Michigan Conference of Teamsters Welfare Fund

MESSENGER

VOLUME 34 ISSUE 2

In This Issue:

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. When referring individually or collectively to participants, spouses, and eligible children, the *Messenger* commonly uses the term "members." When referring individually or collectively to spouses and eligible children, the *Messenger* commonly uses the word "beneficiaries." Michigan Conference of Teamsters Welfare Fund is referred to herein as "Fund" or "MCTWF."

Message from MCTWF's Executive Director

Dear Teamster Families,

It was a week of darkness and light.

A day after the dismal realization had taken root that, for the foreseeable future, there likely would be no halting the emboldened, insidious assault on basic civil and human rights in this country, or the economic and social marginalization and demoralization of a huge swath of the American populace, and the resumption of the greedy, ignorant, death spiraling destruction of the environment, I joined several hundred other mourners at the memorial service for our friend Ron Holzgen, held, most fittingly, in his Teamsters Local 406 members' union hall in Grand Rapids.

We were told that we were gathered to celebrate Ron's life, and although there was a pervasive cloud of grief and loss, that feeling of communal despair, along with the palpable sense of mutual empathy and sympathy, were inspiring testaments to the beauty and grace and power of the man, whose life meant so very much to so many.

We at the Fund had the good fortune and pleasure to be a part of Ron's last few years in his role as Fund Trustee and to benefit from his wisdom and humble leadership, which flowed from his integrity, devotion to ethical conduct, insight, humor, courage and immense generosity of spirit. The Fund's Trustees and staff offer their heartfelt condolences to Ron's wife and soulmate Margie, his children and grandchildren, and to his many friends.

In this edition of the *Messenger*, we review the EyeMed Vision Care program, which began October 1, 2016 and about which you received notification in September from the Fund and from EyeMed. This program will avail most of you with a broader choice of network providers and frames, with equal or better lens options and discounts than you had previously, as well as generally faster lens crafting turnaround times. Also reviewed is the Fund's new medical coverage for medically necessary transgender services and medically necessary, non-implantable contact lenses. From an eligibility perspective, we have listed CVS/caremark's new exclusions to its standard formulary that are **effective January 1, 2017** procedural changes to obtain prior authorization by non-Michigan Blue Cross Blue Shield providers for advanced imaging requests (new BlueCross ID cards will be issued shortly to non-Michigan participants), and the extension of dependent eligibility to wards of legal guardians. Please consult the articles within for details.

We welcome all of our recent and soon to be enrolled participants and their family members, including the following groups: (under Kalamazoo **Local 7**) - CB&I, (under Toledo **Local 20**) - Republic Services, (under Cincinatti **Local 100**) - Ryder Integrated Logistics, (under Detroit **Local 214**) - Ogemaw County Courts, (under Detroit **Local 299**) - Minority Auto Handling, (under Flint **Local 332**) - Central Concrete Products and Tri-City Aggregates, (under South Bend **Local 364**) - Lewis Bakeries, (under Detroit **Local 337**) - Shepard Dog and Veritiv Corporation, (under Grand Rapids **Local 406**) - Baraga Area Schools, (under Mosinee, WI **Local 662**) - Musson Brothers, (under Madison, WI **Local 695**) - City Brewing Company, and (under Cincinnati **Local 1199**) - Dayton Heidelberg Distributing Company.

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

Richard Burker

Notice of Creditable Coverage

All MCTWF Benefit Packages with Prescription Drug Coverage

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 members, is expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is 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 certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs, proton pump inhibitors (after a 90 day generic supply during a 365 day period, or if a brand is requested), selective serotonin reuptake inhibitors (brand name only), anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs, 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 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 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, 2016
Michigan Conference of Teamsters Welfare Fund

CVS/caremark Standard Formulary Exclusions and Add-Backs

As was first announced in the winter 2011-2012 *Messenger*, MCTWF's pharmacy benefit manager, CVS/caremark, made prior authorization for medical necessity of prescription drugs that are excluded from its Standard Formulary list a condition of coverage. The following list reflects those drugs that, **effective January 1, 2017**, either are newly excluded from the Standard Formulary (and therefore require prior authorization), or have been returned to it (and therefore no longer require prior authorization). CVS/caremark is notifying current utilizers and their prescribing physician of the newly excluded drugs, and is providing them with a list of covered alternative drugs that are therapeutically equivalent. Please note that generic drugs are in lowercase italics font and brand drugs are in UPPERCASE roman font. To obtain prior authorization, your physician must contact CVS/caremark at 800-626-3046. Since the full list of drugs excluded from the Standard Formulary (and therefore requiring prior authorization) has become too lengthy for publication here, the list is published on our website at www.mctwf.org (click on the Info Links page and view the list under CVS/caremark).

