

Michigan Conference of Teamsters Welfare Fund



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Messenger

Message from MCTWF's Executive Director

Dear Teamster Families,

For the fourth deeply saddening time in four years, the Fund has suffered the loss of one of its Trustees. This time it was Bob Rayes; for 18 years resolutely devoted to the Trustees' achievement of the highest fiduciary standards and to ensuring that the Fund's focus always remained squarely on the welfare of its members.

What I found perhaps most admirable about Bob was that he was profoundly principled and that he acted with the courage of his convictions. He succeeded with street smarts, intuition, passion, and maybe a bit of theater. I have indelible memories of Fund Board meetings when, perceiving a potential unfairness to the members, Bob would seem to grow immense in his chair, his face stern with indignation and contempt, and he would proceed mercilessly to castigate those unfortunate souls (including me, on occasion) who had espoused the "wrong" point of view. He was remarkably effective. Even during his last stretch of service, when his body had all but quit on him and he had lost much of what he long had held dear, he kept his perspective, remained dutiful and deeply caring, and never compromised his integrity. He'll be fondly and appreciatively remembered.

Please carefully review this issue of the *Messenger*. While each item is of potential importance to you, I would like to call your special attention to a few of those items. Survivor Health Benefits is a new benefit that provides up to 36 months of free medical and prescription drug coverage for the surviving spouse and children of a participant who dies with "active coverage." Other new benefits are bone grafts for dental implants and gastric electrical stimulation therapy. Please note the several new or revised prior authorization requirements, the revised applied behavior analysis benefit revision for treatment of autism spectrum disorders, and the elimination of the Best Doctors program. Also please note the January 1, 2015 increases to copayments under "grandfathered" benefits for all emergency room facility visits and the changes that we are implementing that nonetheless will reduce your out-of-pocket expenses for emergency room services for non-emergent conditions. Finally, please note that standard annual dollar benefit limits for pediatric dental and vision services will resume as of January 1, 2015.

We welcome all of our new participants and family members enrolled since our last *Messenger* publication, including the following groups: under Detroit **Local 214** – Orion Township, Roscommon County Road Commission, City of Romulus, and City of Standish; under Detroit **Local 247** – John D. Osborne Trucking Company, Osborne Concrete Company, and Prairie Lakeside (DBA Superior Materials); under Wyandotte **Local 283** – Savage Refinery Services; under Columbus, OH **Local 284** – Anderson Concrete Corp.; under Detroit **Local 337** – Stafford Transport of Michigan, Inc. and production companies B H P H Productions and Tiger Productions; under South Bend, IN **Local 364** – Wiltfong Moving & Storage; under Grand Rapids **Local 406** – Village of Baraga and Central Warehouse Operations; under Pontiac **Local 614** – K & R Truck & Trailer Repair; and under Zanesville, OH **Local 637** – American Bottling.

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

Richard Burker

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Editor's Note:

For simplicity, the *Messenger* uses the masculine form to refer to participants and children and the feminine form to refer to spouses. Also, when referring collectively to participants, eligible children and spouses, the *Messenger* uses the term "members."

Influenza Vaccination Coverage

It's that time of the year again; please don't forget to get your influenza vaccination. For adults and children covered under a MCTWF medical benefits package, the annual influenza vaccine is covered in full if received from a network provider.

Survivor Health Benefits - New Benefit

MCTWF's Trustees are pleased to announce a new benefit, Survivor Health Benefits, available **effective October 1, 2014** for all eligible spouses and dependent children of participants who die while actively covered under a MCTWF medical benefits package. Survivor Health Benefits, as defined below, provides up to 36 months of free medical and prescription drug coverage.

Key Definitions:

With respect to this benefit rule –

- “Survivor(s)” refers to the spouse and dependent children (as defined by your Summary Plan Description, including unborn children) of the deceased participant who were eligible for MCTWF benefits on the date of the participant’s death.
- “Survivor Health Benefits” refers to the same base medical and prescription drug benefits that the deceased participant’s MCTWF participating group is covered for during the period of the survivors’ Survivor Health Benefits eligibility.
- “Active Coverage” refers to the participant’s eligibility for MCTWF Actives Plan base medical and prescription drug benefits while -
 - actively employed;
 - utilizing MCTWF’s strike benefits;
 - utilizing benefit banks; or
 - utilizing Weekly Accident and Sickness benefits.

