

Michigan Conference of Teamsters Welfare Fund



Messenger



VOLUME 29, ISSUE 1

SPRING 2011

Message from MCTWF's Executive Director

Dear Teamster Families:

It's spring again, the season of new beginnings and renewed hope, of fundamental truths and natural harmony. It's the season of fresh perspective and redoubled resolve, of clarity of purpose and uncompromised integrity. It's the season that honors those who are true of heart and steadfast.

We welcome the 1,400 young women and men, who, as children of our participants and by virtue of your approved applications, are now eligible for Fund coverage through your 26th birthday month. We encourage you to learn about your benefit plan and, particularly, to take advantage of your free access to our wellness program of preventive health services.

The Fund's Trustees have decided to open a second adult child enrollment window between November 1st and December 16th of this year for those who did not enroll during the first window. Advance notification will be provided in the *Messenger*. For those who enroll during the second window, coverage will commence as of January 1, 2012. We remind you that those children who, as dependents, were covered under a MCTWF plan on February 27, 2011 or later, automatically are continued as covered dependents through their 26th birthday month (subject to satisfying ongoing eligibility requirements); no new enrollment will be required of them.

This edition of the *Messenger* provides you with several notices required by the healthcare reform law (the Patient Protection and Affordable Care Act, referred to by the regulators as the Affordable Care Act) and articles otherwise in connection with it. The initial provisions of the healthcare reform law became effective for the Fund as of April 1, 2011, the first day of the new plan year. As to those provisions that affect the Fund by reason of plan design and despite the "grandfathered" status of the Fund's plans – (in addition to the liberalization of eligibility criteria and increase in the age limit for adult children, as noted above) - dollar limits on "essential health benefits" were eliminated on a lifetime basis and phased out on an annual basis and retroactive cancellation ("rescission") of coverage was prohibited unless the individual, or person seeking coverage on behalf of the individual, performs a fraudulent act, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan, or unless contributions are not timely paid.

With regard to these provisions, the Trustees have eliminated all lifetime and annual dollar limits from the Fund's health plans (dental and vision plans are not affected) other than from the two health plans that could not tolerate the resulting projected benefit expense increase attributable to elimination of their overall annual dollar limits; the Retiree Medical Program and the freight "daily rate" mini-med plan. The Fund has been awarded, for both plans, a waiver from the healthcare reform law's minimum overall annual dollar limit requirement for the current plan year and intends to renew its applications for ensuing plan years. The Fund also has applied for and has received the first of, hopefully, several reimbursements for certain Retiree Medical Program expenses from a limited pool of money provided for under the healthcare reform law's Early Retiree Reinsurance Program. Additionally, the Trustees have amended the plans - to bring the definition of "dependent" into compliance with regard to children; to make clear that the failure of an individual to provide timely required notification to the Fund of changes in status that affect the individual's eligibility for coverage will be deemed an intentional misrepresentation of a material fact and therefore will result in the rescission of coverage; and to redesign the chiropractic services benefit, replacing the annual dollar limits with certain frequency limits.

Without regard to healthcare reform, and, of course, to universal applause, the Trustees also have eliminated the eight week benefit eligibility waiting period. Please see the article for details.

We welcome all of our new participants, including the following new groups: (under Detroit **Local 337**) The Ides of March Films and Drunken Pig Production, (under Grand Rapids **Local 406**) SVS Vision and (under Saginaw **Local 486**) the City of Manistique. Please do not hesitate to contact us.

On behalf of the Trustees and staff, I wish you good health, good luck, and a really nice spring.

Richard Burker

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Editor's Note:

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

Required Notices of Waiver from the Annual Limit Requirement of the Affordable Care Act

Retiree Medical Program Plans 145 and 475

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by the Michigan Conference of Teamsters Welfare Fund's Retiree Medical Program Plans 145 and 475, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of \$220,000 on all covered medical benefits.

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 this year (commencing 4/1/2011). That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing \$750,000 in coverage for key benefits this year would result in a significant

increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the MCTWF Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216.

In addition, you can contact the Michigan Consumer Health Assistance Program (MiCHAP) which is run by the Michigan Office of Financial and Insurance Regulation at:

611 W. Ottawa Street
Lansing, MI 48933
(877) 999-6442
<http://michigan.gov/ofir>
ofir-ins-info@michigan.gov

NMFA "Daily Rate" Mini-Med Plan 330

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered

by the Michigan Conference of Teamsters Welfare Fund's National Master Freight Agreement "Daily Rate" Mini-Med Plan 330, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of \$100,000 on all covered medical benefits.

