

Michigan Conference of Teamsters Welfare Fund

Fall

Messenger



VOLUME 29, ISSUE 2

FALL 2011

Message from MCTWF's Executive Director

Dear Teamster Families,

I've been feeling pretty uneasy of late. Well, I guess it's been that way for a while now, trying to stay out in front of our endlessly punishing regional economy, as well as the cynical, reactionary politics and legislation that it has spawned, and, certainly, trying to deal with the dramatic changes and uncertainty wrought by the healthcare reform law. But now, longer term prospects are looking bleaker with the recent, dispiriting, loss of steam in America's economic recovery, the virtual paralysis in Washington, and the poisonous, spreading European sovereign debt crisis. We cannot afford to be dismissive or passive about it.

The world has changed; economists say that many of the jobs we have lost are not coming back. To succeed economically we will need to understand the world's changing needs and how best to accommodate them and we will need to understand its challenges and how to surmount them more effectively, more efficiently than anyone else; the market place has no compassion, no conscience. We will need to be alert, pragmatic, and devoted to excellence. We will need capital commitment, legislative and regulatory support, prudent leadership and expert training. And it is essential that the malevolent anti-labor forces in this country who prey on the ignorance and prejudices of their constituents be defanged. Enlightened collective effort is key. I believe that the Teamsters Union, as a vehicle for such effort, can and will play an ever more vital and transformative role in helping to support its members in achieving these ends.

Please review this issue of the *Messenger* thoroughly. In addition to notification of the continued "grandfathered" status of each of the Fund's benefit plans and other important, legally required notices, as well as several reminders, liberalized rule changes, or clarifications, I call your attention to page 4, "Introducing MCTWF's New Vision Network – VSP Choice." Our change of vision networks, which is effective November 1st, was necessitated by Delta Dental's decision to terminate its vision business, but in *VSP Choice* we have a much broader network of eye care professionals and higher discounts for non-covered expenses. Also of significant note on page 3 is "Specified Organ Transplant Program." The Program utilizes the Blue Distinction Centers for Transplant, a Blue Cross Blue Shield network of transplant centers of excellence, each of which has satisfied the most rigorous standards of care for one or more covered transplant procedures. Under this Program, transplant benefit limits are eliminated. Finally, I direct your attention to page 3, "Adult Dependent Children Up to Age 26 - New Open Enrollment." All adult children who, in order to become eligible for MCTWF coverage on or after April 1, 2011, were required to enroll during the January 15 to February 28, 2011 open enrollment period, but failed to do so, will be given a new opportunity to enroll between November 1 and December 15, 2011 to become eligible for coverage on or after January 1, 2012.

We welcome all of our new participants since our last *Messenger* publication, including the following new groups: (under Kalamazoo **Local 7**) MTI Global Services, (under Akron **Local 24**) Franklin Township, (under Cincinnati **Local 100**) Sun Chemical Corporation, (under Jackson **Local 164**) Willbee Concrete Vaults, (under Detroit **Local 214**) MBS International Airport, (under Detroit **Local 337**) Emerald City Films, Hangman Films, McGee Street Productions, Freaky Deaky Film, Peninsula Films, IAC Productions and Stage 6 Films, (under Grand Rapids **Local 406**) Eurest Dining Services, (under Columbus **Local 413**) Southwest Licking Local School District, (under **Local 486** - Escanaba) Houghton Bottling Co., City of Escanaba, and Gwinn Area Community Schools, (under **Local 486** – Saginaw) Geeding Construction and (under Lansing **Local 580**) the Village of Stockbridge.

On behalf of the Trustees and staff, I wish you good health, good luck, and a happy fall season.