Common Condition/ Therapeutic Class	Drug Newly Excluded from Standard Formulary Effective 1/1/17 (Subject to Prior Authorization)	Recommended Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are not the direct generic equivalent of the brand drug that is subject to prior authorization)	Drug Added Back to Standard Formulary Effective 1/1/17 (No Longer Subject to Prior Authorization)
Allergies Nasal Steroid/Combinations			DYMISTA
Anti-infectives, Antivirals Hepatitis C Agents	DAKLINZA OLYSIO TECHNIVIE ZEPATIER	EPCLUSA, HARVONI, SOVALDI	
Asthma Beta Agonists, Short-Acting	PROVENTIL HFA VENTOLIN HFA	PROAIR HFA, PROAIR RESPICLICK	
Cancer Chronic Myelogenous Leukemia Agents	GLEEVEC TASIGNA	*imatinib mesylate,* BOSULIF, SPRYCEL	
Cancer Prostate Hormonal Agents, Antiandrogens	NILANDRON XTANDI	*bicalutamide,* ZYTIGA	
Cardiovascular Antilipemics HMG-CoA Reductase Inhibitors (HMGs or Statins) / Combinations	CRESTOR	*atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin,* VYTORIN	
Cardiovascular Potassium Supplements	KLOR-CON/25	*potassium chloride liquid*	
Cardiovascular Pulmonary Arterial Hypertension Agents Endothelin Receptor Antagonists	OPSUMIT	LETAIRIS, TRACLEER	
Carnitine Deficiency Agents	CARNITOR CARNITOR SF	*levocarnitine*	
Cystic Fibrosis Inhaled Antibiotics	TOBI TOBI PODHALER	*tobramycin inhalation solution,* BETHKIS	
Depression Antidepressants, Selective Norepinephrine Reuptake Inhibitors (SNRIs)	venlafaxine ext-rel tablet (except 225 mg)	*duloxetine, venlafaxine, venlafaxine ext-rel capsule,* PRISTIQ	
Dermatology Miscellaneous Skin Conditions	ALCORTIN A ALOQUIN NOVACORT	*hydrocortisone*	
Diabetes Long Acting Insulins	LANTUS TOUJEO	BASAGLAR, LEVEMIR, TRESIBA	
Diabetes Supplies, Pen Needles	ALLISON MEDICAL PEN NEEDLES NOVO NORDISK PEN NEEDLES ULTIMED PEN NEEDLES	BD PEN NEEDLES	
Diabetes Supplies, Syringes	ALLISON MEDICAL INSULIN SYRINGES TRIVIDIA INSULIN SYRINGES ULTIMED INSULIN SYRINGES	BD INSULIN SYRINGES	
Gastrointestinal Agents Irritable Bowel Disease - Constipation Predominant			AMITIZA

Common Condition/ Therapeutic Class	Drug Excluded from Standard Formulary Effective 1/1/17 (Subject to Prior Authorization)	Recommended Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are not the direct generic equivalent of the brand drug that is subject to prior authorization)	Drug Added Back to Standard Formulary Effective 1/1/17 (No Longer Subject to Prior Authorization)
Hematologic Anticoagulants (oral)	PRADAXA	*warfarin,* ELIQUIS, XARELTO	
Hematologic Hemophilia Agents	HELIXATE FS	KOGENATE FS	
Hematologic Neutropenia Colony Stimulating Factors	NEUPOGEN	ZARXIO	
Hematologic Platelet Aggregation Inhibitors	PLAVIX	*clopidogrel,* BRILINTA, EFFIENT	
High Blood Pressure Beta-blocker Combinations	DUTOPROL	*metoprolol succinate ext-rel with hydrochlorothiazide*	
Huntington's Disease Agents	XENAZINE	*tetrabenazine*	
Opioid Reversal Agents Antagonists	EVZIO	NARCAN NASAL SPRAY	
Overactive Bladder/Incontinence Urinary Antispasmodics	ENABLEX GELNIQUE	*oxybutynin ext-rel, tolterodine, totlterodine ext-rel, trospium, trospium ext-rel,* MYRBETRIQ, TOVIAZ, VESICARE	TOVIAZ
Pain Headache Agents	butalbital-acetaminophen-caffeine capsule	*naratriptan, rizatriptan, sumatriptan, zolmitriptan,* RELPAX, ZOMIG NASAL SPRAY	
Pain Transmucosal Immediate-release Fentanyl Agents	ABSTRAL	*fentanyl transmucosal lozenge*, FENTORA, SUBSYS	
Pain and Inflammation Corticosteroids	DEXPAK MILLIPRED	*dexamethasone, methylprednisolone, prendisone*	
Pain and Inflammation Nonsteroidal Anti-inflammatory Drugs (NSAIDs)/Combinations			DUEXIS VIMOVO

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 (such as MCTWF) 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.

