Michigan Conference of Teamsters Welfare Fund

Messenger

Fall

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Message from MCTWF's Executive Director

Dear Teamster Families,

Greetings from Trumbull Avenue, where the welfare of Teamster families always is our focus and, indeed, our reason for being here. It's our responsibility to deliver to you benefits representing the best possible value and to reduce to a minimum any difficulty, frustration and confusion that you may experience in using them. We consider ourselves fortunate to be helping people in such a meaningful way. We take pride in your many thoughtful expressions of appreciation and we always pay attention to your suggestions and criticisms in an effort to serve you better.

But, of course, to such a great degree, our physical and mental health are in our own hands. Good health is key to the quality of our lives, our ability to learn and perform and to secure the most rewarding work, and to make and maintain the most essential and gratifying relationships - and for most of us, good health largely is dependent upon the respect that we demonstrate for our physical and mental needs and limitations. This not only includes making good use of information and exercising common sense, but also making good use of our preventive services benefits and behavioral health benefits to permit early, effective treatment when we need it.

The notion of personal responsibility also very clearly pertains to the preservation of workers' rights in Michigan. Great bravery and sacrifice by prior generations of conscientious people secured the rights we now have and which are very seriously threatened in this State. To allow those rights to be stripped away by virtue of our own passivity and short sightedness would be a sad betrayal of ourselves and those who fought and suffered to gain them. This legacy, once lost, will not easily be regained. A good many right-minded, caring people have worked tenaciously to get a measure (Prop 2) on the November 6th ballot that, if passed, will amend the Michigan constitution to guarantee the right to collectively bargain in both the public and private sector and guarantee the enforceability of collectively bargained rights, thereby effectively precluding future enactment of a disastrous right-to-work law in Michigan. It's now in our hands to prevail against Lansing's scornful onslaught.

As always, I urge you to read the *Messenger* carefully. We use the *Messenger* primarily to provide you with notice of benefit and rule changes and clarifications. Please also make use of the Fund's website. In addition to the great deal of valuable information that can be found there (including your individual health and benefit utilization information in the *Participant Web Portal)*, current and prior issues of the *Messenger* are maintained there, as well as a continually updated electronic Summary Plan Description booklet reflecting all benefit and rule changes and clarifications and their effective dates.

We welcome all of our new participants and family members since our last *Messenger* publication, including the following new groups: under Kalamazoo **Local 7** – Stone & Webster and Nationwide Escort; under Louisville **Local 89** – Sentinel Transportation; under Detroit **Local 214** – Clare County Transit; under Detroit **Local 247** – Midwest C&M Construction; under Detroit **Local 299** – Source Providers; under Detroit **Local 337** – Charp's Welding, Precision Pipeline, Topeka Productions, New Line Productions, Bad Blood Films, and Smith Distributing; under Grand Rapids **Local 406** – C.W. Marsh Co.; under Saginaw **Local 486** – United Piping; under Lansing **Local 580** – Holt Public Schools; and under Cincinnati **Local 1199** – American Bottling Co. Please do not hesitate to contact our Customer Communications representatives with your questions and comments.

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

Richard Burker

Inside this issue:

Editor's Note:

For simplicity, unless otherwise stated, the *Messenger* uses the term "participants" to refer to both the employee/participants and their eligible dependents. The *Messenger* also uses the masculine form to refer to employee/participants and children and the feminine form to refer to spouses.

Prescription Brand Drugs Requiring Prior Authorization

As was announced in the Winter 2011-2012 *Messenger*, effective April 1, 2012 prior authorization of certain brand name prescription drugs became required as a condition of coverage. MCTWF's pharmacy benefits manager, CVS Caremark, had sought to impose an absolute exclusion of those drugs due to the inappropriate pricing and marketing of those drugs by their manufacturers, but CVS Caremark however agreed instead to permit a prior authorization process, utilizing reasonable criteria for authorization.

Effective January 1, 2013, prior authorization of the below listed brand name prescription drugs will be added to the list of those brand name drugs requiring prior authorization as a condition of coverage. The list reflects each drug requiring prior authorization, its therapeutic class, the common medical condition that the class treats, and the alternative drugs in that therapeutic class. * Please note that generic drugs are in lowercase *italics* and brand drugs are in CAPS.