Richard Burkner

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"Grandfathered" Status Under The Affordable Care Act

Please be advised that this group health plan, the Michigan Conference of Teamsters Welfare Fund (MCTWF), believes that this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must com-

ply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the MCTWF Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Notice of Creditable Coverage

All MCTWF Plans With Prescription Drug Coverage

The following Notice is published in accordance with regulations promulgated by the Centers for Medicare and Medicaid Services, pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003:

Important Notice from the Michigan Conference of Teamsters Welfare Fund (MCTWF) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with MCTWF and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. MCTWF has determined that the prescription drug coverage offered by the above stated Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, under MCTWF rules you nonetheless may not drop your MCTWF prescription drug coverage. If you have both MCTWF prescription drug coverage and Medicare prescription drug coverage, MCTWF prescription drug coverage will be primary and your Medicare prescription drug plan will be secondary. If you are a COBRA beneficiary you may drop your MCTWF coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug plan. However, you will not be able to get your MCTWF COBRA coverage back later. If you do elect COBRA continuation coverage, your COBRA prescription drug coverage will be secondary to your Medicare prescription drug plan coverage. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current prescription drug plan provides comprehensive coverage for eligible prescription drugs, subject to preauthorization requirements for non-sedating antihistamines, proton pump inhibitors, selective serotonin reuptake inhibitors, anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), oral acne, topical acne (age 26 and above) and oral anti-fungal drugs with both retail and mail order availability, subject to generic and brand copays, as detailed in your Summary Plan Description booklet. Your current coverage pays for other health expenses, in addition to prescription drugs, and you still will be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with MCTWF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...

Contact MCTWF's Customer Communications Department at (313) 964-2400 or (800) 572-7687. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MCTWF changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

September 1, 2011

Michigan Conference of Teamsters Welfare Fund
Customer Communications Department

Specified Organ Transplant Program



Surgical and follow-up coverage for four phases of human organ and tissue transplant services are provided up to a maximum amount dependent upon the organ type. Effective with transplants performed on or after April 1, 2011, transplant services are covered in full through the

Blue Cross Blue Shield of Michigan's Specified Organ Transplant Program (SOTP) and its nationwide network of transplant centers of excellence, the Blue Distinction Centers for Transplant (BDCT). These facilities have demonstrated their commitment to quality care by meeting stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations, resulting in better overall outcomes for transplant patients.

Under the Specified Organ Transplant Program -

- Transplants covered include heart, liver, single or bilateral lung, combination heart and bilateral lung, simultaneous pancreas/kidney (SPK), pancreas and combination liver/kidney and, in the future, small intestine, small intestine/liver and multi-visceral (small bowel and liver with one or more of the following: stomach, pancreas, and/or colon).
- Kidney, cornea, bone marrow and skin transplants are not included; these transplants are covered as medical/surgical expenses, and are subject to the in-network or out-of-network deductible, copayment and/or coinsurance amounts listed in the plan's Schedule of Benefits.

- Covered transplant services must be performed at a designated BDCT facility, a list of which can be obtained from the *Provider Networks* and *Info Links* pages of MCTWF's website.
- Prior authorization for SOTP coverage must be secured by calling 800-242-3504.
- Transplant expenses are covered in full (i.e., no cost sharing, regardless of the plan's deductible, coinsurance, or copayment requirements) for all transplant related care from hospital admission through the 12 month period following the transplant procedure. This includes any copayment requirements for prescription drugs related to the transplant.
- Coverage is provided for transportation and lodging (related to the transplant procedure only) up to a maximum of \$10,000 for the transplant recipient (a) plus one person if the recipient is an adult or (b) plus two people if the recipient is a minor, or if the transplant involves a living-related donor. The coverage period for transportation and lodging begins five days prior to the transplant and ends when the recipient is discharged from the hospital and returns home.
- The recipient is automatically placed in SOTP case management for one year following the transplant.
- After one year the transplant is considered successful and any further related services are covered as medical/surgical expenses subject to the plan's cost sharing requirements.

Adult Dependent Children Up to Age 26 - New Open Enrollment

In accordance with the Patient Protection & Affordable Care Act, MCTWF made coverage available to all dependent adult children through the end of their 26th birthday month, effective April 1, 2011. The temporary exception to this rule is that adult dependent children are not entitled to coverage if they are eligible to enroll in an employer sponsored health plan, other than that of their parents. This exception ends upon the earlier of April 1, 2014 or the cessation of the "grandfathered" status of the participant/parent's MCTWF health plan. Except for those children who already were covered or became covered under MCTWF's rules on or after February 27, 2011, eligibility for coverage on or after April 1, 2011 (depending upon the eligibility of the child's participant/parent) was contingent upon submission to MCTWF of an Adult Child Coverage Application For Enrollment form during an enrollment period that ended February 28, 2011.