NMFA "Daily Rate" Mini-Med Plan 330 Continued on Page 3



In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 this year (commencing 4/1/2011). That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing \$750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

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Required Notice Regarding Reimbursement of Some Costs Under The Early Retiree Reinsurance Program

The healthcare reform law ("Affordable Care Act") provides for the funding of the Early Retiree Reinsurance Program to encourage the continuation of retiree health plans, at least until 2014 when state insurance exchanges must be implemented, by reimbursing retiree health plans for some of their costs. MCTWF applied and was approved for such reimbursements and is therefore required by the Department of Health and Human Services to provide the following notice thereof to individuals who may qualify for retiree health coverage:

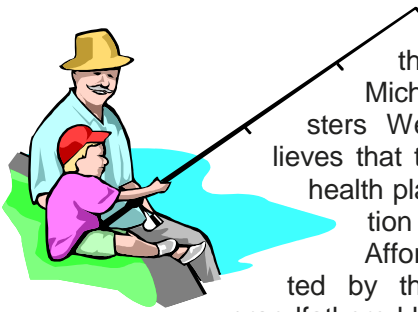
You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives

from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.



"Grandfathered" Status Under The Affordable Care Act



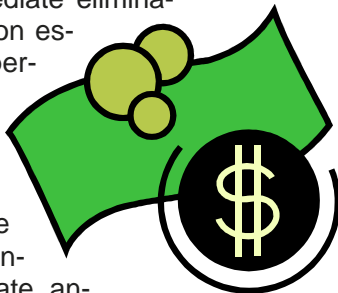
Please be advised that this group health plan, the Michigan Conference of Teamsters Welfare Fund (MCTWF), believes that this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health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

However, grandfathered health plans must 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 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Lifetime and Annual "Essential Health Benefits" Dollar Limits

As it applies to MCTWF, **effective April 1, 2011**, the healthcare reform law ("Affordable Care Act" or "Act") requires the immediate elimination of lifetime dollar limits on essential health benefits and permits a phased-in elimination of annual dollar limits on essential health benefits. The Trustees have decided to not only eliminate lifetime dollar limits on essential benefits, but to eliminate annual dollar limits on essential benefits, as well. While "essential health benefits" is not a precisely defined term under the Act or, as yet, by regulatory guidance, the Act lists the following categories of essential health benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision. We will keep you informed as more detailed guidance regarding essential benefits is made available.



Rescission of Coverage

The healthcare reform law ("Affordable Care Act") prohibits a plan from cancellation of an individual's coverage retroactively (i.e., "rescission") unless the individual "performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage." Coverage also may be rescinded for failure to make timely payment of contributions.

As stated in your Summary Plan Description Booklet (SPD) Introduction, "MCTWF will terminate your coverage if the Trustees, in their sole discretion, determine that you, or your legal representative, knowingly provide false information, directly or indirectly, with the intent to cause MCTWF to provide coverage, benefits, or payments that you or a third party is not entitled to receive." The SPD, in section 2.1(b) also states that "[y]ou must notify the MCTWF immediately when you have a 'change in family status'...."

The Trustees have amended the SPD to make clear that a failure to timely notify MCTWF of a change in status is deemed an intentional misrepresentation of material fact and is therefore prohibited by MCTWF, as follows:

"Any act, practice, or omission by an individual that constitutes fraud or an intentional misrepresentation of material fact to MCTWF is prohibited by the terms of the Summary Plan Description Booklet and Plan document and the Trustees may rescind MCTWF coverage as a result. Failure to provide timely notice to MCTWF of a change in eligibility status, including, but not limited to, a change in status resulting from divorce or eligibility for Medicare, is an intentional misrepresentation of material fact."