Eligibility – Initial and Ongoing:

- Upon receipt of notification of the death of a participant who had Active Coverage on the date of his death, MCTWF will notify the participant’s Survivors of their automatic eligibility for Survivor Health Benefits following the exhaustion of any remaining benefit bank coverage, for a maximum period (including the benefit bank coverage period) of 36 months following the coverage week in which the participant died. Each Survivor, in the alternative, may elect COBRA continuation coverage.
- For each Survivor who does not elect COBRA continuation coverage, Survivor Health Benefits eligibility will continue as follows:

For the surviving spouse, for the earlier of 36 months or –

- remarriage;
- enrollment in the MCTWF Retirees Plan (**Note:** the spouse may defer enrollment until expiration of her Survivor Health Benefits coverage, but must comply with MCTWF rules for timely application for MCTWF Retirees Plan coverage); or
- Medicare eligibility.

For each surviving child, for the earlier of 36 months or –

- the end of the month in which the child turns age 26; or
- the date of the child’s adoption by anyone other than the surviving spouse.

- The deceased participant’s MCTWF participating group’s medical and prescription drug benefits are suspended or terminated for any reason, the Survivor Health Benefits also will be suspended or terminated. MCTWF will require periodic status statements to ensure that each Survivor remains eligible.



Benefit Design:

Survivor Health Benefits always will mirror the design of the then current base medical and prescription drug benefits provided to the deceased participant’s MCTWF participating group. If the group’s base medical and prescription drug benefits change, so too will the Survivor Health Benefits.

Coordination of Benefits:

If a Survivor also is covered under another group health plan (including another MCTWF benefit package) or health insurance policy, Survivor Health Benefits coverage always will be secondary to that other plan or policy.

Drugs Requiring Prior Authorization

As was first announced in the winter 2011-2012 *Messenger*, MCTWF's pharmacy benefit manager, CVS Caremark, made prior authorization of certain prescription drugs a condition of coverage. The following 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 (i.e., those not requiring prior authorization). Those drugs stated in red print have been newly added by CVS Caremark to the list requiring prior authorization **effective January 1, 2015**. CVS Caremark will notify current utilizers of the newly added drugs and their prescribing physician and will provide them with a list of covered alternative drugs that are equally or more efficacious. Please note that generic drugs are in *lowercase italics* font and brand drugs are in UPPERCASE roman font .

Common Condition/ Therapeutic Class	Drug Subject to Prior Authorization	Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)
Allergic Reaction (Anapylaxix) Treatment	ADRENACLICK	AUVI-Q, EPIPEN, EPIPEN JR
Allergies Nasal Steroids/Combinations	BECONASE AQ RHINOCORT AQUA OMNARIS VERAMYST QNASL ZETONNA	<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</i>
	DYMISTA	<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX WITH azelastine spray or PATANASE</i>
Allergies Ophthalmic	LASTACFT	<i>azelastine, cromolyn sodium, PATADAY, PATANOL</i>
Anti-infectives, Antivirals Herpes Agents	VALTRESX	<i>acyclovir, valacyclovir</i>
Asthma Beta Agonists, Short-Acting	PROVENTIL HFA XOPENEX HFA VENTOLIN HFA	PROAIR HFA
Asthma Steroid Inhalants	AEROSPAN ALVESCO	ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR
Asthma or Chronic Obstructive Pulmonary Disease (COPD) Steroid/Beta Agonist Combinations	SYMBICORT	ADVAIR DULERA
Attention Deficit Hyperactivity Disorder Agents	ADDERALL XR	<i>amphetamine-dextroamphetamine mixed salts ext-rel</i>
Cardiovascular Antilipemics HMG Co-A Reductase Inhibitors (HMGs or Statins) / Combinations	ADVICOR LIPITOR ALTROPREV LIPTRUZET LESCOL XL LIVALO	atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, CRESTOR, SIMCOR, VYTORIN
Chronic Obstructive Pulmonary Disease (COPD) Anticholinergics	TUDORZA	SPIRIVA
Dermatology Skin Inflammation and Hives Corticosteroids	APEXICON E	desoximetasone, fluocinonide
Diabetes Biguanides	GLUMETZA RIOMET	<i>metformin, metformin ext-rel</i>
Diabetes Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	NESINA ONGLYZA	JANUVIA, TRADJENTA
Diabetes Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations	KAZANO OSENI KOMBIGLYZE XR	JANUMET, JANUMET XR, JENTADUETO
Diabetes Injectable Incretin Mimetics	BYETTA	BYDUREON, VICTOZA
Diabetes Insulins	APIDRA HUMALOG	NOVOLOG
	HUMALOG MIX 50/50	NOVOLOG MIX 70/30
	HUMALOG MIX 75/25	NOVOLOG MIX 70/30
	HUMULIN 70/30	NOVOLIN 70/30

