Michigan Conference of Teamsters Welfare Fund

Fall Messenger

VOLUME 24, ISSUE 4

FALL 2006

Message from the Fund's Executive Director

Most of us will soon be immersed in the magic of the holidays and then puffed up with visions of self-transformation in the new year. In this season of grand illusions though, few of us entertain any about our future ability to compete globally while shouldering the immense burden of the world's most costly and inefficient health care system. Perhaps even fewer people envision Congress exhibiting the political will to enact the reform legislation for which America is desperate. So although the breadth and depth of the U.S. health care system's dysfunction demands a unified, national solution, increasing numbers of state and local governments, as well as private insurers and healthcare providers acting in their "enlightened" self interests, have become active in addressing related issues that they can control .

With regard to public initiatives, for instance, in addition to Massachusetts' recent enactment of a universal health care mandate, several states are seeking to leverage Medicaid dollars to expand health insurance coverage to their poor, uninsured populations, such as Michigan to help fund its "Michigan First Health Care Plan" initiative, which is designed to provide no cost or low cost access to bare bones, private health insurance for about half of the state's uninsureds, subject to approval of the necessary Medicaid waiver. Local smoking bans are being legislated all over the country. New York City has just approved a ban on the use by restaurants of trans fats in their food preparation. Local governments are implementing innovative plans for their own employees designed to manage chronic multiple disease states through community based collaborations of health care physicians, hospitals and specially trained pharmacists. A primary example of this is the highly successful Asheville [NC] Project, which was designed to address diabetes, and has been replicated throughout the country, both publicly and privately, to address other chronic conditions as well. Public school boards are focusing on combating childhood obesity both through education and control over what is sold in the lunch room and in the vending machines. Public initiatives abound.

Inside this issue:

With regard to private health care initiatives, Blue Cross Blue Shield of Michigan provides a good example of an insurer engaging in "value partnerships" with providers to identify and implement best practices and thereby improve quality of care and resultant outcomes. BCBSM is presently partnering with physicians and hospitals on five wide reaching "collaborative quality initiatives" - cardiac angioplasty (this was its first such initiative and it has proved valuable; the consortium of participating hospitals has experienced large decreases in emergency bypass surgeries, heart attacks, kidney failures and deaths and substantial reductions in costs associated with angioplasty complications), thoracic and cardiac surgery, bariatric surgery, breast oncology, and reduction of surgery related infections, illnesses and deaths. BCBSM also sponsors physician programs designed to improve the management of chronic disease and reduce pharmaceutical costs, as well as hospital programs to improve quality and cost efficiency. Programs addressing other aspects of our malfunctioning health care system are being developed all over the country. Just yesterday (December 6th), it was announced that five huge American companies are collaborating on the development of a web based framework to host, for their lifetime, the personal health records of employees, dependents and retirees, with the goal of facilitating health management and data sharing among their providers. However, these worthwhile public and private efforts will never adequately substitute for a unified, nationwide, social insurance model system that equitably provides health insurance for all, uniform best practice standards of health care delivery, transparency on hospital and physician outcomes, appropriate regulation of "Big Pharma", universally accessible electronic medical records, and other related reforms.

In the midst of this patchwork of independent efforts at improvement around the fringes of the system, MCTWF remains ever mindful of its mission to provide you with affordable, accessible, and high quality health care. We are always seeking to take advantage of new and better approaches, as we have, for instance, by partnering with Blue Cross Blue Shield of Michigan. And we certainly recognize the burden, whether direct or indirect, that health and welfare contribution rates have on you and your employers and understand that in the long term, your good health has a far greater impact on reducing MCTWF's benefit expenses and contribution rates than do your deductible and coinsurance payments. So one of our most important goals for the coming year is to improve markedly our outreach to you - to help you maintain and improve your health through better use of MCTWF's Wellness Program; to provide you, where feasible, with health fairs offering biometric screenings, electronic health risk assessments and follow up lifestyle management and healthy living programs; to urge you to more freely access the nurse advice line; and to provide you with enhanced web tools for support and education, and more widely reaching chronic and specialty condition management. We hope that you will work with us.

