBS PPO Network Providers - All Plans -** Wellness Benefit services rendered by non-BCBS PPO Network providers, will be subject to the same out-of-network benefit level as when the service is received as a matter of medical necessity. So, for example, under the SOA Plan, use of a non-BCBS PPO Network physician for a wellness exam, will be subject to the same 40% coinsurance charge required when using that physician to treat an illness or injury.

- **Radiology Management Program - All Plans –** This Program will replace MCTWF's In-Office Diagnostic Testing Restriction rules. It is a utilization management program administered by BCBSM in partnership with American Imaging Management (AIM), for outpatient diagnostic radiology services and applies only to services rendered in an office or freestanding center in Michigan. BCBS PPO Network providers in Michigan (Blue Preferred PPO providers) are aware of the procedures to follow. Under this Program, the provider must follow guidelines set by the Program in addition to contacting AIM for pre-certification of non-emergent outpatient CT scans and MRIs before services can be rendered. If the provider does not follow Program guidelines, the patient is not held responsible.

- **Durable Medical Equipment and Medical Supplies –** For the SOA, TIF, I&S and PEP Plans all durable medical equipment and all medical supplies will be covered under the Extended Benefits (previously known as Major Medical benefits) category.

- **Lifetime Overall Medical Benefit Maximum -** All active plans will have a 2 million dollar ($2,000,000) lifetime medical benefits maximum per person (including prescription drugs). It also includes Extended Benefits and Additional Services and Supplies, which will still be subject to applicable lifetime and annual maximums and applicable annual restoration limits. The lifetime benefit maximum under the Key I and Key II Plans thus will be increased from $1,000,000 to $2,000,000 per person.

All active plans will share the $2,000,000 lifetime benefit maximum. For current participants of the SOA, TIF, I&S and PEP Plans, accumulation toward this lifetime benefit maximum will commence with medical services received after January 16, 2006. For current participants of Key I and Key II Plans, prior and post transition date accumulations will be counted toward the new lifetime benefits maximum and will follow those participants if they participate in any other active plan. For current participants of SOA, TIF, I&S and PEP Plans, post January 16, 2006 accumulations will follow those participants if they participate in any other active plan.

- **Annual Deductibles and Benefit Maximum Carryovers -** Currently, if a group bargains out of one MCTWF plan into another, or if a participant changes employers and consequently changes plans, MCTWF does not credit the new plan's annual deductibles with those fully or partially satisfied in the old plan. MCTWF also does not charge the new plan with accumulated expenses against maximum annual benefits, or credit the new plan with accumulated expenses against out-of-pocket expense maximums. Effective with the January 17, 2006 BCBS PPO Network transition, all such accumulations will be credited or charged, as appropriate, to participation in the new plan. For example, Key I participant Mr. X commences participation in Key II on April 1, 2006, having satisfied his $100 in-network Key I deductible, having received $200 in chiropractic care benefits and having incurred $400 in out-of-pocket coinsurance charges. As a participant in Key II, Mr. X will have fully satisfied Key II's $100 annual in-network deductible, will have $800 remaining of Key II's $1,000 annual chiropractic benefit and will have satisfied $400 of Key II's $1,500 annual out-of-pocket expense maximum.

- **Claims Filing Deadline – All Plans -** Currently, a claim must be filed within one year from the date the service was received. Effective with the implementation of the BCBS PPO Network, the claim filing limitation is extended to 15 months from the date the service was received.

- **Non-Access Rule -** MCTWF's current Non-Access Rule has been expanded from primary care physicians only, to include specialists when a BCBS PPO Network specialist is not available within 50 miles of the participant's residence. Non-access forms are available on MCTWF's website at www.mctwf.org or through the Customer Service Department.

**Please carefully review these changes. MCTWF's Customer Service Department can assist you with any questions you may have concerning these benefit changes and regarding provider network affiliation.**

We're on the Web!!
www.mctwf.org

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**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.**


MICHIGAN CONFERENCE OF
TEAMSTERS WELFARE FUND

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## MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND



### Major Medical Benefits (now, "Extended Benefits") Lifetime Maximum Increase

**Effective January 1, 2006** the SOA, I&S and PEP Plans, the Major Medical Benefits category lifetime maximum, which is currently $250,000 per person (with annual restoration of up to $5,000), will be increased to $500,000. The SOA Plan Major Medical Rider that currently increases the benefit to $500,000 will then increase the benefit to $1,000,000.

In addition, the Major Medical Benefits category has been renamed the Extended Benefits category (and the Rider has been renamed the Extended Benefits Rider).

### Auto Related Injury/Illness Exclusion Motorcycle Accidents Involving an Automobile

This will clarify that while treatment for injury or illness resulting from a motorcycle accident involving an automobile falls under the auto related injury/illness exclusion and therefore is not generally covered for benefits under MCTWF's benefit plans, a motorcycle accident not involving an automobile does not fall under the exclusion. In such event a resulting injury or illness generally is covered for benefits. Please refer to your Fall 2003 *Messenger* for a complete statement of the exclusion.



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