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Common Condition/ Therapeutic Class	Drug Subject to Prior Authorization	Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)
Diabetes Insulins	HUMULIN N	NOVOLIN N
	HUMULIN R	NOVOLIN R
	NOTE: Humulin R U-500 concentrate will not be subject to prior authorization and will continue to be covered.	
Diabetes Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitors	FARXIGA	INVOKANA
Diabetes Supplies	ACCU-CHEK STRIPS AND KITS BREEZE 2 STRIPS AND KITS CONTOUR STRIPS AND KITS CONTOUR NEXT STRIPS AND KITS FREESTYLE STRIPS AND KITS	ONETOUCH ULTRA STRIPS AND KITS, ONETOUCH VERIO STRIPS AND KITS
Erectile Dysfunction Phosphodiesterase Inhibitors	LEVITRA	CIALIS, VIAGRA
Glaucoma Prostaglandin Analogs	LUMIGAN	latanoprost, travoprost, TRAVATAN Z, ZIOPTAN
Growth Hormones	GENOTROPIN NUTROPIN AQ OMNITROPE	SAIZEN TEV-TROPIN
High Blood Pressure Angiotensin II Receptor Antagonists	EDARBI	candesartan, eprosartan, irbesartan, losartan, telmisartan, BENICAR, DIOVAN
High Blood Pressure Angiotensin II Receptor Antagonist/Diuretic Combinations	EDARBYCLOR TEVETEN HCT	candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide, BENICAR HCT
High Blood Pressure Calcium Channel Blockers	NORVASC	amlodipine
Inflammatory Bowel Disease (IBD), Ulcerative Colitis Aminosalicylates	ASACOL HD DELZICOL	balsalazide, sulfasalazine, sulfasalazine delayed-rel, APRISO, LIALDA, PENTASA
Multiple Sclerosis Agents	REBIF	AVONEX, COPAXONE, EXTAVIA, GILENYA, TECFIDERA
Musculoskeletal Agents	AMRIX	cyclobenzaprine
Opioid Dependence Agents	SUBOXONE FILM	buprenorphine-naloxone sublingual tablet, ZUBSOLV
Osteoarthritis Viscosupplements	EUFLEXXA ORTHOVISC	GEL-ONE, HYALGAN, SUPARTZ
Overactive Bladder/Incontinence Urinary Antispasmodics	DETROL LA OXYTROL	TOVIAZ
Pain and Inflammation Corticosteroids	RAYOS	dexamethasone, methylprednisolone, prednisone
Pain and Inflammation Nonsteroidal Anti-inflammatory Drugs (NSAIDs)/ Combinations	VIMOVO DUEXIS	CELEBREX; diclofenac, meloxicam, or naproxen WITH lansoprazole, omeprazole, omeprazole/sodium bicarbonate, pantoprazole, DEXILANT, or NEXIUM
	FLECTOR PENNSAID	diclofenac, diclofenac sodium solution, meloxicam, naproxen, VOLTAREN GEL
	NAPRELAN	diclofenac, meloxicam, naproxen, CELEBREX
Prostate Condition Benign Prostatic Hyperplasia Agents/ Combinations	JALYN	finasteride or AVODART WITH alfuzosin ext-rel, doxazosin, tamsulosin, terazosin or RAPAFLO
Sleep Hypnotics, Non-benzodiazepines	INTERMEZZO ROZEREM	LUNESTA
Testosterone Replacement Androgens	testosterone gel NATESTO VOGELXO	ANDROGEL TESTIM
Transplant Immunosuppressants, Calcineurin Inhibitors	Hecoria	tacrolimus