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.

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 has been contingent upon submission to MCTWF of an Adult Child Coverage Application for Enrollment form.

The Trustees have authorized another enrollment period for those adult children, beginning November 1, 2016 and ending December 31, 2016, to permit eligibility for coverage commencing on or after January 1, 2017 (contingent upon the eligibility of the child's parent/participant and only if the child's age is less than 26 at that time).

To enroll, an Adult Child Coverage Application for Enrollment form must be fully completed and received by MCTWF **between November 1, 2016 and December 31, 2016**. This form is available on the *Forms* page of MCTWF's website at www.mctwf.org, or by contacting MCTWF's Member Services Call Center. **Please note that the Application must be timely submitted 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.**

MCTWF's New Vision Program - EyeMed Vision Care

We are pleased to formally announce that **effective October 1, 2016**, EyeMed Vision Care is MCTWF's new vision benefits administrator. MCTWF has contracted with it for access to its broad Insight Network. You have received notifications from MCTWF and from EyeMed in September with updated MCTWF Networks cards and EyeMed ID cards and a list of Insight Network participating retail and independent eyewear providers situated closest to your home (you can view a comprehensive list of EyeMed Insight Network providers by linking to them on the *Provider Networks* page of the Fund's website at www.mctwf.org). EyeMed's Insight Network offers MCTWF participants and beneficiaries who have vision benefits a far larger number of optometrists and ophthalmologists and retail eyewear locations, faster lens crafting time, and equal or better vision benefits, options, and discounts than they had previously. Network retailers include SVS Vision (Teamster represented), Lenscrafters, Pearle Vision, Target Optical, Sears Optical, and JCPenney. Please note that if you already have used up your vision benefits (exam, lenses and/or frame, or contacts) for calendar year 2016, you will not be entitled to new vision benefits until January 1, 2017. However, in any year that you've exhausted your vision benefits, EyeMed Insight Network providers will discount their normal retail charges by 40% on each pair of complete prescription eyeglasses.

EyeMed also offers on-line eyeglass options through www.glasses.com (you also can download the glasses.com app, which uses digital try-on technology to create a 3D model of your face, to see how thousands of styles look on you from any angle) and on-line contact lens options through www.contactsdirect.com. To access either site, click on EyeMed on the *Provider Networks* page of the Fund's website and then locate them at the top of the *Provider Search Results* page (you also will find www.eyemedlasik.com. there for in-network laser vision correction providers). Both sites price their products in accordance with the MCTWF vision benefit and provide free shipping.

VISION BENEFITS	EYEMED INSIGHT NETWORK OVERAGE	NON-NETWORK COVERAGE
EXAMINATION with Dilation as Necessary	Covered in full	Up to $50
RETINAL IMAGING	Up to $39 copay	No coverage
CONTACT LENS EXAMINATION OPTIONS		No coverage
Standard Contact Lens Fit and Follow-Up	Up to $40 copay	
Premium Contact Lens Fit and Follow-Up	No coverage. Member receives 10% discount off retail price.	
FRAMES (Any Available Frame at Provider Location)	Covered up to $125, 20% discount off balance over $125	Up to $75
STANDARD PLASTIC LENSES - Per Pair		
Single	Covered in full	Up to $50
Bifocal	Covered in full	Up to $60
Trifocal and Lenticular	Covered in full	Up to $70
Standard Progressive Lens	$42 copay	Up to $70
Premium Progressive Lens Tier 1	$72 copay	
Premium Progressive Lens Tier 2	$82 copay	
Premium Progressive Lens Tier 3	$107 copay	
Premium Progressive Lens Tier 4	$42 copay, then 20% discount off retail price less $120 allowance	
LENS OPTIONS - Per Pair		No coverage
UV Treatment	$15 copay	
Tint (Solid or Gradient)	$15 copay	
Standard Plastic Scratch Coating	Covered in Full	
Standard Polycarbonate - Adults	$35 copay	
Standard Polycarbonate - Kids under 19	Covered in Full	
Standard Anti-Reflective Coating	$40 copay	
Premium Anti-Reflective Coating Tier 1	$55 copay	
Premium Anti-Reflective Coating Tier 2	$68 copay	
Premium Anti-Reflective Coating Tier 3	No coverage. Member receives 20% discount off retail price.	
Polarized	$75 copay	
Photochromatic / Transitions Plastic	$70 copay	
High Index	$60 copay	
Other Lens Options	No coverage. Member receives 20% discount off retail price.	