Despite our several efforts to communicate this enrollment process, many adult children, who were not already covered, did not submit a timely Application. Accordingly, **the Trustees have authorized another enrollment period for those adult children, beginning November 1, 2011 and ending December 16, 2011, to permit eligibility for coverage commencing on or after January 1, 2012** (depending upon the eligibility of the child's parent/participant), if the child was born on or after January 2, 1986. To enroll, an *Adult Child Coverage Application for*

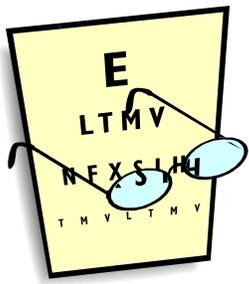
Enrollment form must be fully filled out and received by MCTWF between November 1, 2011 and December 16, 2011. This form is available from the *Forms* page of MCTWF's website, or by contacting MCTWF's Customer Communications Department.

Please note that the Application must be timely submitted -

(a) regardless of whether the adult child's participant/parent is eligible for coverage at the time of submission of the Application. If and when that participant/parent resumes covered employment, the adult child's eligibility will commence; or

(b) regardless of whether the adult child is excluded from MCTWF coverage by virtue of his eligibility to enroll in an employer sponsored health plan, other than that of his parents. In such case, the adult child's eligibility will commence on the earlier of April 1, 2014 or the date upon which his participant/parent's MCTWF health plan ceases to be "grandfathered" under the Act. If, prior to the earlier event, the child loses eligibility under the non-parental health plan, he will have the opportunity to become eligible under his participant/parent's benefit plan by submitting to MCTWF (1) acceptable proof of the loss of that eligibility, which eligibility must have been continuous from the date their participant/parent first became covered under a MCTWF benefit plan, and (2) a completed "Adult Child Coverage Application for Enrollment," within 30 days of the loss of the adult dependent child's eligibility under the non-parental health plan.





Introducing MCTWF's New Vision Network - *VSP Choice*

Effective November 1, 2011, MCTWF's new vision network will be *VSP Choice*, a nationwide network of quality eye care professionals. This change in networks was necessitated by Delta Dental of Michigan's decision to terminate its DeltaVision® program. MCTWF is contracting with Blue Cross Blue Shield of Michigan for access to the *VSP Choice* network.

VSP Choice is America's largest vision network with more than 26,000 professionals in nearly 20,000 locations throughout the country, and includes ophthalmologists, optometrists, independent practitioners, comprehensive eye care centers and optical retailers. We have worked with *VSP Choice* to replicate the current vision plan benefits, but where we were unable to do so, we have improved them. MCTWF's *VSP Choice* benefits are summarized below.

In a few days, you will receive in separate mailings new BCBS ID Cards and MCTWF Networks Cards bearing a *VSP Choice* imprint. Either card should be presented to *VSP Choice* network providers to ensure your coverage with network benefits. Enclosed with your MCTWF Networks Cards you will receive a list of network providers in your area. If you wish a broader list of providers, or to determine whether an unlisted provider is in the *VSP Choice* network, you may call MCTWF's Customer Communications Department at 800-572-7687, or link to a complete *VSP Choice* network provider search from the *Provider Networks* page of MCTWF's website at www.mctwf.org.

Please note that if you use a *non-VSP Choice* provider, reimbursement of billed charges, subject to plan limits, will be made directly to the participant.