To obtain prior authorization, your physician must contact CVS Caremark at 800-626-3046

Notice of Creditable Coverage

All MCTWF Benefit Packages 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 all MCTWF benefit packages with prescription drug coverage, on average for all plan participants, are expected to pay out as much as standard Medicare prescription drug coverage pays and therefore are 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 November 15th through December 31st. 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 certain brand name prescription drugs and for prescription drugs within the following drug classifications: non-sedating antihistamines, proton pump inhibitors, selective serotonin reuptake inhibitors (brand name only), anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, 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 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 November to join.

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

Contact MCTWF's Member Services call center 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 you 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, 2014

Michigan Conference of Teamsters Welfare Fund

Coverage for Emergency Room Facility and Physician Services

In furtherance of the Trustees' efforts to fashion more appropriate benefit rules for coverage of emergency room services, two changes will be made, **effective January 1, 2015**, as explained below:

Change to Copayments for Grandfathered Emergency Room Facility Charges

Please refer to the following chart. **Effective January 1, 2015** the patient's copayment/coinsurance responsibility under all "grandfathered" benefit packages will be changed to the flat copayment amounts noted. Consequently, each of the affected benefit packages will lose its "grandfathered" status under the Affordable Care Act, resulting in the expansion of free preventive services and expanded appeal rights. As always, if the patient is admitted through the emergency room for inpatient services, the emergency room copayment is waived.

Base Medical Benefit	Emergency Room Facility Charges Copayment/Coinsurance Prior to 01/01/15	Emergency Room Facility Charges Copayment Effective 01/01/15
SOA, I&S, PEP	\$20	\$75
Key 1, Key 1a	10% of contracted charges	\$75
Key 1b	10% of contracted charges plus \$75 copayment	\$75
Key 2, Key 2a	15% of contracted charges	\$100
Key 2b, Key 2c, Key 2d	15% of contracted charges plus \$75 copayment	\$125
Key 3	20% of contracted charges	\$100
Key 4	20% of contracted charges	\$125

New Coverage for Emergency Room Services for Treatment of Non-Emergent Conditions

As repeatedly noted in recent issues of the *Messenger*, emergency room treatment of medical conditions that are not "emergent" (meaning sudden and unexpected and which if not immediately treated might result in death or serious bodily harm), are not covered as a MCTWF benefit and therefore are payable by the patient, in full, without benefit of Blue Cross Blue Shield (BCBS) negotiated discounts.

The Trustees remain determined to deny coverage for inappropriate usage of emergency rooms since, had the necessary medical services been obtained in an appropriate setting, there would be no facility charges and the same physician's services would be charged at a substantially reduced rate. However, they have acknowledged their concern about member exposure to non-discounted charges for

denied claims. Accordingly, MCTWF has made arrangements with Blue Cross Blue Shield of Michigan that will avail members of those BCBS discounts.

Effective January 1, 2015, MCTWF will "approve" emergency room facility claims and emergency room physician claims for treatment of non-emergent conditions, thereby triggering the BCBS discounts. MCTWF will continue not to pay any portion of the non-emergent emergency room facility claims, but will make payment toward the non-emergent emergency room physician claims in an amount approximately equivalent to what MCTWF would have paid if the services had been obtained from an urgent care clinic. Accordingly, both the facility and physician bills will be payable by the patient based on discounted charges rather than the full charges and, in addition, the physician bills will be reduced by MCTWF's payment at the urgent care rate for those services.

For a realistic example, a patient obtains emergency room services for a non-emergent condition with facility charges of \$850 and physician's charges of \$475. Under current benefit design, MCTWF would deny these claims and the patient would be responsible for full payment of the charges (\$1,325). Effective January 1, 2015 -

- MCTWF will approve the emergency room facility claim, but pay \$0 and so, instead of the patient having to pay \$850 in facility charges, he would pay the BCBS "allowed amount" of \$474.
- MCTWF will approve the emergency room physician claim and pay toward it the approximately equivalent BCBS urgent care allowed amount (to treat the patient's condition) of \$98, less his benefit package's urgent care level copay of \$35, for a total of \$63. The patient would pay the difference between MCTWF's \$63 payment and the BCBS allowed amount for the emergency room physician claim of \$173. So, instead of the patient having to pay \$473 in physician charges, he would pay \$110.