On behalf of MCTWF's Trustees and staff, I wish you and your family a very happy holiday season.

Richard Burker

Summary Annual Report for Participants

Michigan Conference of Teamsters Welfare Fund

Plan Year Ended March 31, 2006

This is a summary of the annual report of Michigan Conference of Teamsters Welfare Fund (hereafter the Plan), EIN 38-1328578 for the plan year ended March 31, 2006. The annual report has been filed with the Employee Benefits Security Administration of the U.S. Department of Labor as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan provides health, dental, optical, prescription drug, short and long term disability, and death benefits for its participants.

BASIC FINANCIAL STATEMENT

The value of Plan assets, after subtracting liabilities of the Plan, was $193,969,757 as of March 31, 2006 compared to $182,199,968 as of April 1, 2005. During the plan year, the Plan's net assets increased by $11,769,789. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the Plan had total income of $208,305,386 including, but not limited to, employer contributions of $182,514,354, participant contributions of $8,634,053, earnings from investments of $15,057,138, rental income of $12,957 and other income of $2,086,884.

Plan expenses were $196,535,597. These expenses included $185,692,415 in benefits paid on behalf of participants and beneficiaries, and $17,175 in premiums paid to insurance carriers for the provision of benefits, as reflected below, and $10,826,007 in administrative expenses.

Insurance Information - The Plan purchased policies from Prudential Insurance and Hartford Insurance for payment of long-term disability claims incurred by salaried staff of the Plan under the terms of the Plan. The total premium paid for these policies for plan year ended March 31, 2006 was $17,175.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full, annual report, or any part thereof, on request. The items below are included in that report:

- an accountant's report
- Financial information and information on payments to service providers
- assets held for investment
- transactions in excess of five percent of plan assets
- insurance information, including sales commissions paid by insurance carriers
- information regarding any common or collective trusts, pooled separate accounts, master trusts, or 103-12 investment entities in which the plan participates

TO OBTAIN ADDITIONAL INFORMATION

To obtain a copy of the full annual report, or any part thereof, your request should be addressed to: Executive Director, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, Michigan, 48216-1269. The charge to cover copying costs will be $.15 per page. You also have the right to receive, at no charge, the annual report's statement of assets and liabilities and accompanying notes, or a statement of income and expenses and accompanying notes, or both. If you request a copy of the full annual report, these two statements and accompanying notes will be included, at no cost, as part of that report.

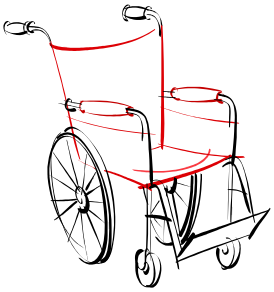
You also have the legally protected right to examine the annual report at the offices of the Michigan Conference of Teamsters Welfare Fund in Detroit, Michigan and at the U.S. Department of Labor in Washington D.C. To obtain a copy from the U.S. Department of Labor, your request should be addressed to:

Public Disclosure Room N 1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Durable Medical Equipment and Medical Supplies

Most types of Durable Medical Equipment (DME) and the medical supplies necessary to utilize them are covered under your plan of benefits. The following information is being provided to help you determine what is covered under these categories:

Durable Medical Equipment



Durable medical equipment is defined as equipment that can withstand repeated use and is primarily used to serve a medical condition. DME may be rented or purchased (rental or purchase is determined by the length of time and/or type of equipment prescribed) and includes basic equipment and medically necessary special features and accessories. All DME rentals and purchases must be prescribed and certified as medically necessary by a licensed physician, and obtained from a provider whom Blue Cross Blue Shield (BCBS) has certified as a DME supplier. The following types of equipment are not considered DME under this definition and therefore are examples of non-covered items: comfort or convenience items, exercise and hygienic equipment, physician's equipment, self help devices, spare equipment and disposable equipment.

Remember, all purchases of DME basic equipment, special features and accessories must be prior authorized through MCTWF.