Type of Service or Product	VSP Choice Network Provider	Non- VSP Choice Provider																														
Examination	Covered in full.	Plan pays up to \$50.																														
Frames	Plan pays up to \$125; you are responsible for any amount over the allowance after a discount of 20% is applied.	Plan pays up to \$75.																														
Single, Bifocal or Trifocal Lenses (basic glass or plastic) Per pair	Covered in full.	Single - Plan pays up to \$50. Bifocal - Plan pays up to \$60. Trifocal - Plan pays up to \$70.																														
Progressive Lenses Per pair	Plan pays up to \$85; you are responsible for the balance up to the following maximum charges* for plastic lenses: \$55 for standard progressive, \$95-\$105 for premium progressive and \$150-\$175 for custom progressive. * Maximum charges are subject to change without notice.	Plan pays up to \$70.																														
Lens Treatments Per pair	No coverage. You are responsible up to the maximum charges* below: <table border="0" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th style="text-align: center;"><u>Single</u></th> <th style="text-align: center;"><u>Bifocal, Trifocal or Progressive</u></th> </tr> </thead> <tbody> <tr> <td>Solid tints and dyes (pink I and II)</td> <td style="text-align: center;">\$0</td> <td style="text-align: center;">\$0</td> </tr> <tr> <td>Solid plastic dye (except pink I and II)</td> <td style="text-align: center;">\$15</td> <td style="text-align: center;">\$15</td> </tr> <tr> <td>Plastic gradient dye</td> <td style="text-align: center;">\$17</td> <td style="text-align: center;">\$17</td> </tr> <tr> <td>Factory applied scratch-resistant coating</td> <td style="text-align: center;">\$17</td> <td style="text-align: center;">\$17</td> </tr> <tr> <td>Polycarbonate lenses age 19 or greater</td> <td style="text-align: center;">\$33</td> <td style="text-align: center;">\$37</td> </tr> <tr> <td>Polycarbonate lenses under age 19</td> <td style="text-align: center;">\$0</td> <td style="text-align: center;">\$0</td> </tr> <tr> <td>UV protection</td> <td style="text-align: center;">\$16 **</td> <td style="text-align: center;">\$16 **</td> </tr> <tr> <td>Anti-reflective coating</td> <td style="text-align: center;">\$43</td> <td style="text-align: center;">\$43</td> </tr> <tr> <td>Photochromic lenses - plastic</td> <td style="text-align: center;">\$70</td> <td style="text-align: center;">\$82</td> </tr> </tbody> </table> * Maximum charges are subject to change without notice. All lens treatments not listed receive a 20% discount. ** Previously stated in error as \$33 for Single and \$37 for Bifocal, Trifocal or Progressive.		<u>Single</u>	<u>Bifocal, Trifocal or Progressive</u>	Solid tints and dyes (pink I and II)	\$0	\$0	Solid plastic dye (except pink I and II)	\$15	\$15	Plastic gradient dye	\$17	\$17	Factory applied scratch-resistant coating	\$17	\$17	Polycarbonate lenses age 19 or greater	\$33	\$37	Polycarbonate lenses under age 19	\$0	\$0	UV protection	\$16 **	\$16 **	Anti-reflective coating	\$43	\$43	Photochromic lenses - plastic	\$70	\$82	No coverage.
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Contact Lenses Fitting	Plan pays up to \$120; you are responsible for the balance. You are responsible for the first \$60.	Plan pays up to \$80. No coverage.																														
Laser Vision Correction	Plan pays up to \$250 per eye per lifetime. Charges not to exceed, per eye, \$1,500 for photorefractive keratectomy, \$1,800 for lasik and \$2,300 for custom, or 5% off the promotional price if available.	Plan pays up to \$250 per eye per lifetime.																														
Benefit Frequency	One exam and one vision correction option per person per calendar year. A vision option is defined as a pair of lenses plus frames, or contact lenses and fitting, or laser vision correction for one or both eyes.																															

Influenza Vaccination

Influenza can occur at any time, but most influenza occurs from October through May. According to the Department of Health and Human Services' Centers for Disease Control and Prevention, the best time to get the influenza immunizations is in October or November. In February 2010 the CDC's Advisory Committee on Immunization Practices (ACIP) recommended that everyone six months and older receive an annual influenza vaccination. The available types of influenza vaccines and their in-network coverage amounts are noted below. For your convenience, in-network coverage for flu vaccines also is available at participating pharmacies. They can be located by going to the *Provider Networks* page of MCTWF's website (find "Physician Search" and select "Immunization Pharmacies" under "Specialty Groups)."