Drug Subject to Prior Authorization	Common Condition Therapeutic Class	*Alternative Generic or Brand Drugs
QNASL VERAMYST	**Allergies** Nasal Steroids	*flunisolide spray, fluticasone spray, triamcinolone spray*, NASONEX
ONGLYZA	**Diabetes** Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	JANUVIA, TRADJENTA†,
KOMBIGLYZE XR	**Diabetes** Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/ Biguanide Combinations	JANUMET, JANUMET XR, JENTADUETO
LUMIGAN	**Glaucoma** Prostaglandin Analogs	*latanoprost,* TRAVATAN Z, ZIOPTAN
GENOTROPIN NUTROPIN/NUTROPIN AQ OMNITROPE SAIZEN TEV-TROPIN	**Growth Hormones**	HUMATROPE, NORDITROPIN
EDARBYCLOR	**High Blood Pressure** Angiotensin II Receptor Antagonists/Diuretic Combinations	*irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide*, BENICAR HCT, DIOVAN HCT, MICARDIS HCT
DETROL LA	**Overactive Bladder/Incontinence** Urinary Antispasmodics	*oxybutynin ext-rel*, tolterodine, trospium, GELNIQUE, VESICARE
JALYN	**Prostate Condition** Benign Prostatic Hyperplasia Agents/ Combinations	*finasteride or* AVODART **WITH** *alfuzosin ext-rel, doxazosin, tamsulosin, terazosin or RAPAFLO*
INTERMEZZO ROZEREM	**Sleep** Hypnotics, Non-benzodiazepines	*zolpidem, zolpidem ext-rel*
ANDROGEL	**Testosterone Replacement** Androgens	ANDRODERM, AXIRON†, FORTESTA†,
HECORIA	**Transplant** Immunosuppressants, Calcineurin Inhibitors	*tacrolimus*

† Drugs no longer requiring prior authorization on or after January 1, 2013.

To obtain prior authorization, your physician must contact CVS Caremark at 800-626-3046. If you are currently utilizing any of these brand name drugs, CVS Caremark will notify you and your prescribing physician and provide a list of covered alternative drugs that are equally or more efficacious.

Dental Expenses Not Covered

Summary Plan Description Sec. 7.6: "Dental Expenses Not Covered" has been amended to add the following exclusion:

- *Dental services or supplies as determined by MCTWF's dental benefits administrator, Delta Dental, for which no valid dental need can be demonstrated, or that are investigational in nature (including service or supplies required to treat complications from investigational procedure), or that are a specialized technique, or that are not provided in accordance with generally accepted standards of dental practice.*

New Blue Cross ID Cards

All currently eligible participants recently should have received new Blue Cross ID cards (participants with more than one dependent on their policy were sent two cards). Blue Cross Blue Shield of Michigan has made system changes that require a change to the three letter prefix in your Enrollee ID to "KMT." **Please begin using your new card on September 22, 2012 by presenting it on or after that date to each medical provider from whom you seek services** so the provider can confirm your eligibility. Please destroy your old Blue Cross ID Cards and only use the new ID card on or after September 22, 2012. Please retain your MCTWF Networks Card; neither your MCTWF "Contract No." nor your benefits have changed.

Retiree Medical Program

Spouse Participation after Retiree Participation Ends

Effective April 26, 2012, the Trustees increased from five years to eight years the period in which the spouse may continue to participate in the Retiree Medical Program (Program) at the retiree self-contribution rate once the retiree's coverage has ended (applied prospectively to an eligible spouse who is participating as of 4/26/12 in the Program). Accordingly, the spouse eligibility rules have been modified as follows:

- Effective April 26, 2012, if the retiree participates in the Program until age 65, his spouse who is not yet age 65 and not eligible for Medicare, may continue participation under the Program at the same retiree self-contribution rate for the earlier of eight years following the date the retiree's Program coverage began or until his spouse attains age 65 or becomes eligible for Medicare.
- Effective April 26, 2012, if the retiree participating in the Program becomes eligible for Medicare before age 65, or dies prior to reaching age 65, his spouse who is not yet age 65 and not eligible for Medicare may continue participation under the Program at the same retiree self-contribution rate until the later of the retiree's 65th birthday or eight years following the date the retiree's Program coverage began.