Revised Definition of "Dependent"

In accordance with the healthcare reform law (the "Affordable Care Act"), effective April 1, 2011 MCTWF generally will make health benefits available to dependent children through the end of their 26th birthday month. Therefore, MCTWF's definition of a Dependent (SPD booklet section 2.1(d)) has been revised, **effective April 1, 2011**, as follows:

Subject to MCTWF enrollment requirements, your Dependents are -

- your spouse, as recognized under the law of the State of Michigan;
- your natural or step child, or child who has been placed with you for adoption, or whom you have adopted, age 18 and under;
- your natural or step child, or child who has been placed with you for adoption, or whom you have adopted, age 19 through the end of his 26th birthday month, unless your child is eligible to enroll in an employer-sponsored health plan other than yours -

(please note: this caveat regarding non-parental plan eligibility will cease upon the earlier of April 1, 2014 or the date upon which the participant/parent's MCTWF health plan is no longer "grandfathered" under the Affordable Care Act);



- your natural or step child, or child who has been placed with you for adoption, or whom you have adopted, regardless of age (except that such child over the age of 26 must be unmarried), who has been determined by a physician, psychologist or psychiatrist to be totally and permanently disabled. If your disabled child is age 26 or greater and his disability began before he was covered under an MCTWF plan, you must present adequate evidence that he was covered under your health plan that immediately preceded MCTWF coverage.

Eligibility Waiting Period Eliminated

As stated in your Summary Plan Description Booklet, for newly hired employees of contributing employers, eligibility for coverage under a MCTWF benefit plan is subject to a waiting period; coverage is established upon receipt of

nine weeks of employer contributions during any consecutive 13 week period, retroactive to the first day (Sunday) of the ninth week. That rule also applies in certain other circumstances to reestablish plan coverage. **The Trustees have decided to eliminate this plan coverage eligibility waiting period.**

Effective April 3, 2011, participants are no longer subject to the eligibility waiting period. Upon MCTWF's receipt of at least one week of employer contributions on a MCTWF enrolled employee's behalf, eligibility for plan coverage will commence, retroactive to the first day of that first contribution week. **For MCTWF enrolled employees who currently are in the process of satisfying their eligibility waiting period under the prior rule, coverage will commence as of April 3, 2011 or the first day of the week thereafter that employer contributions are made for that week.** The elimination of the eligibility waiting period in no way affects entitlement to benefit bank week coverage.



Weekly Accident & Sickness Benefits - Entitlement Clarification

Occasionally, MCTWF receives a claim for Weekly Accident and Sickness Benefits under circumstances in which the medical attention (to treat the accident or illness and to establish that the participant is disabled) is received by the participant on a date that he no longer is eligible for benefits. This is to clarify MCTWF's rule (please see SPD booklet section 4.1) by adding the below bolded language to the relevant portions of that rule, as follows:

Once 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, **providing that the participant is eligible for benefits on the date that the Medical Attention was received**; or
- the eighth day following Medical Attention after the last day worked in the event of a Sickness, **providing that the participant is eligible for benefits on the date that the Medical Attention was received.**



Immunizations

Immunizations received in accordance with MCTWF's approved schedules (which follow the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices) are covered, subject to applicable limits, by all MCTWF plans with medical coverage. Please refer to your schedule of benefits for specifics. The below 2011 *Child and Adolescent Immunization Schedule* remains unchanged from the last schedule published in the *Messenger*. All recommended child and adolescent immunizations are covered in full if received from a network provider.

2011 Child and Adolescent Immunization Schedule

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

Range of recommended

Catch-up immunization

Certain high-risk groups

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

Below is the 2011 *Adult Immunization Schedule*. Please take note that the annual influenza vaccination is now recommended for all ages 19 years and older (previously it was recommended for adults ages 50 years and older) and is covered in full if received from a network provider.

2011 Adult Immunization Schedule

Vaccine	19-26 Years	27-49 Years	50-59 Years	60-64 Years	65 Years and Older
Tetanus diphtheria pertussis (Td/Tdap)	1 dose Td booster every 10 years				
	Substitute 1 dose of Tdap for Td				
Human papillomavirus	One series (females only)				
Measles, Mumps, Rubella (MMR)	1 or 2 doses		1 dose		
Varicella	2 doses (0, 4-8 wks)				
Influenza	1 dose annually				
Pneumococcal (Polysaccharide)	1 - 2 doses				1 dose
Hepatitis A	2 doses (0, 6-12 months or 0, 6-18 months)				
Hepatitis B	3 doses (0, 1-2, 4-6 months)				
Meningococcal (Polysaccharide)	1 or more doses				
Zoster					1 dose

For a detailed statement including the CDC's risk based recommendations, please refer online to <http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm>

For persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

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



Retiree Medical Program Rates - April 2011 - March 2012

Effective April 2011, the monthly self-contribution rates listed below apply to all those participating in MCTWF's basic Retiree Medical Program, Plan 145. For those purchasing the supplemented Program, Plan 475 (which includes MCTWF's hearing, vision, and Dental Plan 2 benefits), add \$141.00 to the below Program rates:

April 2011 Plan 145 Monthly Self-Contribution Rate (Covers Both the Retiree and the Eligible Spouse)*						
	Years Participating in MCTWF under a Plan with Retiree Medical Program Coverage					
Age at MCTWF Retirement Date	5 – 9	10 – 14	15 – 19	20 – 24	25 – 29	30 +
50 – 54	\$700	\$635	\$570	\$515	\$440	\$385
55 – 59	\$535	\$500	\$460	\$420	\$390	\$355
60 – 64	\$385	\$370	\$355	\$340	\$330	\$320

For eligible retirees whose active employment ceased prior to January 1, 2002: \$320

* Eligibility to participate in the Program ceases for the retiree or the spouse when he or she becomes eligible for Medicare Part A coverage or engages in prohibited employment (as defined by the Summary Plan Description Booklet). In the event that the retiree becomes eligible for Medicare Part A, the spouse may continue to participate in the Program at the retiree self-contribution rate until or unless such participation, from the date of commencement, exceeds five years. Spouse participation then requires self-contribution at the Program's cost based rates. If the

retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate in the Program as an "extended retiree spouse" at the retiree's contribution rate, unless or until the later of a) five years from the date that the retiree's Program coverage began or b) until the date the retiree would have attained age 65, after which, for so long as she remains eligible, the spouse may continue to participate at the Program's cost based rate.

Retiree Medical Program Eligibility Ceases Upon Medicare Part A Eligibility

Eligibility for Retiree Medical Program coverage ceases once eligibility for Medicare Part A coverage commences. This rule applies separately to the retiree and the retiree's spouse. In addition to turning age 65, Medicare coverage is provided automatically following 24 months of Social Security disability benefits. Please notify us of the effective date of your approval for Social Security disability benefits so that we can mark ahead, accordingly. Medicare coverage is provided automatically the first month that Social Security disability benefits begin in the case of Amyotrophic Lateral Sclerosis; please notify us immediately. MCTWF will seek recovery directly from the retiree and spouse for whom Retiree Medical Program benefits have been paid as the result of their failure to provide MCTWF with advance notification of their Medicare eligibility.

OTC Allegra® and OTC Allegra-D® Now Available

Non-sedating antihistamines Allegra® and Allegra-D® became available without a prescription ("over-the-counter" or OTC) on March 4, 2011. OTC non-sedating antihistamines are excluded from coverage under the MCTWF prescription drug benefit (as are prescription non-sedating antihistamines unless certain criteria are satisfied through a prior authorization process, as detailed in your Summary Plan Description Booklet).

Thus, in light of the over-the-counter availability of Allegra® (fexofenadine) and Allegra-D® (fexofenadine pseudoephedrine extended release), MCTWF will cease covering the cost of refills or new prescription fills for those drugs after March 31, 2011. Those participants and their dependents that have a current authorization beyond March 31, 2011 have been notified and, effective as of March 4, 2011 no new authorizations for these two drugs are being granted.



Chiropractic Services Benefit

As stated in your Schedule of Benefits, chiropractic expenses are subject to a \$1,000 per person annual benefit limit for in-network and out-of-network services.

Effective April 1, 2011, the annual per person dollar limit is eliminated and the following chiropractic benefits apply:

- 24 spinal manipulation services, per person, annually;
- one mechanical traction service per day and only when performed with a spinal manipulation;
- one "new patient" office visit every 36 months, per chiropractor;
- one "established patient" office visit per calendar year, per chiropractor (but not in the same calendar year as a "new patient" office visit with the same chiropractor); and
- diagnostic X-rays.

Please refer to your Schedule of Benefits for coverage levels and section 3.20 of your Summary Plan Description Booklet for other information regarding your chiropractic services benefit.



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

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The *Messenger* notifies you of changes to your plan of benefits. Please retain all issues of the *Messenger*, along with your SPD booklet and other plan materials, for future reference.

MICHIGAN CONFERENCE OF
TEAMSTERS WELFARE FUND

2700 TRUMBULL AVE.
DETROIT, MICHIGAN 48216
313-964-2400
TOLL FREE 800-572-7687



MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND

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

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

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The Board of Trustees of the Michigan Conference of Teamsters Welfare Fund

Gathered above from left to right are -
Howard McDougall, Bob Rayes, Earl Ishbia, Ray Buratto, Bill Bernard, Bob Jones, Dennis Hands, and Bud Hillard



Spring 2011

If you are married please be sure to share this communication with your spouse.