VISION BENEFITS	EYEMED INSIGHT NETWORK OVERAGE	NON-NETWORK COVERAGE
CONTACT LENSES - Materials Only		
Conventional	Covered up to $120, 15% discount off balance over $120	Up to $80
Disposable	Covered up to $120	Up to $80
Contacts Direct Benefit Booster	$20 additional contact lens allowance when lenses purchased through contactsdirect.com	No Coverage
LASER VISION CORECTION - Per Eye (Lasik or PRK from U.S. Laser Network)	Member receives 15% discount off retail price or 5% off promotional price less $250 allowance per eye per lifetime.	Up to $250 per eye per lifetime
ADDITIONAL BENEFIT	Members receive a 40% discount off complete pair eyeglass purchases once the funded benefit has been used.	No coverage
FREQUENCY: Examination, Lenses or Contact Lenses and Frame	One exam and one vision correction option per person per calendar year. A vision correction option is defined as either (a) one pair of lenses and frames, whether purchased together or separately, (b) contact lenses and fitting, or (c) laser vision correction for one or both eyes. Note: Coverage for one such annual vision option cannot be later replaced with coverage for another vision option.	

Note: If you utilize an ophthalmologist and do not have a medical eye condition, services will be covered under the vision portion of your benefit package. To receive network-level benefits, the ophthalmologist must participate in the EyeMed Insight network. If you are being treated by an ophthalmologist for a medical condition, services will be covered under the medical portion of your benefit package. To receive network-level benefits, the ophthalmologist must participate in the BCBS PPO network.

By clicking on EyeMed on the *Provider Networks* page of the Fund's website and registering through the Member Login, you can view your vision benefits, claims, special vision offers, provider locations and wellness information.

EyeMed also has arranged for discounted hearing aids and services through Amplifon (locations are nationwide), for those who are eligible for MCTWF medical and vision benefits. To find a hearing care provider near you and schedule a hearing exam, call 844- 526 5432. These hearing benefits are covered under your medical program, so please present your Blue Cross ID card to the provider for proper claim submission.

Coverage for Medically Necessary, Non-Implantable Contact Lenses

Certain eye conditions cannot be addressed adequately through surgical correction or the use of eyeglasses and require, as medically necessary, the use of special, non-implantable contact lenses. **Effective September 28, 2016**, the following diagnoses are covered as a medical service when submitted with an appropriate vision procedure code:

- Keratoconus
- Aphakia
- Anisometropia
- Aniseikonia
- Dry Eye Syndrome or Bilateral Lacrimal Glands
- Presence of Intraocular Lens
- Cataract Extraction Status

Medically necessary, non-implantable contact lenses are payable as durable medical equipment and the applicable deductible and/or coinsurance will apply in accordance with your benefit package.

Prior Authorization for Advanced Imaging Requests and In-Lab Sleep Studies

MCTWF has utilized the Blue Cross Blue Shield of Michigan (BCBSM) Clinical Review Management Program ("Program") administered by American Imaging Management (AIM) for BCBSM participating providers to obtain prior authorization for outpatient non-emergency "advanced imaging" diagnostic services (i.e., CT scans, MRIs, PET scans, nuclear medicine, and echocardiography) and for all in-lab sleep studies. Prior to November 1, 2016, Michigan providers who did not participate in the Blue Cross Blue Shield networks and all providers outside of Michigan were required to seek prior authorization for advanced imaging and in-lab sleep studies from MCTWF's Utilization Review Department.

Effective with dates of services November 1, 2016 and after, non-Michigan providers who participate in the Blue Cross Blue Shield networks are required to comply with the Program by seeking prior authorization for outpatient non-emergency advanced imaging diagnostic services from AIM at 800-728-8008. All providers who do not participate in the Blue Cross Blue Shield networks must continue to seek prior authorization for outpatient non-emergency advanced imaging diagnostic services from MCTWF's Utilization Review Department and all providers outside of Michigan must continue to seek prior authorization for in-lab sleep studies from MCTWF's Utilization Review Department. Please be aware that if prior authorization is not granted, you will be responsible for the cost of the service.