When Eligibility for Coverage Ends

Under the Retiree Medical Program (Program) eligibility rules, MCTWF's Summary Plan Description (SPD Sec. 2.3 (a): "Retiree Benefit Plans") states that Program eligibility for coverage ends for the retiree and/or spouse once he or she reaches age 65, or if earlier, once they become eligible for Medicare. However, in the case where a retiree or spouse reaches age 65, but is not eligible for Medicare, eligibility for coverage will continue under the Program until such time as Medicare eligibility has been established. Therefore, the SPD has been revised as follows:

> *Except as otherwise noted, all references to "Medicare" include both early age (Disability) and normal age Medicare Part A coverage. All references above to attaining age 65 refer to the last day of the month preceding the month in which the 65th birthday falls.* ***In such cases where age 65 has been reached, but eligibility for Medicare has not been established, eligibility for coverage will continue under the Program until such time as Medicare eligibility has been established.***

Best Doctors®

As was announced in the Winter 2011-2012 *Messenger,* the 100% free and confidential medical review and consulting service, Best Doctors, was made available to all eligible medical plan participants and dependents effective April 1, 2012. For the first three months, Best Doctors reported that the call volume well exceeded expectations. These interactions not only resulted in a number of referrals to in-network Best Doctor physicians and comprehensive responses from expert physicians to questions posed by individuals with established or unidentified medical conditions, but to several "interconsultations" with full clinical review. According to Best Doctors, these consultations resulted in a change in diagnosis in 63% of the cases and a treatment change in 88% of the cases. Best Doctors also reported that 100% of the individuals responding to its survey gave Best Doctors the highest rating available for its ability to meet their needs. We are very pleased with these initial results and recommend that you take advantage of this MCTWF benefit by calling Best Doctors at 866-904-0910.

Weekly Accident & Sickness Benefits

MCTWF's Summary Plan Description (SPD Part 4: "Weekly Accident and Sickness Benefits") states that weekly accident and sickness benefits are payable only if the participant is incurring a "loss of income" as a result of his disability. The Trustees have clarified that this benefit is to be paid upon the cessation of work as a result of a disability; that looking to a "loss of income" was meant merely to establish with certainty the cessation of work. However, since there are situations in which the participant is entitled to receipt of additional income despite the cessation of work due to disability, the SPD has been revised to state that "[b]enefits are payable only if the Participant has ceased work as a result of his Disability." MCTWF will honor any existing agreements it has made at the request of the employer and local union to base the payment of weekly accident and sickness benefits on the loss of income until the expiration of their current collective bargaining agreement.

Required Notice of "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 all current MCTWF medical plans are "grandfathered plans" 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 comply with certain other consumer protections in the Affordable Care Act for example, the elimination of lifetime limits on benefits. Effective September 30, 2012, certain new, non-grandfathered medical plans will become available that have modifications to cost sharing amounts in their base medical and prescription drug components. These medical plans will be designated as "New SOA," "New Key," or "New I&S."

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.

MCTWF's Participant Web Portal

For those of you who may not be familiar with MCTWF's *Participant Web Portal,* this useful tool provides you access to your protected health information maintained by MCTWF through a fully secured personal account and is accessible from our web site home page at www.mctwf.org. By creating a *Participant Web Portal* account, you have access to –