Medical Supplies

Medical supplies are defined as items that are generally disposable, nondurable and medically necessary. All medical supplies must be prescribed and certified as medically necessary by a licensed physician, and obtained from a provider whom BCBS has certified as a medical supplies provider. Comfort and convenience items are not considered medical supplies under this definition and therefore are not covered.

There are limits to the quantity of certain covered medical supplies, the most common of which are -

- Jobst, surgical or support stockings - 12 pair per calendar year.
- Test strips and lancets *
  - Type I diabetics, 200 each; every 25 days.
  - Type II diabetics, 100 each; every 25 days.

To find out whether a specific DME or medical supply item is a covered item, or to determine whether a provider is a BCBS certified supplier, you may contact the MCTWF Customer Service Department or access the Summary Plan Description page of the MCTWF website at www.mctwf.org for a current list. While the list does not contain quantity limits, all BCBS certified suppliers are aware of these restrictions.

* Diabetic supplies may also be purchased at a retail pharmacy. You are entitled to reimbursement at MCTWF's maximum allowable benefit rate.

Dental Benefit Time Limits

MCTWF's dental benefits include certain frequency limits based on what is considered by the dental community to be appropriate treatment for children and adults. In addition to the dental limits described in your Summary Plan Description, the following limits apply:

- Periodontal scaling/root planing is limited to once in any consecutive 24-month period;
- Amalgam/resin restoration is limited to once in any consecutive 24-month period; and
- Periodontal surgery, including subgingival curettage, is limited to once in any consecutive 36-month period.

Expansion of Dental Benefits

Effective January 1, 2007, MCTWF's dental benefit plans administered by Delta Dental will include expanded preventive services for covered individuals with certain high risk medical conditions, as follows:

- For diabetics with periodontal disease, pregnant women with periodontal disease, individuals with kidney failure or who are undergoing dialysis, those with suppressed immune systems due to chemo or radiation therapy, those with HIV, or organ or bone marrow transplants, MCTWF will cover 4 teeth cleanings per calendar year, either routine or periodontal; and
- For those individuals, regardless of age, undergoing head and neck radiation treatment, MCTWF will cover 2 fluoride applications per calendar year .

The Wellness Program

MCTWF's Wellness Program was designed to encourage full and timely compliance with the childhood immunization schedule recommended by the Centers for Disease Control and Prevention and to facilitate the early diagnosis and treatment of medical disorders.

The Wellness Program is available to all medical plan participants and eligible dependents. It provides full coverage, with no out-of-pocket expense, for eligible services obtained from BCBS PPO providers.

The Trustees have clarified the age and frequency parameters of the Program as follows:

Children's Health Program	Birth to 12 yrs.				12 – 18 yrs.			
Well Baby/Child Exam	One exam in conjunction with each of the age recommended immunizations							
Physical Examination	No more than once annually including exams in conjunction with immunizations							
Electrocardiogram (EKG)					Annually			
Adult Health Program	18-26		27 – 39 yrs.		40 – 49 yrs.		50 yrs. and Older	
	Male	Female	Male	Female	Male	Female	Male	Female
Physical Examination	Annually							
Gynecologic Pelvic Examination		Annually		Annually		Annually		Annually
Cervical Cancer Screening (Pap Smear)		Annually		Annually		Annually		Annually
Mammogram				Baseline age 35-40		Annually		Annually
Electrocardiogram (EKG)	Annually							
Bone Density								Once with follow-up every 2 yrs.
Prostate Specific Antigen (PSA) Test					Annually		Annually	
Colonoscopy or Flexible Sigmoidoscopy							Every 5 yrs.	Every 5 yrs.
Stool Occult Blood Test							Annually	Annually
Human Papillomavirus Immunization * (if not received between ages 9-18)		One series						

School Accreditation

MCTWF plan coverage is available for your unmarried natural, step, or adopted child, age 19 through the end of the month in which the 24th birthday falls, provided that the child is enrolled in a degree or certification program offered by an accredited academic institution or an accredited vocational school and who:

- is a full-time student (as documented by a Full-Time Student Eligibility Verification form submitted for each school grading period); or
- was covered as a full-time student (as documented by a Full-Time Student Eligibility Verification form) on the date of graduation from high school and who demonstrates (through a letter from an accredited academic institution or an accredited vocational school) acceptance for enrollment for the subsequent school term as a full-time student.