In sum, in this example, the patient's billing exposure for having utilized an emergency room to treat a non-emergent condition will be reduced by 56% from \$1,323 to \$584.

Bariatric Surgery – Revised Prior Authorization Guidelines

Effective May 16, 2014, the Trustees revised MCTWF's guidelines for prior authorization of bariatric surgery (gastric surgery for morbid obesity) in all medical benefit packages. MCTWF covers bariatric surgery for patients between the ages of 18 and 60 if all the below general prior authorization criteria are met. The same is true for patients below age 18 if satisfactory documentation is presented that appropriate consideration has been given to the risk of surgery on future growth, the patient's maturity level and ability to understand the surgical procedure and to comply with post-operative instructions, and the adequacy of family support. The same also is true for patients above age 60 if satisfactory documentation is presented that based on the patient's physiologic age and co-morbid conditions, a positive risk/benefit ratio exists. The general prior authorization criteria are as follows:

- The patient has a body mass index (BMI) of 40 or greater. If the patient's BMI is between 35 and 39, authorization will be granted if one or more co-morbid conditions also exist, including but not limited to:
 - degenerative joint disease (including degenerative disc disease)
 - hypertension
 - hyperlipidemia or coronary artery disease
 - other atherosclerotic diseases
 - type II diabetes mellitus
 - sleep apnea
 - congestive heart failure.
- The patient has been clinically evaluated by a physician (or authorized delegate) and the physician has documented the failure of non-surgical management including a structured, professionally supervised (physician or non-physician) weight loss program for a minimum of six consecutive months within the last four years prior to the recommendation for bariatric surgery. However, this requirement is waived for super morbidly obese individuals (i.e., those who have a BMI of 50 or greater). Documentation should include periodic weights, dietary therapy and physical exercise, as well as behavioral therapy, counseling and pharmacotherapy, as indicated.
- Documentation has been provided demonstrating that the physician and the patient have a good understanding of the risks involved and that the physician has a reasonable expectation that the patient will be compliant with all post-surgical requirements.
- The patient has had a psychological evaluation performed as a pre-surgical assessment by a mental health professional in order to establish the patient's emotional stability, ability to comprehend the risk of the surgery and to give informed consent, and ability to cope with expected post-surgical lifestyle.

Reconstructive surgical procedures of any kind, for any reason, occasioned directly or indirectly by the weight loss following bariatric surgery, are excluded from coverage.

Sending Secure Emails to MCTWF

For those who choose to communicate with MCTWF by email, it is important that you protect your health information from undesirable outside sources. MCTWF offers you the ability to secure those emails through an arrangement with a leading provider of email encryption services, Zix Corporation. To make use of MCTWF's email encryption service, go to the *Home* page or *Contact Us* page on MCTWF's website at www.mctwf.org, click on the *For Secure Email Communications to MCTWF* link and connect to the MCTWF *Secure Email Message Center*, on which you may register your email address and personal password and view a tutorial.

Please be aware, however, that it is MCTWF's policy not to utilize email to communicate any protected health information to members. For that purpose, MCTWF will continue to communicate by telephone or first class mail.



Intra-Articular Cartilage Injections – Benefit Revision

Effective July 15, 2014, MCTWF's Trustees limited coverage in all medical benefit packages for intra-articular cartilage injections to members with the following conditions:

lage injections to members with the following conditions:

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

Individuals with osteoarthritis of the knee who have obtained insufficient pain relief from conservative non-pharmacological therapy (such as physical therapy) and simple analgesics and who have failed conservative therapy with a non-steroidal anti-inflammatory drug (NSAID), or who have contraindications to NSAID therapy, are eligible for a course of treatment with intra-articular cartilage injections of from one to five weekly injections, once per three month period.

Required Notice of "Grandfathered" Status Under the Affordable Care Act

Please be advised that this group health plan, the MCTWF Actives Plan, believes that all current medical benefit packages not designated as "New SOA," "New Key,"*, "New I&S," or "New PEP" are "grandfathered benefit packages" under 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 benefit package 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. 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 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.