- *Participant* screen – this displays the participant's contract number, date of birth, gender, current benefit plan (which when clicked links to a current Schedule of Benefits), number of benefit bank weeks remaining, current address, phone number and marital status. If you find that your address or phone number information is not correct, you can go to the *Account Maintenance* screen to update and submit the corrected information.
- *Family* screen – this displays each covered family member's name, date of birth, relation to participant, and the date through which coverage is available. If the "covered through" date is "open-ended," coverage is active and there has been no determined termination date established. Each family member is assigned an "ID" number which, when clicked on, opens up an *Eligibility History* screen.
- *Eligibility History* screen – this displays all periods of eligibility for each family member on or after January 1, 2006. Periods of eligibility are separated by changes in benefit plan, or employer, or by a lapse in eligibility. A link is provided for any codes that appear in the "Notes" column, which is also footnoted at the bottom of the screen. By clicking on the named benefit plan in the "Benefit Plan" column you can view the applicable Schedule of Benefits in its most current form.
- *Plan Limits* screen – this displays your family and individual accruals for the current and prior calendar year towards calendar year dollar limits available and used for applicable medical (commencing with 2011, annual dollar limits apply only to the freight industry mini-med plan and the Retiree Medical plan) and dental benefits, overall medical benefits used, calendar year and lifetime frequency limits available and used for applicable medical, dental and vision benefits and calendar year cost sharing expenses.
- *Claims* screen – this displays a separate screen for each family member. It reflects the status of your medical, prescription drug, dental, vision, mental health and substance abuse, short term disability, total and permanent disability and death claims. You may search this screen by selecting from a number of options available in the search fields area of this screen. Accessible claims are those that have been paid or rejected, with dates of service for the current calendar year and the two years prior. By clicking on the "View" link to the left of each claim line you can access a detailed explanation of benefits.
- *Account Maintenance* screen – this displays your address, telephone number, and email address and gives you the ability to update them or to change your account password.

In order to view personal account information, the participant or dependent must first create an account. An account can be created by any participant or dependent who is currently eligible for coverage (dependents must be age 18 years or older). If eligibility terminates, access to the eligibility history is limited to 24 months from the termination date.

Immunizations

Immunizations received in accordance with MCTWF's approved schedules (which follow the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices) are covered, subject to applicable limits, by all MCTWF medical plans. For children, all immunizations are covered in full if received from a network provider. For adults, coverage is subject to applicable limits (please refer to your schedule of benefits for specifics) with the exception of the influenza vaccine, which is covered in full if received from a network provider. Below are the *2012 Child and Adolescent Immunization Schedule* and the *2012 Adult Immunization Schedule.*

2012 Child and Adolescent Immunization Schedule

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-18 yrs
Hepatitis B	Hep	HepB			HepB								Complete 3 dose series		
Rotavirus			RV	RV	RV										
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DtaP			DTaP				DTaP	Tdap	Tdap	Tdap
Haemophilus Influenzae Type b			Hib	Hib	Hib		Hib								
Pneumococcal			PCV	PCV	PCV		PCV				Pneumococcal				
Inactivated Poliovirus			IPV	IPV	IPV							IPV	Complete 3 dose series		
Influenza					Influenza (annually)										
Measles, Mumps, Rubella							MMR					MMR	Complete 2 dose series		
Varicella							Varicella					Varicella	Complete 2 dose series		
Hepatitis A							HepA dose 1				HepA Series	Complete 2 dose series			
Meningococcal						MCV4								Dose 1	MCV / Booster at 16 yrs. old
Human Papillomavirus														3 dose series	Complete 3 dose series

Range of recommended ages | Catch-up immunization | Certain high-risk groups | Range of recommended ages and for certain high-risk groups

For a detailed statement, please refer online to http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm

2012 Adult Immunization Schedule

Vaccine	19-21 Years	22-26 Years	27-49 Years	50-59 Years	60-64 Years	65 Years and Older
Tetanus diphtheria pertussis (Td/Tdap)	Substitute 1-time dose of Tdap for TD booster; then boost with Td every 10 years					Td/Tdap
Human papillomavirus (Female)	3 doses					
Human papillomavirus (Male)	3 doses					
Measles, Mumps, Rubella (MMR)	1 or 2 doses				1 dose	
Varicella	2 doses					
Influenza	1 dose annually					
Pneumococcal (Polysaccharide)	1 or 2 doses					1 dose
Hepatitis A	2 doses					
Hepatitis B	3 doses					
Meningococcal	1 or more doses					
Zoster					1 dose	

For persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection.