Those affected by this change will receive new, gold colored BCBSM ID cards with the advanced imaging diagnostic services and in-lab sleep studies phone numbers included on the back. Please begin presenting this card immediately for all medical services and destroy your current BCBSM ID card (but retain your white colored MCTWF Networks card; that card remains in effect).

Coverage for Medically Necessary Transgender Services

Effective with dates of service September 1, 2016 and after, the Fund has adopted Blue Cross Blue Shield of Michigan's medical policy guidelines for medically necessary transgender services to provide gender reassignment surgery, hormone therapy, doctor's office and lab testing, and counseling for participants and beneficiaries with gender dysphoria. Investigational transgender services continue not to be covered.

The established treatments of gender dysphoria include:

- Puberty suppression in adolescent
- Cross-sexual hormone therapy (for masculinization/ feminization)
- Medically necessary gender reassignment surgery, which requires prior authorization
  - Genitalia reconstruction
  - Mastectomy in female-to-male transitions.

Gender specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female-to–male transitioned persons who have not undergone a mastectomy.
- Prostate cancer screening may be medically necessary for male-to-female transitioned persons who have retained their prostate.
- Cervical screening may be medically necessary for female-to-male transitioned persons, as needed.

Puberty Suppression

Puberty suppression hormones for adolescents (note: these are covered under the participant's pharmacy benefit) may be indicated for participants and beneficiaries that meet all of the following inclusionary criteria:

- Onset of puberty to at least Tanner stage 2;
- The adolescent dependent child has demonstrated a long-lasting and intense pattern of gender nonconformity of gender dysphoria (whether suppressed or expressed);
- Gender dysphoria emerged or worsened with the onset of puberty;
- Any coexisting psychological, medical or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent dependent child's situation and functioning are stable enough to start treatment;
- The adolescent dependent child has given informed consent and, particularly when the adolescent dependent child has not reached the age of medical consent, the participant and/or spouse or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent dependent child throughout the treatment process; and
- The absence of contraindications to therapy in the judgment of the managing physician.

Hormone Therapy

Hormone therapy (note: covered under the participant's pharmacy benefit) may be indicated for participants and beneficiaries that meet all of the following inclusionary criteria:

- Persistent, well-documented gender dysphoria;
- Capacity to make a fully informed decision and to consent for treatments;
- 18 years of age or older (age of majority);
- if significant medical or mental health concerns are present, they must be reasonably well-controlled; and
- The absence of contraindications to therapy in judgement

Gender Reassignment Surgery

- The absence of contraindications to therapy in the Gender reassignment surgery may be indicated for participants and beneficiaries that meet all of the following inclusionary criteria:
- Persistent, well-documented gender dysphoria;
- The provider must supply documentation that supports the participant or beneficiary meets criteria for gender assignment surgery;
  - This includes a detailed psychological assessment by either a psychiatrist, PhD prepared clinical psycholoist or a master's prepared social worker (MSW) under the supervision of a psychiatrist or PhD prepared clinical psychologist
- 18 years of age or older;
- Capacity to make a fully informed decision and to consent to treatment;
- If significant medical or mental health concerns are present, they must be controlled; and
- 12 continuous months of hormone therapy as appropriate to the patient's gender role (unless there is a contraindication to hormonal therapy):
  - Hormone therapy is not required prior to mastectomy in female-to-male patients.
  - The aim of hormone therapy prior to a gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

Some patients receiving transgender services may require and benefit from ongoing behavioral health services, including psychotherapy.

Exclusions

The following services are excluded under the medically necessary transgender benefit:

- Reversal of transgender surgical procedures.
- All surgical procedures that are primarily cosmetic and not medically necessary including, but not limited to:
  - Abdominoplasty
  - Blepharoplasty
  - Breast enhancements
  - Brow lift
  - Calf implants
  - Cheek/malar implants
  - Chin/nose implants
  - Chondolaryngoplasty (Adam's apple reduction)
  - Collagen injections
  - Construction of a clitoral hood
  - Drugs for hair loss or growth
  - Forehead lift
  - Hair removal
  - Hair transplantation
  - Lip reduction
  - Liposuction
  - Mastopexy
  - Neck tightening
  - Pectoral implants
  - Removal of redundant skin
  - Rhinoplasty
  - Speech-language therapy
  - Non-covered services