The Trustees have modified the accreditation requirement by granting coverage for children enrolled in a non-accredited facility if that facility provides written documentation from a minimum of three accredited institutions that its credits and/or degrees are accepted by them. The participant bears the responsibility of obtaining and providing this documentation to MCTWF.

Revised Medical Criteria

On January 17, 2006 MCTWF transitioned to the Blue Cross Blue Shield (BCBS) PPO Network. As was described in the Fall 2005 issue of the *Messenger*, certain changes to MCTWF's benefit designs were required to conform with Blue Cross Blue Shield of Michigan's medical policy, while others were deemed by the Trustees to be appropriate to make in conjunction with the required changes. The following information is provided to fully and clearly identify these changes for covered individuals. Please be aware that the medical criteria required by BCBS in states other than Michigan is sometimes different than that required in Michigan. Unless otherwise noted, for services provided outside of Michigan by a BCBS participating provider, the medical criteria employed by the local BCBS plan will control.

Bariatric Surgery – This benefit is available, subject to plan limits, for those between the ages of 18 and 60 with a diagnosis of morbid obesity and who meet the following criteria:

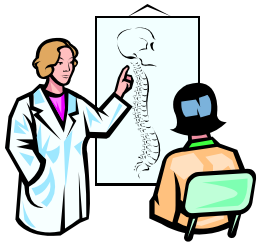
- Have a body mass index of 40 or greater;
- Have obtained a medical examination with an evaluation of any co-morbidities;
- Have obtained a surgical evaluation to determine operability and surgical risk; and
- Have obtained a psychological evaluation that documents the patient's understanding of the procedure and the lifelong dietary and lifestyle modifications required.

Please be reminded 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 MCTWF's plans.

Cardiac Rehabilitation
This benefit is available, subject to plan limits, for a maximum of 36 treatments (3 cardiac sessions per week for up to 12 weeks) and may be provided by the outpatient department of a hospital or in a physician's office. Coverage is subject to the following criteria:

- The facility meets the definition of a hospital outpatient department or a physician-directed clinic;
- The facility has available for immediate use all the necessary cardiopulmonary emergency diagnostic and therapeutic life saving equipment accepted by the medical community as medically necessary, e.g., oxygen, CPR equipment or defibrillator;
- The program is conducted in an area set aside for the exclusive use of the program while it is in session;
- Phase 2 Cardiac Rehab services (where rehab from losses that occurred prior to or during hospitalization are corrected) are for one of the following cardiac conditions:
  - Acute myocardial infarction;
  - Coronary artery bypass;
  - Chronic stable angina pectoris;
  - Percutaneous transluminal coronary angioplasty;
  - Heart valve surgery;
  - Heart transplant; or
  - Class III or IV congestive heart failure unresponsive to medical therapy;
- The patient must have a clear medical need for the services prescribed by the attending physician; and
- The program must begin within 90 days of a cardiac event and be completed within 6 months.

Chiropractic Services – The following chiropractic service diagnoses are recognized as treatable and therefore are covered, subject to plan limits, <u>regardless of the location in which services are provided:</u>



- Nonallopathic lesions -
  - Cervical region;
  - Head region;
  - Lumbar region;
  - Sacral region; and
  - Thoracic region.
- Other, multiple, and ill-defined dislocations -
  - First through the seventh cervical vertebra;
  - Multiple cervical vertebrae; and
  - Thoracic, lumbar, coccyx and sacrum vertebra, closed (i.e. non-exposed).

