



Message from MCTWF's Executive Director

Dear Teamster Families;

As it seems inevitably to be the case, painful economic periods give rise to demagogues who target a group to blame and demonize and then ride to power on the shoulders of the angry, frightened masses whose prejudices they've deceitfully inflamed. Such has been the case in Michigan where, for the past couple of years, the majority of its elected representatives have relentlessly persecuted Michigan's labor unions, which for the better part of a century have made possible a decent life for millions and who, in turn, have helped create incalculable prosperity throughout this State for workers and businesses alike. Now, stoked by extremist money and dripping with self-righteousness and contempt, Lansing has punitively imposed upon this State a "right-to-work" law, designed to cripple Michigan's labor unions as a powerful force against political and workplace tyranny. The strategy is based on the cynical assumption that a material percentage of union members are unprincipled and short-sighted and, given the opportunity, will turn their back on their fellow workers and local unions to avoid the cost of membership. I think that our Lansing legislators will come to regret their arrogance and disrespect for the people of Michigan.

This issue of the *Messenger* contains several important, broadly affecting notifications. MCTWF's mental health and substance use disorder network of providers is changing from ValueOptions to Blue Cross Blue Shield PPO effective April 1, 2013; provision has been made to reduce, and hopefully eliminate, any out-of-pocket exposure for those who seek to transition to a BCBS PPO provider, but we encourage you to confer with our Customer Communications representatives. Those who were recently receiving authorized outpatient services have been notified directly. Also effective April 1st, MCTWF will become compliant with the Mental Health Parity and Addiction Equity Act and therefore treatment limitations and copays and coinsurance charges will be equalized with other medical benefits. Also, Applied Behavior Analysis services are now covered, in accordance with stated rules, for those diagnosed with Autism Spectrum Disorder. You also will note that - excessive emergency room utilization will be subject to greater scrutiny for medical necessity, participants with medical coverage but without accident and sickness coverage will have expanded coverage during their non-occupational, non-auto related disabilities starting April 2013 through March 2016, and glucose monitoring supplies are now covered as a prescription drug benefit as well as a medical benefit, although caution is advised because your cost may be higher through the pharmacy. Also, please review the newly adopted CVS Caremark programs, particularly the Specialty Preferred Drug Program and the "Dispense as Written" rule. You will also find other important notices and MCTWF's Summary Annual Report for the plan year ended March 31, 2012 reflecting a financially stable and healthy Fund.

We welcome all of our new participants and family members enrolled since our last *Messenger* publication, including the following groups: under Gary **Local 142** – School City of East Chicago; under Detroit **Local 214** (Traverse City Office) – Mason County Road Commission; under Detroit **Local 337** – Aramark; under Grand Rapids **Local 406** – Edge Industries; under Omaha **Local 554** – Saunders County; and under Lansing **Local 580** - Village of Fowlerville. Please do not hesitate to contact our Customer Communications representatives with your questions and comments.

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

Richard Burker

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Editor's Note:

For simplicity, unless otherwise stated, the *Messenger* uses the masculine pronoun form to refer to a participant or child and the feminine pronoun form to refer to a spouse.

Dependent Children and Spouses

For the purpose of determining eligibility under the MCTWF's plans of benefits, the Summary Plan Description (subject to additional criteria) defines a dependent as including a participant's children and spouse. In order to conform to the definition of "dependents" under the Affordable Care Act, as recently determined by the U.S. Department of the Treasury, which limits "dependents" to children age 26 and below, MCTWF has removed the spouse from its definition of "dependent" and hereafter will refer separately to a participant's covered dependents and spouse, or together as the participant's "beneficiaries."

Provider Networks Change For Mental Health and Substance Use Disorder Benefits



Effective April 1, 2013, Blue Cross Blue Shield's PPO nationwide provider network will replace ValueOptions as MCTWF's mental health and substance use disorder provider network.

With this network change, outpatient services will no longer require prior authorization. However, providers must continue to receive prior authorization for inpatient services (including admissions and services for programs administered in connection with inpatient hospitalizations for mental health treatment, with partial hospitalizations for mental health treatment, with inpatient residential treatment for substance use disorder treatment) by contacting Blue Cross Blue Shield at 800-762-2382, Monday through Friday 8:30 a.m. to 11:30 a.m. and 12:30 p.m. to 5:00 p.m.