HIPAA Notice of Privacy Practices

HIPAA regulations require the triennial publication of a Plan's HIPAA Notice of Privacy Practices. The following is MCTWF's HIPAA Notice of Privacy Practices, last amended November 2016. It also can be found on the *HIPAA Privacy Rule* page of MCTWF's website at www.mctwf.org:

Notice of Privacy Practices for Protected Health Information. Your Information. Your Rights. Our Responsibilities.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights (see below for more information on these rights and how to exercise them)
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices (see below for more information on these choices and how to exercise them)
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information **(Please note that this Notice uses HHS prescribed model language, but MCTWF does not market or sell medical information, or use it for any purpose other than to administer its benefit plans.)**

Our Uses and Disclosures (see below for more information on these uses and disclosures)

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 8.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes. (note: MCTWF does not market information.)
- Sale of your information. (note: MCTWF does not sell information.)

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you. *Example:* A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services. *Example*: *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.* **(note: MCTWF's Board of Trustees is your plan sponsor.)**

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We never share your health information for marketing purposes. We never sell your health information.

Under the HIPAA privacy and security rules, the Plan is required to comply with State laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This Notice is **effective November 2016**

Privacy Officer: Barbara McGuire
(313) 964-2400 ext. 202
privacyofficer@mctwf.org

MDLIVE Prize Winners

The spring 2016 *Messenger* announced that MDLIVE was conducting a drawing from the names of all those MCTWF participants and beneficiaries who registered with MDLIVE between June 1st and July 15th, or who had previously registered and emailed their entry into the drawing by June 30th.

Four winners were chosen. Each received a $50 VISA gift card and an MDLIVE sport water bottle. The winners (pictured below, clockwise from upper left) are Local 247 member James Lintecum from Allied Waste, Local 337 member Nicholas Bennett from Heartland Steel/Eugene Welding, Local 406 member Sulejman Beslagic from USF Holland, and Local 637 member Anthony Croston from South East Area Transit.

Above photo, taken at the MCTWF office, from left to right are Local 247 Principal Officer Paul Kozicki, winner (Local 247 member) **James Lintecum** and MCTWF Field Services Representative Sherry Hall.

Above photo, taken at the Heartland Steel office, from left to right are MCTWF Field Services Manager Kim Bratek, winner (Local 337 member) **Nicholas Bennett** and Heartland Steel Human Resources Manager Kim Delor.

Above photo, taken in Zanesville, Ohio, from left to right are winner (Local 637 member) **Anthony Croston** and MCTWF Field Services Manager Kim Bratek.

Above photo, taken at the Local 406 office, from left to right, are MCTWF Field Services Representative Sherry Hall, winner (Local 406 member) **Sulejman Beslagic** and Local 406 Business Agent Dave Goller.

We congratulate all of our winners and hope that they have enjoyed their gift card and sport water bottle.

As a reminder, the $10 copay for each MDLIVE consultation has been waived through March 31, 2017. Also, you do not have to register on-line in order to speak to a doctor. You can call 888-632-2738 and provide the MDLIVE "concierge" with the last four digits of the participant's social security number and date of birth, and the patient's name, address, phone number, and date of birth. The doctor will call you shortly thereafter.

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

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.

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

Death and Accidental Death & Dismemberment Benefits Payable to Minors

Effective August 4, 2016, if the named beneficiary of Death or Accidental Death and Dismemberment benefits is under 18 years of age at the time the claim accrues, the beneficiary's claim filing deadline is the greater of 12 months following his/her 18th birthday, or the remaining time under the MCTWF Actives Plan general death benefit claim filing deadline of 36 months from the date of death.

FluMist® Not Covered this Flu Season

The American Academy of Pediatrics and the Centers for Disease Control and Prevention warn that FluMist® (a live attenuated influenza vaccine administered by intranasal spray) generally has proven ineffective in protecting against influenza strains that were most prominent during the past three flu seasons, especially in children (for whom the nasal spray vaccine was developed), and recommend that children ages 6 months and older receive a seasonal flu shot as the best available protection against influenza. Accordingly, and consistent with Blue Cross Blue Shield of Michigan medical policy, MCTWF will not cover FluMist® nasal spray vaccine for the 2016-2017 flu season.

Dependent Eligibility for Wards of Guardians

Effective September 29, 2016, the MCTWF Actives Plan definition of Dependent has been expanded to include minor children whose legal guardian is either a MCTWF covered participant or his spouse.