* New Key Plans 1, 1a, 1b, 2, 2a, 2b, 2c, 2d, 3, 3a, 4 and 4a.

Bone Grafts for Dental Implants - New Benefit

Effective October 2, 2014, MCTWF benefit packages covering dental services will cover, as Class III major restorative services, certain bone graft procedures in conjunction with dental implants.

In-Lab Sleep Studies - Prior Authorization Required

All MCTWF medical benefit packages cover members for sleep studies for the following diagnoses:

- transient difficulty in initiating or maintaining sleep;
- somnambulism or night terrors;
- other dysfunctions of sleep stages or arousal from sleep; and
- cataplexy and narcolepsy.

In light of the significantly higher cost of in-lab sleep studies than home sleep studies and in accordance with Blue Cross Blue Shield of Michigan medical policy, **effective February 1, 2015**, MCTWF will require that all Michigan providers obtain prior authorization for in-lab sleep testing for MCTWF members by contacting AIM Specialty Health at (800) 728-8008. All non-Michigan providers must obtain prior authorization for in-lab sleep testing for MCTWF members by contacting MCTWF's Utilization Review Department at (800) 572-7687, extension 463. To obtain prior authorization, the provider must justify why an in-lab sleep test is more clinically appropriate for the patient than a home sleep test. If services are performed, but not prior authorized, the member may be responsible for full payment of charges.



Breast Reduction Mammoplasty - Revised Prior Authorization Guidelines

Effective July 15, 2014, the Trustees revised MCTWF's prior authorization guidelines in all medical benefit packages for breast reduction mammoplasty coverage. Each of the following requirements must be satisfied:

- The patient must be old enough to ensure that her breasts are fully developed.
- The amount of tissue to be removed must be greater than or equal to the 22nd percentile on the Schnur Sliding Scale.
- Two of the below requirements must be met:
 - Documented pain in the neck and/or shoulders, or postural backache, which must be of long-standing duration. Failure of conservative therapy, including an appropriate support bra, exercises, heat/cold treatments and appropriate non-steroidal anti-inflammatory agents or muscle relaxants.
 - Shoulder grooving.
 - Recurrent intertrigo between the breasts and the chest wall that has not responded to dermatologic treatment.

To obtain prior authorization the provider must contact MCTWF's Utilization Review Department at (800) 572-7687 extension 463. If services are performed without prior authorization, you may be fully responsible for payment of the provider's charges.

MCTWF Retirees Plan Deferral Rules

The current MCTWF Retirees Plan (Plan) participation deferral rules are as follows:

Prior to Commencement of Plan Participation – Automatic Deferral – “30-and-Out” Pensioners who are under age 50, whose application for enrollment for retiree medical benefits has been approved subject to attaining age 50, will be automatically deferred until age 50 or later. The retired individual must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retired individual at the commencement of participation.

Retired individuals who are ages 50 to 56, who are not “30-and-Out” Pensioners, and whose application for enrollment for Retiree Medical benefits has been approved subject to attaining age 57, will be automatically deferred until age 57 or later. The retired individual must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retired individual at the commencement of participation.

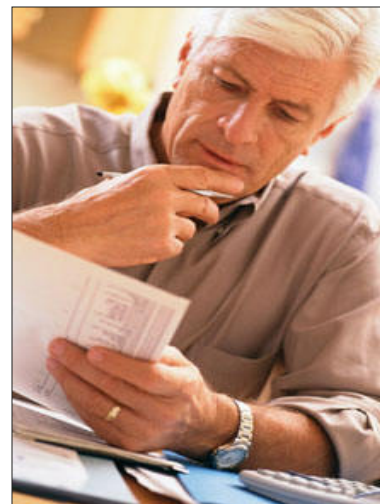
Prior to Commencement of Plan Participation – Voluntary Deferral – Retired individuals, whose application for enrollment for Retiree Medical benefits has been approved, may defer participation upon written request. The retired individual must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retired individual at the commencement of coverage.