To determine whether a mental health or substance use disorder provider participates in the Blue Cross Blue Shield PPO network, you can link to the Blue Cross Blue Shield PPO provider search available on the *Provider Networks* page of MCTWF's website at www.mctwf.org and click on the Blue Cross Blue Shield Michigan or non-Michigan Physician, Hospital and Facilities search, or you can contact MCTWF's Customer Communications Department at 800-572-7687. For referrals after business hours, please contact Blue Cross Blue Shield at 800-810-BLUE (2583).

While the Blue Cross Blue Shield PPO network is extensive, not all ValueOptions outpatient network pro-

viders participate in it. To help facilitate the transition for those who are receiving ongoing authorized outpatient services after March 31, 2013 from a ValueOptions provider who does not participate in the Blue Cross Blue Shield PPO network, MCTWF will treat such services as "in-network" for patient copay or coinsurance purposes, until the earlier of July 1, 2013 or the exhaustion of the ValueOptions authorization. Please note, however, that you may be subject to balance billing if your ValueOptions provider does not accept MCTWF's new "in-network" reimbursement amount (plus your copay or coinsurance amount) as payment in full. Accordingly, should you seek outpatient services between now and April 1, 2013, we encourage you to select a provider who participates in both the ValueOptions and Blue Cross Blue Shield PPO networks. We have sent letters with the foregoing information to all individuals whom we believe to be receiving outpatient services currently. Copay/coinsurance amounts will remain at the "in-network" level for all authorized inpatient services rendered by ValueOptions providers and the patient will have no exposure to balance billing.

In mid to late March, you will receive in separate mailings new BCBS ID Cards and MCTWF Network cards, which will provide the appropriate billing and prior authorization information needed for mental health and substance use disorder services. Your BCBS ID Card should be presented when utilizing any provider for mental health or substance use disorder services on or after April 1, 2013.

Compliance with Mental Health Parity and Addiction Equity Act

Effective April 1, 2013 in accordance with the Mental Health Parity and Addiction Equity Act, mental health and substance use disorders must be covered with treatment limitations that are no more restrictive and at levels that are no lower than that would be the case for other medical benefits offered by a healthcare plan. Accordingly, all MCTWF Plan mental health and substance use disorder benefits outpatient and inpatient visit limits and all inpatient day limits will be eliminated. And with regard to coverage level for all Plans –

- For inpatient hospital services - coverage level is unchanged whether in-network or out-of-network.
- For inpatient professional visits - coverage level is unchanged if in-network; is changed to the medical benefit level if out-of-network (for example, coverage is increased from 50% of Maximum Allowable Benefits to 60%; or, in other words, coinsurance charges are reduced from 50% to 40%).
- For outpatient professional visits - coverage level is changed to the medical benefit level. All outpatient professional visits will be considered as primary care for copay determinations.

Applied Behavior Analysis Coverage

Effective October 30, 2012, eligible MCTWF participants and beneficiaries diagnosed with an autism spectrum disorder are covered by their medical benefits for applied behavior analysis services under certain conditions.

Autism spectrum disorders are neurobiological conditions which include Autistic disorder, Asperger's disorder and other pervasive developmental disorders. While MCTWF had covered a range of services to treat autism spectrum disorders, including physical, speech and occupational therapy, nutritional counseling and other mental health services, it had not covered applied behavior analysis to diagnose and treat autism spectrum disorders. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to provide significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

The conditions which must be satisfied for coverage of applied behavior analysis services for those diagnosed with autism spectrum disorder are -

- Confirmation of the autism spectrum disorder diagnosis by a Blue Cross Blue Shield of Michigan approved autism evaluation center. A list of approved autism evaluation centers can be found on the *Info Links* page of MCTWF's website at www.mctwf.org;
- The provision by an approved autism evaluation center of a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for applied behavior analysis services; and
- The applied behavior analysis is provided by a board certified behavior analyst, subject to prior authorization. A list of applied behavior analysts can be found on the *Info Links* page of MCTWF's website at www.mctwf.org.

Applied Behavior Analysis services are subject to the following annual limits based on the patient's age on January 1st of each year:

- \$50,000 through age 6
- \$40,000 through age 12
- \$30,000 through age 18

Appropriate Use of Emergency Room

Emergency room utilization by MCTWF participants and beneficiaries is about 50% higher than the average utilization throughout the country as reported to MCTWF by its benefits consulting firm, Towers Watson. Emergency room services are far more expensive than comparable services rendered in a physician's office or urgent care facility and should be used only when the need for emergency services is real and otherwise unavailable. MCTWF's extraordinary emergency room claim experience is not only driven by occasional indiscriminate usage by many participants and beneficiaries, but in large part by chronic users; mostly about a half dozen times per year and some with several dozen emergency room visits per year.