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

Tdap recommended for 65 years and older if contact with 12 months or less child. Either Td or Tdap can be used if no infant contact

For a detailed statement, please refer online to http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm

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, 2012
Michigan Conference of Teamsters Welfare Fund

CVS Caremark's Mail Service Pharmacy

The CVS Caremark mail service pharmacy provides a convenient and cost-effective way to receive up to a 90 days' supply of prescribed medications. CVS Caremark operates seven mail services pharmacies across the United States to provide prompt service to plan participants and dependents, wherever they live. Your prescriptions are sent to your home or the location of your choice, free of charge, by U.S. Postal Service, or under certain circumstances by UPS, within 10 business days after CVS Caremark receives your prescription and order form. If you utilize CVS Caremark's FastStart® program, your order will be processed and mailed to you within one to two business days.

CVS Caremark's mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, CVS Caremark mail service pharmacists check each prescription and order information to ensure that your prescription is filled correctly and that there are no expected drug interaction problems.

New Prescriptions

There are three easy ways to have your medications filled for the first time through the CVS Caremark mail service pharmacy -

1. Call CVS Caremark's FastStart® toll-free at 800-875-0867 from 8 a.m. to 8 p.m. (Eastern Time), Monday through Friday, or log on to www.caremark.com/faststart and sign in (or register if this is your first time using the FastStart® program). Please have available your MCTWF contract number, your medication name, your physician's name and telephone number, and your payment information. Caremark's representative will take care of contacting your physician to obtain the prescription; or
2. have your physician call in your new prescription by using CVS Caremark's Physician Rx Line at 800-378-5697; or
3. complete a mail service order form, available from MCTWF's Customer Communications Department in an electronically fillable format from the *Forms* page of the MCTWF website at www.mctwf.org, along with your original prescription (not a photocopy) and the appropriate payment (if that is the payment option chosen). Then mail to CVS Caremark as noted.

Refilling Your Prescriptions

Once CVS Caremark mail service pharmacy has your prescription on file, you can obtain remaining refills one of the following ways:

1. Order refills online at www.caremark.com using your secure personal online account and by enrolling online in ReadyFill at Mail™ (click on the *Refill a Prescription* link), CVS Caremark will automatically send your eligible medications at the right time, request a new prescription from your physician when your prescription is about to expire or when the last refill has been filled and keep you informed about your prescription status using the method you choose – phone call, e-mail or text message; or
2. contact CVS Caremark Customer Care at 888-727-0495; or
3. mail a completed mail service order form to CVS Caremark, along with the appropriate payment.

If you have any questions, need immediate assistance with your mail service prescriptions, or need to speak to a pharmacist, CVS Caremark's Customer Care representatives are available 24 hours a day, seven days a week to assist you at 888-727-0495.

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.

Change in Family Status Reminder

Family status changes include marriage, divorce, death, birth, placement for adoption, adoption, new dependent child status due to total and permanent disability, cessation of dependent child status, or a change in your spouse's primary group health, dental or vision insurance carrier. **It is very important that you immediately notify MCTWF of any family status changes** by a phone call to our Customer Communications Department and through the completion of a *Change in Family Status Form,* along with the appropriate documentation. This form is available by request from our Customer Communications Department, or online by printing it from the *Forms* page on our website at www.mctwf.org.

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

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FIRST-CLASS MAIL
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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

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 MCTWF Claims	800-637-6907
For Delta Dental or Optical Claims	800-524-0147
For BCBSM Hospital Claims	800-482-3787

MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND

Adult Dependent Children Up to Age 26
New Open Enrollment Window

In accordance with the Affordable Care Act, MCTWF has made coverage available to all dependent adult children through the end of their 26th birthday month. 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 was contingent upon submission to MCTWF of an Adult Child Coverage Application for Enrollment form during enrollment periods in January – February 2011 and November – December 2011.

Despite our several efforts to communicate the enrollment requirements to affected participants and their eligible children, a few adult children still have been unable to submit a timely Application. Accordingly, **the Trustees have authorized a final enrollment period for those adult children, beginning November 1, 2012 and ending December 16, 2012, to permit eligibility for coverage commencing on or after January 1, 2013** (contingent upon the eligibility of the child's parent/participant and the child's age at that time).

To enroll, an *Adult Child Coverage Application for Enrollment* form must be fully filled out and received by MCTWF between November 1, 2012 and December 16, 2012. This form is available on the *Forms* page of MCTWF's website at www.mctwf.org, 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 you you are married please be sure to share this communication with your spouse.