Following Commencement of Plan Participation – Automatic Deferral – Effective July 31, 2014, if either a Retiree or retiree spouse participating on her own ceases Plan participation for any reason other than - (a) becoming Medicare eligible, or (b) in the case of a retiree spouse participating on her own, divorce or remarriage - but is otherwise eligible for participation, he or she will be placed in an automatic deferral status and, after no less than six months deferral, may request, in writing, re-enrollment. Also **effective July 31, 2014**, re-enrollment must occur during the MCTWF Retirees Plan annual open re-enrollment period from November 1st through December 10th. Participation

will recommence thereafter on January 1st if the Retiree is not engaged in Prohibited Employment and the required self-contributions are timely made.

Following Commencement of Plan Participation – Voluntary Deferral – Retirees and retiree spouse participating on their own may defer coverage any number of times after commencement of Plan participation. **Effective July 31, 2014**, re-enrollment must occur during the MCTWF Retirees Plan annual open re-enrollment period from November 1st through December 10th. Participation will recommence thereafter on January 1st if the Retiree is not engaged in Prohibited Employment and the required self-contributions are timely made. However, if the deferral is for the purpose of employment as a bargaining unit member by an employer that contributes to the MCTWF Actives Plan for medical benefit coverage, the six month minimum deferral period and open enrollment window requirements will be waived for re-enrollment if MCTWF is notified in writing of the termination of that employment, within 45 days of such termination, coupled with a request to re-enroll. In such case, eligibility will recommence as of the first day of the month following MCTWF’s receipt thereof.

If the deferral is for the purpose of resuming employment, the Retiree or retiree spouse participating on her own may continue Plan participation until the new, employer sponsored coverage commences, by continuing payment of monthly self-contributions.



Weekly Accident & Sickness Benefits

The MCTWF Summary Plan Description (SPD) currently states in relevant part that, "[o]nce the Participant establishes eligibility, weekly accident and sickness benefits may begin on –

- the first day following Medical Attention after the last day worked in the event of an Accidental Injury,...; or
- the eighth day following Medical Attention after the last day worked in the event of a Sickness...."

The SPD defines "Accidental Injury" as "a bodily injury that is the direct result of an Accident and is not related to any cause other than the Accident" and it defines a "Sickness or Illness" as "any disorder of the body or mind (but not an injury) and pregnancy (including abortion, miscarriage, or childbirth)." MCTWF's Trustees have amended these definitions to more clearly reflect their intent. Effective immediately –

- An "Accidental Injury" is defined as "any disabling disorder of the body or mind that is the direct result of an occurrence that is not a sickness."
- A "Sickness or Illness" is defined as "any disabling disorder of the body or mind (other than an Accidental Injury as above defined) and pregnancy (including abortion, miscarriage, or childbirth)."

Pediatric Dental and Vision Benefits - New Limits

Pediatric dental and vision benefits are deemed "essential health benefits" by the Affordable Care Act and therefore are subject to the Act's market reform requirements unless they are "excepted," meaning that they are not an integral part of the group health plan. In such case, among other market reform provisions, they are not subject to the Act's prohibition on annual dollar benefit limits. Recently, final regulations were issued by the applicable federal regulatory agencies under which MCTWF's dental and vision benefits are deemed "excepted" effective January 1, 2015. Accordingly, MCTWF's Trustees have determined that the unlimited pediatric dental and vision benefits that have been in effect since April 1, 2014 in all benefit packages that include dental and vision benefits, will be subject to the same annual dollar benefit limits as adult dental and vision benefits effective January 1, 2015.

Elimination of Best Doctors Program

Despite the high quality and value and MCTWF's free provision of Best Doctors medical review and consulting services, after more than two years of extremely low member utilization and lack of response to our survey earlier this year, the Trustees decided that they could no longer justify the cost of this program to MCTWF and therefore terminated MCTWF's contract with Best Doctors effective September 6, 2014.

Echocardiography Services - Prior Authorization Required



Effective January 1, 2015, in accordance with Blue Cross Blue Shield of Michigan medical policy, MCTWF will expand its current radiology management program by requiring prior authorization of nonemergency outpatient echocardiography ser-

vices performed in a physician's office, freestanding radiology center, or hospital outpatient setting (but not in a inpatient, observation, or emergency room setting). Michigan providers must obtain prior authorization by contacting AIM Specialty Health at (800) 728-8008. Non-Michigan providers must obtain prior authorization by contacting MCTWF's Utilization Review department at (800) 572-7687, extension 463. If services are performed, but not prior authorized, the member may be responsible for full payment of charges.