Accordingly, as a first step in curbing inappropriate usage, MCTWF's Medical Director is carefully reviewing for medical necessity all emergency room claims incurred by individuals in excess of three per 12 month period. If the use of the emergency room is determined to not have been medically necessary, the individual will bear the full cost of the billed services.

All participants and beneficiaries are urged to consider whether their medical condition warrants emergency room attention (please consult your Summary Plan Description booklet), or whether it can be addressed appropriately by their physician or by a local urgent care facility.



Short-Term Disabilities

Participants who suffer a non-occupational, or non-auto related accident or sickness, and who otherwise meet MCTWF's requirements, are entitled to ongoing coverage for themselves and their beneficiaries in accordance with the terms of their medical plan of benefits. The duration of such ongoing full plan coverage may be only for the period of additional employer contributions required by the participant's collective bargaining agreement (but, in accordance with MCTWF's rules, not less than four weeks) or, if their benefit plan includes Weekly Accident & Sickness benefits, then up to a maximum of 26 weeks of disability.

MCTWF's Trustees have resolved that for non-occupational and non-auto related disabilities that commenced (in accordance with MCTWF's rules) on or after April 1, 2013 and through April 2, 2016, full plan coverage will continue for the period of the disability, not to exceed 26 weeks, regardless of whether the participant's plan provides for Weekly Accident & Sickness benefits. Thereafter, such ongoing full plan coverage beyond the period of additional employer contribution, up to a maximum duration of 26 weeks of disability, will be limited to participants whose plan includes Weekly Accident & Sickness benefits.

New CVS Caremark Programs

In an effort to assist participants in improving their health and safety as well as reducing costs, the following CVS Caremark programs were implemented as part of MCTWF's prescription drug program for prescriptions filled on or after January 1, 2013:

Specialty Preferred Drug Program

If you are newly prescribed a "non-preferred" specialty medication for certain autoimmune diseases (rheumatoid arthritis, crohn's disease or psoriasis) or for multiple sclerosis, the program requires that you be treated with the most common clinically effective medication. If you are not effectively treated with that medication, you will be provided authorization for use of a "non-preferred" medication. This process is referred to as "step therapy." If you were being continuously treated for any of these diseases prior to January 1, 2013 you will not be subject to this Program.

Specialty medications are sent to you by mail. If you go to a retail pharmacy, the pharmacist will ask you to contact CVS Caremark at 800-237-2767 to initiate the direct relationship with Specialty Pharmacy Services. CVS Caremark will communicate directly with your prescribing physician regarding your treatment plan.

Pharmacy Advisor Support Program

If you are taking medications for any of the following chronic conditions and you do not refill your prescription timely, the Pharmacy Advisor Program will reach out to you in writing, by telephone, or face-to-face through your CVS pharmacist to remind you to refill your prescription and, in certain cases, provide disease treatment counseling:

Benign prostatic hypertrophy (BPH)
Coronary artery disease/ischemic heart disease
Diabetes
Heart failure
High Cholesterol
Hypertension

Osteoporosis
Parkinson's disease
Respiratory diseases
Rheumatoid arthritis

The goal of the Program is to drive favorable behavior changes in the short term and improve clinical outcomes over the longer term by encouraging adherence with your physician's prescribed drug treatment of your chronic condition .



"Dispense as Written" Rule

MCTWF encourages the use of generic drugs by covering them at much lower patient cost than it does for brand name drugs. A generic drug must have the same active ingredients as its brand name counterpart and are considered by the U.S. Food and Drug Administration identical in dose, strength, route of administration, safety, efficacy, and intended use.

If a generic version of your prescribed brand name drug is available, your MCTWF prescription drug benefit plan only will cover the generic version, regardless of whether your physician instructs the pharmacy to "Dispense [the brand name drug] as Written" ("DAW"). If you insist on receiving the prescribed brand name drug, you will be responsible for payment of the difference in the applicable charges (the "allowed amounts") between the generic and brand name drug and for payment of the generic copay or coinsurance amount.

