



The Michigan Conference of Teamsters Welfare Fund

Important Notice to Participants

FUND ENROLLMENT CARD

As a participant of the Michigan Conference of Teamsters Welfare Fund you have the obligation to provide to the Fund complete, accurate and timely information necessary for the Fund to determine the eligibility of the participant and his or her spouse and dependent to receive benefits. Under the revised rules, in order to fulfill that obligation every participant shall:

- A. Complete and sign a new Enrollment Card periodically as requested by the Fund; and
- B. Promptly notify the Fund of any changes in the information provided in the most recent Enrollment Card, i.e., marriage, divorce, birth, death, other insurance coverage etc.

By signing the Enrollment Card a participant:

- A. Certifies that the information provided is complete and accurate as of the date of signature;
- B. Agrees promptly to notify the Fund office of any changes in the information stated on the Enrollment Card i.e., marriage, divorce, birth, death, other insurance coverage, etc.;
- C. Acknowledge that failure to provide complete and accurate information or failure to promptly notify the Fund of changes in information may result in suspension of processing and payment of claims until complete and accurate information is provided to the Fund; and
- D. Acknowledges that the Fund has the right to recover from the participant any overpayments caused by the participant's failure to provide complete, accurate and timely information to the Fund.

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Revised Eligibility Rules For Pre-65 Retiree Benefits

In March, 2000 the Board of Trustees announced the revised eligibility rules for Pre-65 Retiree Benefits. They are as follows:

PRE-65 RETIREE ELIGIBILITY

To be eligible for Pre-65 Retiree Benefit Coverage, the Retiree must:

- A. Be at least age 57 and
 - Have had contributions (either by an employer or self-contributions at the applicable COBRA rate) made on his or her behalf for at least 40 weeks in each of the five consecutive 52-week periods immediately preceding retirement or at least 40 weeks in seven out of the ten consecutive 52-week periods immediately preceding retirement; *except that*
 - For periods while an employee performed seasonal work (see "Definition A" in the last section of this article), contributions must have been made for an *average* of at least 40 weeks per 52-week period for five consecutive 52-week periods immediately preceding retirement, or, an *average* of at least 40 weeks per 52 week period for seven out of the ten consecutive 52-week periods immediately preceding retirement (the appropriate test shall be applied pro rata based on the type of work in which the employee was engaged during the measuring period).
- A. Be at least age 50 and
 - Have had contributions (either by an employer or self-contributions at the applicable COBRA rate) made on his or her behalf for at least 40 weeks in each of the five consecutive 52-week periods immediately preceding retirement or at least 40 weeks in seven out of the ten consecutive 52-week periods immediately preceding retirement, *except that*
 - For periods while an employee performed seasonal work (see "Definition A", in the last section of this article), contributions must have been made for an *average* of at least 40 weeks per 52-week period for five consecutive 52-week periods immediately preceding retirement, or, an *average* of at least 40 weeks per 52 week period for seven out of the ten consecutive 52-week periods immediately preceding retirement (the appropriate test shall be applied pro rata based on the type of work in which the employee was engaged during the measuring period), and
 - Have worked at least 20 years under collective bargaining agreements with affiliated local unions of the International Brotherhood of Teamsters.
- B. Not be eligible for Medicare coverage.
- C. Not be engaged in Prohibited Employment (see "Definition B" in the last section of this article).
- E. Elect to receive Pre-65 Retiree Benefit Coverage by filing with the Fund the Election Form during the 61-day period beginning on the 30th day immediately preceding the Retirement Date and ending on the 30th day immediately following the Retirement Date (see "Definition C" in the last section of this article).

TERMINATION OF PRE-65 RETIREE ELIGIBILITY

- A. Pre-65 Retiree Benefit Coverage will cease upon the first of the following dates:
 - The date the Retiree attains age 65
 - The date the Retiree first becomes eligible for Medicare coverage
 - The date the Retiree dies
 - The date the Retiree becomes eligible for coverage under the Fund as an active employee
 - The date the Retiree engages in Prohibited Employment
 - The date the Fund fails to receive a monthly contribution when due
 - The effective date of (1) termination of Pre-65 Retiree Benefit Coverage as determined by the Trustees, or (2) an

amendment to Pre-65 Retiree Benefit Coverage by the Trustees that makes the Retiree no longer eligible.

- B. A Retiree whose Pre-65 Retiree Benefit Coverage ceased as a result of the Retiree's engagement in Prohibited Employment or failure to make a monthly contribution when due cannot re-elect this coverage.
- C. Failure to file an Election Form on time will result in the loss of eligibility, however, the Trustees may, in their discretion, permit a late filing if the Retiree demonstrates to the Trustees' satisfaction that such failure to file timely resulted from circumstances beyond the Retiree's control.