Continued on page 6

Intra-articular Injections of the Knee with Hyaluronic Acid; Synvisc (Hylan G-F20) and Hyalgan (Sodium Hyaluronate) – Intra-articular injections are covered, subject to plan limits, for the following conditions/diagnoses:

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

Covered individuals with osteoarthritis of the knee or TMJ who have insufficient pain relief from conservative non-pharmacological therapy (e.g. physical therapy) and simple analgesics, and have failed conservative therapy with non-steroid anti-inflammatory drugs (NSAID), or who have contraindications to NSAID therapy, are eligible for a single course of 3-5 weekly injections .

Midwife Services – Certified Nurse Midwife services are covered, subject to plan limits, for the following procedures:

- Normal vaginal delivery when provided in an inpatient hospital setting or a birthing center which is hospital affiliated, state licensed and accredited as defined and approved by BCBS;
- Pre-natal care; and
- Post-natal care, including a PAP smear.

Sclerotherapy - Sclerotherapy services are covered, subject to plan limits, and are limited to one injection per day, up to a maximum of 10 injections per calendar year.

Sleep Studies - Sleep studies are covered, subject to plan limits, for the following diagnoses :

- Transient difficulty in initiating or maintaining sleep;
- Somnambulism or night terrors;
- Other dysfunctions of sleep stages or arousal from sleep;
- Cataplexy and narcolepsy; and
- Sleep disturbances.

Benefit Clarifications

Infusion Therapy , IV Therapy and Dialysis

Infusion therapy involves the administration of medicines and fluids through a catheter into your bloodstream and is most commonly used for a course of prescribed drugs including antibiotics, chemotherapy drugs, pain medicines and nutrients, while **Intravenous (IV) Therapy** involves the administration of one dose of prescribed drugs.

Dialysis is a method of removing toxic substances (impurities or wastes) from the blood when the kidneys are unable to do so, and is most frequently used for patients who have kidney failure.

Infusion therapy, IV therapy and dialysis are covered, without distinction, under the Key and Retiree Medical Plans for both inpatient and outpatient services. However, under the SOA, TIF, TIF2, I&S and PEP Plans these services are covered as "basic benefits" when provided in the inpatient setting and as "extended benefits" when provided in the outpatient setting.

Non-Sedating Antihistamines & Proton Pump Inhibitors

MCTWF excludes coverage under its prescription drug program for all non-sedating antihistamines and all proton pump inhibitors unless your physician obtains prior authorization by satisfying MCTWF's medical necessity criteria. If authorization is granted, any prescription non-sedating antihistamine or proton pump inhibitor prescription filled up to four days prior to the post, fax or email date of the request for prior authorization is eligible for reimbursement in an amount not to exceed that which MCTWF would have paid for filling the prescription. Requests for prior authorization must be sent in writing addressed to "MCTWF Utilization Review Coordinator."

Adult Immunizations

Adult immunizations (those recommended by the Centers for Disease Control and Prevention) administered by an in-network or out-of-network provider are covered by all MCTWF plans with medical coverage. Coverage for services are subject to the applicable Plan provisions and in-network and out-of-network deductibles/coinsurance requirements. Please refer to your schedule of benefits for specifics. Below is a summary of the 2006-2007 age-based recommendations for immunizations. This is the first change to the schedule since it was last published in the Spring 2003 issue of the *Messenger*. For a detailed statement including the CDC's risk based recommendations, please refer online to http://www.cdc.gov/Nip/recs/**adult**-schedule.pdf

Vaccine	19-26 Years	27-49 Years	50-60 Years	61-64 Years	65 Years and Older
Tetanus diphtheria pertussis (Td/Tdap)	**1 dose Td booster every 10 years**				
	Substitute 1 dose of Tdap for Td				
Human papillomavirus	**One series (females only)**				
Measles, Mumps, Rubella (MMR)	**1 or 2 doses**		**1 dose**		
Varicella	**2 doses (0, 4-8 wks**		**2 doses (0, 4-8 wks)**		
Influenza	**1 dose annually**		**1 dose annually**		
Pneumococcal (Polysaccharide)	**1 - 2 doses**				**1 dose**
Hepatitis A	**2 doses (0, 6-12 months or 0, 6-18 months)**				
Hepatitis B	**3 doses (0, 1-2, 4-6 months)**				
Meningococcal (Polysaccharide)	**1 or more doses**				

For persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g. on the basis of medical, occupational, lifestyle, or other indications)

Influenza Immunization

According to the American Lung Association, "the best tool for preventing the flu is the flu vaccine, and the best time to get a flu vaccine is from early October to mid-November. The vaccine can also be given at any point during the flu season, even if the virus has already begun to spread in your community. You need a flu vaccine every year because the virus is constantly changing and new vaccines are developed annually to protect against new strains." [emphasis added] For more in-depth information on the influenza vaccination, you may access a link to the American Lung Associations website at www.flucliniclocator.org/.

Under MCTWF's medical plans of benefits, for children ages 6 months to 18 years, the influenza vaccine is covered in full under the Wellness Program when administered in-network. Coverage for adults, is subject to applicable plan limits.

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

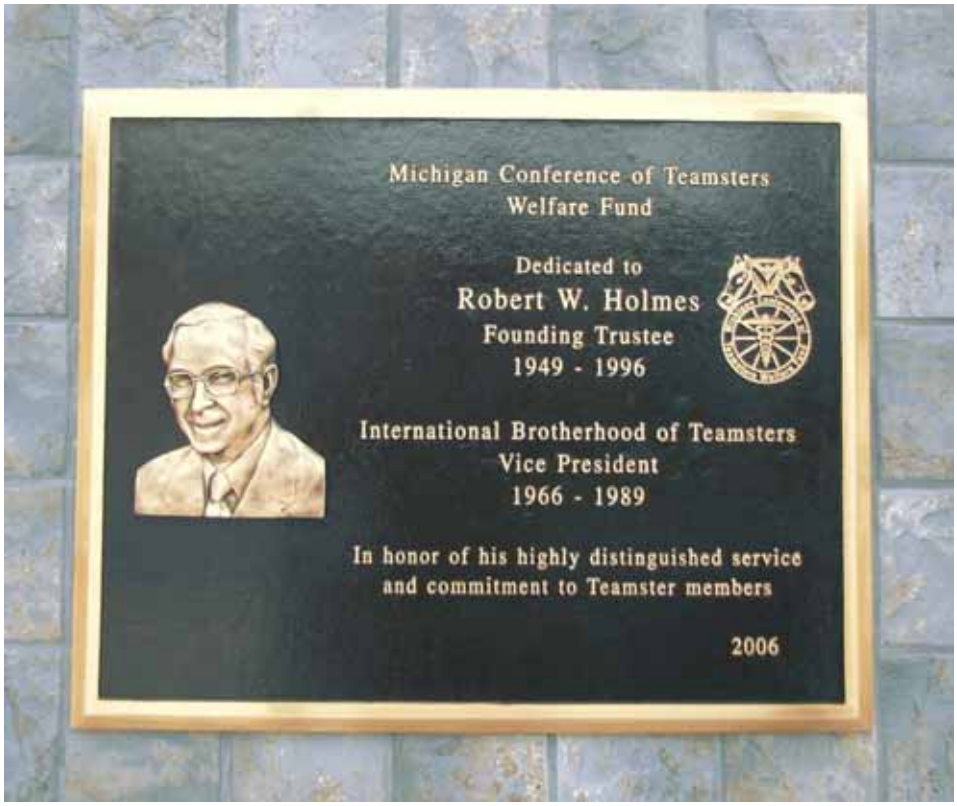
2700 TRUMBULL AVE.
DETROIT, MICHIGAN 48216
313-964-2400

Metro Detroit 1-800-572-7687
Upstate 1-800-824-3158
Out-of-State 1-800-334-9738

MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND

Commemorating Robert Holmes

MCTWF's Trustees commissioned the casting of this bronze plaque, which is now hanging in our atrium, in recognition of founding Trustee, Robert Holmes who served with great distinction from 1949 to 1996.



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