The only exception to this rule is if, through a prior authorization request, your physician presents to CVS Caremark, or, where applicable, to MCTWF, adequate evidence of medical necessity for use of the brand name drug. In such case, you will be responsible only for the payment of the brand name drug copay or coinsurance amount.

Glucose Monitoring Supplies Now Also Covered As a Prescription Drug Benefit

For those who are covered under a MCTWF medical plan, the purchase of glucose monitoring supplies have been covered solely as "Medical Supplies" benefits for lancets and test strips and as "Durable Medical Equipment" benefits for glucose meters (so long as they are prescribed and certified as medically necessary by a licensed physician and obtained from a provider whom Blue Cross Blue Shield has certified as a medical supply or durable medical equipment provider).

Effective February 1, 2013 you also may obtain your prescribed lancets, test strips and glucose meter from any participating in-network pharmacy, at your Plan's brand copay or coinsurance level. *Accu-Chek* and *One Touch* test strips and lancets are the preferred brand products and do not require prior authorization. Freestyle test strips do require prior authorization.



You also may be qualified to receive a free *OneTouch* or *Accu-Chek* glucose meter through the CVS Caremark mail service program. To qualify, your prescription must state that you are diabetic and it must provide for a 90-day supply of *OneTouch* or *Accu-Chek* test strips (or you must inform CVS Caremark mail service pharmacy that you wish to switch to *One Touch* or *Accu-Chek*) and you must not have received a free meter through the program within the last 365 days. To see if you qualify, you can contact CVS Caremark toll-free at 1-800-588-4456 .

Retiree Medical Program Rates: April 2013 - March 2014

Effective April 2013, the monthly self-contribution rates listed below apply to all those participating in MCTWF's basic Retiree Medical Program, Plan 145. For those purchasing Plan 475, which includes the Retiree Supplemental Benefits Rider (MCTWF's hearing, vision, and Dental Plan 2 benefits), add \$128.50 to the following Plan 145 monthly rates:

April 2013 Plan 145 Monthly Self-Contribution Rate (Covers Both the Retiree and the Eligible Spouse)*						
<i>Years Participating in MCTWF under a Plan with Retiree Medical Program Coverage</i>						
Age at MCTWF Retirement Date	5 – 9	10 – 14	15 – 19	20 – 24	25 – 29	30 +
50 – 54	\$750	\$680	\$615	\$550	\$470	\$415
55 – 59	\$575	\$535	\$495	\$450	\$420	\$385
60 – 64	\$415	\$400	\$385	\$365	\$355	\$345
For eligible retirees whose active employment ceased prior to January 1, 2002: <u>\$345</u>						

To drop the Retiree Supplemental Benefits Rider you must have been covered by it for a minimum of 12 months and you must notify MCTWF in writing 45 days prior to the calendar month for which the Rider coverage is to terminate. For example, to drop coverage as of January 1st, MCTWF must receive written notification by November 15th. Once the Retiree Supplemental Benefits Rider is dropped, it will not be available to you again.

* 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 eight 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 at the retiree's contribution rate, unless or until the later of a) eight 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 as an "Extended Retiree Spouse."

Reminder Retiree Eligibility Ceases Upon Medicare Eligibility

In addition to the other causal events stated in your Summary Plan Description, Retiree Medical Program (Program) participation and benefits entitlement cease as of the earlier of a) the first of the month in which the participant's (i.e., the retiree's or spouse's) 65th birthday falls or b) the date that the participant becomes eligible for early Medicare Part A coverage.

If you are a retiree or a retiree's spouse, it is imperative that you immediately call to inform MCTWF of your early Medicare eligibility date and that you cease the use of Program benefits. MCTWF then will ask you for a copy of your Medicare card or letter from the Social Security Administration stating your effective eligibility date. MCTWF will pursue recovery from you for any Program benefits paid for services incurred on or after your Medicare eligibility date.



Reminder Retiree Medical Program Self-Contributions Must be Paid on Time

For those who participate in the Retiree Medical Program, timely receipt of your monthly self-contributions is essential to preserve your right to participate. The fact that you did not receive MCTWF's invoice and payment coupon does not relieve you of that responsibility. Coverage will terminate if your self-contributions are not received when due.

Self-contributions are due on or before the 20th day of the month preceding the month of coverage. Participants who have not made payment by the last business day of the month for which a payment is due will be sent a late notice for contributions due as well as for a \$50 late fee. If the required payments (monthly contribution plus \$50 late fee) are not received by the 15th of the following month, coverage will be terminated and cannot be reinstated.