SURVIVING SPOUSE PRE-65 RETIREE BENEFIT COVERAGE

- A. In the event that an eligible retiree dies or attains age 65, the retiree's spouse may continue to receive Pre-65 Retiree Benefit Coverage upon timely payment of the required monthly contribution until the earlier of:
 - The spouse's attainment of age 65
 - The spouse's eligibility for Medicare
 - Five years following the commencement of the retired member's Retiree Coverage,
 - The effective date of (1) termination of Pre-65 Retiree Benefit Coverage as determined by the Trustees, or (2) an amendment to Pre-65 Retiree Benefit Coverage by the Trustees that makes the Surviving Spouse no longer eligible.
- B. A Surviving Spouse who has not attained age 65 or become eligible for Medicare, but who has received Pre-65 coverage for five years following the commencement of the retired member's Retiree Coverage, may continue coverage through payment of a *higher* self-contribution rate, as determined annually by the Trustees, until such time as the spouse attains age 65 or becomes eligible for Medicare. This option is subject to termination or amendment as determined by the Trustees.

DEFERRAL OF PRE-65 RETIREE BENEFIT COVERAGE

- A Retiree who has met all eligibility requirements but has other medical coverage may defer electing Pre-65 Retiree Benefit Coverage by written request and submitting documentation of other coverage to the Fund.
- A Retiree who qualifies for a 30 and Out Pension from a Teamster Pension Fund (see "Definition D" in the last section of this article) and who has met all eligibility requirements with the exception of attaining the age of 50, may defer Pre-65 Retiree Coverage until he or she attains age 50, by written request and submitting documentation of the 30 and Out Pension eligibility.

A Retiree who elects to defer Pre-65 Retiree Coverage, must meet all of the requirements in effect when he/she later elects coverage and submit proof of termination of other coverage. Coverage will begin upon receipt of the required monthly contribution.

In the event of the Retiree's death, attainment of age 65 or eligibility for Medicare, the period of time that participation was "*deferred*" does not count toward the five years for determining the surviving spouse continued eligibility.

DEFINITIONS APPLICABLE TO PRE-65 RETIREE BENEFIT COVERAGE

- A. *Seasonal Work* means work that is performed only during temperate weather and that ceases during all or a substantial portion of the winter months due to low temperatures, snow or icy conditions.
- B. *Prohibited Employment* means Employment in any position by an Employer that contributes to the Fund.
 - Employment by any Employer, other than a government agency, in a position covered by a collective bargaining agreement between the Employer and any affiliate of the International Brotherhood of Teamsters.
 - Employment, including but not limited to self-employment, other than government employment, in the same industry in which the Retiree was an active employee covered by the Fund.
- C. *Retirement Date* means the date an individual ceases to be covered by the Fund as an active employee as a result of retirement
- D. *Teamster Pension Fund* means a pension plan maintained pursuant to a collective bargaining agreement or collective bargaining agreements between one or more employers and the International Brotherhood of Teamsters or its local unions or affiliates (i.e., Central States, SE & SW Areas Pension Fund).

Contact our Member Services Department at extension 430 if you have any questions

Maximizing Your Benefits Under the Senior Drug Program

FROM THE FUND'S MEDICAL DIRECTOR

Getting the Most from Your Post-65 Retiree Prescription Drug Benefit

This is the first in a series of discussions I plan to have with you through the Messenger on various medical topics. This article will address "Arterial Hypertension" as well as getting the most out of your pharmacy benefits.

With the cooperation of your physician, you can get the most out of your pharmacy benefits. It is important that you put forth your interest in dollar stretching at the beginning of therapy because, unfortunately, this is often a period that is unintentionally overlooked. Building a personal relationship with your physician so that you can discuss the matters in this article will result in "stretching your dollars" without effecting your quality of care. For example, there is no relationship between the cost of a drug and its effectiveness in reducing your blood pressure.

Arterial hypertension may affect as many as 30% of our Teamster population. The mainstay of therapy is medication. The severity of this disorder is determined by the level of pressure that is found in at least three separate tests on three different dates. There are three established categories (1) mild to moderate, (2) moderate and (3) severe. These groupings tell us what the expected negative impact will be to the heart, the kidneys and the brain if the disorder is not treated. Fortunately for us, all but the most severe cases can now be controlled with prescription drugs. Some require only one medication but others may need as many as four to achieve the desired therapeutic results. The pharmaceutical industry has offered us a tremendous number of safe and effective drugs that run the gamut in cost, anywhere from \$10.00 to \$150.00 per month. Most of us can control our blood pressure using one medication and many of us can do this by using the less expensive drug.