Gastric Electrical Stimulation Therapy - New Benefit

Gastric Electrical Stimulation (GES) Therapy is a treatment option for those who suffer with chronic nausea and vomiting associated with gastroparesis, a common gastrointestinal motility disorder. This most commonly occurs in diabetic patients and may require frequent hospitalization due to hypoglycemia or hyperglycemia, electrolyte imbalance or other complications of this disease.

Effective June 5, 2014, MCTWF is covering GES Therapy under all of its medical benefits packages for members suffering from both diabetes and gastroparesis. Physicians must obtain prior authorization by contacting MCTWF's Utilization Review Department at (800) 572-7687, extension 463. If services are performed, but not prior authorized, the member may be responsible for full payment of charges.

ABA Coverage for Autism Spectrum Disorders - Revised Benefit

Effective October 30, 2012, dependent children diagnosed with an autism spectrum disorder became eligible under their MCTWF medical benefits package for coverage of Applied Behavior Analysis (ABA) services up to a calendar year limit of \$50,000 for patients through age 6, \$40,000 for patients through age 12, and \$30,000 for patients through age 18, with such limits being based on the patient's age as of January 1st of each year.

In accordance with the Affordable Care Act's prohibition on annual dollar benefit limits for essential health benefits, **effective April 1, 2014**, MCTWF's calendar year dollar limits for ABA services were actuarially converted to hour limits, as follows:

- 1,300 hours limit through age 6 (subject to service limitations below)
- 1,040 hours limit through age 12 (subject to service limitations below)
- 780 hours limit through age 18 (subject to service limitations below)

In accordance with Blue Cross Blue Shield of Michigan (BCBSM) medical policy, the requirements which must be satisfied for coverage of ABA services are as follows:

- **Services in Michigan** – An approved Blue Cross Blue Shield of Michigan (BCBSM) autism evaluation center must make or confirm the autism spectrum disorder diagnosis and provide a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for ABA services, before treatment begins. If ABA treatment is recommended, the services must be obtained from a board-certified behavior analyst for the treatment to be payable. The analyst must obtain prior authorization from BCBSM to provide ABA services. The board-certified behavior analyst may be non-participating but must be registered with BCBSM. A link to Approved Autism Evaluation Centers and Board-Certified Behavior Analysts is available on the *Info Links* page of MCTWF's website.
- **Services Outside of Michigan** – The participant must obtain a multidisciplinary evaluation from an academic medical center or a hospital based facility (participating with the Blue Cross Blue Shield plan in the state where services will be provided) that makes or confirms the autism spectrum disorder diagnosis and provides a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for ABA services. If ABA treatment is recommended, the services must be obtained from a board-certified behavior analyst for the treatment to be payable. The analyst must obtain prior authorization from BCBSM to provide ABA services. The board-certified behavior analyst must be a participating provider in the Blue Cross plan in the state where services will be provided. A link to Blue Cross Blue Shield Non-Michigan Physician, Hospital and Urgent Care Searches is available on the *Provider Networks* page of MCTWF's website.

ABA Services	Limitations
Initial Assessment	Once per patient
Reassessment	No limitation
Line Therapy	Limited to 25 hours per patient per 7 days (Sunday-Saturday) in combination with skills training services
Skills Training	Limited to 25 hours per patient per 7 days (Sunday-Saturday) in combination with line therapy services
Supervision	Limited to 3 hours per patient per 7 days (Sunday-Saturday)
Caregiver Training	Limited to 3 hours per patient per 7 days (Sunday-Saturday)

Choosing Between Total and Permanent Disability and Retiree Medical Benefits

This is to clarify that if a participant who is eligible for both MCTWF Total & Permanent Disability (TPD) benefits and MCTWF Retiree Medical benefits applies for TPD benefits and is issued a notification of approval, the participant irrevocably loses his eligibility for Retiree Medical benefits.

Similarly, if the same participant is approved for and makes his first contribution payment for Retiree Medical benefits, he irrevocably loses his eligibility for TPD benefits.



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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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Fall 2014

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