MCTWF encourages you to take advantage of Automated Clearing House (ACH) electronic funds transfers in which, with your authorization, monthly self-contributions are automatically withdrawn from your checking or savings account on the date the payment is due, thereby eliminating the monthly concern about making timely payment. To begin the ACH transfer process, complete the authorization form (which can be obtained by contacting MCTWF's Retiree Department), include a voided check (for identification of your checking account) or a deposit slip (for identification of your savings account), and return it to MCTWF's Retiree Department.

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

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This calendar year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least \$2 million.

Your health coverage, offered by the Michigan Conference of Teamsters Welfare Fund's Retiree Medical Program Plans 145 and 475 and Freight Industry "Daily Rate" Mini-Med Plan 330, do not meet the minimum standards required by the Affordable Care Act described above. Your Retiree Medical Program Plans' coverage have annual limits of \$220,000 on all covered medical benefits and your Mini-Med Plan has an annual limit of \$100,000.

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around \$1,853 per day. At this cost, under your Retiree Medical Program Plans 145 and 475, your insurance would only pay for 119 days, and under your Freight Industry "Daily Rate" Mini-Med Plan 330, your insurance would only pay for 54 days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the require-

ment to provide coverage for certain key benefits of at least \$2 million this calendar year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until March 31, 2014.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Michigan Conference of Teamsters Welfare Fund Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. In addition, you can contact the Michigan Health Insurance Consumer Assistance Program (HICAP) 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> (website)

OFIR-HICAP@michigan.gov (email)

Summary Annual Report for Participants

Michigan Conference of Teamsters Welfare Fund

Plan Year Ended March 31, 2012

This is a summary of the annual report of Michigan Conference of Teamsters Welfare Fund (hereafter the Plan), EIN 38-1328578 for the plan year ended March 31, 2012. The annual report has been filed with the Employee Benefits Security Administration of the U.S. Department of Labor as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The plan provides health, dental, optical, prescription drug, short and long term disability, and death benefits for its participants.

BASIC FINANCIAL STATEMENT

The value of plan assets, after subtracting liabilities of the Plan was \$274,820,839 as of March 31, 2012 compared to \$265,307,226 as of April 1, 2011. During the plan year, the Plan's net assets increased by \$9,513,613. This increase includes unrealized depreciation in the value of plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the Plan had total income of \$206,320,314 including, but not limited to, employer contributions of \$188,743,422, participant contributions of \$8,098,295, other contributions of \$3,255,688, realized losses of \$3,607,421 from the sale of assets, earnings from investments of \$9,812,867, and rental and other income of \$17,463.

Plan expenses were \$196,806,701. These expenses included \$184,243,285 in benefits paid on behalf of participants and beneficiaries and \$12,563,416 in administrative expenses.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full, annual report, or any part thereof, on request. The items below are included in that report:

- an accountant's report
- financial information and information on payments to service providers
- assets held for investment
- transactions in excess of five percent of plan assets
- Insurance information, including sales commissions paid by insurance carriers information regarding any common or collective trusts, pooled separate accounts, master trusts, or 103-12 investment entities in which the plan participates

TO OBTAIN ADDITIONAL INFORMATION

To obtain a copy of the full annual report, or any part thereof, your request should be addressed to: Executive Director, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, Michigan, 48216-1269. The charge to cover copying costs will be \$.15 per page. You also have the right to receive, at no charge, the annual report's statement of assets and liabilities and accompanying notes or a statement of income and expenses and accompanying notes, or both. If you request a copy of the full annual report, these two statements and accompanying notes will be included, at no cost, as part of that report.

You will also have the legally protected right to examine the annual report at the offices of the Michigan Conference of Teamsters Welfare Fund in Detroit, Michigan and at the U.S. Department of Labor in Washington D.C. To obtain a copy from the U.S. Department of Labor, your request should be addressed to:

Public Disclosure Room N 1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

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

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“Grandfathered” Status Under The Affordable Care Act

Please be advised that this group health plan, the Michigan Conference of Teamsters Welfare Fund (MCTWF), believes that all current MCTWF medical plans not designated as “New SOA”, “New Key”*, “New I&S” or “New PEP” are “grandfathered plans” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act for example, the elimination of lifetime limits on benefits.

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.

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

Spring 2013