The four major drug categories most frequently used in the treatment of arterial hypertension are (1) diuretics, (2) beta blockers, (3) Ace inhibitors, and (4) calcium channel blockers. ARBs (often used when cough is a side effect) are similar to the Ace inhibitors, but not clearly better. Numerous and extensive studies have demonstrated no significant difference in the effectiveness of these groups as to their power in reducing blood pressure --- the same intensity of beneficial result is obtained in proportion to the reduction of pressure and not which agent is used to reduce it.

As of the last report (1996) from the national organization that establishes quality of care in hypertension, the two less expensive drug categories (diuretics and beta blockers) are still their first choices in the treatment of most hypertension cases. These drug agents are available for generally \$20 per month and in low to moderate doses are well tolerated with minimum side effects. This is not to say that some of you may not experience a problem with these drugs, but in my opinion, the severity and frequency of side effects is probably overstated.

Why then do the more expensive drug agents exist and why are we using them?

- We occasionally need a second, third or even fourth drug in controlling your blood pressure. In adding these, each new agent must be of a new class to be effective (i.e., there is no value in using two beta blockers together).
- Special, complicated circumstances require us to apply certain agents, as in the use of Ace inhibitors for diabetes and beta blockers for coronary heart disease.
- Pharmaceutical companies keep their new agents under tight proprietary hold because this is where they get most of their profit (and even they deserve some profit after research and development costs).

In summary, most of us can have our blood pressure controlled by drug therapy. The majority of us can do so on average doses of a single drug. A significant number can also do this on the least expensive drug categories without significant side effects. To accomplish this, we need to let our physicians know our objectives and if the objectives are not possible, we should expect a reasonable explanation as to why not. Finally, we can help ourselves by doing a little exercise, reducing our excess weight by 10 to 25 pounds and keeping our sodium intake at a reasonable limit.

Here's to your good health, Elliotte D. Moss, M.D.

I & S Plan Total and Permanent Disability

In the January/February 2000 issue of the Messenger, Total and Permanent Disability changes were announced for Plans SOA, TIF, Key I and Key II. Please be advised that changes also apply to the I&S Plan as well.

If an active employee covered by the I & S Plan, has met the requirements for the Total and Permanent Disability Benefit, the Fund will pay a monthly benefit of \$283.20. The first payment will commence on the first day of the month following the date that the payment of the benefit is approved, and will continue each month thereafter while the employee remains totally and permanently disabled, up to a maximum of sixty (60) months. If an employee dies while receiving Total and Permanent Disability Benefits, the spouse or designated beneficiary will receive the remaining benefits in a single lump sum payment. Eligibility requirements for the Total and Permanent Disability Benefit, as set forth in our last issue, are the same for all Plans providing for this benefit.

Here is a recap of the benefit requirements that have been eliminated for the Total and Permanent Disability benefit on Plans SOA, TIF, Key I, Key II and **I&S**:

- Elimination of the waiting period (9 consecutive months of continuous total and permanent disability after becoming totally and permanently disabled.
- Elimination of the requirement that a member has to receive a Social Security Disability Award in which the Social Security Administration determined eligibility for disability benefits within twelve (12) months after termination of Fund active coverage
- Elimination of the age dependent monthly benefit (decreased schedule based on increased age). All Plans now provide an established single monthly benefit regardless of age.

Fund Policy Reminder

Appeals of Denied Claims

The Fund's Board of Trustees has the final, discretionary authority to decide payment of benefit claims. Any Fund member who is affected by an adverse claim determination is entitled to an appeal and may initiate an appeal through a written request to the Board of Trustees. Appeals of denied claims will be made solely upon *written submissions*. A request for review of a claim must be submitted within 60 days after the date the notice of the claim denial was sent to the member's last known address.

The member will receive an acknowledgment of appeal receipt from the Fund within

five working days. An appeal decision will be rendered within 60 days of the Fund's receipt of the appeal. If special circumstances require an extension of the time for processing, written notice of the extension will be furnished to the member within the initial 60-day period. The extension will not exceed an additional 60 days. The written response will state specific reasons for the decision and have specific references to the pertinent benefits or plan provisions on which the decision is based.

Remember, members are required to exhaust this procedure before commencing legal action against the Fund.

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Welfare Fund***

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FUND TIP

Attention Fund Retirees: Are You eligible For Medicare?

If you are a Retiree (age 65 or under) and you or your spouse *become eligible for Medicare (either Part A or Part B)* coverage through the Fund must cease for that individual.

The Retiree Benefit Plan is designed to provide health care benefits until a member (or spouse) becomes *eligible* for Medicare. It is your responsibility to notify the Fund when you become eligible to avoid any claim overpayments for which you will be responsible.

The Fund must receive this notification in writing, i.e. a copy of the individual's Medicare card or a letter from the Social Security Administration stating the effective date for either Medicare Part A and/or Part B. As with all correspondence sent to the Fund, please include the **member's Social Security number**.