Influenza Vaccine Type	Age Recommendation	In-network Benefit
Inactivated vaccine - intramuscular injection (the standard flu shot)	Ages 6 months and older. Children ages 6 months through 8 years require 2 doses (administered a minimum of 4 weeks apart during their first season of vaccination.)	Covered in full.
Inactivated vaccine - intradermal injection.	Ages 18 years through 64 years.	Covered up to the BCBSM contracted charge; participant responsible for the balance.
High-dose inactivated vaccine - intramuscular injection	Ages 65 years and older.	Covered in full.
FluMist live attenuated vaccine - sprayed into the nostrils	Ages 2 years through 49 years.	Covered in full.



Dependent Child Death Benefit - Age Extension

Historically, if a participant was eligible for death benefits under an active MCTWF plan, a death benefit was payable to the participant upon the death of his dependent children, under age 19, whose death was due to natural or accidental causes. Effective April 1, 2011, dependent child death benefits are extended through the end of the child's 26th birthday month.

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 (ERISA) and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Under the Women's Health Act, group health 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 lymphedema.

BiPAP and CPAP Machines - Elimination of Prior Authorization Requirement

Under MCTWF's durable medical equipment (DME) benefit, coverage for the purchase of prescribed Bilevel Positive Airway Pressure (BiPAP) or Continuous Positive Airway Pressure (CPAP) machines have required prior authorization. Such prior authorization has been authorized when a patient has been diagnosed as having obstructive sleep apnea syndrome, severe chronic obstructive pulmonary disease, end-stage neuromuscular disease, or kyphoscoliosis and when specific supporting criteria were met.

Effective September 1, 2011, prior authorization is no longer required for coverage for prescribed BiPAP and CPAP machines purchased from a Blue Cross Blue Shield certified (network) medical equipment supplier. Prior authorization continues to be required for coverage of such purchase from a non-network supplier.



IUDs - Elimination of Quantity Limit

Intra-uterine devices (IUDs) are covered under MCTWF medical plans as a medical supply, and have been subject to a limit of one per three year period. Effective July 1, 2011, this quantity limit has been eliminated.

For a complete list of covered medical supplies, go to the *Schedule of Benefits* page of MCTWF's website.

The *Messenger* 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
TOLL FREE 800-572-7687



MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND

If in reviewing any Explanation of Benefits provided to you from MCTWF, or any of its vendors, you identify possible fraud, please contact the appropriate toll free **Anti-fraud Hotline** as follows:

For Medical Professional or Vision Claims 800-637-6907
For Dental Claims 800-524-0147
For Hospital Claims 800-482-3787

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Retiree Medical Program - Spouse Eligibility

MCTWF has long administered the Retiree Medical Program to permit a participant's spouse to enroll on her own if (a) on the date of the participant's death, he would have been able to satisfy the Program's age, years of service and active coverage requirements and (b) the spouse submits a completed MCTWF Retiree Medical Program Application Form within the Program's prescribed period; such period running from the date of cessation of her active coverage. This rule is now stated in the Summary Plan Description booklet, Sec. 2.3 (a) "Retiree Medical Program - Covering Your Spouse."



Retired Participants Covered Under an Active Benefit Plan

As a reminder to those retired participants covered under a MCTWF active benefit plan, benefit eligibility for you or your spouse (if applicable) ceases as of the earlier of (a) the first of the month in which you or your spouse attains age 65, or (b) the date you or your spouse becomes eligible for early Medicare Part A coverage. While MCTWF's eligibility system stores the birth dates of you and your spouse and will automatically terminate coverage upon attainment of age 65, it is imperative that you notify MCTWF's Customer Communications Department no later than 30 days prior to your (or your spouse's) early Medicare Part A eligibility date. MCTWF will pursue recovery from you and your spouse for benefits paid for services received on or after the date Medicare eligibility commences.